PHYSICIAN'S BULLETIN

September 22, 2021: Vol. LXVI, ISSUE 13

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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PREAMBLE CHANGE

Effective September 17, 2021 the rate for detention time is increased:

Current Definition	New Definition
Detention Time (5.1.75) …This may include time spent with the patient travelling from one location to another. However, travel time to transport donor organs from a donor site to the recipient site for transplantation begins at the time the retrieving surgeon accompanied by the donor organs leave the donor site. Where any service is performed during the time spent with the patient, either the service or the detention time, but not both, should be claimed. The circumstances in each case, and the time involved, should be documented with the service encounter. *(5.1.77)* The fee for detention is 12.5 units per 15 minutes. The detention modifier RO=DETE must be indicated on the service encounter. *(5.1.78)…*	**Detention Time (5.1.75)** **…**This may include time spent with the patient travelling from one location to another. However, travel time to transport donor organs from a donor **facility** to the recipient **facility** for transplantation begins at the time the retrieving surgeon accompanied by the donor organs leave the donor **facility**. Where any service is performed during the time spent with the patient, either the service or the detention time, but not both, should be claimed. The circumstances in each case, and the time involved, should be documented with the service encounter. *(5.1.77)* The fee for detention is **15 units per 15 minutes for general practitioners and 17.5 units per 15 minutes for specialists**. The detention modifier RO=DETE must be indicated on the service encounter. *(5.1.78)…*

FEE REVISION

Effective September 17, 2021 the following health service code value has been updated:

Category	Code	Description	Base Units
ADON	87.98A	**Detention During Obstetrical Delivery (for attendance beyond three hours) RO=DETE** **Description** Detention time for obstetrical delivery performed by a family physician when the physician is required to be in attendance beyond three hours, notwithstanding clause 5.2.75 *(see below)* of the Physicians Manual (2014). Each 15-minute time increment beyond three hours has a rate of **15** MSU to a maximum of 8 hours. **Billing Guidelines** May only be claimed as an add-on for HSC 87.98 Delivery NEC. 1 multiple = 3 hours with patient 2 multiples = 3 hours, 15 minutes 3 multiples = 3.5 hours 4 multiples = 3.75 hours 5 multiples = 4 hours etc. to a maximum of: 21 multiples = 8 hours **Specialty Restriction** SP=GENP {ATTENDANCE AT LABOUR AND DELIVERY *(5.2.75)}* This is a service involving constant or periodic attendance on a patient during the period of labour to provide all aspects of care. This includes the initial assessment, and such subsequent assessment as may be indicated, including ongoing monitoring of the patient's condition. Obstetrical delivery covers services rendered during delivery, including medical or surgical inductions by the attending physician, suturing of minor lacerations, hypnosis, detention time during labour, local or regional anesthesia and manual removal of placenta by the attending physician, and all obstetrical manoeuvers that may be required, e.g. use of forceps.}	**15** MSU per 15 minutes

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PREAMBLE CHANGES

Current Definition	New Definition
Prolonged Consultation A prolonged consultation may be claimed only by the following specialties: a) Anesthesia 15 units per 15 minutes b) Internal Medicine 13.5 units per 15 minutes c) Neurology 13.5 units per 15 minutes d) Physical Medicine 13.5 units per 15 minutes e) Paediatrics 16.3 units per 15 minutes f) Psychiatry 18.22 units per 15 minutes g) Obstetrics and Gynaecology 13.5 units per 15 minutes h) Palliative Care 15.5 units per 15 minutes *(5.1.105)*	**Prolonged Consultation** A prolonged consultation may be claimed only by the following specialties: a) Anesthesia 15 units per 15 minutes b) Internal Medicine 13.5 units per 15 minutes c) Neurology 13.5 units per 15 minutes d) Physical Medicine 13.5 units per 15 minutes e) Paediatrics 16.3 units per 15 minutes f) Obstetrics and Gynaecology 13.5 units per 15 minutes g) Palliative Care 15.5 units per 15 minutes *(5.1.105)*
Psychiatric Care (5.2.122) Psychiatric care is any form of assessment or treatment by a psychiatrist on the register of specialists of the Province of Nova Scotia, in which there is consideration and attempted alteration of the patient's biopsychosocial functioning. *(5.2.123)*	**Psychiatric Care (5.2.122)** Psychiatric care is any form of assessment or treatment by a psychiatrist on the register of specialists of the Province of Nova Scotia, in which there is consideration and attempted alteration of the patient's biopsychosocial functioning. **When psychiatric care extends beyond six months, the psychiatrist must document the rationale for continued specialist care in the patient's health record, and in a brief written report to the patient's primary care provider at least every six months.** *(5.2.123)*
Therapeutic/Diagnostic Interview (5.1.126) This service relates to a specific child and may take place with allied health professionals, education, correction, or other community resources. This applies to interviews by psychiatrists but does not preclude resident involvement. *(5.2.127)*	**Therapeutic/Diagnostic Interview (5.2.126)** This service relates to a specific child and may take place with **parents and/or caregivers,** allied health professionals, education, correction, or other community resources. This applies to interviews by psychiatrists but does not preclude resident involvement. *(5.2.127)*

FEE REVISION

Category	Code	Description	Base Units
PSYC	08.19B	Therapeutic/diagnostic interview - relating to a child with **parents and/or caregivers,** allied health professionals, education, correction, and other community resources **Specialty Restriction** SP=PSYC	44.44 MSU 22.22 units per 15 min. thereafter

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NEW FEE

Effective September 17, 2021 the following health service code is available for billing:

Category	Code	Description	Base Units
CONS	03.08A	**Extended Comprehensive Psychiatry Consultation - When direct physician to patient time exceeds 60 minutes**	132.19 MSU + MU

Description
The extended comprehensive psychiatry consultation follows all of the preamble rules pertaining to comprehensive visits and consultations. After the initial 60 minutes of direct physician to patient time, the psychiatrist must spend at least 80% of the time in direct physician to patient contact (in person or synchronous PHIA compliant virtual care platform).

Multiples may be claimed after 75 minutes and are calculated in 15-minute intervals, or portion thereof. 80% of the time must be in direct physician to patient contact (in person or synchronous PHIA compliant virtual care platform). Multiples will be paid at ¼ of the current negotiated MSU value for the 03.08 psychiatry comprehensive consultation. If service time extends beyond 180 minutes, the claim must be submitted for manual assessment with clinical documentation.

Billing Guidelines
- Start and stop times must be recorded in the health record.
- Direct physician to patient time must be 61 minutes or greater.
- Consultations of 60 minutes or less to be reported as 03.08 at the current rate.
- No other services may be claimed for the same patient during that time period.
- If clinical service exceeds maximum time of 9 multiples (180 minutes) submit as EC for manual assessment with clinical documentation and electronic text.

Multiples
MU per 15 minutes, or portion thereof beyond 75 minutes.
Maximum 9MU (total service time 180 minutes)

Multiples	Time Claimed	Time Spent with Patient
1 multiple	61 minutes	61-71 minutes
2 multiples	75 minutes	72-86 minutes
3 multiples	90 minutes	87-101 minutes
4 multiples	105 minutes	102-116 minutes
5 multiples	120 minutes	117-131 minutes
6 multiples	135 minutes	132-146 minutes
7 multiples	150 minutes	147-161 minutes
8 multiples	165 minutes	162-176 minutes
to a maximum of:		
9 multiples	180 minutes	177-180 minutes

Specialty Restriction:
SP=PSYC

Location:
LO=OFFC, LO=HOSP

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Billing Matters Billing Reminders, Updates, New Explanatory Codes

Expanded eligibility for High-Dose Influenza Vaccine during 2021/22 flu season

Initially expanded in fall 2020, the high-dose influenza vaccine 13.59L RO=HDIN will again be available to patients equal to or greater than 65 years of age who are also hospitalized and designated alternate level of care awaiting long-term care facility placement. This extended eligibility will expire once the 2021/22 influenza season ends.

Services provided by non-physicians

Physicians are reminded that services provided by non-physicians, including nurses, nurse practitioners and other groups are not insured by MSI. The only exception to this is that community-based family physicians who directly employ a nurse may claim for the following procedures done by the nurse, provided the physician is physically on the premises: Paps, provincial immunizations and other simple injections. If the nurse is not employed by the physician, such as in instances in which the nurse is an employee of Nova Scotia Health or the IWK, no services rendered by the nurse may be claimed by the physician. Other services, including but not limited to, procedures, visit services, and counselling services may not be claimed by a physician when they are rendered by non-physicians.

Physicians are reminded they may not claim for injections, immunizations and other services provided by pharmacists.

2021 Holiday Dates

Physicians are advised that September 30, 2021, National Day for Truth and Reconciliation is considered as a recognized holiday by MSI with respect to billing. Physicians may claim the holiday premium rate for certain services provided on an emergency basis. An emergency basis is defined as services that must be performed without delay because of the medical condition of the patient (Preamble 5.1.81). If a physician chooses to provide routine, scheduled services during a statutory holiday, they are not entitled to payment at the holiday rate.

The designated times where premium fees may be claimed and the payment rates are: (5.1.84)

Time Period	Time	Payment Rate
Monday to Friday	17:00 – 23:59	US = PREM (35 percent)
Tuesday to Saturday	00:00 – 07:59	US = PR50 (50 percent)
Saturday	08:00 – 16:59	US = PREM (35 percent)
Saturday to Monday	17:00 – 07:59	US = PR50 (50 percent)
Recognized Holidays	08:00 – 23:59	US = PR50 (50 percent)

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday September 17th, 2021. The files to download are:
Health Service (SERVICES.DAT), and Health Service Description (SERV_DSC.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
www.novascotia.ca/dhw/

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NOVA SCOTIA MEDICAL SERVICES INSURANCE

Provision of Publicly Funded Virtual Health Services

The policy for publicly funded virtual health services has been published on the NS Department of Health and Wellness website. This policy applies to all publicly funded services funded by the Department of Health and Wellness (DHW), the Nova Scotia Health Authority (NSHA), and the IWK Health Centre (IWK) as they exercise their interdependent statutory mandates, as outlined under the Public Service Act, the Health Services Insurance Act, and the Health Authorities Act.

Virtual Health Care

Virtual health care is defined in the policy to be any interactions between patients and/or members of their circle of care, occurring remotely, using synchronous or asynchronous forms of communication.

Synchronous methods of virtual care (e.g., real-time telephone or *Personal Health Information Act* (PHIA, 2010) compliant video platforms such as Telehealth or Zoom for Healthcare) are permitted for the use and billing in accordance with the policy. Asynchronous methods of virtual care, such as secure messaging through an Electronic Medical Record (EMR) are permitted for use in accordance with the policy. However, asynchronous methods of virtual care are not approved for billing within Nova Scotia at this time.

The full policy can be accessed here:
https://novascotia.ca/dhw/publications/Provision-of-Publicly-Funded-Virtual-Health-Services.pdf

Please read the policy carefully- Appendix 2 includes some provisions specific to physicians providing virtual services. While this policy has been in effect since March 2021, physician adherence to this policy is effective September 16, 2021.

PHYSICIAN'S BULLETIN
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NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

MSI DOCUMENTATION REMINDER

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribed, and start and stop times for time based codes.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptation's, or emotional problems, the physician "deliberately established a professional relationship with the patient for the purposes of removing, modifying or alleviating existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional wellbeing of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy," etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule. Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim. Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service on that date, then the service is not paid for or a lesser benefit is given. When the clinical record does not support the service claimed, there may be a recovery to MSI at the time of audit. Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

NEW INTERIM FEE

The following interim fee is effective July 23, 2021:

Category	Code	Description	Base Units	Anaes Units
VEDT	47.25C	**Transcutaneous Aortic Valve Implantation (TAVI)** **First Physician (RO=FPHN)** **Second Physician (RO=SPHN)**	 611 MSU 611 MSU	15+T

Description
This comprehensive health service code includes all physician work required to perform a transcutaneous aortic valve implantation. This work includes, when performed percutaneous and/or open arterial cardiac access, placement of any sheath required, balloon aortic valvuloplasty, delivery, deployment and placement of the valve, temporary pacemaker insertion and closure of access sites. All means used to guide the procedure such as contrast injections, angiography, fluoroscopy, right and left cardiac catheterization, supravalvular aortography, aortic and left ventricular outflow tract measurements are included such that any radiological supervision and interpretation should not be reported or claimed.

Billing Guidelines
Do not report with the following same patient same day:

- 47.03 - Closed heart valvotomy, aortic valve
- 47.25 - Other replacement of aortic valve
- 47.52A - Closure of arterial septal defect
- 49.73 - Implantation of endocardial electrodes
- 50.82 - Aortography
- 50.82C - Aortic arch study
- 50.91 - Arterial catheterization
- 50.99C - Femoral vein puncture
- 51.61B - Off pump coronary artery bypass surgery

Do not report with:
R1071 - Aortic root (cardiac)

Specialty Restriction:
SP=CASG, SP=CARD, SP=GNSG

Location:
LO=HOSP (QEII only)

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NEW AND UPDATED EXPLANATORY CODES

Code	Description
VE033	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED A SEPARATE FEE FOR A PORTION OF THIS SERVICE ON THE SAME DATE.
VE034	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED THE COMPREHENSIVE TRANSCUTANEOUS AORTIC VALVE IMPLANTATION (TAVI) FEE FOR THIS PATIENT ON THIS DAY.
VE035	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THIS INTERPRETATION IS INCLUDED IN THE COMPREHENSIVE FEE FOR TRANSCUTANEOUS AORTIC VALVE IMPLANTATION PERFORMED ON THAT DATE.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday July 23rd, 2021. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

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July 2, 2021: Vol. LXVI, ISSUE 10

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

FACILITY ON-CALL, PMC, CHIP – TRANSITION TO ELECTRONIC BILLING

Effective July 1, 2021 Facility On-Call payments are transitioning to electronic billing and will be made directly by MSI to physicians as Fee-for-Service (FFS) claims. All other components of the program (i.e., established rotas, eligibility or rates) remain unchanged.

New health service codes (i.e., fee codes) have been established for each existing rota. As of July 1, physicians will submit their Facility On-Call claims directly to MSI. All shifts will be directly paid to the on-call physicians through either an individual or group FFS Business Arrangement (BA). If you do not have a FFS BA, please contact MSI at 902-496-7011 (HRM local), 1-866-553-0585 (toll free) or msiproviders@medavie.bluecross.ca.

Physicians will continue to be paid per the categories as specified in the Nova Scotia Facility On-Call Program Guidelines. Categories of the Program are based on different levels of service and apply to physicians providing on-call services in approved regional and tertiary hospitals and/or participating Community Hospital Inpatient Program (CHIP) and Primary Maternity Care (PMC) program sites.

Where rotas have organized themselves to share in the call payments for any given shift(s), the following options exist:

1. Physicians share a call shift equally:
   - Use the 50% modifier when billing; both physicians would claim the Facility On-Call fee and use the modifier PO=HALF.
2. Multiple physicians regularly share in the daily call stipend:
   - Using a group BA; the most responsible physician would claim the stipend for the shift. MSI will make the payment to the group bank account. It is left to the group administrator to disburse funding to the participating physicians.

When submitting claims for Facility On-Call:

- Use the generic health card number **0000002352**, date of birth **April 1, 1969** and diagnostic code **V689** for billing purposes.
- Use the **service date that aligns with the beginning time of the shift covered** (for both normal coverage and call-backs). For a weekday coverage running from 1700 to 0800 hours the following day, the claim should include the service date that aligns with the 1700 start time.

For more examples or information, please refer to the FAQs below.

Note: Where on-call services are remunerated within program funding (e.g., AFP, ICU-APP Option Levels 1-3) there will be no change; these physicians will continue to be remunerated through existing processes.

Q: What is the intent of the Facility On-Call Program?
A: Although the Facility On-Call Program is for 24-hours, the funding being provided is intended to recognize "after hours" emergency calls/services, not routine consultation, or the routine care of inpatients. "After-hours" is defined as weekday evenings/nights (1700 - 0800), weekends (24 hours) and holidays (24 hours) beginning at 0800. It is meant to provide remuneration for the physician where personal time is disrupted by having to provide on-call services.

Q: How do I know which category I am in or which health service code to bill?
A: Physicians should use the health service code appropriate to their category, specialty, and location. Please see the Fee Code Table below to clarify the locations for each health service code. Physicians will continue to be paid per the categories as specified in the Nova Scotia Facility On-Call Program Guidelines. Only the submission and payment processes are changing.

Q: Can I bill regular health service codes in addition to the Facility On-Call health service codes?
A: Eligible physicians who are called into the facility can claim services rendered in addition to receiving on-call funding where applicable with their funding (e.g. specialists with APP may claim after hours services as fee for service with the implementation of the current Master Agreement). Providers should confirm what services are appropriate for billing purposes before attempting to do so. Note: all after-hours claims should be billed using appropriate health card numbers and after-hours modifiers.

Q: How do I bill the Facility On-Call health service codes?
A: The health services codes are available for download in the vendor software.

Q: What if I do not have the ability to submit electronic claims?
A: If you do not have a FFS or Group FFS Business Arrangement (BA) you will need to obtain one by contacting MSI at 902-496-7011 (HRM local), 1-866-553-0585 (toll free) or msiproviders@medavie.bluecross.ca. Physicians who do not have billing software often engage the services of a Service Bureau. Service Bureaus are independent billing providers who do complete billing for physicians for a fee. *Prices vary and are set by the independent Service Bureaus; physicians should choose the Service Bureau which best suits their needs.*

Q: What about my Facility On-Call coverage for service dates up to June 30?
A: All claims up to June 30, 2021, will continue to be paid via the invoice method through NSHA/IWK. As of July 1, 2021, Facility On-Call claims should be submitted as FFS using the new health service codes.

Q: How often can I bill the Facility On-Call health service code?
A: The health service code can be billed once per eligible physician per rota per 24-hour period.

Q: Can I bill for covering two facilities or two rotas in the same facility at the same time?
A: Physicians cannot claim for more than one on-call payment on the same day. For example, an OBGYN cannot claim separate call shifts when covering the Dartmouth General (as primary) and IWK (as secondary) on the same day. The physician would claim the call which provides the higher compensation – typically the primary call rota. Similarly, if a physician who is on-call for PMC was requested to also cover hospitalist, the physician would claim the on-call for PMC as there is no difference in the category between those two programs.

Q: When do I use the US=CALL modifier?

A: A physician may also claim a callback rate in addition to the Category 3 daily rate if they are required to return to the hospital while providing call services. To claim, first submit for the appropriate daily rate, followed by a second claim for the same health service code using the US=CALL modifier. Physicians not scheduled to provide Facility On-Call services may not claim a callback. Facility On-Call Category 4 callback fee can only be claimed once per 24 hours. It is available to physicians whose specialty or subspecialty does not have a designated on-call rota.

Q: How do I bill when I am on call for a half shift?

A: If you provide coverage for a half shift, use the PO=HALF modifier to indicate the partial coverage. A separate physician providing coverage for the remainder of the rota is to claim the other half. Total claims for each day cannot exceed 100% of the Facility On-Call Category daily value. For example, if two Anaesthesiologists are sharing a Saturday call – one is doing daytime, the other is doing nighttime – they would both bill the fee code F1001, use the weekend modifier DA-RGE1 and use the additional modifier PO=HALF. Each physician will be paid half the call rate for that shift ($200 each).

Q: How will this work for group payments?

A: For physicians who receive remuneration through group funding, the Facility On-Call code can be billed to the Group FFS Business Arrangement. Using this group BA, one physician will claim the stipend for the shift. MSI will make the payment to the group bank account. It is left to the group administrator to disburse funding to the participating physicians.

Q: What documentation is required to substantiate my Facility On-Call claims?

A: For quarterly and annual review purposes, DHW will require documentation. This will include written on-call schedules and, for callback claims, documentation of the reason for each callback. Physicians should keep records of their call participation and what portion of call shifts are fulfilled. Additionally, all service claims made while on-call should use the appropriate modifiers where applicable (e.g. nighttime claims should use nighttime and/or urgent modifiers).

Q: How does this transition to electronic billing affect CHIP and PMC workbooks?

A: The sessional-paid Community Hospital Inpatient Program (CHIP) or Primary Maternity Care (PMC) Program will also transition to the new health service codes after June 30, 2021. All CHIP and PMC workbooks have been revised to remove the Facility On-Call claims. MSI has sent these workbook templates to each site lead.

Facility On-Call Category 1 (with PMC)

Heath Service Code	Description	Weekday	Weekend/ Holidays (DA=RGE1)	Approved Regional and Tertiary Hospitals
F1001	Facility on Call Category 1 – Anaestheia	$300	$400	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Cumberland Regional, Aberdeen, St. Martha's, Cape Breton Regional, Dartmouth General.
F1002	Facility on Call Category 1 – General Surgery	$300	$400	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Cumberland Regional, Aberdeen, St. Martha's, Cape Breton Regional, Dartmouth General.
F1003	Facility on Call Category 1 – Internal Medicine	$300	$400	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Cumberland Regional, Aberdeen, St. Martha's, Cape Breton Regional, Dartmouth General.
F1004	Facility on Call Category 1 – Obstetrics/Gynecology RO=OBS1 (Yarmouth and IWK only) RO=OBS2 (IWK only) RO=GYN1 (Dartmouth and IWK only)	$300	$400	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Aberdeen, St. Martha's, Cape Breton Regional, Dartmouth General, IWK/Grace.
F1005	Facility on Call Category 1 – Family Medicine-Primary Maternity Care	$300	$400	South Shore Regional, Yarmouth Regional, Valley Regional, Cumberland Regional, St. Martha's, Cape Breton Regional.
F1006	Facility on Call Category 1 – Hospitalist	$300	$400	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Cumberland Regional, Aberdeen, St. Martha's, Cape Breton Regional, Glace Bay, Dartmouth General, QEII, IWK/Grace.
F1007	Facility on Call Category 1 – Diagnostic Imaging	$300	$400	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Aberdeen, St. Martha's, Cape Breton Regional, Dartmouth General, QEII.
F1008	Facility on Call Category 1 – Family Medicine O.R. Call Assists	$300	$400	Valley Regional, St. Martha's, Cape Breton Regional, Dartmouth General.
F1009	Facility on Call Category 1 – Family Medicine (Mental Health)	$300	$400	Cape Breton Regional
F1010	Facility on Call Category 1 – Orthopedics	$300	$400	Valley Regional, Aberdeen, Cape Breton Regional
F1011	Facility on Call Category 1 – Pediatrics	$300	$400	Valley Regional, Colchester East Hants, St. Martha's, Cape Breton Regional,
F1012	Facility on Call Category 1 – Psychiatry	$300	$400	Colchester East Hants, St. Martha's, Cape Breton Regional,
F1013	Facility on Call Category 1 – Urology	$300	$400	Valley Regional, Cape Breton Regional, Dartmouth General, QEII.
F1014	Facility on Call Category 1 – Ophthalmology	$300	$400	St. Martha's, Cape Breton Regional, QEII.
F1015	Facility on Call Category 1 – Palliative Care	$300	$400	Cape Breton Regional
F1016	Facility on Call Category 1 – Nephrology	$300	$400	Cape Breton Regional, QEII, IWK/Grace.

Facility On-Call Category 2

Heath Service Code	Description	Weekday	Weekend/ Holidays (DA=RGE1)	Approved Regional and Tertiary Hospitals
F2010	Facility on Call Category 2 – Orthopedics	$250	$300	Dartmouth General
F2011	Facility on Call Category 2 – Pediatrics	$250	$300	Yarmouth Regional, Aberdeen
F2013	Facility on Call Category 2 – Urology	$250	$300	Colchester East Hants
F2014	Facility on Call Category 2 – Ophthalmology	$250	$300	Yarmouth Regional
F2017	Facility on Call Category 2 – Otolaryngology	$250	$300	Valley Regional, St. Martha's, Cape Breton Regional
F2018	Facility on Call Category 2 – Vascular Surgery	$250	$300	Valley Regional, Cape Breton Regional
F2004	Facility on Call Category 2 – Obstetrics/Gynecology	$250	$300	Cumberland Regional
F2019	Facility on Call Category 2 – Plastic Surgery	$250	$300	St. Martha's, Cape Breton Regional
F2020	Facility on Call Category 2 – Neonatology	$250	$300	Cape Breton Regional
F2021	Facility on Call Category 2 – Neurosurgery	$250	$300	Cape Breton Regional
F2022	Facility on Call Category 2 – Neurology	$250	$300	Cape Breton Regional

Facility On-Call Category 3

Heath Service Code	Description	Weekday	Weekend/ Holidays (DA=RGE1)	Callback (US=CALL)	Approved Regional and Tertiary Hospitals
F3012	Facility on Call Category 3 – Psychiatry	$150	$200	$100	South Shore Regional, Yarmouth Regional, Valley Regional
F3023	Facility on Call Category 3 – Pathology	$150	$200	$100	South Shore Regional, Colchester East Hants, St. Martha's, Cape Breton Regional
F3024	Facility on Call Category 3 – Child Psychiatry	$150	$200	$100	Colchester East Hants
F3017	Facility on Call Category 3 – Otolaryngology	$150	$200	$100	Cumberland Regional
F3025	Facility on Call Category 3 – Radiation Oncology	$150	$200	$100	Cape Breton Regional
F3026	Facility on Call Category 3 – Medical Oncology	$150	$200	$100	Cape Breton Regional
F3027	Facility on Call Category 3 – Tissue Bank	$150	$200	$100	QEII
F3028	Facility on Call Category 3 – Hyperbaric Unit	$150	$200	$100	QEII
F3029	Facility on Call Category 3 – Urology Transplant	$150	$200	$100	QEII
F3030	Facility on Call Category 3 – Ophthalmology - Orbital Reconstruction	$150	$200	$100	QEII

Facility On-Call Category 4

Heath Service Code	Description	Callback (US=CALL)	Approved Regional and Tertiary Hospitals
F4CB1	Facility on Call Category 4 – Callback (US=CALL modifier required)	$300	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Cumberland Regional, Aberdeen, St. Martha's, Cape Breton Regional, Dartmouth General, QEII, IWK/Grace

Community Hospital Inpatient Program (CHIP)

Heath Service Code	Description	Weekday	Weekend/ Holidays (DA=RGE1)	Approved CHIP Hospitals
FCHP1	Facility on Call – Community Hospital Inpatient Program	$300	$400	Strait-Richmond Hospital, Northside General Hospital, Fishermans Memorial Hospital, Soldiers Memorial Hospital, Queens General Hospital, Roseway Hospital, New Waterford Consolidated

Code	Description
GN109	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS ROTA HAS ALREADY BEEN CLAIMED AT EITHER HALF OR FULL VALUE FROM THIS FACILITY FOR THE SAME SERVICE DATE.
GN110	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS ROTA HAS ALREADY BEEN CLAIMED AT FULL VALUE FROM THIS FACILITY FOR THE SAME SERVICE DATE.
GN111	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED A FACILITY ON-CALL CALLBACK RATE FOR THIS SERVICE DATE.
GN112	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE COMMUNITY HOSPITAL INPATIENT PROGRAM HAS ALREAD BEEN CLAIMED FROM THE SAME HOSPITAL ON THIS DATE.
GN113	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST CLAIM A CATEGORY 3 FACILITY ON-CALL DAILY RATE PRIOR TO CLAIMING THE ASSOCIATED CALLBACK FEE.
GN114	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM OF 2 OPHTHALMOLOGY ROTAS HAVE ALREADY BEEN CLAIMED FROM THIS FACILITY ON THIS DATE.
GN115	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM OF 4 DIAGNOSTIC IMAGING ROTAS HAVE ALREADY BEEN CLAIMED FROM THIS FACILITY ON THIS DATE.
GN116	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR THE FACILITY ON-CALL OBSTETRICS/GYNECOLOGY ROTA USING THE SAME ROLE MODIFIER HAS ALREADY BEEN CLAIMED FROM THE IWK FOR THIS DATE.
GN117	SERVICE ENCOUNTER HAS BEEN REFUSED AS CLAIMS FOR HSC F1004 FROM THIS FACILITY SHOULD NOT INCLUDE A ROLE MODIFIER.
GN118	SERVICE ENCOUNTER HAS BEEN REFUSED AS CLAIMS FOR HSC F1004 FROM YARMOUTH SHOULD BE MADE USING THE RO=OBS1 MODIFIER.
GN119	SERVICE ENCOUNTER HAS BEEN REFUSED AS CLAIMS FOR HSC F1004 FROM DARTMOUTH GENERAL SHOULD BE MADE USING THE RO=GYN1 MODIFIER.
GN120	SERVICE ENCOUNTER HAS BEEN REFUSED AS CLAIMS FOR HSC F1004 FROM THE IWK SHOULD BE MADE USING THE APPROPRIATE RO MODIFIER FOR 1ST OR 2ND OBSTETRICS, OR 1ST GYNECOLOGY.

PHYSICIAN'S BULLETIN
June 18, 2021: Vol. LXVI, ISSUE 9

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Physician Reminder

ELECTIVE OUT OF PROVINCE AND OUT OF COUNTRY SERVICES

ELECTIVE OUT OF PROVINCE SERVICES (WITHIN CANADA)

Prior approval is required from the Nova Scotia Department of Health and Wellness before referring a patient out of province for insured health services unavailable in Nova Scotia if the patient wishes to be considered for travel and accommodation assistance. Approval must be sought through the Medical Consultant, MSI.

The referral must be from a specialist registered in Nova Scotia, who is actively involved in the eligible resident's care. The referral must include the following:

- A description of the eligible resident's relevant medical history.
- A description of the health services requested as well as an estimation of the expected benefit to the patient.
- Confirmation that the health service(s) are provided in a publicly funded facility and are covered by the medical insurer in the proposed province.
- Written confirmation of the medical evidence supporting the requested health service.
- When the proposed health service is a new or emerging health service, documentation must be included of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.
- Information on the available health services in Nova Scotia and an explanation of why these are not sufficient for the resident's needs.
- The contact information of the physician who will be treating the patient so a copy of the approval documentation can be forwarded to their office.
- A description of any follow-up requirements.
- A written recommendation in support of the out-of-province health services, confirming that this is the specialist's recommendation and that the referral is not being provided solely at the request of the patient.
- Written confirmation of, the patient's medical requirement for travel with an escort, if required.
- The costs for an escort will not be covered by DHW if there is no medical evidence to support the need for an escort. Evidence of medical need for an escort is not required if the resident is under 19 years of age.

MSI will review the application and provide a response to the appropriate specialist within 30 days of receiving a complete application.

Upon approval of the application, the Department of Health and Wellness will contact the eligible resident and provide the appropriate application forms for travel and accommodation assistance.

ELECTIVE OUT OF COUNTRY SERVICES

Individuals requiring elective, insured health services that are not available within Canada must be authorized by the DHW prior to making any medical and/or travel arrangement to ensure the service will be insured and in order for the DHW/MSI to negotiate a reasonable and fair compensation with out of country providers prior to the provision of services. In order for a patient to be referred outside Canada for treatment, prior written approval is required from the Medical Consultant, MSI.

The referral must be from a specialist registered in Nova Scotia, who is actively involved in the eligible resident's care. The referral must include the following:

- A description of the eligible resident's relevant medical history.
- A description of the health services requested as well as an estimation of the expected benefit to the patient.
- The contact information of the physician who will be treating the patient so a copy of the approval documentation can be forwarded to their office.
- Written confirmation of the medical evidence supporting the requested health service.
- When the proposed health service is a new or emerging health service, documentation must be included of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.
- Information on the available health services in Canada and an explanation of why these are not sufficient for the resident's needs.
- A description of any follow-up requirements.
- A written recommendation in support of the out-of-country health services, confirming that this is the specialist's recommendation and that the referral is not being provided solely at the request of the patient.
- Written confirmation of the patient's medical requirement for travel with an escort, if required.
- The costs for an escort will not be covered by DHW if there is no medical evidence to support the need for an escort. Evidence of medical need for an escort is not required if the resident is under 19 years of age.

MSI will review the application and provide a response to the appropriate specialist within 30 days of receiving a complete application.

Upon approval of the application, the Department of Health and Wellness will contact the eligible resident and provide the appropriate application forms for travel and accommodation assistance.

MEDICARE PAYMENT STATEMENT REMINDER

Prior to June 2021, MSI distributed the following pay statements:

- Electronic statement associated with the biweekly payment of FFS patient specific claims. There are two versions: a preformatted report and an extract of the data on the statement. This statement is accessible via an electronic request often submitted through your practice management software.
- Paper statement associated with the payment of non-FFS patient specific claims, e.g., AFP, APP, sessional, psychiatric hourly, CMPA and incentives.

Effective June 2, 2021 onward, the paper statement noted above has been replaced with an electronic statement. You are able to view and print this statement through a new web-based user interface. The statement is identical to the previous preformatted report.

The existing process that submitters utilize to download the statement associated with FFS patient specific claims has not changed.

If you have any questions regarding this change, please do not hesitate to contact us. We can be reached at msi_assessment@medavie.bluecross.ca or 902-496-7011/toll-free 1-866-553-0585.

PHYSICIAN'S BULLETIN
June 1, 2021: Vol. LXVI, ISSUE 8

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

MEDICARE PAYMENT STATEMENT DISTRIBUTION CHANGE – JUNE 2, 2021

Currently MSI distributes the following pay statements:

- Electronic statement associated with the biweekly payment of FFS patient specific claims. There are two versions: a preformatted report and an extract of the data on the statement. This statement is accessible via an electronic request often submitted through your practice management software.
- Paper statement associated with the payment of non-FFS patient specific claims, e.g., AFP, APP, sessional, psychiatric hourly, CMPA and incentives. This statement is mailed to the address that the physician or group has provided to MSI.

Effective June 2, 2021 onward, the paper statement noted above will be replaced with an electronic statement. You will be able to view and print this statement through a new web-based user interface. The statement will be identical to the current preformatted report.

You should have received a letter within the past week providing you with your login instructions. For physicians, the instructions indicate that you are to log in using your MSI Provider Number as your username. Your MSI provider number is a unique 6-digit number provided to you during the MSI registration process and used during claims' submission. Enter only the 6-digit number. Do not include 'PH' or 'PH-' in front of or following the 6-digit number.

The existing process that submitters utilize to download the statement associated with FFS patient specific claims will not change.

If you have any questions regarding this change, please do not hesitate to contact us. We can be reached at msi_assessment@medavie.bluecross.ca or 902-496-7011/toll-free 1-866-553-0585.

PHYSICIAN'S BULLETIN

May 14, 2021: Vol. LXVI, ISSUE 7

NOVA SCOTIA MEDICAL SERVICES INSURANCE

CONTENTS

Billing Matters Billing Reminders, Updates, New Explanatory Codes

COVID-19 VACCINATION (1ST AND 2ND DOSES) PHYSICIAN CLINIC REMUNERATION

The various payment methods for COVID-19 Vaccination indicated below are available for **Physician Clinics coordinated by Doctors Nova Scotia**. These do not apply to NSHA 'community' or 'public health' clinics (e.g. large arenas, First Nations Reserves, mobile units, longterm care facilities) nor does it apply to physicians who are independently participating in pharmacy or other clinics where remuneration has been pre-arranged.

For immunizations, tray fees (health service code 13.59M) may only be claimed if a physican incurs costs and may not be claimed when the supplies are provided by the government. For the current provincial rollout (doses 1 and 2), supplies will be provided by Nova Scotia and, therefore, cannot be claimed.

Physicians seeking to claim for immunizations rendered by nurses and nurse practitioners in their practice can only do so when the physicians are onsite during the time of immunization and those healthcare personnel are directly employed by the physician, and not when they are employed by the Nova Scotia Health Authority. Note: for the sessional payment option, physicians must provide the services themselves and cannot claim for any immunizations administered by other healthcare personnel.

1. **Fee for Service**
   For individual physicians who are providing COVID-19 immunizations as Fee for Service (FFS), these injections are to be claimed under the existing FFS business arrangement. These services will be claimed using the health service code 13.59L, following the rules set in Preamble 5.3.26 concerning provincial immunizations. A modifier has been developed for COVID-19 vaccines and must be used in conjunction with the 13.59L: **RO=CO19**.

Category	Code	Description	Base Units
ADON	13.59L	**Provincial Immunization for COVID-19** RO=CO19 **Description** COVID-19 vaccination	6 MSU

COVID-19 VACCINATION PHYSICIAN CLINIC REMUNERATION (CONTINUED)

2. **Alternative Funding (e.g., APP, CEC, C/AFP)** – No shadow billing requirement
Physicians who are providing COVID-19 immunizations as part of their Alternative Funding agreement deliverables (e.g., APP, CEC, C/AFP) will have the option to integrate any COVID-19 work into their existing contracted hours and be paid through their existing business arrangement. Although shadow billing is not required for immunizations, the shadow billing could make a positive difference to overall shadow billing for the year (e.g., eligibility for the APP 5.6% bonus). These injections would be shadow billed using health service code 13.59L following the rules set in Preamble 5.3.26 concerning provincial immunizations. A modifier has been developed for COVID-19 vaccines and must be used in conjunction with the 13.59L: **RO=CO19**.

   Alternatively, physicians may request an exclusion from the Department of Health and Wellness (DHW) to deliver the vaccination services over and above their regular contracted hours. A request for exclusion must be approved by DHW by emailing: alternate.funding@novascotia.ca.

3. **Individual Sessional** – No shadow billing requirement
Physicians receiving remuneration via sessional funding for the hours administering the vaccine are paid at the GP rate of $157.80 per hour (2021-22 rate). Sessional funding claims should be submitted to Medavie on a weekly basis; however, all claims must be submitted within 90 days of service per the Physician Manual. Any claims submitted outside this 90-day approval period are not payable. The claim must be reviewed and approved by an immunization clinic site manager or designate. Once approved, the claim should be submitted to Medavie for payment: email afpclaims@medavie.bluecross.ca and copy alternate.funding@novascotia.ca. If a physician requries a sessional form, they should contact alternate.funding@novascotia.ca.

   NOTE:
   Each clinic must be remunerated in the same method; sessional and FFS cannot be combined in a clinic. The only exception would be if an APP, CEC or C/AFP physician is including immunization into their scheduled hours for any given week; these physicians can do so while their collegues are receiving FFS or individual sessional payment.

REMINDERS

CMPA Rebate

The Department of Health and Wellness (through MSI) will continue to provide reimbursement of all eligible Canadian Medical Protective Association (CMPA) fees directly to physicians. Payments will be issued on a quarterly payment schedule and deposited through an electronic funds transfer. Medavie and DHW are working on options to better enable appropriate payment and better accountability. Stay tuned for changes.

These payments are deposited through an electronic funds transfer. If you do not already have a CMPA Business Arrangement set up to receive these deposits, you may fill out the MSI Provider Business Arrangement Form with a void cheque and email to msiproviders@medavie.ca or fax to 902-469-4674.

Should you have any questions regarding your CMPA rebate, please contact: CMPA@medavie.ca

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NEW AND UPDATED EXPLANATORY CODES

Code	Description
AD088	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR 13.59L RO=CO19 HAS BEEN APPROVED IN THE PREVIOUS 18 DAYS.
MA008	SERVICE ENCOUNTER HAS BEEN REFUSED. INTERIM SERVICE CODE HAS EXPIRED. APPLICATION MUST BE SUBMITTED TO THE FEE COMMITTEE FOR ESTABLISHING A PERMANENT HEALTH SERVICE CODE.
VE029	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS AN OUTPATIENT VISIT OR CONSULT FROM A RELATED SPECIALTY HAS BEEN CLAIMED FOR THIS PATIENT ON THAT DATE.
VT172	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A CHRONIC DIALYSIS MANAGEMENT DAILY TREATMENT AND SUPERVISION FEE HAS BEEN CLAIMED FOR THIS PATIENT ON THAT DATE.
PC036	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE NOT INDICATED THAT PRIOR APPROVAL HAS BEEN ISSUED. MAXIMUM LIMIT OF 9 HOURS FOR A PSP PHYSICIAN PER YEAR FOR COUNSELLING HAS PREVIOUSLY BEEN APPROVED.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday May 14th, 2021. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), Modifiers (MODVALS.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
www.novascotia.ca/dhw/

In partnership with

NOVA SCOTIA

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PHYSICIAN'S BULLETIN
May 11, 2021: Vol. LXVI, ISSUE 6

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Physician Advisor Opportunity

The Department of Health and Wellness (DHW) is seeking an inaugural Physician Advisor, Quality and Patient Safety (QPS) on a part time basis (approximately up to 45 hours per month).

The Quality and Patient Safety Branch at DHW provides leadership to guide and drive quality improvement across the health care system through policy, legislation, measurement, monitoring and reporting.

A DHW physician resource for QPS is critical to support and enable the Department to fully realize the dual responsibilities of leadership and monitoring and accountability in the areas of quality and patient safety.

The mandate of this exciting new role is to:

- assist in driving continuous quality improvement in health care for Nova Scotia by providing leadership, expertise and advice on current DHW quality and patient safety priorities and
- participating in the development of provincial oversight & reporting mechanisms to improve health-system performance.

Physician engagement is essential for quality and patient safety improvements; this will be a key role for the Physician Advisor.

The inaugural Physician Advisor is an exceptional leader with the vision and scholarly profile to understand and nurture the complex interrelationships required to develop and implement quality improvement that integrates the public, health teams, health leaders, physicians and policy makers to strengthen and improve healthcare patient outcomes.

Please click here to view further details on the scope of work.

To apply, please send a covering letter that highlights your interest and how you meet the qualifications, along with a detailed CV with two references, including contact information to: Krizia.Sadi@novascotia.ca before midnight June 14, 2021.

PHYSICIAN'S BULLETIN
May 10, 2021: Vol. LXVI, ISSUE 5

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

MEDICARE PAYMENT STATEMENT DISTRIBUTION – UPCOMING CHANGES

Currently MSI distributes the following pay statements:

- Electronic statement associated with the biweekly payment of FFS patient specific claims. There are two versions: a preformatted report and an extract of the data on the statement. This statement is accessible via an electronic request often submitted through your practice management software.
- Paper statement associated with the payment of non-FFS patient specific claims, e.g., AFP, APP, sessional, psychiatric hourly, CMPA and incentives. This statement is mailed to the address that the physician or group has provided to MSI.

Effective June 2, 2021 onward, the paper statement noted above will be replaced with an electronic statement. You will be able to view and print this statement through a new web-based user interface. The statement will be identical to the current preformatted report. In the next few weeks, you will receive a letter providing you with the link to access these statements, your unique login information, and login instructions.

The existing process that submitters utilize to download the statement associated with FFS patient specific claims will not change.

If you have any questions regarding this change, please do not hesitate to contact us. We can be reached at msi_assessment@medavie.bluecross.ca or 902-496-7011/toll-free 1-866-553-0585.

PHYSICIAN'S BULLETIN

March 19 2021: Vol. LXVI, ISSUE: 4

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT

Effective April 1, 2021, the Medical Service Unit (MSU) value will increase from $2.58 to $2.63.

ANAESTHESIA UNIT

Effective April 1, 2021, the Anaesthesia Unit (AU) value will increase from $22.71 to $23.88.

PSYCHIATRY FEES

Effective April 1, 2021, the hourly psychiatry rate for General Practitioners will increase to $154.57 while the hourly rate for Specialists increases to $209.59 as per the tariff agreement.

WORKERS COMPENSATION BOARD UNIT VALUE CHANGES

WCB MEDICAL SERVICE UNIT

Effective April 1, 2021, the Workers Compensation Board Medical Service Unit (WCB MSU) value will increase from $2.87 to $2.92.

WORKERS COMPENSATION BOARD ANAESTHESIA UNIT

Effective April 1, 2021, the Workers Compensation Board Anaesthesia Unit (WCB AU) value will increase from $25.23 to $26.53.

WORKERS COMPENSATION BOARD FEE CODE INCREASES

Workers' Compensation Board Fee Code Update

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been calculated for the listed WCB specific fees for fiscal year 2021-22.

Due to the increase in CPI for 2020, all of the WCB specific services listed below will have their values increased by 0.81% effective April 1st, 2021:

CODE	DESCRIPTION	APRIL 2021 VALUE
WCB12	EPS physician assessment Service. Combined office visit and completion of Form 8/10 For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15-minute increments to a maximum of 1 additional hour	**Initial visit:** $189.42 + $55.39 per 15 minutes to a maximum 4x (RO=EPS1 and RP=INTL) **Subsequent visit:** $189.42 (RO=EPS1 and RP=SUBS)
WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable	GPs…….$46.31 per 15 min EPS(RO=EPS1).. $55.39 per 15 min Specialists…….$62.31 per 15 min
WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable	GPs…….$46.31 per 15 min EPS(RO=EPS1)..$55.39 per 15 min Specialists……....$62.31 per 15 min
WCB17	Photocopies of Chart Notes	10 pgs or less (ME=UP10)……..$27.74 11-25 pgs (ME=UP25)…….$55.39 26-50 pgs (ME=UP50)…….$110.67 Over 50 pgs (ME=OV50)…….$165.94
WCB20	Carpal Tunnel Syndrome (CTS) Assessment Report	$71.04
WCB21	Follow-up visit report	$41.55
WCB22	Completed Mandatory Generic Exemption Request Form	$13.90 per form
WCB23	Completed Non-Opioid Special Authorization Request Form	$13.90 per form
WCB24	Completed Opioid Special Authorization Request Form	$46.57 per form
WCB25	Completed WCB Substance Abuse Assessment Form	$31.04
WCB26	Return to Work Report – Physician's Report Form 8/10	$71.04
WCB27	Eye Report	$62.31

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CODE	DESCRIPTION	APRIL 2021 VALUE
WCB28	Comprehensive Visit for Work Related Injury or Illness	$71.48
WCB29	Initial Request Form For Medical Cannabis	$77.12
WCB30	Extension Request Form For Medical Cannabis	$46.31
WCB31	WCB Interim Fee – Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed	$71.48

FEE CODE INCREASES

INCREASES IN COMPREHENSIVE PRIMARY CARE FEE CODES

As per the master agreement, the following fees shall have their values increased for family physicians. (New Value is the value effective April 1, 2021)

	Old Value	New Value
Description	**MSU**	**MSU**
Office Visit (ME=CARE)	15.95	16.96
Geriatric Office Visit (ME=CARE)	19.73	20.99
Office Visit After-Hours (ME=CARE)	19.94	21.20
Geriatric Office Visit After-Hours (ME=CARE)	24.67	26.24
Office Visit – Well Baby Care (ME=CARE)	15.95	16.96
Office Visit Well Baby Care After-Hours (ME=CARE)	19.94	21.20
Office Visit Prenatal Care (ME=CARE)	15.95	16.96
Office Visit Prenatal Care After-Hours (ME=CARE)	19.94	21.20
Office Visit Postnatal Care After-Hours (ME=CARE)	25.67	27.30
Subsq. Inpatient Care Visit (Days 2, 3)	24.85	26.43
Subsq. Inpatient Care Visit – Newborn (Days 2, 3)	24.85	26.43
Subsq. Inpatient Care Visit – Post-Partum (Days 2, 3)	24.85	26.43
Subsq. Inpatient Care Visit (Days 4-7)	20.53	21.84
Subsq. Inpatient Care Visit – Post-Partum (Days 4-7)	20.53	21.84
Subsq. Inpatient Care Visit (Daily to 56 days)	17.29	18.39
Subsq. Inpatient Care Visit (Weekly after Day 56)	17.29	18.39

INCREASES IN PSYCHIATRY FEE CODES

As per the master agreement, the following fees shall have their values increased for psychiatrists. (New Value is the value effective April 1, 2021) *Note: these increases are for psychiatrists only.*

	Old Value	New Value
Description	**MSU**	**MSU**
Routine Psychiatric Visit (08.5B)	42.68	43.41
Psychotherapy (08.49B)	43.25	44.46
Comprehensive Consultation (03.08)	94.85	103.24
Child Psychiatric Assessment (08.19A)	48.87	50.23
Group Therapy (08.44)	11.66	11.99
Therapeutic/Diagnostic Interview Relating to a child (08.19B)	43.23	44.44

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FEE CODE INCREASES (CONTINUED)

INCREASES IN OBSTETRIC AND GYNECOLOGY FEE CODES

As per the master agreement, the following fees shall have their values increased for obstetrics and gynecology services. (New Value is the value effective April 1, 2021)

Gynecology Fee Code Changes

HSC	Description	Old Value MSU	New Value MSU
03.03V	Medical Abortion/Termination of early pregnancy	62.63	67.03
80.89A	Abortion – Incomplete; examination of the uterus without D&C or anaes.	32.96	35.28
79.1	Conization of cervix including colposcopy	67.24	71.97
87.21	Dilation and Curettage for termination of pregnancy	93.61	100.19
81.09	Other Dilation and Curettage	56.04	59.98
81.09A	Endocervical Curettage	13.19	14.11
98.12V	Curettage of warts, including papillomata, keratosis, nevi, moles, pyogenic granulomata, etc., for malignant or recognized pre-malignant condition	15.82	16.93
81.69A	Endometrial Biopsy	25.05	26.81
80.4C	Laparoscopic Hysterectomy	395.55	423.36
80.3	Total Abdominal Hysterectomy	316.44	338.69
80.4A	Vaginal Hysterectomy – uterus-total vaginal w/ rectocoele / cystocoele repair	378.41	405.01
80.4	Vaginal Hysterectomy (subtotal)	316.44	338.69
80.2A	Subtotal Abdominal Hysterectomy	316.44	338.69
80.3A	Uterus – total abdominal w/ rectocoele / cystocoele repair	378.41	405.01
80.3C	Abdominal hysterectomy with salpingo-oophorectomy including bilateral selective pelvic lymphadenectomies, omental biopsy / selective periaortic	527.40	564.48
77.19C	Laparoscopic ovarian cystectomy	197.78	211.68
86.3A	Surgical removal of extrauterine (ectopic) preg. by any means (incl. tubal)	171.41	183.45
78.1A	Salpingectomy for morbidity, not for sterilization	171.41	183.45
10.16	Insertion of vaginal pessary	30.98	33.16
80.19A	Endometrial ablation including D&C	210.96	225.79
82.81A	Colposcopy	11.21	12.00
78.39A	Interruption or removal of fallopian tubes for sterilization purposes	138.44	148.18
77.51	Removal of both ovaries and tubes	257.11	275.18
80.81	Hysteroscopy	56.04	59.98
77.19A	Salpingectomy and salpingo-oophorectomy	171.41	183.45

Obstetric Fee Code Changes

HSC	Description	Old Value MSU	New Value MSU
87.98	Delivery (RF=REFD, SP=OBGY)	342.81	366.91
87.98	Delivery (SP=OBGY or SP=GENP)	263.70	282.24
86.1	Cervical Caesarean Section	342.81	366.91
84.79	Other Vacuum Extraction	342.81	366.91
86.1A	Caesarean section with tubal ligation	369.18	395.13
84.71	Vacuum extraction with episiotomy	342.81	366.91
84.0	Low forceps delivery without episiotomy	342.81	366.91
84.1	Low forceps delivery (with episiotomy)	342.81	366.91
84.8	Other specified instrumental delivery	342.81	366.91
84.29	Other mid forceps delivery	342.81	366.91
84.21	Mid forceps delivery (with episiotomy)	342.81	366.91
84.53	Total breech extraction	342.81	366.91
84.51	Breech extraction, unqualified	342.81	366.91
84.31	High forceps delivery with episiotomy	342.81	366.91
84.39	Other high forceps delivery	342.81	366.91
84.52	Partial breech extraction	342.81	366.91
84.61	Partial breech extraction with forceps to aftercoming head	342.81	366.91
84.62	Total breech extraction with forceps to aftercoming head	342.81	366.91
84.9	Unspecified instrumental delivery	342.81	366.91

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FEE CODE INCREASES (CONTINUED)

INCREASES IN OBSTETRIC AND GYNECOLOGY FEE CODES *(continued)*

As per the master agreement, the following fees shall have their values increased for obstetrics and gynecology services. (New Value is the value effective April 1, 2021)

Gynecology and Obstetrics Fee Code Changes

HSC	Description	Old Value MSU	New Value MSU
81.8	Insertion of intra-uterine contraceptive device	42.19	45.16
81.01	Dilation and curettage following delivery or abortion	75.15	80.44
81.61	Aspiration curettage following delivery or abortion	75.15	80.44

OB/GYN Consultation Fee Code Changes

HSC	Description	Old Value MSU	New Value MSU
03.08	Comprehensive Consultation (Prolonged)	37.60	40.10
03.07	Limited Consultation	27.00	29.50
03.07	Repeat Consultation (Prolonged)	25.00	27.50

UPDATED FEES

Teaching Stipend

Health service code TESP1 and TESP2 have been retroactively revised to daily rate fees for both fee for service and shadow billing. Any physicians who have claimed these fees since April 2020 will be contacted and directed to update their claims once an approved list of physicians is confirmed with Dalhousie University.

Category	Code	Description	Base Units
DEFT	TESP1	TEACHING STIPEND FOR MEDICAL STUDENT	$90 per day
DEFT	TESP2	TEACHING STIPEND FOR RESIDENT ELECTIVE	$90 per day

TESP1 and TESP2 revised to daily fees with a value of $90 each.

A claim for these services is designated to remunerate for any teaching responsibilities incurred during the service date.

These daily codes are available as both FFS and APP claims for physicians that meet the eligibility criteria outlined below.

Not eligible for any premiums

Maximum claimable amount of $450 per weekly period (i.e. only 5 teaching stipend claims per physician per week will be accepted)

Eligibility restrictions:

- Only available for those who have an academic appointment and are teaching Dalhousie residents and students
- FFS family physicians are eligible
- FFS royal college specialists are eligible
- APP physicians are able to shadow bill at the $90 daily rate

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- AFP physicians are not eligible for this fee code for work done in the AFP, likewise FFS physicians working within one of the FFS Academic Departments are not eligible
- Physicians (part time Academic Department and part time FFS) are eligible for work done outside the Academic Health Centre/IWK and not otherwise compensated through their clinical department or AFP (for example a physician in their private clinic teaching a student/resident).

Dalhousie will confirm the list of physicians approved to claim the teaching stipend to MSI, as well as any updates to the list as they occur.

Electronic claims for TESP1 and TESP2 should be claimed using health card number 0000002352 with date of birth April 1, 1969. Diagnostic code V623 is also required.

FEE REVISIONS

The effective period for interim health service code 03.04I – PSP Mental Health Comprehensive Visit to Establish the PSP Mental Health Plan (Practice Support Program) has been extended to October 31, 2021.

Physicians are reminded of the description for this service:
*Based on these requirements it is expected that a physician would have no more than 5 eligible patients per year.

Category	Code	Description	Base Units
VIST	03.04I	**PSP Mental Health Comprehensive Visit to establish the PSP (PSP= Practice Support Program) Mental Health Plan** This code is for the complete assessment of the patient with a confirmed mental illness meeting the diagnostic criteria in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of sufficient severity and acuity to cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and warrant the development of a Mental Health care plan. This is not intended for patients with self-limited or short-lived mental health symptoms. The assessment is to be performed by the PSP trained family physician most responsible for the patient's mental health care. The Mental Health Plan and start and stop times must be documented in the health record. This complete assessment is to include **all** of the following elements and be documented in the health record: • The patient's DSM diagnosis, psychiatric history and current mental state including suicide risk assessment as appropriate • Obtaining collateral history and information from caregivers as required • Performance of a complete medication review to include collateral information from pharmacy and assisted living facility as appropriate • Reviewing and documenting results of relevant validated assessment tools, laboratory, and other test results • Documentation of a clinical plan for the patient's care over the next year. Includes advanced care planning where appropriate • Outline of expected outcomes as a result of the treatment plan • Outline of linkages with other health care providers and community resources who will be involved in the patients care. • Confirmation that the plan has been created jointly and shared with the patient or their medical representative. The plan is to be shared with other care providers as appropriate	50 MSU +MU

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Category	Code	Description	Base Units

- A documented care plan must be in place before access to additional counselling hours is provided

It is recognized that the required elements may require more than one visit to complete. This health service code may be claimed at the final visit only when all of the information is complete and documented in the health record; other visits may be reported at the usual rate.

All elements must be documented in the health record before reporting this PSP MHP visit service.

Billing Guidelines

- Reportable by the patient's PSP trained physician only
- Not reportable with any other visit fee for the same physician, same patient, same day
- Not reportable for services provided at walk-in clinics
- Not to be used for patients living in nursing homes, residential care facilities or hospices
- Reportable only once per patient per year
- 50 MSU for first 30 minutes, 25 MSU for each additional 15 minutes, up to a maximum of 1 hour (5 multiples)
- Start and stop times must be reported in the text field of the claim to MSI, as well as in the clinical record

Specialty Restriction
GENP with PSP Training

Location
OFFC, HOME

Clarification to Health Service Code 51.95B

Orginally introduced in the October 2020 Physician's Bulletin, HSC 51.95B – Chronic Dialysis, treatment and supervision of care for the patient with end stage kidney disease, in an urban satellite hemodialysis unit as designated by the Health Authority for a 24 hour period have been updated to be consistent with the fee description. Face-to-face clinical assessment should be documented within a 42-day period, not the previously communicated 14-day.

Category	Code	Description	Base Units
VEDT	51.95B	**Chronic Hemodialysis – treatment and supervision of care for the patient with end stage kidney disease, in an urban satellite hemodialysis unit as designated by the Health Authority (for example; Halifax Infirmary, Dartmouth General, and North Sydney hemodialysis units) for a 24 hour period.** **Description** This comprehensive, daily fee (24 hour period beginning at 12:00 am until 11:59 pm of the same calendar day) is for the treatment and supervision of care for a patient with end stage kidney disease who is registered in the Renal Program (NSHA, STARS or PHS, as a series visit for dialysis) and requires chronic dialysis in an urban satellite hemodialysis unit as designated by the Health. The physician is expected to supervise all aspects of the patient's dialysis care and to provide direct, face-to-face clinical assessment of the patient, including a physical examination appropriate to the patient's medical condition, at least once in every 42 day period, and via PHIA compliant, synchronous virtual care platform once in every 14 day period, with additional clinical assessments as required based on concerns related to changes in the patient's medical condition. Each assessment will be documented in the patient's health record. Elements of care include:	12.11 MSU

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A. All management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital in-patients and in-person emergency department visits related to the management of chronic dialysis. It does not include acute dialysis. Acute dialysis is defined as dialysis rendered to a hospital inpatient in an intensive care setting, or to a patient beginning dialysis for the first time in their lifetime through to their 6th treatment at which point the dialysis is defined as chronic. A visit service, consultation or directive care as appropriate, may be claimed for hospital inpatients if the nephrologist is asked by the patient's most responsible physician to render an opinion and furnish advice regarding the patient's ongoing nephrological care during their hospital stay. The most responsible physician requesting the advice may not be another nephrologist.

B. All outpatient consultations and visits within the scope of practice of nephrology for the assessment and treatment of complications of chronic dialysis and management of end-stage kidney disease.
Including:
    a. Review of laboratory and diagnostic test results
    b. Management of volume status, ideal body weight and blood pressure
    c. Assessment of dialysis access, such as central venous catheter, arteriovenous fistula and peritoneal catheter, and management of any complications as required.
    d. Complete and document the Ambulatory Medication Reconciliation every six months

C. All related counselling, interviews and family meetings

D. Perform all assessments and consultation requests to refer the chronic dialysis patient to the Multiorgan Transplant Program for determination of kidney transplant eligibility.

E. All related case conferences, such as, but not limited to:
    a. Weekly Morning Program Rounds
    b. Review of laboratory and diagnostic test results with multidisciplinary team

For all patients in all hemodialysis units, the Nephrologist assigned to each unit will provide daily coverage of all dialysis patients to address any dialysis issues by being available to speak with the unit charge nurse or team lead every shift to discuss any problems or concerns with individual patients at any time.

The Nephrologist assigned to each unit will provide additional care and address concerns or problems that arise during the course of a hemodialysis treatment or within the 24 hour period of supervision, such as, but not limited to, changes to dialysis prescription or medications based on laboratory results like serum potassium or INR for patients on oral anticoagulants, when results are received after the treatment time.

A standardized review of the patient's overall status on dialysis will be completed and updated every 6 weeks and documented in the patient's health record.

The document will include:
    a. Review and interpretation of laboratory and diagnostic test results
    b. Volume status, ideal body weight, blood pressure and physical examination appropriate to the patient's medical needs.
    c. Assessment of dialysis access, such as; central venous pressure catheter, arteriovenous fistula, peritoneal catheter, and management of any complications as required.

Billing Guidelines

- Claimable by the Most Responsible Nephrologist once per patient per 24-hour period beginning at 12:00 am (midnight) and ending at 11:59 pm.
- May not claim any other chronic dialysis HSCs for the same patient, same 24-hour period.
- May not claim any other outpatient visit HSCs same physician, same patient, same 24-hour period.

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- A Nephrologist providing coverage for care of the chronic dialysis patient on behalf of the most responsible nephrologist may not claim any outpatient visit HSCs or chronic dialysis HSCs.
- Emergency hospital visits to attend the patient for a condition unrelated to the management of dialysis, its complications and end stage kidney disease may be claimed but must be submitted for manual assessment with supporting information in the text (clinical documentation may be required). Should the patient be admitted to hospital under the care of the nephrologist, who is acting as the most responsible physician, inpatient visits may be claimed.
- First claim may be made on the date of the patient's first chronic dialysis treatment.
- May not be claimed after the treatment terminates by, for example, successful transplantation, loss of resident status, or death.
- When a face-to-face clinical assessment is not documented in the patient's health record in the **42** day period, payment will be recovered from the Most Responsible Physician who claimed for the service for the majority of days in the preceding seven day period at the end of which the examination was to have occurred.

Specialty Restriction:
SP=NEPH

Location:
LO=HOSP

Billing Matters Billing Reminders, Updates, New Explanatory Codes

2019/2020 Provider Profiles

As announced in 2019, provider profiles will only be sent out by request. If you would like to receive your provider profile for 2019/20 please send your request by email to msi_assessment@medavie.bluecross.ca. In the email please include: your name and provider number, and the profile will be mailed to the address on file.

COVID-19 Immunization

As announced in February, all physician work for COVID-19 immunization will be remunerated via sessional funding for the hours worked. Please refer to the February 19, 2021 Physicians Bulletin for full details on sessional funding.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
GN107	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED A TEACHING STIPEND ON THIS DATE.
GN108	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU ARE NOT AUTHORIZED TO CLAIM THE TEACHING STIPEND.
VA100	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED ONE OF THE FOLLOWING HEALTH SERVICE CODES: 50.99C, 50.91, 50.06C, OR 50.08B. THESE SERVICES ARE CONSIDERED TO BE INCLUSIVE OF THE CURRENT CLAIM.
VA101	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED ONE OF THE FOLLOWING HEALTH SERVICE CODES: 50.82, 50.82C, OR 50.88A. THESE SERVICES ARE CONSIDERED TO BE INCLUSIVE OF THE CURRENT CLAIM.

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Code	Description
VA102	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED ONE OF THE FOLLOWING COMPREHENSIVE HEALTH SERVICE CODES: 48.0A, 48.0C, or 48.0F.
VA103	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED ONE OF THE FOLLOWING COMPREHENSIVE HEALTH SERVICE CODES: 48.0A, 48.0C, or 48.0F.
VA104	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED HSC 48.0A PERCUTANEOUS CORONARY ANGIOPLASTY DURING THIS ENCOUNTER. THE CLAIM FOR CORONARY ANGIOPLASTY INCLUDES SELECTIVE CORONARY ANGIOGRAPHY.
VA105	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED A PORTION OF THIS FEE (HSC 48.98B SELECTIVE CORONARY ANGIOGRAPHY) DURING THIS ENCOUNTER. PLEASE SUBMIT A REVERSAL FOR THE PRIOR 48.98B BEFORE SUBMITTING A REASSESSMENT REQUEST FOR THIS COMPREHENSIVE CLAIM.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday March 19th, 2021. The files to download are:
Health Service (SERVICES.DAT),
Health Service Description (SERV_DSC.DAT),
Modifiers (MODVALS.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
www.novascotia.ca/dhw/

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Master Agreement - Program Payment Schedule (2021/22)

Program	Payment
EMR (Envelope "A" Payments) EMR Envelope "A" payments continue monthly to eligible physicians	Monthly
CME (GP & Specialist) Payment for 2020/21 fiscal year (eligible billings based on 2020 calendar year)	Issued by May 31, 2021
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from April 1, 2021 – June 30, 2021	Issued by July 31, 2021
CMPA Premium Reimbursement Covering April - June 2021	Issued by August 31, 2021
Electronic Medical Records (EMR – B&C) Payments for 2020/21 Fiscal Year	Issued by August 31, 2021
Family Physician Alternative Payment Plan 5.6% Incentive	Issued by September 30, 2021
Surgical Assist Payments Payment based on eligible billings from April 1, 2020 – March 31, 2021	Issued by September 30, 2021
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from July 1, 2021 – September 30, 2021	Issued by October 31, 2021
Collaborative Practice Incentive Program Payments for 2020/21 Fiscal Year	Issued by October 31, 2021
CMPA Premium Reimbursement Covering July -September 2021	Issued by December 31, 2021
Rural Specialist Incentive Program Measurement period April 1st, 2020 – March 31st, 2021 / Payment for 2020/21 fiscal year	Issued by December 31, 2021
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from October 2021 – December, 2021	Issued by January 31, 2022
CMPA Premium Reimbursement Covering October -December 2021	Issued by March 31, 2022
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from January 2022 – March, 2022	Issued by April 30, 2022
CMPA Premium Reimbursement Covering January - March 2022	Issued by May 31, 2022

*Please be advised payment dates noted are the **anticipated** payments for these programs.

Payments for fiscal 2020/21	Continuing payments

PHYSICIAN'S BULLETIN
February 19 2021: Vol. LXVI, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians: COVID-19 Immunization

At the present time, all physician work for COVID-19 immunization will be remunerated via sessional funding for the hours worked (at the GP rate of $154.80 per hour presently). This includes vaccinations delivered in healthcare worker clinics, community clinics delivered by the NSHA or IWK, long term care facilities and any prototype clinics in physicians' offices.

Sessional funding claims should be submitted to Medavie on a weekly basis; however, all claims must be submitted within 90 days of service per the Physician Manual. Any claims submitted outside of this 90-day approval period are not payable. The claims must be reviewed and approved by an immunization clinic site manager or designate, or long-term care administrator or designate. Once approved, please submit the claim to Medavie for payment: afpclaims@medavie.bluecross.ca with alternate.funding@novascotia.ca copied. If you require the sessional form please send a request to afpclaims@medavie.bluecross.ca.

Work is underway to pilot immunization that is similar to the flu vaccine. At that time, payment will be fee for service and a bulletin will be provided with additional information.

Alternate Payment Plan (APP), Collaborative Emergency Centre (CEC) and Clinical/Academic Funding Plan (C/AFP) physicians will have the option to integrate any COVID-19 vaccination work into their existing contracted hours and be paid through their existing arrangement. Alternatively, they may request an exclusion from the Department of Health and Wellness (DHW) to deliver the vaccination services over and above their regular contracted hours. A request for exclusion must be approved by DHW by emailing: alternate.funding@novascotia.ca.

PHYSICIAN'S BULLETIN

January 29 2021: Vol. LXVI, ISSUE 2

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

ORGAN AND TISSUE DONATION

The new *Human Organ and Tissue Donation Act (HOTDA)* is now in effect as of January 18, 2021.

MSI Health card renewal forms have been updated to reflect this change.

For more information please see the January 18, 2021 Physicians Bulletin or visit https://novascotia.ca/DHW/msi/health_cards.asp

Fees New Fees and Fee Revisions

NEW INTERIM FEE

Category	Code	Description	Base Units
VEDT	02.75C	**Coronary Computed Tomographic (CT) Angiography for the preoperative evaluation of paediatric patients with congenital heart disease** **Description** Coronary CT angiography with reconstruction of coronary arteries and related vascular structures under the direct supervision of the radiologist for the purpose or evaluating cardiac structure for pre-operative assessment of the paediatric patient with congenital heart disease. This fee includes the performance and interpretation of the scan with administration of contrast material and medication, as required, to control the heart rate along with necessary work station processing. **Billing Guidelines:** Not billable with: • R1135 CT Thorax without contrast • R1141 CT Thorax with contrast • R1145 CT Thorax with and without contrast • R1180 3D Reconstruction **Specialty Restriction:** Sub-specialty trained cardiac paediatric radiologist at the IWK Health Centre (credentials and list of physicians eligible to report this service must be submitted to MSI) **Location:** LO=HOSP (IWK only)	120 MSU

Billing Matters Billing Reminders, Updates, New Explanatory Codes

BILLING REMINDERS

Enhanced office and geriatric visit fees (03.03/03.03A; ME=CARE)

Please click here to view the updated FAQ for billing ME=CARE.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
BK062	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 02.75C HAS ALREADY BEEN CLAIMED FOR THIS PATIENT AT THE SAME ENCOUNTER.
VE032	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC R1135, R1141, R1145 OR R1180 HAS ALREADY BEEN CLAIMED FOR THIS PATIENT AT THE SAME ENCOUNTER.

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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
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(In Nova Scotia)
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NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS
www.novascotia.ca/dhw/

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PHYSICIAN'S BULLETIN
January 18 2021: Vol. LXVI, ISSUE 1

NOVA SCOTIA MEDICAL SERVICES INSURANCE

MSI HEALTH CARD RENEWAL FORM AND ORGAN/TISSUE DONATION

Revised Health Card Renewal Form

Please be advised there is an updated version of the Nova Scotia MSI health card renewal form. This form has been updated as a result of the new *Human Organ and Tissue Donation Act* (HOTDA) that is effective January 18, 2021. This form should be used when a Nova Scotia resident's health card has expired. If the card has been expired for more than one year instruct the resident to contact the MSI office to confirm eligibility. The updated form can also be found online at https://novascotia.ca/DHW/msi/health_cards.asp

This form cannot be used for new residents moving to Nova Scotia, to make changes to a residents file such as name, date of birth or gender changes and cannot be used to request duplicate or replacement health cards if lost or stolen. This form cannot be used to renew cards for international students or foreign workers.

Helpful tips to ensure completeness of the renewal form and timely processing:

- Resident must sign the form to confirm they are ordinarily present in NS and to authorize the release of information for payment and audit purposes, this is mandatory to issue a health card.
- A parent or guardian must sign for children under the age of 16.

With implementation of the new legislation, Nova Scotians 19 and over, who are not exempt, will be considered for organ and tissue donation, unless they register their decision to opt out of donation. Nova Scotians can register their decision to opt out of donation by visiting www.novascotia.ca/organtissuedonation.

If you have any questions, please contact MSI Resident Services at 902-496-7008 or toll free at 1-800-563-8880.

PHYSICIAN'S BULLETIN

December 14 2020: Vol. LXV, ISSUE 21

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

INCOME STABILIZATION PROGRAM RECONCILIATION & TRAVEL/EXPOSURE PAYMENTS

The DHW and MSI are currently working on the Income Stabilization Program payment reconciliation and isolation payments. The target payment date for any funding owed to physicians is December 30, 2020. If you participated in the program, you will be receiving a letter regarding your reconciliation.

TRAVEL/EXPOSURE FUNDING PROGRAM END DATE

Effective December 3, 2020, the travel/exposure funding program has ended. This program provided funding to those approved physicians who were required to self-isolate as a result of travel and/or exposure while at work during the Pandemic.

VIRTUAL CARE FEE CODE UPDATE

Effective December 31, 2020, the Telephone Management and Telehealth Management for presumptive/confirmed COVID-19 as well as routine/interval care during pandemic (HSC 03.03X) will no longer be available for billing.

All office based non-procedural services that are normally rendered in a face to face setting will still be permitted to be reported whether they are provided in person, by telephone, via telehealth network, or via a PHIA compliant virtual care platform as outlined in the March 24, 2020 Physicians Bulletin.

2021 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

Please see below, the 2021 cut-off dates for receipt of paper and electronic claims, as well as the 2021 Holiday dates.

2020/2021 MASTER AGREEMENT PROGRAM PAYMENT SCHEDULE

Please see below, the anticipated incentive payment timelines for the 2020/2021 fiscal year.

2021 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE	SALARY CONTRACT PAY PERIOD
January 4, 2021	January 7, 2021	January 13, 2021	December 25, 2020-January 7, 2021
January 18, 2021	January 21, 2021	January 27, 2021	January 8-21, 2021
February 1, 2021	February 4, 2021	February 10, 2021	January 22-February 4, 2021
February 12, 2021	February 18, 2021	February 24, 2021	February 5-18, 2021
March 1, 2021	March 4, 2021	March 10, 2021	February 19-March 4, 2021
March 15, 2021	March 18, 2021	March 24, 2021	March 5-18, 2021
March 26, 2021**	**March 31, 2021****	April 7, 2021	March 19-April 1, 2021
April 12, 2021	April 15, 2021	April 21, 2021	April 2-15, 2021
April 26, 2021	April 29, 2021	May 5, 2021	April 16-29, 2021
May 10, 2021	May 13, 2021	May 19, 2021	April 30-May 13, 2021
May 21, 2021**	May 27, 2021	June 2, 2021	May 14-27, 2021
June 7, 2021	June 10, 2021	June 16, 2021	May 28-June 10, 2021
June 21, 2021	June 24, 2021	June 30, 2021	June 11-24, 2021
July 5, 2021	July 8, 2021	July 14, 2021	June 25-July 8, 2021
July 19, 2021	July 22, 2021	July 28, 2021	July 9-22, 2021
July 30, 2021**	August 5, 2021	August 11, 2021	July 23-August 5, 2021
August 16, 2021	August 19, 2021	August 25, 2021	August 6-19, 2021
August 30, 2021	**September 1, 2021****	September 8, 2021	August 20-September 2, 2021
September 13, 2021	September 16, 2021	September 22, 2021	September 3-16, 2021
September 27, 2021	September 30, 2021	October 6, 2021	September 17-30, 2021
October 8, 2021**	October 14, 2021	October 20, 2021	October 1-14, 2021
October 25, 2021	October 28, 2021	November 3, 2021	October 15-28, 2021
November 5, 2021**	November 11, 2021	November 17, 2021	October 29-November 11, 2021
November 22, 2021	November 25, 2021	December 1, 2021	November 12-25, 2021
December 6, 2021	December 9, 2021	December 15, 2021	November 26-December 9, 2021
December 17, 2021**	**December 22, 2021****	December 29, 2021	December 10-23, 2021
January 3, 2022	January 6, 2022	January 12, 2022	December 24-January 6, 2022
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, Sessional Payments and Locum Claim Forms. 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

2021 HOLIDAY DATES

Please make a note in your schedule of the following dates MSI will accept as "Holidays".	
NEW YEAR'S DAY	FRIDAY, JANUARY 1, 2021
HERITAGE DAY	MONDAY, FEBRUARY 15, 2021
GOOD FRIDAY	FRIDAY, APRIL 2, 2021
EASTER MONDAY	MONDAY, APRIL 5, 2021
VICTORIA DAY	MONDAY, MAY 24, 2021
CANADA DAY	THURSDAY, JULY 1, 2021
CIVIC HOLIDAY	MONDAY, AUGUST 2, 2021
LABOUR DAY	MONDAY, SEPTEMBER 6, 2021
THANKSGIVING DAY	MONDAY, OCTOBER 11, 2021
REMEMBRANCE DAY	THURSDAY, NOVEMBER 11, 2021
CHRISTMAS DAY	MONDAY, DECEMBER 27, 2021
BOXING DAY	TUESDAY, DECEMBER 28, 2021
NEW YEAR'S DAY	MONDAY, JANUARY 3, 2022

Master Agreement - Program Payment Schedule (2020/21)

Program	Payment *
EMR (Envelope "A" Payments) EMR Envelope "A" payments continue monthly to eligible physicians	Monthly
CME (GP & Specialist) Payment for 2019/20 fiscal year (eligible billings based on 2019 calendar year)	Issued by May 31, 2020
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from April 1, 2020 – June 30, 2020	Issued by July 31, 2020
CMPA Premium Reimbursement Covering April - June 2020	Issued by August 31, 2020
Electronic Medical Records (EMR – B&C) Payments for 2019/20 Fiscal Year	Issued by August 31, 2020
Family Physician Alternative Payment Plan 5.6% Incentive	Issued by August 31, 2020
Surgical Assist Payments Payment based on eligible billings from April 1, 2019 – March 31, 2020	Issued by September 30, 2020
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from July 1, 2020 – September 30, 2020	Issued by October 31, 2020
Collaborative Practice Incentive Program Payments for 2019/20 Fiscal Year	Issued by October 31, 2020
CMPA Premium Reimbursement Covering July -September 2020	Issued by December 31, 2020
Rural Specialist Incentive Program Measurement period April 1st, 2019 – March 31st, 2020 / Payment for 2020/21 fiscal year	Issued by December 31, 2020
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from October 2020 – December, 2020	Issued by January 31, 2021
CMPA Premium Reimbursement Covering October -December 2020	Issued by March 31, 2021
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from January 2021 – March, 2021	Issued by April 30, 2021
CMPA Premium Reimbursement Covering January - March 2021	Issued by May 31, 2021

*Please be advised payment dates noted are the anticipated payments for these programs.

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November 13 2020: Vol. LXV, ISSUE 20

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

IMMUNIZATIONS ADMINISTERED BY OTHER HEALTH CARE PROFESSIONALS

Family physicians are reminded that they may only claim for vaccines they have either personally administered or those administered by nurses under direct supervision and employment of the physician. In the latter circumstance, the physician may only claim for the procedure if the physician is personally on the premises when the nurse administers the vaccine.

Family physicians cannot bill for services provided by nurses that are hired by NSHA as they would not be directly employed by the physician and therefore no service can be billed.

In the past, some family physicians have claimed for influenza vaccines administered by pharmacists, as a reminder, physicians may not claim for any immunizations/vaccines administered by a pharmacist.

NEW INTERIM FEES

The following Interim Health Service codes are effective November 13, 2020 – May 31, 2022.

Category	Code	Description	Base Units
VEDT	66.98E	**Percutaneous Insertion of Tunneled Intraperitoneal Catheter for use in dialysis.** **Description** This is a comprehensive code for the percutaneous insertion of a tunneled intraperitoneal catheter, it includes all imaging guidance and injection of contrast as required to complete the procedure. **Specialty Restriction:** SP=NEPH **Location:** LO=HOSP (QEII only)	125 MSU
VEDT	66.98F	**Removal of Tunneled Intraperitoneal Catheter (for use in dialysis)** **Description** This is a comprehensive code for the removal of tunneled intraperitoneal catheter, it includes all services required to remove the device and close the wound. **Specialty Restriction:** SP=NEPH **Location:** LO=HOSP (QEII only)	75 MSU
VEDT	66.98G	**Repositioning of Tunneled Intraperitoneal Catheter for use in dialysis** **Description** This is a comprehensive code for the repositioning of a tunneled intraperitoneal catheter, it includes all imaging guidance and injection of contrast as required to complete the procedure. **Specialty Restriction:** SP=NEPH **Location:** LO=HOSP (QEII only)	75 MSU

The following Interim Health Service code is effective November 13, 2020 – May 31, 2022.

Category	Code	Description	Base Units
VEDT	15.93D	**Removal or Revision of Intracranial neurostimulator electrodes (SEEG)** **Description** This is a comprehensive code for the removal of neurostimulator electrodes such as stereoelectroencephalography (SEEG) electrodes. **Specialty Restriction:** SP=NUSG, SP=PEDI **Location:** LO=HOSP (QEII & IWK only)	124 MSU

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NEW INTERIM FEES (CONTINUED)

As described in the October 15, 2020 Physicians Bulletin, the following interim health service codes are now available for billing effective October 19, 2020:

51.95A - Chronic Dialysis, treatment and supervision of care for the patient with end stage kidney disease, in hospital (hemodialysis or peritoneal dialysis) or in central outpatient hemodialysis units (for example; Halifax Victoria General Hospital, Yarmouth Regional Hospital, Cape Breton Regional Hospital) for a 24 hour period

51.95B - Chronic Hemodialysis, treatment and supervision of care for the patient with end stage kidney disease, in an urban satellite hemodialysis unit as designated by the Health Authority (for example; Halifax Infirmary, Dartmouth General, and North Sydney hemodialysis units) for a 24 hour period

51.95C - Chronic Hemodialysis, treatment and supervision of care, in a rural satellite hemodialysis unit as designated by the Health Authority (for example; Inverness, Straight Richmond, Antigonish, Pictou, Springhill, Liverpool, Berwick) for a 24 hour period.

51.95D - Chronic dialysis, treatment and supervision of care, for the patient on home peritoneal dialysis or home hemodialysis for a 24 hour period

FEE REVISIONS

Expanded eligibility for high dose influenza

As announced in the September 24, 2020 Physicians Bulletin, for the 2020/21 flu season the high-dose influenza vaccine may now be claimed for patients equal to or greater than 65 years of age who are also hospitalized and designated alternate level of care awaiting long-term care facility placement. Physicians holding eligible inpatient claims for health service code 13.59L RO=HDIN services performed on or after October 13, 2020 may now submit.

Infants under 5kg modifier (CO=UN5K) added to ANAE services

The infants under 5kg modifier has been added to the following health service codes so the proper anesthetic procedure fee may be claimed without a reassessment request:

- 65.01A - Repair of inguinal hernia with hydrocele
- 65.01 - Repair of inguinal hernia, unqualified
- 66.19 - Other laparotomy
- 50.24A - Coarctation of aorta
- 02.76 - Magnetic resonance imaging
- 51.0B - Pulmonary repair - subclavian – Blalock
- 01.09 - Other nonoperative bronchoscopy
- 15.34 - Ventricular shunt to abdominal cavity and organs
- 50.93G - Implantation of subcutaneous venous access system
- 03.39Q - Examination under anaesthesia with intubation
- 49.95 - Right cardiac catheterization

*For additional information on anesthetic service modifiers please see Physician's Manual preamble 3.2.33.

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FEE REVISIONS (CONTINUED)

Premium time modifiers may now be claimed on health service codes 47.25A and 47.25B

Category	Code	Description	Base Units	Anaes Units
MASG	47.25A	**Aortic Valve and ascending aorta replacement with reimplantation of coronary arteries (Bio-Bentall or Mechanical Bentall repair)** **Description** This is a comprehensive code for aortic root replacement with ascending aorta graft and valve conduit including coronary reimplantation. **Billing Guidelines** Not reportable with: • 47.25 Other replacement of Aortic valve • 50.34B Excision of thoracic aorta aneurysm • 48.13 Aortocoronary bypass of two coronary vessels May report, where clinically indicated, with: • ADON 51.61 Extracorporeal Circulation Auxiliary to open heart surgery • ADON 49.99C Repeat open heart surgery **Premium** US=PREM, US=PR50 **Specialty Restriction:** SP=CASG **Location:** LO=HOSP	1105 MSU	35+T
MASG	47.25B	**Valve sparing aortic root replacement or remodeling (David or Yacoub) with reimplantation or coronary arteries (VSR)** **Description** This is a comprehensive code for valve sparing aortic root replacement with graft, aortic valve suspension or remodeling, and coronary artery reimplantation. **Billing Guidelines** Not reportable with: • 47.25 Other replacement of Aortic valve • 50.34B Excision of thoracic aorta aneurysm • 48.13 Aortocoronary bypass of two coronary vessels May report, where clinically indicated, with: • ADON 51.61 Extracorporeal Circulation Auxiliary to open heart surgery • ADON 49.99C Repeat open heart surgery **Premium** US=PREM, US=PR50 **Specialty Restriction:** SP=CASG **Location:** LO=HOSP	1105 MSU	35+T

*Please refer to Physician's Manual preamble 5.1.81 for designated premium times.

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The effective period for interim health service code 03.04I – PSP mental health comprehensive visit to establish the Practice Support Program (PSP) mental health plan, has been extended to April 30, 2021.

Category	Code	Description	Base Units
VIST	03.04I	**PSP Mental Health Comprehensive Visit to establish the PSP Mental Health Plan (PSP= Practice Support Program)** This code is for the complete assessment of the patient with a confirmed mental illness meeting the diagnostic criteria in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of sufficient severity and acuity to cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and warrant the development of a Mental Health care plan. This is not intended for patients with self-limited or short lived mental health symptoms. The assessment is to be performed by the PSP trained family physician most responsible for the patient's mental health care. The Mental Health Plan and start and stop times must be documented in the health record. This complete assessment is to include **all** of the following elements and be documented in the health record: • The patient's DSM diagnosis, psychiatric history and current mental state including suicide risk assessment as appropriate • Obtaining collateral history and information from caregivers as required • Performance of a complete medication review to include collateral information from pharmacy and assisted living facility as appropriate • Reviewing and documenting results of relevant validated assessment tools, laboratory, and other test results • Documentation of a clinical plan for the patient's care over the next year. Includes advanced care planning where appropriate • Outline of expected outcomes as a result of the treatment plan • Outline of linkages with other health care providers and community resources who will be involved in the patients care. • Confirmation that the plan has been created jointly and shared with the patient or their medical representative. The plan is to be shared with other care providers as appropriate • A documented care plan must be in place before access to additional counselling hours is provided It is recognized that the required elements may require more than one visit to complete. This health service code may be claimed at the final visit only when all of the information is complete and documented in the health record; other visits may be reported at the usual rate. **All** elements must be documented in the health record before reporting this PSP MHP visit service. **Billing Guidelines** • Reportable by the patient's PSP trained physician only • Not reportable with any other visit fee for the same physician, same patient, same day • Not reportable for services provided at walk-in clinics • Not to be used for patients living in nursing homes, residential care facilities or hospices • Reportable only once per patient per year • 50 MSU for first 30 minutes, 25 MSU for each additional 15 minutes, up to a maximum of 1 hour (5 multiples) • Start and stop times must be reported in the text field of the claim to MSI, as well as in the clinical record **Specialty Restriction** GENP with PSP Training **Location** OFFC, HOME	50 MSU +MU

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INTERIM FEES MADE PERMANENT

As announced in the October 26, 2020 Physician's Bulletin, the following health service codes are now permanent. Physicians holding their claims for service dates after October 30, 2020 may now submit their billings.

Category	Code	Description	Base Units
VADT	13.59P	**Insertion of Buprenorphine Implant (e.g. Probuphine) for the treatment of opioid use disorder** This HSC is for the insertion of the non-biodegradable buprenorphine delivery implant for the treatment of opioid use disorder	20 MSU
VADT	13.59Q	**Removal of Buprenorphine Implant (e.g. Probuphine)** This HSC is for the removal of the non-biodegradable buprenorphine delivery implant For removal and reinsertion of the non-biodegradable buprenorphine delivery implant, report the removal code at 100% and the insertion code at LV50. **Billing Guidelines** May not be claimed in addition to OAT1 or OAT2 by any physician for the same patient for 6 months following implantation. If the implant is removed early or there are special circumstances to consider the physician should add text to the OAT management claim explaining the circumstances.	20 MSU

As announced in the October 26, 2020 Physician's Bulletin, the following health service code is now permanent. Physicians holding their claims for service dates after October 30, 2020 may now submit their billings.

Category	Code	Description	Base Units
VEDT	50.0B	**Endovascular Thrombectomy-Intracranial** 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** HOSP (QEII only)	300 MSU

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INTERIM FEES MADE PERMANENT (CONTINUED)

The health service code for Mindfulness Based Cognitive Therapy is now a permanent fee.

Category	Code	Description	Base Units
PSYC	08.44A	**Mindfulness-Based Cognitive Therapy (MBCT)** **Group therapy fee per patient per two hour session (minimum 8 to maximum 12 patients per group)** **Description** MBCT is defined as a specific psychological intervention incorporating elements of cognitive behavioral therapy and mindfulness. This fee is for each two hour session of the eight week MBCT course provided for a group of 8 to 12 patients with recurrent episodes of depression. **Billing Guidelines** • Fee is per patient, per two hour session • Session dates and start/stop times must be documented in the health record of each participant • One series of 8 sessions per patient per 365 days • Additional fees may be charged to the patient for non-billable services such as the provision of course materials and for the services of a privately paid non-MD therapist if applicable. Start and stop time to be documented in the health record; however session outline and activities are standardized to be completed in 2 hours. **Specialty Restriction:** SP=GENP with approval from MSI SP=PSYC with approval from MSI Physicians eligible to claim this code must submit credentials to MSI directly. Once MSI receives a physician's credentials and grants approval, the physician will be permitted to claim for this fee after the next system update. **Location:** LO=OFFC, LO=HOSP, LO=OTHR	14.3 MSU

Billing Matters Billing Reminders, Updates, New Explanatory Codes

BILLING REMINDERS

Tonometry and Surgical Procedures

Physicians are reminded that tonometry is considered to be an included part of any surgical procedure services claimed, thus a separate claim should not be made for this service.

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NEW AND UPDATED EXPLANATORY CODES

Code	Description
AD087	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS RO=HDIN MAY ONLY BE CLAIMED FROM A LONG TERM CARE/RESIDENTIAL CARE FACILITY OR HOSPITAL INPATIENT FOR PATIENT DESIGNATED ALTERNATE LEVEL OF CARE AWAITING LONG TERM CARE FACILITY PLACEMENT.
GN105	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE ALREADY CLAIMED A SURGICAL PROCEDURE ON THIS DAY. TONOMETRY IS CONSIDERED TO BE AN INCLUDED PART OF ANY SURGICAL PROCEDURE.
GN106	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE ALREADY CLAIMED FOR TONOMETRY ON THIS DAY FOR THIS PATIENT. TONOMETRY IS CONSIDERED TO BE AN INCLUDED PART OF ANY SURGICAL PROCEDURE.
VE028	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CHRONIC DIALYSIS MANAGEMENT DAILY TREATMENT AND SUPERVISION FEE HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THAT DATE.
VE029	SERVICE ENCOUNTER HAS BEEN REFUSED AS AN OUTPATIENT VISIT OR CONSULT FROM A RELATED SPECIALTY HAS BEEN CLAIMED FOR THIS PATIENT ON THAT DATE.
VE030	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE SPECIALTY SUBMITTED MAY ONLY CLAIM THIS SERVICE FROM THE YARMOUTH REGIONAL HOSPITAL.
VE031	SERVICE ENCOUNTER HAS BEEN REFUSED AS ANOTHER CHRONIC DIALYSIS FEE HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THAT DATE.
VT172	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CHRONIC DIALYSIS MANAGEMENT DAILY TREATMENT AND SUPERVISION FEE HAS BEEN CLAIMED FOR THIS PATIENT ON THAT DATE.
VT173	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED A DAILY DIALYSIS MANAGEMENT FEE FOR THIS PATIENT ON THIS DATE. IF THIS VISIT IS UNRELATED TO DIALYSIS MANAGEMENT PLEASE SUBMIT A REASSESSMENT REQUEST WITH SUPPORTING INFORMATION.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday November 13th, 2020. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), Modifiers (MODVALS.DAT) and, Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

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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
www.novascotia.ca/dhw/

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NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

CHANGE TO BREAST REDUCTION CRITERIA

Effective November 2, 2020, DHW has added the diagnosis of Persistent and Well Documented Gender Dysphoria to the list of criteria for MSI coverage for a breast reduction. Approved GAS applications must be on file and the request for approval must come from the NS physician who will be providing this service.

LOCUM PHYSICIANS PARTICIPATING IN SUPPLEMENTAL ACTIVITIES

Where locum physicians desire to participate in supplemental activities (e.g. CHIP, PMC), they will be eligible to do so in addition to the locum hours and will be compensated per the supplemental program's funding model. However, a locum physician must fulfill the hours specified for the locum income received on the day before claiming any additional remuneration. Locum hours cannot be 'made up' on a subsequent day.

- Where possible, the supplemental activity should be fulfilled before or after the 'locum' hours.
- Where frequent interruptions are expected throughout any given day (e.g. urgent inpatient response, antenatal services) and there is a considerable likelihood a full day of locum services cannot be achieved, the host/locum physicians should consider the half-day guarantee or FFS remuneration for the care services.
- If a locum physician does not fulfill the service requirement as stated on the host application and/or claim form, the locum physician must advise Medavie for an adjustment to the locum compensation where applicable.

- Please click here for a Primary Maternity Care (PMC) Program QA.
- Please click here for a Community Hospital Inpatient Program (CHIP) QA.

Please see the updated GP Locum Application Form and GP Specialist Locum Claim Form

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October 26 2020: Vol. LXV, ISSUE 18

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

INTERIM FEES MADE PERMANENT

Please be advised that the following interim health service codes will be made permanent. However, physicians are asked to hold any claims with service dates October 31, 2020 – November 12, 2020 until the MSI system is updated on November 13, 2020.

50.0B – Endovascular Thrombectomy - Intracranial

Details on the above code can be found in the May 14, 2020 Physician's Bulletin.

13.59P – Insertion of Buprenorphine Implant (e.g. Probuphine) for the Treatment of Opioid Use Disorder

13.59Q – Removal of Buprenorphine Implant (e.g. Probuphine)

Details on the above codes can be found in the April 5, 2019 Physician's Bulletin.

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NOVA SCOTIA MEDICAL SERVICES INSURANCE

New Interim Fees

INTERIM HEMODIALYSIS FEES

The following interim fees are effective October 19, 2020. Physicians are advised to hold these claims until the MSI system is updated on November 13, 2020.

Category	Code	Description	Base Units
VEDT	51.95A	**Chronic Dialysis – treatment and supervision of care for the patient with end stage kidney disease, in hospital (hemodialysis or peritoneal dialysis) or in central outpatient hemodialysis units (for example; Halifax Victoria General Hospital, Yarmouth Regional Hospital, Cape Breton Regional Hospital) for a 24 hour period.** **Description** This comprehensive, daily fee (24 hour period beginning at 12:00am until 11:59pm of the same calendar day) is for the treatment and supervision of care for a patient with end stage kidney disease who is registered in the Renal Program (NSHA, STARS or PHS, as a series visit for dialysis) and requires chronic dialysis (hospital or central outpatient hemodialysis unit). The physician is expected to supervise all aspects of the patients dialysis care and to provide direct, face-to-face clinical assessment of the patient, including a physical examination appropriate to the patient's medical condition, at least once in every 14 day period with additional clinical assessments as required based on concerns related to changes in the patient's medical condition. Each assessment will be documented in the patient's health record. Elements of care include: A. All management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital in-patients and in-person emergency department visits related to the management of chronic dialysis. It does not include acute dialysis. Acute dialysis is defined as dialysis rendered to a hospital inpatient in an intensive care setting, or to a patient beginning dialysis for the first time in their lifetime through to their 6th treatment at which point the dialysis is defined as chronic. A visit service, consultation or directive care as appropriate, may be claimed for hospital inpatients if the nephrologist is asked by the patient's most responsible physician to render an opinion and furnish advice regarding the patient's ongoing nephrological care during their hospital stay. The most responsible physician requesting the advice may not be another nephrologist. B. All outpatient consultations and visits within the scope of practice of nephrology for the assessment and treatment of complications of chronic dialysis and management of end stage kidney disease. Including: a. Review of laboratory and diagnostic test results b. Management of volume status, ideal body weight and blood pressure c. Assessment of dialysis access, such as; central venous catheter, arteriovenous fistula and peritoneal catheter, and management of any complications as required. d. Complete and document the Ambulatory Medication Reconciliation every six months	12.11 MSU

C. All related counselling, interviews and family meetings

D. Perform all assessments and consultation requests to refer the chronic dialysis patient to the Multiorgan Transplant Program for determination of kidney transplant eligibility.

E. All related case conferences, such as, but not limited to:
   a. Weekly Morning Program Rounds
   b. Review of laboratory and diagnostic test results with multidisciplinary team

For all patients in all hemodialysis units, the Nephrologist assigned to each unit will provide daily coverage of all dialysis patients to address any dialysis issues by being available to speak with the unit charge nurse or team lead every shift to discuss any problems or concerns with individual patients at any time.

The Nephrologist assigned to each unit will provide additional care and address concerns or problems that arise during the course of a hemodialysis treatment or within the 24 hour period of supervision, such as, but not limited to, changes to dialysis prescription or medications based on laboratory results like serum potassium or INR for patients on oral anticoagulants, when results are received after the treatment.
A standardized review of the patient's overall status on dialysis will be completed and updated every 6 weeks and documented in the patient's health record.

The document will include:
   a. Review and interpretation of laboratory and diagnostic test results
   b. Volume status, ideal body weight, blood pressure and physical examination appropriate to the patient's medical needs.
   c. Assessment of dialysis access, such as; central venous pressure, arteriovenous fistula, peritoneal catheter, and management of any complications as required.

Billing Guidelines

- Claimable by the Most Responsible Nephrologist once per patient per 24 hour period beginning at 12:00am (midnight) and ending at 11:59pm.
- May not claim any other chronic dialysis HSCs for the same patient, same 24 hour period.
- May not claim any other outpatient visit HSCs same physician, same patient, same 24 hour period.
- A Nephrologist providing coverage for care of the chronic dialysis patient on behalf of the most responsible nephrologist may not claim any outpatient visit HSC or chronic dialysis HSCs.
- Emergency hospital visits to attend the patient for a condition unrelated to the management of dialysis, its complications and end stage kidney disease may be claimed but must be submitted for manual assessment with supporting information in the text (clinical documentation may be required). Should the patient be admitted to hospital under the care of the nephrologist, who is acting as the most responsible physician, inpatient visits may be claimed.
- First claim may be made on the date of the patient's first chronic dialysis treatment.
- May not be claimed after the treatment terminates by, for example, successful transplantation, loss of resident status, or death.
- When a face-to-face clinical assessment is not documented in the patient's health record in the 14 day period, payment will be recovered from the Most Responsible Physician who claimed for the service the majority of the days in the preceding seven day period at the end of which the examination was to have occurred.

Specialty Restriction:
SP=NEPH, SP=INMD acting in the role of the NEPH at the Yarmouth Regional Hospital as designated by NSHA Renal Program Senior Medical Director.

Location:
LO=HOSP

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Category	Code	Description	Base Units
VEDT	51.95B	**Chronic Hemodialysis – treatment and supervision of care for the patient with end stage kidney disease, in an urban satellite hemodialysis unit as designated by the Health Authority (for example; Halifax Infirmary, Dartmouth General, and North Sydney hemodialysis units) for a 24 hour period.** **Description** This comprehensive, daily fee (24 hour period beginning at 12:00 am until 11:59 pm of the same calendar day) is for the treatment and supervision of care for a patient with end stage kidney disease who is registered in the Renal Program (NSHA, STARS or PHS, as a series visit for dialysis) and requires chronic dialysis in an urban satellite hemodialysis unit as designated by the Health. The physician is expected to supervise all aspects of the patient's dialysis care and to provide direct, face-to-face clinical assessment of the patient, including a physical examination appropriate to the patient's medical condition, at least once in every 42 day period, and via PHIA compliant, synchronous virtual care platform once in every 14 day period, with additional clinical assessments as required based on concerns related to changes in the patient's medical condition. Each assessment will be documented in the patient's health record. Elements of care include: A. All management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital in-patients and in-person emergency department visits related to the management of chronic dialysis. It does not include acute dialysis. Acute dialysis is defined as dialysis rendered to a hospital inpatient in an intensive care setting, or to a patient beginning dialysis for the first time in their lifetime through to their 6th treatment at which point the dialysis is defined as chronic. A visit service, consultation or directive care as appropriate, may be claimed for hospital inpatients if the nephrologist is asked by the patient's most responsible physician to render an opinion and furnish advice regarding the patient's ongoing nephrological care during their hospital stay. The most responsible physician requesting the advice may not be another nephrologist. B. All outpatient consultations and visits within the scope of practice of nephrology for the assessment and treatment of complications of chronic dialysis and management of end-stage kidney disease. Including: a. Review of laboratory and diagnostic test results b. Management of volume status, ideal body weight and blood pressure c. Assessment of dialysis access, such as; central venous catheter, arteriovenous fistula and peritoneal catheter, and management of any complications as required. d. Complete and document the Ambulatory Medication Reconciliation every six months C. All related counselling, interviews and family meetings D. Perform all assessments and consultation requests to refer the chronic dialysis patient to the Multiorgan Transplant Program for determination of kidney transplant eligibility. E. All related case conferences, such as, but not limited to: a. Weekly Morning Program Rounds b. Review of laboratory and diagnostic test results with multidisciplinary team For all patients in all hemodialysis units, the Nephrologist assigned to each unit will provide daily coverage of all dialysis patients to address any dialysis issues by being available to speak with the unit charge nurse or team lead every shift to discuss any problems or concerns with individual patients at any time. The Nephrologist assigned to each unit will provide additional care and address concerns or problems that arise during the course of a hemodialysis treatment or within the 24 hour period of supervision, such as, but not limited to, changes to dialysis prescription or medications based on laboratory results like serum potassium or INR for patients on oral anticoagulants, when results are received after the treatment time.	12.11 MSU

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A standardized review of the patient's overall status on dialysis will be completed and updated every 6 weeks and documented in the patient's health record.

The document will include:

a. Review and interpretation of laboratory and diagnostic test results
b. Volume status, ideal body weight, blood pressure and physical examination appropriate to the patient's medical needs.
c. Assessment of dialysis access, such as; central venous pressure catheter, arteriovenous fistula, peritoneal catheter, and management of any complications as required.

Billing Guidelines

- Claimable by the Most Responsible Nephrologist once per patient per 24 hour period beginning at 12:00 am (midnight) and ending at 11:59 pm.
- May not claim any other chronic dialysis HSCs for the same patient, same 24 hour period.
- May not claim any other outpatient visit HSCs same physician, same patient, same 24 hour period.
- A Nephrologist providing coverage for care of the chronic dialysis patient on behalf of the most responsible nephrologist may not claim any outpatient visit HSCs or chronic dialysis HSCs.
- Emergency hospital visits to attend the patient for a condition unrelated to the management of dialysis, its complications and end stage kidney disease may be claimed but must be submitted for manual assessment with supporting information in the text (clinical documentation may be required). Should the patient be admitted to hospital under the care of the nephrologist, who is acting as the most responsible physician, inpatient visits may be claimed.
- First claim may be made on the date of the patient's first chronic dialysis treatment.
- May not be claimed after the treatment terminates by, for example; successful transplantation, loss of resident status, or death.
- When a face-to-face clinical assessment is not documented in the patient's health record in the 14 day period, payment will be recovered from the Most Responsible Physician who claimed for the service for the majority of days in the preceding seven day period at the end of which the examination was to have occurred.

Specialty Restriction:
SP=NEPH

Location:
LO=HOSP

Category	Code	Description	Base Units
VEDT	51.95C	**Chronic Hemodialysis – treatment and supervision of care, in a rural satellite hemodialysis unit as designated by the Health Authority (for example; Inverness, Strait Richmond, Antigonish, Pictou, Springhill, Liverpool, Berwick) for a 24 hour period.** **Description** This comprehensive, daily fee (24 hour period beginning at 12:00 am until 11:59 pm of the same calendar day) is for the treatment and supervision of care for a patient with end stage kidney disease who is registered in the Renal Program (NSHA, STARS or PHS, as a series visit for dialysis) and requires hemodialysis in a rural satellite hemodialysis unit as designated by the Health Authority. The physician is expected to supervise all aspects of the patient's dialysis care and to provide direct, face-to-face clinical assessment of the patient, including a physical examination appropriate to the patient's medical condition, at least once in every 90 day period, and via PHIA compliant, synchronous virtual care platform once in every 14 day period, with additional clinical assessments as required based on concerns related to changes in the patient's medical condition. Each assessment will be documented in the patient's health record.	12.11 MSU

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Elements of care include:

A. All management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital in-patients and in-person emergency department visits related to the management of chronic dialysis. It does not include acute dialysis. Acute dialysis is defined as dialysis rendered to a hospital inpatient in an intensive care setting, or to a patient beginning dialysis for the first time in their lifetime through to their 6th treatment at which point the dialysis is defined as chronic. A visit service, consultation or directive care as appropriate, may be claimed for hospital inpatients if the nephrologist is asked by the patient's most responsible physician to render an opinion and furnish advice regarding the patient's ongoing nephrological care during their hospital stay. The most responsible physician requesting the advice may not be another nephrologist.

B. All outpatient consultations and visits within the scope of practice of nephrology for the assessment and treatment of complications of chronic dialysis and management of end-stage kidney disease.
Including:
    a. Review of laboratory and diagnostic test results
    b. Management of volume status, ideal body weight and blood pressure
    c. Assessment of dialysis access, such as; central venous catheter, arteriovenous fistula and peritoneal catheter, and management of any complications as required.
    d. Complete and document the Ambulatory Medication Reconciliation every six months

C. All related counselling, interviews and family meetings

D. Perform all assessments and consultation requests to refer the chronic dialysis patient to the Multiorgan Transplant Program for determination of kidney transplant eligibility.

E. All related case conferences, such as, but not limited to:
    a. Weekly Morning Program Rounds
    b. Review of laboratory and diagnostic test results with multidisciplinary team

For all patients in all hemodialysis units, the Nephrologist assigned to each unit will provide daily coverage of all dialysis patients to address any dialysis issues by being available to speak with the unit charge nurse or team lead every shift to discuss any problems or concerns with individual patients at any time.

The Nephrologist assigned to each unit will provide additional care and address concerns or problems that arise during the course of a hemodialysis treatment or within the 24 hour period of supervision, such as, but not limited to, changes to dialysis prescription or medications based on laboratory results like serum potassium or INR for patients on oral anticoagulants, when results are received after the treatment time.

A standardized review of the patient's overall status on dialysis will be completed and updated every 6 weeks and documented in the patient's health record.

The document will include:
    a. Review and interpretation of laboratory and diagnostic test results
    b. Volume status, ideal body weight, blood pressure and physical examination appropriate to the patient's medical needs.
    c. Assessment of dialysis access, such as; central venous pressure catheter, arteriovenous fistula, peritoneal catheter, and management of any complications as required.

Billing Guidelines

- Claimable by the Most Responsible Nephrologist once per patient per 24 hour period beginning at 12:00 am (midnight) and ending at 11:59 pm.
- May not claim any other chronic dialysis HSCs for the same patient, same 24 hour period.
- May not claim any other outpatient visit HSCs same physician, same patient, same 24 hour period.

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- A Nephrologist providing coverage for care of the chronic dialysis patient on behalf of the most responsible nephrologist may not claim any outpatient visit HSCs or chronic dialysis HSCs.
- Emergency hospital visits to attend the patient for a condition unrelated to the management of dialysis, its complications and end stage kidney disease may be claimed but must be submitted for manual assessment with supporting information in the text (clinical documentation may be required). Should the patient be admitted to hospital under the care of the nephrologist, who is acting as the most responsible physician, inpatient visits may be claimed.
- First claim may be made on the date of the patient's first chronic dialysis treatment.
- May not be claimed after the treatment terminates by, for example; successful transplantation, loss of resident status, or death.
- When a face-to-face clinical assessment is not documented in the patient's health record in the 90 day period, payment will be recovered from the Most Responsible Physician who claimed for the service for the majority of days in the preceding seven day period at the end of which the examination was to have occurred.

Specialty Restriction:
SP=NEPH, SP=INMD acting in the role of the NEPH at the Yarmouth Regional Hospital as designated by NSHA Renal Program Senior Medical Director.

Location:
LO=HOSP

Category	Code	Description	Base Units
VEDT	51.95D	**Chronic Dialysis – treatment and supervision of care for the patient on home peritoneal dialysis or home hemodialysis for a 24 hour period.**	12.11 MSU

Description
This comprehensive, daily fee (24 hour period beginning at 12:00 am until 11:59 pm of the same calendar day) is for the treatment and supervision of care for a patient with end stage kidney disease who is registered in the Renal Program (NSHA, STARS or PHS) and requires home peritoneal dialysis or home hemodialysis. The physician is expected to supervise all aspects of the patient's dialysis care and to provide direct, face-to-face clinical assessment of the patient, including a physical examination appropriate to the patient's medical condition, at least once in every 90 day period with additional clinical assessments as required based on concerns related to changes in the patient's medical condition. Each assessment will be documented in the patient's health record.

Elements of care include:

A. All management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital in-patients and in-person emergency department visits related to the management of chronic dialysis. It does not include acute dialysis. Acute dialysis is defined as dialysis rendered to a hospital inpatient in an intensive care setting, or to a patient beginning dialysis for the first time in their lifetime through to their 6th treatment at which point the dialysis is defined as chronic. A visit service, consultation or directive care as appropriate, may be claimed for hospital inpatients if the nephrologist is asked by the patient's most responsible physician to render an opinion and furnish advice regarding the patient's ongoing nephrological care during their hospital stay. The most responsible physician requesting the advice may not be another nephrologist.

B. All outpatient consultations and visits within the scope of practice of nephrology for the assessment and treatment of complications of chronic dialysis and management of end-stage kidney disease.
Including:
   a. Review of laboratory and diagnostic test results
   b. Management of volume status, ideal body weight and blood pressure
   c. Assessment of dialysis access, such as; central venous catheter, arteriovenous fistula and peritoneal catheter, and management of any complications as required.
   d. Complete and document the Ambulatory Medication Reconciliation every six months

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C. All related counselling, interviews and family meetings

D. Perform all assessments and consultation requests to refer the chronic dialysis patient to the Multiorgan Transplant Program for determination of kidney transplant eligibility.

E. All related case conferences, such as, but not limited to:
   a. Weekly Morning Program Rounds
   b. Review of laboratory and diagnostic test results with multidisciplinary team

In addition, the nephrologist will be available on a daily basis to address the following:
a. All dialysis related concerns of outpatients that are managed by the home dialysis unit
b. Unexpected or planned drop-in visits by home dialysis patients with concerns related to their dialysis care
c. Concerns of patients who are training for home hemodialysis or peritoneal dialysis

A standardized review of the patient's overall status on dialysis will be completed and updated every 90 days in the patient's health record.

The document will include:
   a. Review and interpretation of laboratory and diagnostic test results
   b. Volume status, ideal body weight, blood pressure and physical examination appropriate to the patient's medical needs.
   c. Assessment of dialysis access, such as; central venous pressure catheter, arteriovenous fistula, peritoneal catheter, and management of any complications as required.

Billing Guidelines
- Claimable by the Most Responsible Nephrologist once per patient per 24 hour period beginning at 12:00 am (midnight) and ending at 11:59 pm.
- May not claim any other chronic dialysis HSCs for the same patient, same 24 hour period.
- May not claim any other outpatient visit HSCs same physician, same patient, same 24 hour period.
- A Nephrologist providing coverage for care of the chronic dialysis patient on behalf of the most responsible nephrologist may not claim any outpatient visit HSCs or chronic dialysis HSCs.
- Emergency hospital visits to attend the patient for a condition unrelated to the management of dialysis, its complications and end stage kidney disease may be claimed but must be submitted for manual assessment with supporting information in the text (clinical documentation may be required).). Should the patient be admitted to hospital under the care of the nephrologist, who is acting as the most responsible physician, inpatient visits may be claimed.
- First claim may be made on the date of the patient's first chronic dialysis treatment.
- May not be claimed after the treatment terminates by, for example; successful transplantation, loss of resident status, or death.
- When a face-to-face clinical assessment is not documented in the patient's health record in the 90 day period, payment will be recovered from the Most Responsible Physician who claimed for the service for the majority of days in the preceding seven day period at the end of which the examination was to have occurred.

Specialty Restriction:
SP=NEPH

Location:
LO=HOME, LO=OFFC

Modifiers:
ME=PERI (peritoneal dialysis), ME=HEMO (hemodialysis)

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PHYSICIAN'S BULLETIN
September 24 2020: Vol. LXV, ISSUE 16

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

NON-FACE-TO-FACE SERVICES DURING PANDEMIC

Physicians are advised that eligible dates of service for non-face-to-face services provided by telephone, via telehealth network or via PHIA compliant virtual care platforms as outlined in the March 27, 2020 bulletin have been extended to December 31, 2020. As a reminder, all services are only eligible to be claimed when rendered by a physician currently physically located in Nova Scotia.

EXPANDED ELIGIBILITY FOR HIGH-DOSE INFLUENZA VACCINE DURING 2020/21 FLU SEASON

Effective from October 13, 2020 to April 1, 2021 the high-dose influenza vaccine will be available to patients equal to or greater than 65 years of age who are also hospitalized and designated alternate level of care awaiting long-term care facility placement. This eligibility is limited to the 2020/21 influenza season only. Please hold your eligible hospital inpatient claims for HSC 13.59L RO=HDIN until MSI is able to update the billing system. Once updated a communication will be provided via the Physician's Bulletin.

PHYSICIAN'S BULLETIN
August 20 2020: Vol. LXV, ISSUE 15

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

REMINDER: INCOME STABILITY SHADOW BILLING BA END DATE

The Department of Health and Wellness, Doctors Nova Scotia, IWK and the NSHA worked together to address income stability for fee-for-service (FFS) physicians during COVID-19 through the voluntary Income Stability Program.

Please note that if you have participated in the program, the program formally ended on **July 13, 2020**.

Q: When should I start to use my existing FFS business arrangement(s) (BA) that I used prior to joining the Income Stability Program?

Effective **July 14, 2020** claims with services provided from July 14, 2020 must be submitted using your existing FFS BA(s) to receive payment.

Q: Can MSI make the switch between Income Stability shadow billing arrangement(s) (BA) and my existing FFS business arrangement(s) (BA)?

A: No, your Administrative/Office staff need to revert to your existing FFS BA in your computer software billing system.

Q: Should the Income Stability Program shadow billing business arrangement(s) (BA) continue to be used?

A: Your shadow billing BA(s) must still be used to submit any outstanding claims associated with services provided from March 13, 2020 to July 13, 2020.

Q: Claims have been submitted under my Income Stability shadow billing arrangement(s) (BA) with dates of service July 14, 2020 forward. What do I do with these claims?

A: Claims with dates of service July 14, 2020 forward submitted under the Income Stability shadow billing BA(s) must be reversed and resubmitted under the existing FFS BA(s) to receive payment.

PHYSICIAN'S BULLETIN
August 19 2020: Vol. LXV, ISSUE 14

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

REQUEST FOR PROPOSALS – PHYSICIAN CONSULTANT

The Department of Health and Wellness is seeking the services of a Physician Consultant to provide support and advice on a range of policy issues related to physician services, Pharmacare, Children's Oral Health Program, and other extended health benefit programs.

A Request for Proposals (RFP) is posted in the Government Procurement site at https://procurement.novascotia.ca/tender-details.aspx?id=DOC463104797.

The RFP closes September 11, 2020, 2 PM.

PHYSICIAN'S BULLETIN
July 10 2020: Vol. LXV, ISSUE 13

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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Outdated Policy Reminder

All original claims must be submitted to MSI within 90 days from the date of service. Claims that are outside of the specified time limitations will only be considered if extenuating circumstances can be demonstrated for a late submission and are within a reasonable time frame past the 90 day limit. Request for an extension must be made to MSI in writing and will be approved on a case by case basis. The time frame for submitting the request to MSI for late submission should be within one month following the 90 day limit.

Examples of extenuating circumstances may include physical damage to office such as fire or flood and or a serious technical issue.

Service encounters submitted over the 90-day limitation will be adjudicated to pay "zero" with the following exceptions:
- Reciprocal billing claims (out of province) must be submitted within 12 months of the date(s) of service.
-Resubmission of refused claims or incorrect billings. These claims must be resubmitted to MSI within 185 days of the date of service. Each resubmission must contain an annotation in the text field of the service encounter submission referencing the previous service encounter number.

Circumstances relating to staffing issues/shortages and mislaid, misfiled, or lost claims cannot be accepted by MSI as valid explanations for a late submission.

Claims for registered hospital in-patients must also be submitted within the 90 day time limitation regardless if the patient has been discharged or continues on an in-patient basis. It is incumbent on the physician to obtain the required billing information for these patients and submit claims within the prescribed time limitations. Explanations relating to late discharge summaries, or facilities not consolidating the required information for the physician, cannot be accepted as a valid explanation for a late submission.

Please note: Failure to use a preauthorization code given by MSI and annotate the text field with the previous service encounter number will result in an adjudication paid at "zero".

UPDATES

87.98 Delivery NEC

Effective April 1, 2020 the non-referred GENP fee for HSC 87.98 Delivery NEC has been increased to 263.70 MSU. Physicians who have already submitted their claims at the lower rate may delete and resubmit to be paid at the higher fee. For claims that are now over 90 days, physicians are required to submit with a preauthorization number in the appropriate field.

Non-Face-to-Face services during Pandemic

Physicians are advised that eligible dates of service for health service code 03.03X and non-face-to-face services provided by telephone, via telehealth network or via PHIA compliant virtual care platforms as outlined in the March 27, 2020 bulletin have been extended to September 30, 2020.

01.09D 01.09E EBUS Facility Update

As published in the March 6, 2020 Bulletin, HSC's 01.09D and 01.09E are location restricted to the QEII site. The system has been updated to include the VG as part of the QEII for billing purposes.

03.38A Specialty Restriction

With the title/description changes as noted in the May 2020 bulletin, there were also updates to the speciality restriction for 03.38A. This HSC may now be claimed by SP=RSMD in addition to SP=INMD and SP=PEDI.

BILLING REMINDERS

Physician Confirmation Letter Reminder

General Practitioners are reminded that to be eligible to use the modifier ME=CARE you must have submitted a Confirmation Letter attesting to your status as a primary care provider providing continuity of care in the context of an ongoing relationship with your patients (see original notification here). Only physicians who have submitted the Confirmation Letter will be eligible to bill with the ME=CARE modifier. Physicians are reminded that eligibility will commence as of the date the letter is received, unless otherwise notified. The letter can be found here and can be sent to: primary_care_investments@medavie.bluecross.ca.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
VT146	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED THE COMPLEX COMPREHENSIVE ACUTE CARE HOSPITAL DISCHARGE FEE FOR THIS PATIENT ON THE SAME DAY.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday July 10th, 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
www.novascotia.ca/dhw/

In partnership with

NOVA SCOTIA

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PHYSICIAN'S BULLETIN
June 26 2020: Vol. LXV, ISSUE 12

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

INCOME STABILITY PROGRAM END DATE

The Department of Health and Wellness, Doctors Nova Scotia, IWK and the NSHA have worked together to address income stability for fee-for-service (FFS) physicians during COVID-19 through the voluntary Income Stability Program.

Please note that if you have participated in the program, the program will formally end on **July 13, 2020**.

Physician Income Stability Program Completion Q&A

Q: What is the last payment date under the Income Stability Program?
A: You will continue to receive regular bi-weekly Income Stability payments on June 30, 2020 and July 15, 2020. The last Income Stability payment will occur on July 29, 2020. The final payment on July 29, 2020 will include payments for the July 10 to July 13, 2020 time period.

Q: When will the final reconciliation and associated payment under the program be completed?
A: Physicians have 90 days to submit shadow claims associated with services provided during the program's effective period. The reconciliation will be completed after the 90 day submission window has closed. The associated payment date will be communicated at a later date.

Q: Should the Income Stability Program shadow billing business arrangement(s) (BA) continue to be used?
A: Your shadow billing BA(s) must still be used to submit any outstanding claims associated with services provided from March 13, 2020 to July 13, 2020.

Q: When can I start to use my existing FFS business arrangement(s) (BA) that I used prior to joining the Income Stability Program?
A: You may start to submit claims using your existing FFS BA(s) effective July 14, 2020 for services provided from July 14, 2020 onward.

Q: If my shadow billings under the program period exceed my Income Stability payments, how will my top-up be paid?
A: Any required top-up will be paid when the reconciliation process noted above is completed.

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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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** **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	11.5 MSU

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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/

In partnership with

NOVA SCOTIA

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PHYSICIAN'S BULLETIN
May 6, 2020: Vol. LXV, ISSUE 10

NOVA SCOTIA MEDICAL SERVICES INSURANCE

PHYSICIAN INCOME STABILITY PROGRAM

As published in the April 27th MSI Physicians Bulletin, Physicians have until May 7/20 to submit a completed declaration form if they would like to participate in the Physician Stabilization Program. Due to higher than expected call volumes and email requests, there may be a delay in responding to incoming inquires. If you do not receive a response to your inquiry by May 7, please be assured that you will have the opportunity to submit the declaration form once MSI is in contact with you.

PHYSICIAN INCOME STABILITY PROGRAM Q&A

Q: What will be included in MSI's calculation of my 2019 billings?
A: MSI FFS billings will include all of a physician's billings to the MSI program for codes in the MSI tariff of fees for insured medical services, excluding the following billings:

- The unattached patient bonus
- Workers' Compensation
- Inpatient care billings (if the physician is a core team member of an approved Community Hospital Inpatient Program (CHIP) site), and
- Primary Maternity Care (PMC) billings if the physician is a core team member of a PMC.

If a physician has either increased or decreased their regular work hours since 2019, the base income will be adjusted accordingly (e.g., if a physician has gone from full-time to part-time, or vice versa).

Q: Are chronic disease management codes excluded from the calculation?
A: No, payment for chronic disease management codes are included in the 2019 FFS calculation.

Q: Where can I obtain information on my 2019 billings so I can decide which option to choose?
A: If physicians need information about their 2019 billing they can contact MSI at 902-496-7011 or toll-free 1-866-553-0585 (option 1/option 1) or email msiproviders@medavie.ca.

Q: Will extended leaves in 2019 be taken into account when the income for the Physician Stabilization Program is calculated?
A: Physicians will need to request special consideration when submitting the declaration form.

Q: When will the first payment for this program be?
A: The first biweekly payment under the program will be June 3/20. Physician declaration forms are due back to MSI by May 7, 2020.

PHYSICIAN INCOME STABILITY PROGRAM Q&A

Q: Where can I get more information on COVID-19 deployment?
A: The Nova Scotia Health Authority is managing deployment efforts. Physicians seeking more information about deployment can contact physicianrecruit@nshealth.ca.

Q: I am a family doctor who has been working in a COVID assessment clinic. To date, I have been paid at the GP sessional rate. Is the work I have done so far eligible to be paid at the pandemic sessional rate?
A: Yes, the new pandemic sessional rate of $180.60 now applies to all COVID assessment clinic work.

Q: Can I continue to bill FFS for my evening and weekend on call work?
A: If a physician enters into the Physician Stabilization Program, these claims are to be shadow billed as they are included in the income within this program, with the exception for PMC and CHIP.

Q: Can this program be prorated for part-time physicians?
A: Yes, this program can be prorated for part time physicians.

Q: Are FFS physicians who work at walk-in clinics able to apply for this program?
A: Yes.

Q: I am a new physician who began practising late in early 2020. Am I eligible to participate?
A: Physicians who started their practice in Nova Scotia after 1 January 2020 will be eligible for a base income of $9,973 bi-weekly, based on a full-time practice, plus any COVID-19 deployment compensation as detailed in the *Program Terms*. That amount will be pro-rated for part time physicians. Please indicate this special circumstance on your physician declaration.

Q: Can I opt into the program now and opt out later?
A: As per the program terms, a physician may terminate their participation in the program *after July 1, 2020*, by providing written notice to the Minister at least two weeks in advance. The Minister may terminate a physician's participation in the program as described in clause 25 by providing written notice to the physician.

Q: What are the accountability expectations within this program? Do I have to shadow bill?
A: Physicians are required to shadow bill for all regular office or hospital-based services delivered within their practice while participating in the program. Shadow billings remain subject to billing rules and billing audit provisions.

Q: I don't want to opt into this program. Can I still participate in COVID-19 deployment?
A: Participation in the income stability program is voluntary. If you choose not to participate you can still be deployed and compensated for COVID-19 work. Please contact the NSHA to organize your COVID-19 deployment work.

PHYSICIAN INCOME STABILITY PROGRAM Q&A

Q: Can I refuse deployment?

A: A physician may refuse a deployment request only in one of the following circumstances:

- the work is outside the physician's individual competence or contrary to the physician's license or any restrictions or conditions imposed by the College
- a lack of PPE results in an extraordinary risk to the physician
- the deployment would require the physician to breach public health orders (e.g. a requirement to self-isolate)
- the deployment would require the physician to travel greater than 120 kilometres one-way, and such travel would result in undue hardship to the physician (as determined by the Department).

Q: If I refuse deployment, am I still eligible to participate in this program?

A: When deploying physicians, the health authority or Minister will make reasonable efforts to accommodate limitations on the Physician's availability for deployment. If a physician refuses a deployment request, the physician must give notice in writing to the health authority and to the Minister outlining the reason for the refusal (and provide any further information or supporting information requested by the health authority and/or Minister) and remain available for other deployment as needed.

Q: I have an AFP/APP as well as FFS billings for exclusions to my contract. Am I eligible for the stabilization funding for my FFS contract exclusions and my AFP/APP funding will continue?

A: The income stability program will only apply to the FFS portion of your earnings. Physicians will remain eligible to receive other payments that are typically payable in addition to a physician's fee-for-service claims including:

- Master Agreement incentive programs
- Leadership/administrative stipends
- Pathology List B payments
- Facility on-call stipends
- Workers' compensation billings
- Payment under other programs or funding models for which the physician is eligible (including the Primary Maternity Care (PMC) Program
- Community Hospital Inpatient Program (CHIP), payment for Emergency Department or Hospitalist shifts, part-time APP or C/AFP entitlements, etc.)

Q: Can I access other federal or provincial wage subsidy programs on top of this?

A: This program does not restrict physicians from participating in other provincial or federal COVID stabilization initiative. However, participating physicians' consent to the disclosure of any information concerning financial assistance, support, insurance or indemnity of any kind received by the Physician in connection with the COVID-19 pandemic to the Minister. This could include COVID-19 pandemic related funding from the Government of Canada, the Government of Nova Scotia, the government of any other Canadian province, and any of their Ministers, Departments or related corporations or entities, and any other person or entity. It is recommended that physicians read the guidelines of the other provincial or federal programs carefully to ensure eligibility.

PHYSICIAN INCOME STABILITY PROGRAM Q&A

Q: Can I take a vacation or leave of absence if I participate in this program?
A: A physician participating in this program may take a short leave of absence from practice during the pandemic, if approved in writing in advance by the Minister. Otherwise the physician must remain in NS (except as authorized to leave for work required by the health authority or the Department or for those who regularly commute to work in NS from NB). Please direct inquiries to Vimy Glass at Vimy.Glass@novascotia.ca

Q: If my shadow billings under the program period exceed what I was paid, will I be eligible for a top-up for the difference between what I was paid and the value of my shadow billings?
A: Physicians will shadow bill for all services delivered within their regular practice while participating in the program. If a physician shadow bills for non-deployment work more than their base income (Option 1 or Option 2), then the physician will be paid the difference. This will be paid to the physician following the end of the program.

Q: When will retroactive payments from March 13 to the implementation date be made?
A: All retroactive payments owing under the program (base income for the period of March 13, 2020 to the first bi-weekly pay period of the program) will be calculated and paid following termination of the program.

PHYSICIAN'S BULLETIN
April 29 2020: Vol. LXV, ISSUE 9

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

CMPA – CHANGE IN REBATE FREQUENCY

The Department of Health and Wellness (through MSI) will continue to provide reimbursement of all eligible Canadian Medical Protective Association (CMPA) fees directly to physicians. Payments will move from the current semi-annual schedule to a new quarterly payment schedule. The first quarterly payment will be for period January – March 2020 to be issued in spring 2020.

These payments are deposited through an electronic funds transfer. If you do not already have a CMPA Business Arrangement set up to receive these deposits, you may fill out the MSI Provider Business Arrangement Form with a void cheque.

Should you have any questions regarding your CMPA payments, please contact: masteragreement@novascotia.ca

PHYSICIAN'S BULLETIN
April 27 2020: Vol. LXV, ISSUE 8

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

INCOME STABILITY PROGRAM FOR FEE FOR SERVICE PHYSICANS DURING COVID-19

Recently the Department of Health and Wellness, Doctors Nova Scotia, IWK and the NSHA have worked together to address income stability for fee-for-service (FFS) physicians during COVID-19 and stabilize the supply of physicians to meet the demands of the health-care system during the pandemic. This voluntary income stability program compensates FFS physicians who commit to be available for redeployment as needed during the COVID-19 pandemic.

If you are a FFS physician and choose to participate, you may be deployed to do a variety of tasks in hospitals, assessment centres, long-term care centres or in other locations as needed and as safe and appropriate for your training. Under this program, when you are not deployed you are still required to continue to provide all normal office or hospital-based services (in person or virtually) to the best of your ability within the context of the pandemic.

The physician declaration form offers FFS Physician's two income stability options to choose from and lays out the program terms. Please read the declaration carefully.

If you elect to participate, please complete the declaration form and return it to MSI by May 7, 2020. Only those physicians having signed and returned the declaration form by May 7, 2020 will be eligible for this program unless evidence is provided of extenuating circumstances.

- mail: MSI, PO Box 500, Halifax, NS B3J 2S1
- email: msiproviders@medavie.ca, or
- fax: 902-469-4674

If you have questions or require assistance in competing this form, please contact MSI at 902-496-7011 or toll-free 1-866-553-0585 (option 1/option 1) or email msiproviders@medavie.ca.

Thank you for your leadership in the health care system during COVID-19.

PHYSICIAN'S BULLETIN
April 9 2020: Vol. LXV, ISSUE 7

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

COVID-19 UPDATE

Physician Stabilization Program

The Nova Scotia Department of Health and Wellness and Doctors Nova Scotia are in the process of finalizing details of an income stabilization program for Nova Scotia fee for service physicians.

Physicians wishing to participate in the program will receive a fixed bi-weekly income that will provide a base payment in lieu of their fee for service activities. These physicians will be eligible for additional payment for COVID-19 specific redeployment work.

While the program is optional, it is mandatory that all participating physicians agree to be redeployed as necessary to areas of need during the pandemic.

The program will be retroactive to March 13, 2020 and will end at the conclusion of the pandemic.

Details of this program are being finalized and more information will be made available in the coming days. In the meantime, fee for service physicians should continue to submit claims for their services as they normally would. Once further details are available, there will be adjustments made to payments for services rendered between March 13 and the implementation date.

Staff at MSI and the Nova Scotia Department of Health and Wellness thank Nova Scotia's physicians for their dedication to Nova Scotians during this unprecedented time.

PHYSICIAN'S BULLETIN
April 1 2020: Vol. LXV, ISSUE 6

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

WCB-SPECIFIC HEALTH SERVICE CODES FOR PHONE, TELEHEALTH, VIRTUAL CARE SERVICES PROVIDED DURING PANDEMIC

WCB Nova Scotia is committed to doing their part to help reduce the spread of COVID-19, and is following the directions of public health officials during these unprecedented times. They are encouraging the use of alternate service delivery methods to promote physical distancing, but also the continued delivery of care to workers.

Effective March 13, 2020 the following WCB-specific health service codes (normally for services rendered in an in-person setting) will be permitted to be billed whether they are provided in person, by telephone, via hospital telehealth network, or via PHIA-compliant virtual care platform:

WCB12 EPS Physician Assessment Service (combined office visit and completion of form 8/10)
WCB28 Comprehensive Visit for Work Related Injury or Illness
WCB31 WCB Interim Fee – Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed

During this time, these services will be paid at the same rate as they would be if delivered in person.

Please submit your claims as you usually would, using your regular practice location. However, for services **not rendered in-person** at that location, include one of the below on the claim to indicate how care was delivered:

- If service was provided over the phone, use: **Pandemic telephone**
- If service was provided over the hospital telehealth network, use: **Pandemic telehealth**
- If service was provided over a virtual care platform, use: **Pandemic virtual care**

As per usual, all encounters must be recorded in the patient's health record. If the health record is not available at the time care is provided, a note should be made and placed in the patient's health record as soon as feasible. This should include your location, if other than the office, and the technology used to deliver care.

All other office-based non-procedural health service codes associated with care being provided to workers during the COVID-19 pandemic (for example, 03.03, 03.03A) are billable as per the direction provided in the MSI Physician's Bulletins of March 18, 24 and 27, 2020.

PHYSICIAN'S BULLETIN
March 27 2020: Vol. LXV, ISSUE 5

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

COVID-19 UPDATE

As announced in the March 18, 2020 MSI Bulletin, effective March 13, 2020, health service code 03.03X is available for billing on an interim basis for telephone management and telehealth management for presumptive/confirmed Covid-19 diagnosis as well as routine/interval care during the pandemic.

March 18, 2020 Physician's Bulletin

As announced in the March 24, 2020 MSI Bulletin, effective March 13, 2020 on an interim basis all office-based non-procedural services that are normally rendered in a face to face setting will be permitted to be reported whether they are performed in person, by telephone, via telehealth network, or via PHIA compliant virtual care platform.

March 24, 2020 Physician's Bulletin

Both Bulletins state that these services are only reportable when the communication is rendered personally by the physician reporting the service is not reportable if the service is delegated to another professional such as a:

- Nurse Practitioner
- Resident in training
- Clinical Fellow
- Medical Student

Update:
Effective March 13, 2020, the services announced in the March 24 bulletin may be claimed if performed by a resident including a licensed post graduate medical trainee (e.g. PGY-6 or PGY-7) under the direct supervision of a physician. The clinical record must indicate that they were supervised as well as the name of the supervising physician. The supervising physician must be onsite at the time the resident renders the service and additionally must be immediately available to render assistance.

The physician may claim for either the resident's services or his/her own, but not both, if they are performed at the same time.

For clarity, health service code 03.03X can only be claimed when rendered personally by the physician and not when provided by a resident.

Neither health service code 03.03X nor the services announced on March 24 may be claimed when rendered by another health care provider such as a nurse or nurse practitioner.

*All services are only eligible to be claimed when rendered by a physician currently physically located in Nova Scotia.

PHYSICIAN'S BULLETIN
March 24 2020: Vol. LXV, ISSUE 4

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

IMPORTANT INFORMATION ON NON FACE TO FACE SERVICES PROVIDED DURING PANDEMIC

Last week the new health service code 03.03X was announced to facilitate the provision of synchronous clinical care by physicians to their patients using technology that supports non face to face encounters; Telephone, Telehealth, and PHIA compliant virtual care platforms. This was provided at the same rate as is afforded to physicians who provided comprehensive primary care to their patients (ME=CARE) and is meant to encourage provision of non face to face care wherever possible and appropriate.

This new health service code will be available to load into your vendor software on Friday, March 27th. Once your vendor software has been updated, you may submit claims for any services rendered since March 13th.

In view of the extenuating circumstances and recommendations for social distancing, and in order to promote continued delivery of patient care as seamlessly as possible, **effective March 13th, 2020 all office based non-procedural services that are normally rendered in a face to face setting will be permitted to be reported whether they are provided in person, by telephone, via telehealth network, or via a PHIA compliant virtual care platform**. Such services would include limited visits, consultations, psychotherapy, and counselling where appropriate to be delivered in a synchronous non face to face encounter. Long Term Care, Residential Care, and Hospice services normally rendered face to face due to medical necessity could be reported using this format. During this interim measure these services will be paid at the same rate as they would be if delivered face to face.

Please submit your claims for encounters as you usually would, using your normal practice location. For all services not rendered face to face at that location, include the following text on the claim to denote the mode of synchronous care delivery:

- If service was provided via phone call: **Pandemic telephone**
- If service was provided over the telehealth network: **Pandemic telehealth**
- If service was provided over a virtual care platform: **Pandemic virtual care**

If the service is rendered to a patient with suspected or confirmed diagnosis of Covid-19, include diagnostic code **487.8** in the appropriate diagnostic field. For the duration of the pandemic, diagnostic code 487.8 should only be used in confirmed or suspected cases of Covid-19. For other influenza strains please use a separate applicable diagnostic code.

IMPORTANT INFORMATION ON NON FACE TO FACE SERVICES PROVIDED DURING PANDEMIC *(CONTINUED)*

Please note:

We recognize that due to the extenuating circumstances of these difficult times, the ability to perform a comprehensive physical examination using these platforms may be limited, otherwise the usual preamble requirements apply to all services.

- The HSC is not reportable for administrative tasks
- 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
  - Renew prescription
  - Arranging to provide a sick note
  - 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 not reportable for other forms of communication such as:

- Written email or fax communication
- Electronic verbal forms of communication that are not PHIA complaint.

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

The service is not reportable if the decision is to see the patient at the next available appointment in the office or outpatient clinic and is not available for walk-in clinics. The HSC is reportable for Health Authority supported clinics.

All encounters must be recorded in the patient's health record. It is recognized that the health record may not be available at the time of the call, but a note should made and placed in health record as soon as feasible. This should include the location of the provider (if other than office) and the technology used to render the service.

Physicians should offer and book their telephone, telehealth and virtual appointments during the same time periods in the same manner as they would for face to face encounters.

PHYSICIAN'S BULLETIN
March 18 2020: Vol. LXV, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

COVID-19

Due to the current risk of Coronavirus (COVID-19) effective March 13, 2020 the following new interim service fee code is available for Telephone Management and Telehealth Management for presumptive/confirmed Covid-19 diagnosis as well as routine/interval care during pandemic.

Category	Code	Description	Base Units
VIST	03.03X	**Telephone Management and Telehealth Management for presumptive/confirmed Covid-19 as well as routine/interval care during pandemic** **ME=TELE** **ME=VTCR** **Description** Telephone or Telehealth communication between the physician and an established patient or a new patient seeking care during a pandemic (or patient's parent, guardian or proxy as established by written consent). Telephone or Telehealth communication is intended to take the place of an office visit initiated by the patient (or patient's parent, guardian or proxy as established by written consent). Telephone or Telehealth management requires two-way synchronous communication between the patient and physician on a clinical level. **Billing Guidelines** • Physicians to bill no more than 2 telephone or telehealth management sessions per patient per day. • Ideally can differentiate between presumptive/confirmed diagnosis of Covid-19 or exacerbation of Covid-19, vs a follow up visit that would have otherwise been scheduled by either the physician or the patient, when a physical examination of the patient is not required. (i.e. Covid-19 related and non Covid-19 related) • The encounter must include a discussion of the clinical problem and a management decision. • The HSC is not reportable for administrative tasks. • The service is not reported if the decision is to see the patient at the next available appointment in the office. • The HSC is not available for walk-in clinics. • The HSC is not reportable for facility-based patients. • The HSC is reportable for Health Authority supported clinics.	15.28 MSU Increasing to: 15.95 MSU Eff. April 1, 2020

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
- Arranging to provide a sick note
- 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 not reportable for other forms of communication such as:

- Written email or fax communication
- Electronic verbal forms of communication that are not PHIA complaint.

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

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Documentation Requirements

- 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 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 on the MSI claim
- Use ME=TELE for services provided over the telehealth network; or ME=VTCR if provided over a virtual care platform. For telephone calls, no additional modifier is required.
- If for a presumptive/confirmed diagnosis of Covid-19 submit electronic claim with diagnostic code: 487.8 Influenza with other manifestations.

Specialty Restriction:
N/A

Premium:
No evening/weekend premium

Location:
N/A

Note: Please hold all eligible service encounters to allow MSI the required time to update the system. Once the system has updated it will be published that the code is available to submit.

PHYSICIAN'S BULLETIN

March 6 2020: Vol. LXV, ISSUE 2

NOVA SCOTIA MEDICAL SERVICES INSURANCE

CONTENTS

MSI News

MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT

Effective April 1, 2020, the Medical Service Unit (MSU) value will increase from $2.53 to $2.58.

ANAESTHESIA UNIT

Effective April 1, 2020, the Anaesthesia Unit (AU) value will increase from $21.56 to $22.71.

PSYCHIATRY FEES

Effective April 1, 2020, the hourly psychiatry rate for General Practitioners will increase to $150.60 while the hourly rate for Specialists increases to $204.20 as per the tariff agreement.

SESSIONAL FEES

Effective April 1, 2020 the hourly sessional payment rate for General Practitioners will increase to $154.80 and the hourly rate for Specialists will increase to $180.60 as per the tariff agreement.

EMERGENCY DEPARTMENT HOURLY RATES

Effective April 1, 2020 the regional emergency department hourly rate will increase to $232.51. Other levels will increase as per page 45 of the tariff agreement.

WORKERS COMPENSATION BOARD UNIT VALUE CHANGES

WCB MEDICAL SERVICE UNIT

Effective April 1, 2020, the Workers Compensation Board Medical Service Unit (WCB MSU) value will increase from $2.81 to $2.87.

WORKERS COMPENSATION BOARD ANAESTHESIA UNIT

Effective April 1, 2020, the Workers Compensation Board Anaesthesia Unit (WCB AU) value will increase from $23.96 to $25.23.

UPDATED FEES

Workers' Compensation Board Medical Service Unit Update

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been calculated for the listed WCB specific fees for fiscal year 2019-20, as well as 2020-21.

Due to the increase in CPI for 2018 and 2019, all of the WCB specific services listed below will have their values increased by 2.2% effective April 1st, 2019 followed by an additional increase of 2.09% effective April 1st, 2020:

CODE	DESCRIPTION	APRIL 2019 VALUE	APRIL 2020 VALUE
WCB12	EPS physician assessment Service. Combined office visit and completion of Form 8/10 For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15 minute increments to a maximum of 1 additional hour	**Initial visit:** $184.00 + $53.78 per 15 minutes to a maximum 4x (RO=EPS1 and RP=INTL) **Subsequent visit:** $184.00 (RO=EPS1 and RP=SUBS)	**Initial visit:** $187.87 + $54.93 per 15 minutes to a maximum 4x (RO=EPS1 and RP=INTL) **Subsequent visit:** $187.87 (RO=EPS1 and RP=SUBS)
WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable	GPs……$44.96 per 15 min EPS(RO=EPS1) $53.78 per 15 min Specialists……..$60.50 per 15 min	GPs……$45.92 per 15 min EPS(RO=EPS1) $54.93 per 15 min Specialists……..$61.79 per 15 min
WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable	GPs……$44.96 per 15 min EPS(RO=EPS1) $53.78 per 15 min Specialists……..$60.50 per 15 min	GPs……$45.92 per 15 min EPS(RO=EPS1) $54.93 per 15 min Specialists……..$61.79 per 15 min
WCB17	Photocopies of Chart Notes	10 pgs or less (ME=UP10)……..$26.92 11-25 pgs (ME=UP25)……..$53.76 26-50 pgs (ME=UP50)….. $107.48 Over 50 pgs (ME=OV50)…...$161.21	10 pgs or less (ME=UP10)……..$27.49 11-25 pgs (ME=UP25)……..$54.93 26-50 pgs (ME=UP50)….. $109.75 Over 50 pgs (ME=OV50)…...$164.59
WCB20	Carpal Tunnel Syndrome (CTS) Assessment Report	$68.99	$70.46
WCB21	Follow-up visit report	$40.35	$41.21
WCB22	Completed Mandatory Generic Exemption Request Form	$13.49 per form	$13.78 per form
WCB23	Completed Non-Opioid Special Authorization Request Form	$13.49 per form	$13.78 per form
WCB24	Completed Opioid Special Authorization Request Form	$45.21 per form	$46.18 per form
WCB25	Completed WCB Substance Abuse Assessment Form	$30.12	$30.77
WCB26	Return to Work Report – Physician's Report Form 8/10	$68.99	$70.46

CODE	DESCRIPTION	APRIL 2019 VALUE	APRIL 2020 VALUE
WCB27	Eye Report	$60.50	$61.79
WCB28	Comprehensive Visit for Work Related Injury or Illness	$69.41	$70.89
WCB29	Initial Request Form For Medical Cannabis	$74.89	$76.49
WCB30	Extension Request Form For Medical Cannabis	$44.96	$45.92
WCB31	WCB Interim Fee – Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed	$69.41	$70.89

Note: these increases will be automatically applied to any claims with a date of service on or after March 6, 2020. Claims made with service dates from April 1, 2019 – March 5, 2020 will be identified and a retroactive payment will be sent to physicians once the 90 day window for these services has elapsed.

FEE REVISIONS

INCREASES IN COMPREHENSIVE PRIMARY CARE FEE CODES

As per the master agreement, the following fees shall have their values increased for family physicians.
(New Value is the value effective April 1, 2020)

	Old Value	New Value
Description	**MSU**	**MSU**
Office Visit (ME=CARE)	15.28	15.95
Geriatric Office Visit (ME=CARE)	18.90	19.73
Office Visit After-Hours (ME=CARE)	19.10	19.94
Geriatric Office Visit After-Hours (ME=CARE)	23.63	24.67
Office Visit – Well Baby Care (ME=CARE)	15.28	15.95
Office Visit Well Baby Care After-Hours (ME=CARE)	19.10	19.94
Office Visit Prenatal Care (ME=CARE)	15.28	15.95
Office Visit Prenatal Care After-Hours (ME=CARE)	19.10	19.94
Office Visit Postnatal Care After-Hours (ME=CARE)	24.58	25.67
Subsq. Inpatient Care Visit (Days 2, 3)	23.81	24.85
Subsq. Inpatient Care Visit – Newborn (Days 2, 3)	23.81	24.85
Subsq. Inpatient Care Visit – Post-Partum (Days 2, 3)	23.81	24.85
Subsq. Inpatient Care Visit (Days 4-7)	19.67	20.53
Subsq. Inpatient Care Visit – Post-Partum (Days 4-7)	19.67	20.53
Subsq. Inpatient Care Visit (Daily to 56 days)	16.56	17.29
Subsq. Inpatient Care Visit (Weekly after Day 56)	16.56	17.29

INCREASES IN PSYCHIATRY FEE CODES

As per the master agreement, the following fees shall have their values increased for psychiatrists.
(New Value is the value effective April 1, 2020) *Note: these increases are for psychiatrists only*

	Old Value	New Value
Description	**MSU**	**MSU**
Routine Psychiatric Visit (08.5B)	38.16	42.68
Psychotherapy (08.49B)	38.32	43.25
Comprehensive Consultation (03.08)	82.30	94.85
Child Psychiatric Assessment (08.19A)	42.08	48.87
Group Therapy (08.44)	9.63	11.66
Therapeutic/Diagnostic Interview Relating to a child (08.19B)	38.30	43.23

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INCREASES IN OBSTETRIC AND GYNECOLOGY FEE CODES

As per the master agreement, the following fees shall have their values increased for obstetrics and gynecology services.
(New Value is the value effective April 1, 2020)

Gynecology Fee Code Changes

HSC	Description	Old Value MSU	New Value MSU
03.03V	Medical Abortion/Termination of early pregnancy	47.50	62.63
80.89A	Abortion – Incomplete; examination of the uterus without D&C or anaes.	25.00	32.96
79.1	Conization of cervix including colposcopy	51.00	67.24
87.21	Dilation and Curettage for termination of pregnancy	71.00	93.61
81.09	Other Dilation and Curettage	42.50	56.04
81.09A	Endocervical Curettage	10.00	13.19
98.12V	Curettage of warts, including papillomata, keratosis, nevi, moles, pyogenic granulomata, etc., for malignant or recognized pre-malignant condition	12.00	15.82
81.69A	Endometrial Biopsy	19.00	25.05
80.4C	Laparoscopic Hysterectomy	300.00	395.55
80.3	Total Abdominal Hysterectomy	240.00	316.44
80.4A	Vaginal Hysterectomy – uterus-total vaginal w/ rectocoele / cystocoele repair	287.00	378.41
80.4	Vaginal Hysterectomy (subtotal)	240.00	316.44
80.2A	Subtotal Abdominal Hysterectomy	240.00	316.44
80.3A	Uterus – total abdominal w/ rectocoele / cystocoele repair	287.00	378.41
80.3C	Abdominal hysterectomy with salpingo-oophorectomy including bilateral selective pelvic lymphadenectomies, omental biopsy / selective periaortic	400.00	527.40
77.19C	Laparoscopic ovarian cystectomy	150.00	197.78
86.3A	Surgical removal of extrauterine (ectopic) preg. by any means (incl. tubal)	130.00	171.41
78.1A	Salpingectomy for morbidity, not for sterilization	130.00	171.41
10.16	Insertion of vaginal pessary	23.50	30.98
80.19A	Other excision or destruction of lesion of uterus myomectomy	160.00	210.96
82.81A	Colposcopy	8.50	11.21
78.39A	Interruption or removal of fallopian tubes for sterilization purposes	105.00	138.44
77.51	Removal of both ovaries and tubes	195.00	257.11
80.81	Hysteroscopy	42.50	56.04
77.19A	Salpingectomy and salpingo-oophorectomy	130.00	171.41

Obstetric Fee Code Changes

HSC	Description	Old Value MSU	New Value MSU
87.98	Delivery (RF=REFD, SP=OBGY)	260.00	342.81
87.98	Delivery (SP=OBGY or SP=GENP; RF=REFD)	200.00	263.70
86.1	Cervical Caesarean Section	260.00	342.81
84.79	Other Vacuum Extraction	260.00	342.81
86.1A	Caesarean section with tubal ligation	280.00	369.18
84.71	Vacuum extraction with episiotomy	260.00	342.81
84.0	Low forceps delivery without episiotomy	260.00	342.81
84.1	Low forceps delivery (with episiotomy)	260.00	342.81
84.8	Other specified instrumental delivery	260.00	342.81
84.29	Other mid forceps delivery	260.00	342.81
84.21	Mid forceps delivery (with episiotomy)	260.00	342.81
84.53	Total breech extraction	260.00	342.81
84.51	Breech extraction, unqualified	260.00	342.81
84.31	High forceps delivery with episiotomy	260.00	342.81
84.39	Other high forceps delivery	260.00	342.81
84.52	Partial breech extraction	260.00	342.81
84.61	Partial breech extraction with forceps to aftercoming head	260.00	342.81
84.62	Total breech extraction with forceps to aftercoming head	260.00	342.81
84.9	Unspecified instrumental delivery	260.00	342.81

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INCREASES IN OBSTETRIC AND GYNECOLOGY FEE CODES *(continued)*

As per the master agreement, the following fees shall have their values increased for obstetrics and gynecology services.
(New Value is the value effective April 1, 2020)

Gynecology and Obstetrics Fee Code Changes

HSC	Description	Old Value MSU	New Value MSU
81.8	Insertion of intra-uterine contraceptive device	32.00	42.19
81.01	Dilation and curettage following delivery or abortion	57.00	75.15
86.61	Aspiration curettage following delivery or abortion	57.00	75.15

OB/GYN Consultation Fee Code Changes

HSC	Description	Old Value MSU	New Value MSU
03.08	Comprehensive Consultation (Prolonged)	35.10	37.60
03.07	Limited Consultation	24.50	27.00
03.07	Repeat Consultation (Prolonged)	22.50	25.00

Effective March 6, 2020 the ADON health service code 99.09A has been revised as follows:

Category	Code	Description	Base Units	Anesthesia Units
ADON	99.09A	**BMI Surgical Premium** **Description:** This premium may be reported by physicians providing surgical services, as described in the billing guidelines, and general or neuraxial anaesthesia for a patient with a body mass index (BMI) greater than or equal to 40. **Billing Guidelines:** Billable once per patient per physician in addition to the amount payable for the major procedure(s) where a patient with an elevated BMI undergoes surgery to the neck, hip, or trunk and: a) Has a body mass index (BMI) greater than or equal to 40 and this is recorded in the patient's health record b) The procedure is performed using an open technique through an incision for major neck and hip surgery and an open or laparoscopic technique for the trunk and is performed under general, or neuraxial anaesthesia. c) The principle technique is neither aspiration, core or fine needle biopsy, dilation, endoscopy, cautery, ablation, nor catheterization. d) Not billable for bariatric surgery. **Location:** LO=HOSP	32.9 MSU	4.6 AU

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PREAMBLE CHANGE

Current Definition	New Definition
Morbid Obesity (5.2.38) When providing general, or neuraxial anaesthesia for a patient with a body mass index (BMI) greater than 50, the units will be increased. a) Has a BMI (body mass index) greater than 50 and this is recorded in the patient's health record.	**Morbid Obesity (5.2.38)** When providing general, or neuraxial anaesthesia for a patient with a body mass index (BMI) greater than or equal to 40, the units will be increased. a) Has a BMI (body mass index) greater than or equal to 40 and this is recorded in the patient's health record.
Morbid Obesity Add on Fee (5.3.85) a) has a BMI (body mass index) greater than 50 and this is recorded in the patient's health record.	**Morbid Obesity Add on Fee (5.3.85)** a) has a BMI (body mass index) greater than or equal to 40 and this is recorded in the patient's health record.

NEW FEES

Effective March 6, 2020 the following codes are available for billing:

Category	Code	Description	Base Units	Anesthesia Units
MASG	52.31A	**Resection of Upper Aerodigestive Tract Malignancy with Lymphadenectomy** **Description** This is a comprehensive health service code for the resection of an upper aerodigestive tract (nasal cavity, oral cavity, oropharynx, hypopharynx, larynx, trachea and esophagus) malignancy and lymphadenectomy of at least two contiguous levels (e.g. levels I-III neck dissection, levels II-IV neck dissection). All necessary ablative procedures, resection of multiple soft tissue and bony subsites, resection of cranial or peripheral nerves, and ligation of major vessels are included in this HSC. Nerve monitoring via EMG, placement of NG tube and tracheostomy tube are included. A diagnosis of malignancy must be established preoperatively, by intraoperative frozen section, or on final pathology. Complex reconstruction by pedicled flaps or free tissue transfer may be reported in addition to this HSC. **If the case time exceeds 5 hours based on actual case start time to actual end time (or the time the primary surgeon leaves the case) then report EC @ 160 MSU/hr** with operative note and operating room record. **Billing Guidelines** This is a comprehensive fee not to be reported with other resection, ablative or lymphadenectomy codes. May be reported with reconstruction by pedicled flaps or free tissue transfer. Usual rules of multiples apply. **Specialty Restriction:** SP=OTOL members of the head and neck subsection within the Dalhousie Division of ORL-HNS* **Location:** LO=HOSP – Restricted to QEII site only	800 MSU	10 + T

Category	Code	Description	Base Units	Anesthesia Units
MASG	38.39C	**Resection of Salivary Gland Malignancy with Lymphadenectomy** This is a comprehensive health service code for the resection of a salivary gland (parotid, submandibular, sublingual) malignancy and lymphadenectomy of at least two contiguous levels (e.g. levels I-III neck dissection, levels II-IV neck dissection). All necessary ablative procedures, resection of multiple soft tissue and bony subsites, resection of cranial or peripheral nerves, and ligation of major vessels are included in this HSC. Nerve monitoring via EMG, placement of NG tube and tracheostomy tube are included. A diagnosis of malignancy must be established preoperatively, by intraoperative frozen section, or on final pathology. Complex reconstruction by pedicled flaps or free tissue transfer may be reported in addition to this HSC. **If the case time exceeds 4 hours based on actual case start time to actual end time (or the time the primary surgeon leaves the case) then report EC @ 160 MSU/hr** with operative note and operating room record. **Billing Guidelines** This is a comprehensive fee not to be reported with other resection, ablative or lymphadenectomy codes. May be reported with reconstruction by pedicled flaps or free tissue transfer. Usual rules of multiples apply. **Specialty Restriction:** SP=OTOL members of the head and neck subsection within the Dalhousie Division of ORL-HNS* **Location:** LO=HOSP – Restricted to QEII site only	640 MSU	10 + T

Category	Code	Description	Base Units
VADT	01.09D	**Bronchoscopy and Endobronchial Ultrasound (EBUS) with sampling of one or two mediastinal nodal stations and or hilar nodal stations or structures.** **Description** This is a comprehensive health service code to include diagnostic bronchoscopy, including imaging guidance where required, and endobronchial ultrasound guided transbronchial sampling of one or two mediastinal and/or hilar nodal stations or structures. **Billing Guidelines** Report number of stations or structures in text. For complex cases, such as endobronchial debulking of tumor, report EC with operative report and time to be remunerated at 125 MSU/hr. **Not to be reported** with other bronchoscopy HSCs: 01.08A Transbronchial lung biopsy with fiberscope 01.09 Other non-operative bronchoscopy 01.09A Bronchoscopy with biopsy 01.09B Bronchoscopy with foreign body removal **Not to be reported** with mediastinoscopy HSCs: 46.82 Mediastinoscopy 46.82A Mediastinoscopy with flexible bronchoscopy 46.82B Mediastinoscopy with rigid bronchoscopy **Specialty Restriction:** SP=RSMD with fellowship in interventional thoracic surgery and CASG (Thoracic surgeons) with EBUS training in their fellowship **Location:** LO=HOSP – Restricted to QEII site only	125 MSU

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Category	Code	Description	Base Units
VADT	01.09E	**Bronchoscopy and Endobronchial Ultrasound (EBUS) with sampling of three or more nodal stations and or hilar nodal stations or structures.** **Description** This is a comprehensive health service code to include diagnostic bronchoscopy, including imaging guidance where required, and endobronchial ultrasound guided transbronchial sampling of three or more mediastinal and/or hilar nodal stations or structures. **Billing Guidelines** Report number of stations or structures in text. For complex cases, such as endobronchial debulking of tumor, report EC with operative report and time to be remunerated at 125 MSU/hr. **Not to be reported** with other bronchoscopy HSCs: 01.08A Transbronchial lung biopsy with fiberscope 01.09 Other non-operative bronchoscopy 01.09A Bronchoscopy with biopsy 01.09B Bronchoscopy with foreign body removal **Not to be reported** with mediastinoscopy HSCs: 46.82 Mediastinoscopy 46.82A Mediastinoscopy with flexible bronchoscopy 46.82B Mediastinoscopy with rigid bronchoscopy **Specialty Restriction:** SP=RSMD with fellowship in interventional thoracic surgery and CASG (Thoracic surgeons) with EBUS training in their fellowship **Location:** LO=HOSP – Restricted to QEII site only	150 MSU

Teaching Stipend

As per the master agreement, effective April 1, 2020 the following codes will be availble for physician preceptors on an alternate payment plan to shadow bill the value of their teaching stipend when assuming responsibility for a Medical Student or a Resident Elective:

Category	Code	Description	Base Units
DEFT	TESP1	TEACHING STIPEND FOR MEDICAL STUDENT	0
DEFT	TESP2	TEACHING STIPEND FOR RESIDENT ELECTIVE	0

A teaching Stipend may only be claimed once per week per medical student/resident elective you are respnsible for. To shadow bill teaching stipend please use health card number 0000002352 with date of birth April 1, 1969. Diagnostic code V623 should also be included on the claim.

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UPDATES

Amendment

HSC 87.98A Add On for Detention during Obstetrical Delivery (for attendance beyond three hours) had indicated the maximum number of multiples for 8 hours was 33. This has been corrected as the maximum of 8 hours is 21 multiples.

Facility On-Call for APP Specialist

Effective October 25, 2019, APP Specialists are eligible to bill Fee-For-Service (FFS) for Facility On-Call. APP Specialists who are eligible and wish to bill FFS for Facility On-Call must have a FFS Business Arrangement (BA) set up by MSI, if there is not an existing FFS BA. The BA form and contact information can be found at: https://msi.medavie.bluecross.ca/update-registration/

It is recognized that there may be claims with dates of service past the 90 day limit for claim submissions. An exception has been made to allow billing of outdated Facility On-Call claims with dates of service between October 25, 2019 to December 31, 2019. All outdated claims from this time period must be submitted no later than March 31, 2020. For information required to submit outdated claims contact: MSI_Assessment@medavie.bluecross.ca

APP Specialists who have submitted shadow claims from October 25, 2019 forward for Facility On-Call may reverse the claims and resubmit as FFS once a BA has been set up by MSI.

Clinic Sessional

Sessional arrangements are established for clinical services. With the exception of a few unique clinics, submission of claim forms without associated shadow billing will not be paid. If a clinic is cancelled due to inclement weather, closure of a facility, etc., the physician may reschedule that clinic for a later date and claim for those services. When submitting such claims, they should provide a summary on the claim form.

In cases where patients do not present for scheduled clinics and there is no shadow billing for a particular date, the physician should provide a summary of the unbillable services they provided for consideration and approval of payment. Physicians should expect to provide additional information to Medavie upon request where necessary to make an assessment.

Upcoming Changes

Please note that health service code 50.0B Endovascular Thrombectomy-Intracranial will be revised to permit surgical assist claims. More information will be available in the upcoming May 2020 Physician's Bulletin.

Please note there are upcoming changes to the billing guidelines for health service code 13.59O Injection of OnabotulinumtoxinA for the treatment of Chronic Migraine (prior approval). More information will be available in the upcoming May 2020 Physician's Bulletin.

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NEW AND UPDATED EXPLANATORY CODES

Code	Description
GN104	SERVICE ENCOUNTER HAS BEEN REFUSED. HEALTH CARD NUMBER IS NOT VALID FOR SERVICE PROVIDED.
VA097	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 01.09D OR 01.09E FOR THIS PATIENT AT THE SAME ENCOUNTER.
VA098	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 01.08A, 01.09, 01.09A OR B, 46.82, 46.82A OR B FOR THIS PATIENT AT THE SAME ENCOUNTER.
VA099	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE NOT INCLUDED TEXT STATING THE NUMBER OF STATIONS OR STRUCTURES.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday March 6th, 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
www.novascotia.ca/dhw/

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PHYSICIAN'S BULLETIN
January 24th 2020: Vol. LXV, ISSUE 1

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

ALTERNATIVE PAYMENT PLAN (APP) SPECIALISTS BILLING FEE FOR SERIVCE (FFS) WHILE ON-CALL

Effective October 25, 2019, APP Specialists are eligible to bill FFS for services delivered while on-call. APP Specialists who are eligible and wish to bill FFS must have a FFS Business Arrangement (BA) set up by MSI, if there is not an existing FFS BA. The BA form and contact information can be found at: https://msi.medavie.bluecross.ca/update-registration/

It is recognized that there may be claims with dates of service past the 90 day limit for claim submissions. An exception has been made to allow billing of outdated claims for services delivers while on-call with dates of service between October 25, 2019 to December 31, 2019. All outdated claims from this time period must be submitted no later than March 31, 2020. For information required to submit outdated claims contact: MSI_Assessment@medavie.bluecross.ca

APP Specialists who have submitted shadow claims for services delivered while on-call from October 25, 2019 forward may reverse the claims and resubmit as FFS once a BA has been set up by MSI.

PHYSICIAN'S BULLETIN
December 31st 2019: Vol. LXIV, ISSUE 18

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

UNATTACHED PATIENT BONUS INCENTIVE UPCOMING END DATE

Effective March 1st, 2020, the unattached patient bonus incentive (health service code UPB1) will no longer be available for billing. Physicians who take on patients prior to March 1st and who meet the current criteria are advised to submit their claims within 90 days of the date of service.

Revised January 3, 2020

PHYSICIAN'S BULLETIN

December 13th, 2019: Vol. LXIV, ISSUE 17

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT

Effective April 1, 2019, the Medical Service Unit (MSU) value will be increased from $2.48 to $2.53.
Note: This increase was automatically implemented on any claims made with a date of service on or after November 29, 2019. Claims made with service dates from April 1, 2019 – November 28, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window for these services has elapsed.

ANAESTHESIA UNIT

Effective April 1, 2019, the Anaesthesia Unit (AU) value will be increased from $21.07 to $21.50, followed by an additional increase to $21.56 effective October 25, 2019.
Note: The current $21.56 value was automatically implemented on any claims made with a service date on or after November 29, 2019. Claims made with service dates from April 1, 2019 – November 28, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window for these services has elapsed.

PSYCHIATRY FEES

Effective April 1, 2019 the hourly Psychiatry rate for General Practitioners has increased to $115.60 while the hourly rate for Specialists increased to $156.74 as per the tariff agreement. An additional increase effective October 25, 2019 has raised the hourly Psychiatry rate for General Practitioners to $137.85 and the hourly rate for Specialists increased to $186.91.
Note: These rates will automatically take effect on any claims made as of December 13th. Claims made with service dates from April 1, 2019 – December 12, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window for these services has elapsed.

WORKERS COMPENSATION BOARD MEDICAL SERVICE UNIT

Effective April 1, 2019, the Workers Compensation Board Medical Service Unit (WCB MSU) value will be increased from $2.76 to $2.81.
Note: This increase was automatically implemented on any claims made with a date of service on or after December 13, 2019. Claims made with service dates from April 1, 2019 – December 12, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window for these services has elapsed.

WORKERS COMPENSATION BOARD ANAESTHESIA UNIT

Effective April 1, 2019, the Workers Compensation Board Anaesthesia Unit (WCB AU) value will be increased from $23.41 to $23.89, followed by an additional increase to $23.96 effective October 25, 2019.
Note: The current $23.96 value was automatically implemented on any claims made with a service date on or after December 13, 2019. Claims made with service dates from April 1, 2019 – December 12, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window for these services has elapsed.

PROVIDER PROFILE CHANGES

This year Provider Profiles will only be sent out by request. If you would like to receive your Provider Profile for 2018/19 please send your request by email to: MSI_Assessment@Medavie.Bluecross.ca
In the email please include: your name, your provider number, and the profile will be mailed to the address on file.

★ Fees New Fees and Fee Revisions

NEW FEES

Effective November 1, 2019 the following code is available for billing:

Category	Code	Description	Base Units
ADON	13.34A	**Rotavirus Immunization** **Description** Rotavirus vaccine, administered orally. Immunization to occur at 2, 4, and 6 months of age. **Billing Guidelines** • Maximum three claims of rotavirus immunization per patient per lifetime. • May only be claimed for patients born on or after November 1, 2019. • May not be claimed for patients greater than 8 months old. • Follows normal provincial immunization billing guidelines with one exception – a tray fee may not be claimed for this immunization.	6 MSU

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Effective December 13, 2019 the following codes are available for billing:

Category	Code	Description	Base Units
MASG	98.99H	**MOHS Micrographic surgery (MMS) for the Removal of a Histologically Confirmed Cutaneous Malignancy – Initial Level and Debulking** **Description** This HSC is specific to the Mohs micrographic surgery (MMS) technique for the removal of a histologically confirmed cutaneous malignancy. Reportable only when the preparation of slides is rendered or supervised by the Mohs surgeon claiming the MMS code(s) and all microscopic tissue sections are personally reviewed and interpreted by the Mohs surgeon. If a pathologist reviews the slides and claims for service, the Mohs physician may not report using these codes. Closure of the wound by undermining or advancement flaps is included in this service. When a more complex closure is required, such as rotation flaps, transposition or skin grafting, it may be reported and paid in full (100%) for the first HSC reported followed by the usual rates for multiples. Other lesions addressed by the same surgeon, same day will be paid according to rules of multiples. **Billing Guidelines** • Payable once per surgeon per lesion – even if the service extends more than one day. • May not be reported if there is a pathology claim for the same patient same day. • Complex closure may be reported at 100% for the first HSC once per MMS lesion. • If additional closure HSC is reported, the usual rules of multiples apply. • May be reported with: ○ 98.51B Local tissue shifts with free skin graft to secondary defect - single ○ 98.51C Local tissue shifts – advancements, rotations, transpositions, 'Z' plasty - single ○ 98.51D Local tissue shifts– advancements, rotations, transpositions, 'Z' plasty - multiple ○ 98.51E Local tissue shifts with free skin graft to secondary defect - multiple ○ 98.53A Local tissue shifts, advancements, rotations, transpositions, 'Z' plasty, etc., eyebrow, eyelid, lip, ear, nose – single ○ 98.53B Local tissue shifts, advancements, rotations, transpositions, 'Z' plasty, etc., eyebrow, eyelid, lip, ear, nose – two stages • Other non-MMS lesions same patient, same day are subject to the rules of multiples. **Specialty Restriction:** SP=DERM SP=PLAS (with proof of Mohs Micrographic surgery fellowship in keeping with the standards of the American College of Mohs Surgery (ACMS)	155 MSU
ADON	98.99I	**Additional Levels (Comprehensive of all additional levels required for complete excision)** **Billing Guidelines** Payable once per surgeon per lesion **Specialty Restriction:** SP=DERM SP=PLAS (with proof of Mohs Micrographic surgery fellowship in keeping with the standards of the American College of Mohs Surgery (ACMS)	135 MSU

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NEW FEES (CONTINUED)

Effective October 25, 2019 the following code is available for billing:

Category	Code	Description	Base Units
ADON	87.98A	**Detention During Obstetrical Delivery (for attendance beyond three hours)** **RO=DETE** **Description** Detention time for obstetrical delivery performed by a family physician when the physician is required to be in attendance beyond three hours, notwithstanding clause 5.2.75 *(see below)* of the Physicians Manual (2014). Each 15 minute time increment beyond three hours has a rate of 12.5 MSU to a maximum of 8 hours. **Billing Guidelines** May only be claimed as an add-on for HSC 87.98 Delivery NEC. 1 multiple = 3 hours with patient 2 multiples = 3 hours, 15 minutes 3 multiples = 3.5 hours 4 multiples = 3.75 hours 5 multiples – 4 hours etc. to a maximum of: 21 multiples = 8 hours **Specialty Restriction** SP=GENP {ATTENDANCE AT LABOUR AND DELIVERY*(5.2.75)* This is a service involving constant or periodic attendance on a patient during the period of labour to provide all aspects of care. This includes the initial assessment, and such subsequent assessment as may be indicated, including ongoing monitoring of the patient's condition. Obstetrical delivery covers services rendered during delivery, including medical or surgical inductions by the attending physician, suturing of minor lacerations, hypnosis, detention time during labour, local or regional anesthesia and manual removal of placenta by the attending physician, and all obstetrical manoeuvers that may be required, e.g. use of forceps.}	12.5 MSU /15 mins

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PREAMBLE CHANGE

Current Definition	New Definition
Detention Time *(5.1.75)*	**Detention Time *(5.1.75)***
Medical Detention occurs when a service provider's time is given exclusively to one patient for active treatment and/or monitoring of that patient at the sacrifice of all other work. Detention time is not payable when provided in the office. *(5.1.76)* Detention (see section 6 (6.0.23)) commences 30 minutes after the practitioner is first in attendance and may be claimed in 15 minute increments thereafter. When claimed with a Comprehensive or Limited consultation, detention time commences after 1 hour. This may include time spent with the patient travelling from one location to another. However, travel time to transport donor organs from a donor site to the recipient site for transplantation begins at the time the retrieving surgeon accompanied by the donor organs leave the donor site. Where any service is performed during the time spent with the patient, either the service or the detention time, but not both, should be claimed. The circumstances in each case, and the time involved, should be documented with the service encounter. *(5.1.77)* The first 30 minutes is the appropriate visit fee. The fee for detention is 12.5 units per 15 minutes. The detention modifier RO=DETE must be indicated on the service encounter. *(5.1.78)* Detention time does not apply to: a) Waiting time for an operating room, x-rays, laboratory results or administrative duties b) Counselling or psychotherapy c) Advice given to the patient or patient's family or representatives d) Waiting time for a patient's arrival for assessment or treatment e) Waiting time for attendance by another medical practitioner or consultant f) Return trip if the physician is not in attendance with the patient g) Time spent in completing or reviewing patient charts h) More than one patient at a time i) Office visits *(5.1.79)* Detention time is not payable in conjunction with fees paid for the following on the same day: a) Intensive care or critical care (section 5 (5.1.112 and 5.1.123)) b) Diagnostic and therapeutic procedures c) Obstetrical delivery *(5.1.80)*	Medical Detention occurs when a service provider's time is given exclusively to one patient for active treatment and/or monitoring of that patient at the sacrifice of all other work. Detention time is not payable when provided in the office. (See section 6 (6.0.23)). *(5.1.76)* Visits: When detention is claimed with limited or comprehensive visit services, detention commences 30 minutes after the practitioner is first in attendance and may be claimed in 15 minute increments thereafter. The first 30 minutes is the appropriate visit fee. Consultations: When claimed with a Comprehensive or Limited consultation, detention time commences after 1 hour. Obstetrical Delivery: When claimed with an obstetric delivery provided by a general practitioner, detention time commences after 3 hours. This may include time spent with the patient travelling from one location to another. However, travel time to transport donor organs from a donor site to the recipient site for transplantation begins at the time the retrieving surgeon accompanied by the donor organs leave the donor site. Where any service is performed during the time spent with the patient, either the service or the detention time, but not both, should be claimed. The circumstances in each case, and the time involved, should be documented with the service encounter. *(5.1.77)* The fee for detention is 12.5 units per 15 minutes. The detention modifier RO=DETE must be indicated on the service encounter. *(5.1.78)* Detention time does not apply to: a) Waiting time for an operating room, x-rays, laboratory results or administrative duties b) Counselling or psychotherapy c) Advice given to the patient or patient's family or representatives d) Waiting time for a patient's arrival for assessment or treatment e) Waiting time for attendance by another medical practitioner or consultant f) Return trip if the physician is not in attendance with the patient g) Time spent in completing or reviewing patient charts h) More than one patient at a time i) Office visits *(5.1.79)* Detention time is not payable in conjunction with fees paid for the following on the same day: a) Intensive care or critical care (section 5 (5.1.112 and 5.1.123)) b) Diagnostic and therapeutic procedures c) Obstetrical delivery by specialties other than general practitioner *(5.1.80)*

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PREAMBLE CHANGE

Upcoming increases to bilateral and multiple surgical procedures:

Current Definition	New Definition
Surgical Services Major or Minor *(5.3.66)* k) Bilateral Procedures i. Unless otherwise specified, bilateral procedures are claimed at an additional 50 percent of the unilateral procedure. ii. When bilateral procedures are performed subsequent to a major procedure through the same incision they should be claimed at 50 percent and 25 percent. iii. When bilateral procedures are performed subsequent to a major procedure through a separate incision, they should be claimed at 65 percent and 32.5 percent. iv. When performed under separate anesthetics at an interval, the full fee will be charged for each procedure. *(5.3.78)* l) Multiple Procedures Same Physician i. When multiple operative procedures are performed through a single incision in the course of an abdominal operation or on any one organ or cavity, the principle procedure will be claimed plus 50 percent for the secondary procedures (secondary incidental procedures, such as appendectomy which are not indicated by pathology, shall not be claimed). ii. A physician who performs multiple operative procedures simultaneously in different areas and through different incisions shall claim for the major procedure plus an additional 65 percent for each of the lesser procedures. Laparoscopic operations are considered to utilize a single incision regardless of the number of incisions. iii. When an appendectomy is claimed with another abdominal surgery, a pathology report must be forwarded to MSI. *(5.3.79)*	Surgical Services Major or Minor *(5.3.66)* k) Bilateral Procedures i. Unless otherwise specified, bilateral procedures are claimed at an additional 70 percent of the unilateral procedure. ii. When bilateral procedures are performed subsequent to a major procedure through the same incision they should be claimed at 70 percent and 35 percent. iii. When bilateral procedures are performed subsequent to a major procedure through a separate incision, they should be claimed at 70 percent and 35 percent. iv. When performed under separate anesthetics at an interval, the full fee will be charged for each procedure. *(5.3.78)* l) Multiple Procedures Same Physician i. When multiple operative procedures are performed through a single incision in the course of an abdominal operation or on any one organ or cavity, the principle procedure will be claimed plus 70 percent for the secondary procedures (secondary incidental procedures, such as appendectomy which are not indicated by pathology, shall not be claimed). ii. A physician who performs multiple operative procedures simultaneously in different areas and through different incisions shall claim for the major procedure plus an additional 70 percent for each of the lesser procedures. Laparoscopic operations are considered to utilize a single incision regardless of the number of incisions. iii. When an appendectomy is claimed with another abdominal surgery, a pathology report must be forwarded to MSI. *(5.3.79)*

Note: This change applies only to MASG and MISG procedures.
It does not apply to Diagnostic and Therapeutic procedures.

*These fee increases will take effect January 1, 2020. At that time, the LV=LV50 and LV=LV65 modifiers previously used to denote multiple procedures will no longer be applicable to major or minor surgical category procedures. These will be replaced with the following new modifiers to facilitate payment at the increased rate:
LV=DIFF – Indicates the surgical procedure done through a separate approach.
LV=SAME – The second or subsequent surgical procedure done through the same approach.

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FEE REVISIONS

INCREASES IN COMPREHENSIVE PRIMARY CARE FEE CODES

As per the master agreement, the following fees shall have their values increased for family physicians.
(New Value is the value effective October 25, 2019)

	Old Value	New Value
Description	**MSU**	**MSU**
Office Visit (ME=CARE)	14.76	15.28
Geriatric Office Visit (ME=CARE)	18.26	18.90
Office Visit After-Hours (ME=CARE)	18.45	19.10
Geriatric Office Visit After-Hours (ME=CARE)	22.83	23.63
Office Visit – Well Baby Care (ME=CARE)	14.76	15.28
Office Visit Well Baby Care After-Hours (ME=CARE)	18.45	19.10
Office Visit Prenatal Care (ME=CARE)	14.76	15.28
Office Visit Prenatal Care After-Hours (ME=CARE)	18.45	19.10
Office Visit Postnatal Care After-Hours (ME=CARE)	23.76	24.58
Subsq. Inpatient Care Visit (Days 2, 3)	23	23.81
Subsq. Inpatient Care Visit – Newborn (Days 2, 3)	23	23.81
Subsq. Inpatient Care Visit – Post-Partum (Days 2, 3)	23	23.81
Subsq. Inpatient Care Visit (Days 4-7)	19	19.67
Subsq. Inpatient Care Visit – Post-Partum (Days 4-7)	19	19.67
Subsq. Inpatient Care Visit (Daily to 56 days)	16	16.56
Subsq. Inpatient Care Visit (Weekly after Day 56)	16	16.56

*The effective date of these increases is October 25, 2019 however the fees in the system will only display the correct values as of December 13, 2019.
Claims made for these services from October 25 – December 12, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window has elapsed.

INCREASES IN PSYCHIATRY FEE CODES

As per the master agreement, the following fees shall have their values increased for psychiatrists.
(New Value is the value effective October 25, 2019)
Note: these increases are for psychiatrists only)

	Old Value	New Value
Description	**MSU**	**MSU**
Routine Psychiatric Visit (08.5B)	35.8	38.16
Psychotherapy (08.49B)	35.8	38.32
Comprehensive Consultation (03.08)	75	82.30
Child Psychiatric Assessment (08.19A)	39.32	42.08
Group Therapy (08.44)	9	9.63
Therapeutic/Diagnostic Interview Relating to a child (08.19B)	35.78	38.30

*The effective date of these increases is October 25, 2019 however the fees in the system will only display the correct values as of December 13, 2019.
Claims made for these services from October 25 – December 12, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window has elapsed.

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UPDATES

Youth Clinic Sessional

Sessional arrangements are established for clinical services. With the exception of a few unique clinics, submission of claim forms without associated shadow billing will not be paid. If a clinic is cancelled due to inclement weather, closure of a facility, etc., the physician may reschedule that clinic for a later date and claim for those services. When submitting such claims, they should provide a summary on the claim form.

In cases where patients do not present for scheduled clinics and there is no shadow billing for a particular date, the physician should provide a summary of the unbillable services they provided for consideration and approval of payment. Physicians should expect to provide additional information to Medavie upon request where necessary to make an assessment.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
MJ068	SERVICE ENCOUNTER HAS BEEN REDUCED TO 70%. WHEN MULTIPLE SURGICAL PROCEDURES ARE PERFORMED AT THE SAME TIME, ONLY ONE IS APPROVED AT 100%.
GN103	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THIS SERVICE MAY NOT BE BILLED IF A PATHOLOGIST HAS REVIEWED THE SLIDES AND CLAIMED FOR THE SERVICE.
AD086	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST CLAIM THE BASE DELIVERY FEE (HSC 87.98) PRIOR TO CLAIMING DETENTION DURING OBSTETRICAL DELIVERY.
AD085	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF ROTAVIRUS IMMUNIZATIONS HAS BEEN REACHED.
AD028	SERVICE ENCOUNTER HAS BEEN REDUCED TO 50%. ONLY ONE IMMUNIZATION AT FULL FEE IS PAYABLE WHEN A VISIT IS CLAIMED
BK061	SERVICE ENCOUNTER HAS BEEN DISALLOWED. PLEASE SUBMIT A COPY OF THE FIRST AND SUBSEQUENT ECHO REPORTS ALONG WITH THE CLINICAL DOCUMENTATION BEFORE REQUESTING REASSESSMENT FOR THIS CLAIM.

Note: BK061 was introduced and available for download on October 4, 2019.

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Claiming for Referred Services

A consultation is a service that results from a formal referral from the patient's physician, nurse practitioner, midwife, optometrist or dentist for an evaluation by a physician qualified to furnish advice. In addition to a formal (i.e. written) referral, a consultation also requires a written report to the referring provider.

A comprehensive consultation (Health Service Code 03.08) is a comprehensive visit. It requires a complete history and physician examination appropriate to the physician's specialty and the working diagnosis. The elements of a comprehensive visit have been outlined in previous MSI Bulletins. (August 2017)

In instances in which a comprehensive assessment is not medically necessary for a referred patient, a limited consultation (Health Service Code 03.07) may be claimed. This is an assessment that is focused on the problem that has led to the referral.

Both comprehensive and limited consultations require a physical examination by the physician.

Here are common questions we receive at MSI with respect to consultation services:

Q: Another physician in my specialty is retiring. If she sends me a written referral, may I claim for a consultation the first time I see one of her patients?
A: The situation you describe represents transferral of care. In this situation, where care is transferred either temporarily or permanently from one physician to another, the receiving physician may not claim either a consultation or comprehensive visit.

Q: I am a family doctor who works in a clinic with several other family doctors. Recently, we were discussing the fact that a specialist in town follows our patients for some chronic conditions. However, if it has been longer than six months since he last saw them, he insists that we send a new referral before he will see them again. This is extra paperwork that I don't need. Does MSI require that a new referral be sent after six months?
A: MSI has no such requirement. In situations where the specialist wishes to review the patient, the visit should be claimed as a follow-up visit (normally continuing care or directive care) and not as a new consultation.

Q: I am a specialist. Can I claim a new consultation without a new referral if considerable time has passed since I last saw them?
A: A valid referral is required each time you claim a new consultation. The referring provider must have assessed the patient and deemed that he/she requires a new opinion from you. If a patient is seen for a new or worsening condition in the absence of a new referral, and a new comprehensive visit is medically necessary and carried out, claim an initial visit with complete examination (HSC 03.04). If there is no new or worsening condition, claim as a limited visit (HSC 03.03).

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday December 13th, 2019. The files to download are:
Health Service (SERVICES.DAT),
Health Service Description (SERV_DSC.DAT),
Modifiers (MODVALS.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
www.novascotia.ca/dhw/

In partnership with

NOVA SCOTIA

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2020 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE	SALARY CONTRACT PAY PERIOD
December 19, 2019**	**December 24, 2019****	December 31, 2019	December 13-26, 2019
January 6, 2020	January 9, 2020	January 15, 2020	December 27, 2019-January 9, 2020
January 20, 2020	January 23, 2019	January 29, 2020	January 10-23, 2020
February 3, 2020	February 6, 2020	February 12, 2020	January 24-February 6, 2020
February 14, 2020**	February 20, 2020	February 26, 2020	February 7-20, 2020
March 2, 2020	March 5, 2020	March 11, 2020	February 21-March 5, 2020
March 16, 2020	March 19, 2020	March 25, 2020	March 6-19, 2020
March 30, 2020	April 2, 2020	April 8, 2020	March 20-April 2, 2020
April 13, 2020	April 16, 2020	April 22, 2020	April 3-16, 2020
April 27, 2020	April 30, 2020	May 6, 2020	April 17-30, 2020
May 8, 2020**	**May 13, 2020****	May 20, 2020	May 1-14, 2020
May 25, 2020	May 28, 2020	June 3, 2020	May 15-28, 2020
June 8, 2020	June 11, 2020	June 17, 2020	May 29-June 11, 2020
June 19, 2020**	**June 24, 2020****	**June 30, 2020****	June 12-25, 2020
July 6, 2020	July 9, 2020	July 15, 2020	June 26-July 9, 2020
July 20, 2020	July 23, 2020	July 29, 2020	July 10-23, 2020
July 31, 2020**	August 6, 2020	August 12, 2020	July 24-August 6, 2020
August 17, 2020	August 20, 2020	August 26, 2020	August 7-20, 2020
August 28, 2020**	**September 2, 2020****	September 9, 2020	August 21-September 3, 2020
September 14, 2020	September 17, 2020	September 23, 2020	September 4-17, 2020
September 28, 2020	October 1, 2020	October 7, 2020	September 18-October 1, 2020
October 9, 2020**	October 15, 2020	October 21, 2020	October 2-15, 2020
October 26, 2020	October 29, 2020	November 4, 2020	October 16-29, 2020
November 6, 2020**	November 12, 2020	November 18, 2020	October 30-November 12, 2020
November 23, 2020	November 26, 2020	December 2, 2020	November 13-26, 2020
December 7, 2020	December 10, 2020	December 16, 2020	November 27-December 10, 2020
December 17, 2020**	**December 22, 2020****	December 30, 2020	December 11-24, 2020
January 4, 2021	January 7, 2021	January 13, 2021	December 25, 2020-January 7, 2021
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, Sessional Payments and Locum Claim Forms. 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

2020 HOLIDAY DATES

Please make a note in your schedule of the following dates MSI will accept as "Holidays".	
NEW YEAR'S DAY	WEDNESDAY, JANUARY 1, 2020
HERITAGE DAY	MONDAY, FEBRUARY 17, 2020
GOOD FRIDAY	FRIDAY, APRIL 10, 2020
EASTER MONDAY	MONDAY, APRIL 13, 2020
VICTORIA DAY	MONDAY, MAY 18, 2020
CANADA DAY	WEDNESDAY, JULY 1, 2020
CIVIC HOLIDAY	MONDAY, AUGUST 3, 2020
LABOUR DAY	MONDAY, SEPTEMBER 7, 2020
THANKSGIVING DAY	MONDAY, OCTOBER 12, 2020
REMEMBRANCE DAY	WEDNESDAY, NOVEMBER 11, 2020
CHRISTMAS DAY	FRIDAY, DECEMBER 25, 2020
BOXING DAY	MONDAY, DECEMBER 28, 2020
NEW YEAR'S DAY	FRIDAY, JANUARY 1, 2021

PHYSICIAN'S BULLETIN
August 9th, 2019: Vol. LXIV, ISSUE 16

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

SEEKING PHYSICIAN ASSESSORS

The Nova Scotia Practice Ready Assessment Program (NSPRAP) is a new program funded by the Department of Health and Wellness and developed by multiple stakeholders to assess international medical graduates (IMGs) who have practiced abroad and would like to practice family medicine in underserved communities in Nova Scotia. Those who successfully meet eligibility requirements and pre-screening will need to be placed with experienced family physicians in our communities to determine whether they are in fact practice-ready. The internationally-trained physicians will be placed and assessed in two different communities for 6 weeks each. They are to be exposed to a variety of clinical settings but are not being assessed to provide intrapartum obstetrical care or ER care.

Physician assessors will receive assessor training, be remunerated both for the training and the 6-week assessment period and will be able to claim some Main-Pro credits.

The Assessors' primary duties are to:

- Orient the candidate to the clinical practice including local and regional healthcare services;
- Provide clinical exposures appropriate for the purpose of assessment of candidates (eg. ambulatory/clinic, ER, hospital in-patient and long term-care);
- Assess candidate's clinical skills (should be at the level of a Canadian-trained family medicine resident entering practice);
- Assess candidate's ability to communicate both verbally and in writing;
- Assess their professional demeanor and conduct with patients and colleagues; and
- Complete the required evaluation forms of the candidates' performance and any other documentation required by the program.

Physicians interested in being a physician assessor should contact Gwen MacPherson, Program Coordinator at info@nsprap.ca or Dr. Fiona Bergin, Program Clinical Director at fiona.bergin@dal.ca or 902-473-7188 for more information.

*Candidates will be looking for short-term rentals in the communities in which they will be assessed. If you know of any in your community (whether you wish to be an assessor or not), we would appreciate you providing us with that information to share with them.

FEE REVISION

The following health service code may now be claimed from a nursing home location:

Category	Code	Description	Base Units
CONS	03.09C	**Palliative Care Consultation** **Description** The palliative care consultation can only be claimed by designated physicians, general practitioners or specialists, with recognized expertise in palliative care. The service provided must fulfil the normal requirements for a consultation as specified in the preamble. The consultation includes a psychosocial assessment, comprehensive review of pharmacotherapy, appropriate counselling, and consideration of appropriate community resources where indicated. **Billing Guidelines** Payable once per patient per physician Maximum 3 hours (8 multiples) Start and stop times must be recorded in the health record and in the text field of the claim when billing multiples. **Specialty Restriction** Physicians with recognized expertise in Palliative Care or Certificate of added Competence Physician must forward a letter to MSI indicating their credentials **Location** LO=HOSP, LO=OFFC, LO=HOME, LO=NRHM	62 + MU

WCB UPDATES

Submission Requirements

As noted in the June Physician's Bulletin, when submitting claims with a payment responsibility of WCB, one or both of the following are now required:

- Patient's WCB claim number
- Patient's Injury date (month and year)

In some cases, you may provide a service to a patient before a WCB claim exists. In these cases, the month and year of injury should be submitted.

This additional information will be used to verify that the patient was eligible for WCB coverage on the date that the service was provided. Although Medavie will be receiving WCB eligibility updates daily, you may notice a difference in the length of time it takes to process some WCB claims, as this required verification will be completed prior to the claim being paid. Confirming whether your patient is eligible for benefits at the time the claim is submitted for payment will help prevent billing errors and reduce the need for payment reversals.

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WCB UPDATES (CONTINUED)

Return to Work (RTW) Service

Physicians are now able to claim a WCB28 (Comprehensive Visit for Work Related Injury or Illness) or 03.03/03.03A (Limited Visit) depending upon the service provided. If you have been holding any 03.03/03.03A claims since June 27/19, these can now be submitted for payment.

Long Term Benefits (LTB) Service

If your patient has been transitioned to receiving long term benefits, WCB no longer requires the Physician's Report Form 8/10 for follow-up visits. Generally, visits would be no more than monthly for follow-up of the original compensable injury. The health service code to be used for these visits is 03.03 or 03.03A. If WCB28 is submitted, the claim will be refused.

If your patient's condition changes and it is necessary to provide a comprehensive visit, the following interim WCB health service code is now available for billing. Under these circumstances, you may submit a Physician's Report Form 8/10 to WCB outlining the changes in the patient's condition or treatment.

Category	Code	Description	Value
DEFT	WCB31	**WCB Interim Fee - Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed.**	$67.90

Billing Matters Billing Reminders, Updates, New Explanatory Codes

UPDATES

Addendum – 03.09A
In the June 14, 2019 Physicians Bulletin HSC 03.09A was incorrectly categorized as a 'VIST' 03.09A is a consult service and is categorized as a 'CONS'.

2019 Cut off Dates
Please see the updated 2019 Cut off Dates as changes have been made.

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BILLING REMINDERS

Multiple Long Bone Fractures

This is a reminder that the LV=LV85 modifier applies to certain open reduction fractures.
The following is a list of applicable codes:

HSC	DESCRIPTION
91.30A	Fractured humerus neck without dislocation of head - open reduction
91.30B	Fractured humerus shaft - open reduction
91.30C	Fractured humerus - epicondyle - medial - open reduction
91.30D	Fractured humerus - epicondyle - lateral - open reduction
91.30E	Fractured humerus tuberosity - open reduction
91.30F	Fractured humerus neck with dislocation of head - open reduction
91.30G	Fractured humerus - supra or transcondylar - open reduction
91.31	Open reduction of fracture with internal fixation, radius and ulna
91.31A	Open reduction - fractured olecranon
91.31B	Open reduction - radius - head or neck
91.31C	Open reduction fractured radius or ulna - shaft
91.31D	Colles' or Smith's fracture - open reduction
91.31E	Monteggia's or Galleazzi's fracture - open reduction
91.31G	Distal comminuted intra-articular fracture of radius (to include distal ulna) due to high energy trauma. To include open reduction, internal/external fixation as required when performed in conjunction with remote donor site bone graft.
91.34A	Fracture femur neck - open reduction with internal fixation
91.34B	Fractured femur - pertrochanteric - open reduction
91.34C	Fractured femur - shaft or transcondylar - open reduction
91.34D	Fracture femur neck - prosthetic replacement
91.35A	Fracture - tibia with or without fibula - shaft - open reduction
91.35B	Fractured tibial plafond, with or without fibula, open reduction and internal fixation - including removal of pre-existing internal or external fixation devices.
91.35C	Fractured tibia with or without fibula - plateau - open reduction
91.35D	Fractured ankle - single malleolus - open reduction
91.35E	Fracture fibula - open reduction
91.35F	Fractured ankle - bi or trimalleolar - open reduction
91.38A	Fractured - clavicle - open reduction
91.95C	External fixation of tibial plafond fracture
91.95D	External fixation of tibial plafond fracture, with open reduction and internal fixation of fibular fracture.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
VT165	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.03N CANNOT BE CLAIMED UNLESS THE PROVIDER HAS PREVIOUSLY CLAIMED FOR A MAID SERVICE WITH THE SAME PATIENT.
WBHOK	ELIGIBILITY APPROVED BY WCB
WBHNM	WCB DID NOT RECEIVE MEDICAL DOCUMENTATION FOR SERVICE DATE BILLED

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday August 9th, 2019. The files to download are health service (SERVICES.DAT), health service description (SERV_DSC.DAT), and, explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

CONTACT INFORMATION

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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

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2019 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE	SALARY CONTRACT PAY PERIOD
December 19, 2018**	**December 24, 2018****	January 2, 2019	December 14-27, 2018
January 7, 2019	January 10, 2019	January 16, 2019	December 28, 2018-January 10, 2019
January 21, 2019	January 24, 2019	January 30, 2019	January 11-24, 2019
February 4, 2019	February 7, 2019	February 13, 2019	January 25-February 7, 2019
February 15, 2019**	February 21, 2019	February 27, 2019	February 8-21, 2019
March 4, 2019	March 7, 2019	March 13, 2019	February 22-March 7, 2019
March 18, 2019	March 21, 2019	March 27, 2019	March 8-21, 2019
April 1, 2019	April 4, 2019	April 10, 2019	March 22-April 4, 2019
April 12, 2019**	**April 17, 2019****	April 24, 2019	April 5-18, 2019
April 29, 2019	May 2, 2019	May 8, 2019	April 19-May 2, 2019
May 10, 2019**	**May 15, 2019****	May 22, 2019	May 3-16, 2019
May 27, 2019	May 30, 2019	June 5, 2019	May 17-30, 2019
June 10, 2019	June 13, 2019	June 19, 2019	May 31-June 13, 2019
June 21, 2019**	**June 26, 2019****	July 3, 2019	June 14-27, 2019
July 8, 2019	July 11, 2019	July 17, 2019	June 28-July 11, 2019
July 22, 2019	July 25, 2019	July 31, 2019	July 12-25, 2019
August 2, 2019**	August 8, 2019	August 14, 2019	July 26-August 8, 2019
August 19, 2019	August 22, 2019	August 28, 2019	August 9-22, 2019
August 30, 2019**	September 5, 2019	September 11, 2019	August 23-September 5, 2019
September 16, 2019	September 19, 2019	September 25, 2019	September 6-19, 2019
September 30, 2019	October 3, 2019	October 9, 2019	September 20-October 3, 2019
October 11, 2019**	October 17, 2019	October 23, 2019	October 4-17, 2019
October 28, 2019	October 31, 2019	November 6, 2019	October 18-31, 2019
November 8, 2019**	November 14, 2019	November 20, 2019	November 1-14, 2019
November 25, 2019	November 28, 2019	December 4, 2019	November 15-28, 2019
December 9, 2019	December 12, 2019	December 18, 2019	November 29-December 12, 2019
December 19, 2019**	**December 24, 2019****	December 31, 2019	December 13-26, 2019
January 6, 2020	January 9, 2020	January 15, 2020	December 27, 2019-January 9, 2020
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, Sessional Payments and Locum Claim Forms. 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

Please make a note in your schedule of the following dates MSI will accept as "Holidays".	
NEW YEAR'S DAY	TUESDAY, JANUARY 1, 2019
HERITAGE DAY	MONDAY, FEBRUARY 18, 2019
GOOD FRIDAY	FRIDAY, APRIL 19, 2019
EASTER MONDAY	MONDAY, APRIL 22, 2019
VICTORIA DAY	MONDAY, MAY 20, 2019
CANADA DAY	MONDAY, JULY 1, 2019
CIVIC HOLIDAY	MONDAY, AUGUST 5, 2019
LABOUR DAY	MONDAY, SEPTEMBER 2, 2019
THANKSGIVING DAY	MONDAY, OCTOBER 14, 2019
REMEMBRANCE DAY	MONDAY, NOVEMBER 11, 2019
CHRISTMAS DAY	WEDNESDAY, DECEMBER 25, 2019
BOXING DAY	THURSDAY, DECEMBER 26, 2019
NEW YEAR'S DAY	WEDNESDAY, JANUARY 1, 2020

PHYSICIAN'S BULLETIN
June 28, 2019: Vol. LXIV, ISSUE 14

NOVA SCOTIA MEDICAL SERVICES INSURANCE

MSI News

CHANGE TO BREAST AUGMENTATION COVERAGE

Starting July 1, 2019, the province will cover breast augmentation surgery for transgender women in Nova Scotia. Breast augmentation is being added to the list of publicly funded gender affirming surgeries. Eligibility is determined based on the criteria outlined in the revised application form. Assessment and referral by a physician and pre-approval by MSI are required.

Please view the DHW website for more information on gender affirming surgeries:
https://novascotia.ca/dhw/gender-affirming-surgery/

PHYSICIAN'S BULLETIN
June 17, 2019: Vol. LXIV, ISSUE 13

NOVA SCOTIA MEDICAL SERVICES INSURANCE

PATIENT ENROLMENT INCENTIVE UPDATE – EXTENSION

The Department of Health and Wellness (DHW) has decided to provide an additional extension to the deadline for finalizing your patient panel. Your patient panel will be accessible via the link provided until midnight on **July 2, 2019**. Your patient panel will need to be updated and finalized by July 2 as the DHW has indicated there will be no further extensions. We recommend that you finalize your panel early to avoid any unexpected system issues which may occur closer to the deadline.

As noted in previous Physician's Bulletins, an incentive will only be paid to those physicians who completed the verification process and finalized their panel. The payment date associated with the incentive has changed given that the time to complete your panel is being extended to July 2. Your payment will be deposited into the same bank account that you have provided for other incentive and CMPA payments as per the Master Agreement on August 14, 2019.

If you have any questions while you are completing your patient panel, please do not hesitate to contact us. The following sections of the Patient Panel Verification Instructions have been updated based on questions/feedback received:

- Accessing Your Panel
- Resetting a Forgotten Password

Please click here to view the updated instructions.

We can be reached at 902-496-7011 / toll-free 1-866-553-0585 Mon – Fri, 8am – 5pm or at msi_assessment@medavie.bluecross.ca

PHYSICIAN'S BULLETIN
June 14th, 2019: Vol. LXIV, ISSUE 12

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

WCB CLAIMS PROCESSING – UPCOMING CHANGES

As noted in previous Physician's Bulletins, additional information will be required when submitting claims to Medavie for WCB payment, effective June 27, 2019.

Submission requirements

From June 27, 2019 onward, you will need to include one or both of the following when submitting claims with a payment responsibility of WCB:

- Patient's WCB claim number
- Patient's injury date (month and year)

In some cases, you may provide a service to a patient before a WCB claim exists. In these cases, the month and year of injury should be submitted.

This additional information will be used to verify that the patient was eligible for WCB coverage on the date that the service was provided. Although Medavie will be receiving WCB eligibility updates daily, you may notice a difference in the length of time it takes to process some WCB claims, as this required verification will be completed prior to the claim being paid. Confirming whether your patient is eligible for benefits at the time the claim is submitted for payment will help prevent billing errors and reduce the need for payment reversals.

Your billing vendor has made changes to their software to enable you to provide this additional information. Please contact your vendor directly if you have any questions regarding the rollout of their software changes. If you do not provide the WCB claim number and/or injury date, your claim will be refused.

★MSI News Continued

Return to Work (RTW) Service

As you know, WCB believes strongly that work is a healthy part of recovery. As a health care provider, you play a vital role in formulating a plan for successful return-to-work of your patient, and you understand the importance of helping your patient stay active and connected to their workplace. WCB encourages you to follow your patient as frequently as needed to ensure a successful return-to-work.

The health service code to be used when claiming for these visits is WCB28 (Comprehensive Visit for Work Related Injury or Illness). The typical visit frequency is biweekly. If health service code 03.03 or 03.03A (limited visit) is submitted, the claim will be refused.

The associated reporting to WCB is to occur within 5 days of each visit using the report Form 8/10. Health service code WCB26 is to be used for billing purposes.

Long Term Benefits (LTB) Service

If your patient has been transitioned to receiving long term benefits, WCB no longer requires Form 8/10 for follow-up visits. Generally, visits would be no more than monthly for follow-up of the original compensable injury. The health service code to be used for these visits is 03.03 or 03.03A. If WCB28 is submitted, the claim will be refused.

If your patient's condition changes, you can submit a Form 8/10 to WCB. WCB26 is to be used for billing purposes.

Ongoing updates will be provided via the MSI Physician's Bulletin. Relevant information will also be posted on the MSI Website, https://msi.medavie.bluecross.ca. If you have any questions, please email msi_assessment@medavie.bluecross.ca or call 902-496-7011/toll-free 1-866-553-0585.

★ Fees New Fees and Fee Revisions

NEW FEES

The following new WCB codes are available for billing:
Request forms submitted since June 1st may now be claimed using these codes.

Category	Code	Description	Base Units
DEFT	WCB29	**Initial Request Form for Medical Cannabis** **Description** Completed Initial Request Form for Medical Cannabis **Billing Guidelines** No multiple submissions permitted for the same patient on the same day **Notes:** Incomplete forms may be subject to fee reversal	$73.25

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NEW FEES (CONTINUED)

Category	Code	Description	Base Units
DEFT	WCB30	**Extension Request Form for Medical Cannabis** **Description** Completed Extension Request Form for Medical Cannabis **Billing Guidelines** No multiple submissions permitted for the same patient on the same day **Notes:** Incomplete forms may be subject to fee reversal	$43.95

Effective June 14, 2019 the following codes are available for billing:

Category	Code	Description	Base Units
VIST	03.03W	**Medical Geneticist Virtual Care Follow Up Visit – Per 15 Minutes** **ME=VTCR** **Description** This is a time based health service code for follow up visits by the geneticist post genetics consultation using a PHIA compliant, synchronous, virtual care platform. Report virtual face to face care with geneticist only, 80% of the documented clinical encounter time must be virtual face to face with the geneticist. Start and stop times must be documented in the health record and submitted in text with the claim. **Billing Guidelines** • 80% of the documented clinical encounter time must be virtual face to face with the geneticist • A total of four 15 minute time periods may be reported for any one encounter. Should the patient-physician encounter take longer than 60 minutes, report EC with a note explaining the clinical circumstances. • Start and stop times must be documented in the health record and submitted in text with the claim. • Service must be delivered via a PHIA compliant, synchronous, virtual care platform. **Specialty Restriction** SP=HUGE, SP=MEGE **Location** LO=OFFC, LO=HOSP **Notes:** Total of 60 minutes per encounter	16.3 MSU

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Category	Code	Description	Base Units
VEDT	03.39T	**Clinical Interpretation of complex genetics tests (e.g. microarray analysis, next generation sequencing, and exome sequencing) by geneticist – findings must be recorded in health record and recommendations made in writing to the referring physician. Per 15 Minutes** **RO=INTP** **Description** This is a time based code to enable clinical reporting of the time spent by the geneticist who interprets complex abnormal genetic test results and relays that information in writing to the referring physician. Start and stop times must be recorded in the health record. No other HSC's reportable during that time period for that physician. **Billing Guidelines** Start and stop times must be recorded in the health record. No other HSC to be reported by the physician in the same time period. **Specialty Restriction** SP=HUGE, SP=MEGE **Location** LO=OFFC, LO=HOSP	15 MSU

Category	Code	Description	Base Units
VEDT	RGN1	**Review by Geneticist of Patient encounter with Genetics Counsellor** **Description** This health service code is for the review by the geneticist of the patient encounter performed solely by the genetics counsellor. This service includes the review of any pertinent investigations and results. The letter back to the referring physician must be reviewed and co-signed by the geneticist and must indicate that the patient was seen by the genetics counsellor. Not payable if the patient has been seen by geneticist within 30 days. **Billing Guidelines** The encounter must be documented in the health record and indicate that the patient was seen by the genetics counsellor alone but the clinical information and letter to the referring physician were reviewed by the geneticist. **Specialty Restriction** SP=HUGE, SP=MEGE **Location** LO=OFFC, LO=HOSP	30 MSU

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FEE REVISIONS

Effective June 14, 2019 the description for 03.09A has been updated:

Category	Code	Description	Base Units
CONS	03.09A	**Complex Genetic Counselling Consultation**	125 MSU

Description

1. This code may only be used by a physician who is:
   a) Certified in Medical Genetics by the RCPSC or;
   b) Certified in Clinical Genetics by the Canadian College of Medical Genetics and/or;
   c) Registered by the College of Physicians and Surgeons of Nova Scotia as a specialist in Medical Genetics or Human Genetics.
2. This is a specific and detailed activity, which includes interviewing of appropriate family members, and collection and assessment of adequate clinical and genetic data to characterize the problem, establish a likely diagnosis (or differential diagnosis), construct a family pedigree and assess (both qualitatively and quantitatively) the risks to the persons seeking advice. It includes imparting this information and the various options for dealing with the problem to the individuals and appropriate family members in such a way that they can make informed decisions about the genetic problem. It may, in addition or alternatively, include the establishment or verification of a plan for further investigative and/or therapeutic management.
3. This type of consultation is to be distinguished from a routine genetics consult. It requires one or both of the following:
   a) Detailed, intensive review of patient data (including medical records and diagnostic studies), ***or***
   b) Detailed and lengthy review of appropriate medical literature because of the complexity and/or rarity of the problem.
4. Because of the complexity involved in such a service it is expected that more than one hour is required for the completion of this consultation.
5. As is the case for all consultations, a request for consultation must be initiated by a referring physician, and a written report with the opinion and recommendations of the consultant must be sent to the referring physician. A written summary or report may be also sent to the patient or family. This fee code may be claimed only once per patient.
6. A prolonged Complex Genetic Counselling Consultation may be reported if the encounter exceeds 90 minutes. No other fee codes may be reported for the same patient for that time period; two additional 15 minute multiples may be reported for a total of 120 minutes. If reporting a prolonged consultation service, start and stop times must be documented in the health record and in the text field of the MSI claim. MU=16.3 MSU/15 min

Note:

May be provided via PHIA compliant, synchronous, virtual care platform
ME=VTCR

Specialty Restriction

SP=HUGE, SP=MEGE

Effective June 14, 2019 the virtual care modifier (ME=VTCR) is available for use on the follow-up visit services (03.03 office visit and 03.03A geriatric office visit) by providers designated as Virtual Care Health Care Providers.

Effective June 14, 2019, any extra patient (PT=EXPT) visits performed in a hospital or nursing home location will also require the correct time of day modifier TI=AMNN (8:01am – 12pm) TI=NNEV (12:01pm – 5pm) on the claim.

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FEE ADJUSTMENTS

Select time based HSC have the following fee adjustments:

Category	Code	Description	Base Units
VIST	Select time based codes	03.03C Palliative Care Support **Specialty Restriction** N/A	30 MSU per 30 minutes
VIST PSYC	Select time based codes	03.03D Case Management Conference Fee 08.41 Hypnotherapy 08.44 Group Therapy 08.45 Family Therapy 08.49A Counselling 08.49B Psychotherapy 08.49C Lifestyle Counselling **Specialty Restriction** SP=GENP	15 MSU per 15 minutes 30 MSU per 30 minutes 7.6 MSU per 30 minutes 30 MSU per 30 minutes 15 MSU per 15 minutes 30 MSU per 30 minutes 15 MSU per 15 minutes

Billing Matters Billing Reminders, Updates, New Explanatory Codes

BILLING REMINDERS

Ultrasounds and 02.84A

Physicians are reminded HSC 02.84A for Obstetrical Doppler is a stand-alone procedure, thus no ultrasound should be claimed during the same encounter. If an ultrasound does occur, the appropriate ultrasound fee should be claimed along with HSC 02.84B – Obstetrical Doppler in conjunction with ultrasound.

Tonsillectomy 40.2A

Physicians are reminded that HSC 40.2A is only to be claimed for surgical tonsillectomy and/or adenoidectomy at a hospital location.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
AD084	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 02.84A WHICH IS A STAND ALONE PROCEDURE HAS ALREADY BEEN CLAIMED DURING THE SAME ENCOUNTER
GN012	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 02.84A WHICH IS A STAND ALONE PROCEDURE HAS ALREADY BEEN CLAIMED DURING THE SAME ENCOUNTER. IF AN ULTRASOUND HAS OCCURRED THE APPROPRIATE ULTRASOUND FEE SHOULD BE CLAIMED ALONG WITH ADD ON HSC 02.84B – OBSTETRICAL DOPPLER IN CONJUNCTION WITH ULTASOUND

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Code	Description
VA096	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 02.84A IS A STAND ALONE PROCEDURE AND MAY NOT BE CLAIMED WITH ANY OTHER ULTRASOUNDS DURING THE SAME ENCOUNTER
VE025	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU PREVIOUSLY CLAIMED A VISIT WITH THIS PATIENT IN THE LAST 30 DAYS
VE026	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO OTHER FEES ARE PAYABLE DURING THE SAME TIME PERIOD AS HSC 03.39T
VE027	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO OTHER FEES ARE PAYABLE DURING THE SAME TIME PERIOD AS HSC 03.09A
WB036	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE INITIAL OR EXTENSION FOR MEDICAL CANNABIS FORM HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY
WB037	SERVICE ENCOUNTER HAS BEEN REFUSED AS AN INITIAL OR EXTENSION REQUEST FOR MEDICAL CANNABIS WAS PREVIOUSLY CLAIMED IN THE PAST SEVEN WEEKS
VT169	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU ARE NOT AUTHORIZED TO PROVIDE THIS SERVICE OVER A VIRTUAL CARE PLATFORM

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday June 14th, 2019. The files to download are health service (SERVICES.DAT), health service description (SERV_DSC.DAT), and, explanatory codes (EXPLAIN.DAT).

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MEDICAL CONSULTANT JOB POSTING

Job Title: Medical Consultant
Department: Medicare Programs
Competition: 5131
Internal/External: Internal/External
Employment Type: External Consultant – Part Time (21.75 hours per week)
Location(s): Dartmouth
Salary: Competitive Compensation
Reports to: Team Leader
Closing Date: July 5, 2019

Role Summary:

We are currently accepting applications for a part time external Medical Consultant. The successful candidate will work onsite with the Medicare Programs team in our Dartmouth office and will be responsible for providing professional medical guidance in support of the MSI assessment and audit functions. In this role, the successful candidate will be responsible for providing a professional link between physicians, government and patients.

As an External Medical Consultant, your key responsibilities will include:

- Providing direction and guidance to the Claims Assessment team regarding claims adjudication and payment.
- Reviewing requests for pre-authorization of in-province physician services; out-of-province/country physician services or hospitalization and retroactive payment of out-of-province/country physician services or hospitalization claims.
- Ensuring all administrative processes are followed for out-of-province/country referrals for addiction and mental health services.
- Providing or assisting in the first level of appeals for citizen/provider complaints regarding issues of medical insurability, medical necessity and treatment not normally insured as well as provider appeals regarding claims payment.
- Conduct fee for service and shadow billing audits in collaboration with the Medicare 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 pre and post payment monitoring operations, and the development of risk analysis strategies to utilize departmental resources efficiently.
- Providing assistance to the Department of Health and Wellness Medical Consultant to support medical policy, medical tariff development and activities related to claims assessment
- 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.
- Responding to enquiries from patients, physicians, Doctors NS, Nova Scotia College of Physicians and Surgeons, Medical Directors and the Department of Health and Wellness with respect to individual patient claims and the insurability of specific services for an individual according to Department of Health and Wellness policy.

MEDICAL CONSULTANT JOB POSTING (CONTINUED)

As the ideal candidate, you possess the following qualifications:

Education: University degree with a Doctorate in Medicine.

Work Experience: 10 to 15 years' experience as a physician in a range of practice settings. Surgical and administrative experience would be an asset.

Other Qualifications: Strong interpersonal skills and the ability to resolve conflicts and deal with stressful situations.

Computer Skills: General computer knowledge.

Communication Skills: Excellent written and verbal communication skills are fundamental to the position.

You also demonstrate the following core competencies:

Knowledge: Uses knowledge and industry best practices to provide guidance and/or advice to leaders and coworkers on key issues in own area of expertise. Demonstrates a specialized knowledge of all processes, policies and precedents to do the job and solve day to day issues independently.

Analytical Thinking: Uses knowledge and experience to solve a variety of routine and complex technical problems. Identifies the cause of problems and implements the most appropriate solution.

Communication: Able to communicate complex information effectively through both oral and written means. Demonstrates the full range of effective verbal communication skills in a variety of settings such as formal meetings, presentations, and any one on one situation.

Customer Orientation: Independently processes many unusual and demanding customer requests. Maintains library/database/network of all customer information and materials to meet both routine and complex customer needs.

Execution and Organization Skills: Exceptional organizational and time-management skills. Able to prioritize work within in a changing work environment under the pressure of deadlines.

Team Work: Provides professional advice and direction to team members and leads work processes and proactively searches for ways to improve team effectiveness and performance.

If you are interested in working with a team of professionals in a challenging role and you possess the necessary qualifications, please follow the instructions for applying online via the Medavie Blue Cross Corporate website by clicking on the link below.

Apply Now

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

Medavie Blue Cross is an equal opportunity employer.

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PHYSICIAN'S BULLETIN
June 11, 2019: Vol. LXIV, ISSUE 11

NOVA SCOTIA MEDICAL SERVICES INSURANCE

PATIENT ENROLMENT INCENTIVE UPDATE

This is a reminder that your patient panel will be accessible via the link provided until midnight on **June 21, 2019**. Your patient panel will need to be updated and finalized during this time period as there will be no further extensions/exceptions beyond the June extension. We recommend that you finalize your panel early to avoid any unexpected system issues which may occur closer to the deadline.

As noted in previous Physician's Bulletins, an incentive will only be paid to those physicians who completed the verification process and finalized their panel. The payment date associated with the incentive had changed given that the time to complete your panel was extended to June 21. Your payment will be deposited into the same bank account you have provided for other incentives and CMPA payments as per the Master Agreement on August 14, 2019.

If you have any questions while you are completing your patient panel, please do not hesitate to contact us. The following sections of the Patient Panel Verification Instructions have been updated based upon questions/feedback received:

- Accessing Your Panel
- Resetting a Forgotten Password

Please click here to view the updated instructions.

We can be reached at msi_assessment@medavie.ca or 902-496-7011/toll-free 1-866-553-0585 Mon – Fri, 8am – 5pm.

PHYSICIAN'S BULLETIN
June 5, 2019: Vol. LXIV, ISSUE 10

NOVA SCOTIA MEDICAL SERVICES INSURANCE

PATIENT ENROLMENT INCENTIVE UPDATE

We would like to remind you that your patient panel will be available via the link provided until midnight on **June 21, 2019**. Your patient panel will need to be updated and finalized during this time period as there will be no further extensions/exceptions beyond the June extension. As noted in previous Physician's Bulletins, an incentive will only be paid to those physicians who completed the verification process and finalized their panel.

The following sections of the Patient Panel Verification Instructions have been updated based upon questions/feedback received:

- Accessing Your Panel
- Resetting a Forgotten Password

Please click here to view the updated instructions.

If you have any questions while you are completing your patient panel, please do not hesitate to contact us. We can be reached at msi_assessment@medavie.ca 902-496-7011/toll-free 1-866-553-0585 Mon – Fri, 8am – 5pm.

PHYSICIAN'S BULLETIN
May 29, 2019: Vol. LXIV, ISSUE 9

NOVA SCOTIA MEDICAL SERVICES INSURANCE

WCB CLAIMS PROCESSING – UPCOMING CHANGES

As noted in the Physician's Bulletin dated March 27, 2019, the implementation date for including the WCB claim number and/or the worker's injury date (month and year) when submitting claims to Medavie for WCB payment is, June 27, 2019.

Accredited billing vendors have been contacted regarding this implementation date. Please contact your vendor directly if you have any questions regarding the rollout of their software changes.

Ongoing updates will be provided via the MSI Physician's Bulletin. Relevant information will also be posted on the MSI website, https://msi.medavie.bluecross.ca. If you have any questions, please email msi_assessment@medavie.bluecross.ca or call 902-496-7011/toll-free 1-866-553-0585.

PHYSICIAN'S BULLETIN
May 7, 2019: Vol. LXIV, ISSUE 8

NOVA SCOTIA MEDICAL SERVICES INSURANCE

PATIENT ENROLMENT INCENTIVE UPDATE

The Department of Health and Wellness has decided to extend the deadline for finalizing your patient panel. Your patient panel will be available via the link provided until midnight on **June 21, 2019**. Your patient panel will need to be updated and finalized during this time period as there will be no further extensions/exceptions beyond the June extension. As noted in the Physician's Bulletin of April 5, an incentive will only be paid to those physicians who completed the verification process and finalized their panel.

Please click here to view the updated instructions based on questions/feedback received.

If you have any questions while you are completing your patient panel, please do not hesitate to contact us. We can be reached at msi_assessment@medavie.ca or Mon – Fri, 8am – 5pm, 902-496-7011/toll-free 1-866-553-0585.

PHYSICIAN'S BULLETIN
May 6, 2019: Vol. LXIV, ISSUE 7

NOVA SCOTIA MEDICAL SERVICES INSURANCE

PATIENT ENROLMENT INCENTIVE REMINDER

A patient panel package was mailed to eligible physicians on April 15, 2019. The package was sent to family physicians who attested that they are providing comprehensive and continuous care to their patients by signing and returning the Physician Confirmation Letter provided by MSI, prior to February 1, 2019.

We would like to remind you that your patient panel will be accessible via the link provided until May 23, 2019. Your patient panel will need to be updated and finalized during this time period. As noted in the Physician's Bulletin of April 5, an incentive will only be paid to those physicians who completed the verification process and finalized their panel.

The following sections of the Patient Panel Verification Instructions have been updated based upon questions/feedback received:

- Accessing Your Panel
- Resetting a Forgotten Password

Please click here to view the updated instructions.

If you have any questions while you are completing your patient panel, please do not hesitate to contact us. We can be reached at msi_assessment@medavie.ca or Mon – Fri, 8am – 5pm, 902-496-7011/toll-free 1-866-553-0585.

PHYSICIAN'S BULLETIN
April 26, 2019: Vol. LXIV, ISSUE 6

NOVA SCOTIA MEDICAL SERVICES INSURANCE

PATIENT ENROLMENT INCENTIVE REMINDER

A patient panel package was mailed to eligible physicians on April 15, 2019. The package was sent to family physicians who attested that they are providing comprehensive and continuous care to their patients by signing and returning the Physician Confirmation Letter provided by MSI, prior to February 1, 2019.

We would like to remind you that your patient panel will be accessible via the link provided until May 23, 2019. Your patient panel will need to be updated and finalized during this time period. As noted in the Physician's Bulletin of April 5, an incentive will only be paid to those physicians who completed the verification process and finalized their panel.

The following sections of the Patient Panel Verification Instructions have been updated based upon questions/feedback received over the last week:

- Accessing Your Panel
- Resetting a Forgotten Password

Please click here to view the updated instructions.

If you have any questions while you are completing your patient panel, please do not hesitate to contact us. We can be reached at msi_assessment@medavie.ca or Mon – Fri, 8am – 5pm, 902-496-7011/toll-free 1-866-553-0585.

PHYSICIAN'S BULLETIN

April 5, 2019: Vol. LXIV, ISSUE 5

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

UNIT VALUES AND PAYMENT RATES

MEDICAL SERVICE UNIT / ANAESTHESIA UNIT VALUE
Effective April 1, 2019 the Medical Service Unit (MSU) value is $2.48 and the Anaesthesia Unit (AU) Value is $21.07.

WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC UNIT VALUE
Effective April 1, 2019 the Workers' Compensation Board MSU Value is $2.76 and the Workers' Compensation Board Anaesthetic Unit Value is $23.41.

PSYCHIATRY FEES
Effective April 1, 2019 the hourly Psychiatry rate for General Practitioners is $113.33 and the hourly rate for Specialists is $153.67 as per the tariff agreement.

SESSIONAL PAYMENTS
Effective April 1, 2019 the hourly Sessional payment rate for General Practitioners is $148.80 and the hourly rate for Specialists is $173.60 as per the tariff agreement.

CHANGE TO BREAST REDUCTION CRITERIA

Effective immediately DHW has removed the criteria that patients have a BMI of 27 or less to qualify for MSI coverage for a breast reduction. All other requirements remain unchanged.

REISSUING REQUEST FOR PROPOSALS – MEDICAL CONSULTANT

The Department of Health and Wellness is reissuing the Request for Proposals (RFP) for part time services of a Medical Consultant to provide support and advice on a range of policy issues related to Physician Services, Pharmacare, Children's Oral Health Program, and other extended health benefit programs. It is anticipated that the RFP will be posted on the Government Procurement site the week of April 8, 2019 and will be posted for a period of 15 days. Please watch for it on the Government Procurement site at https://novascotia.ca/tenders/default.aspx

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PATIENT PANEL ENROLLMENT INCENTIVE

In March 2018 the Premier announced a number of new investments in Primary Care. This announcement included a one-time flat enrollment fee of $7.50 per current patient to enable family physicians to identify a panel of patients for whom they are providing comprehensive and continuing care.

As noted in the Physician's Bulletins posted on December 11, 2018 and January 14, 2019 the patient enrollment incentive is available to those family physicians who attest that they are providing comprehensive and continuous care to their patients by signing and returning the Physician Confirmation Letter provided by MSI, prior to February 1, 2019. Participation in the patient panel verification initiative is on a voluntary basis.

An initial patient panel has been created for each eligible physician based upon claims submitted to MSI over the past 3 years. A package containing instructions on how to access your panel online and verify your patients will be mailed to you on April 15, 2019. Your patient panel will be accessible via the link provided until May 23, 2019. Your patient panel will need to be updated and finalized during this time period. An incentive will only be paid to those physicians who completed the verification process and finalized their panel. Your incentive will be based upon the number of patients that appear on your final approved and validated panel. The payment will be issued on July 17, 2019. Additional details will be provided in the package.

If you have any questions regarding this upcoming verification process, please do not hesitate to contact us. We can be reached at msi_assessment@medavie.bluecross.ca or 902-496-7011/toll-free 1-866-553-0585.

★ Fees New Fees and Highlighted Fees

UPDATED FEES

Effective April 6, 2019 Health Service Code 02.02B has been updated to include patients starting hydroxychloroquine or chloroquine treatment.

Category	Code	Description	Base Units
VADT	**02.02B**	**Optic Nerve Imaging** Optic Nerve Imaging by any means (e.g. OCT, HRT) for patients with a diagnosis of glaucoma, wet AMD, retinal vein occlusion, diabetic macular edema, *and patients starting hydroxychloroquine or chloroquine treatment.* This fee is for the interpretation of scanning computerized ophthalmic diagnostic imaging, with interpretation and written report, unilateral or bilateral, of the optic nerve and/or retina regardless of the technology used to perform the imaging. Not to be used for glaucoma screening. **Billing Guidelines** • Glaucoma Diagnosis – once per patient per year. • Diabetic macular edema, retinal vein occlusion or wet age related macular degeneration having been treated once in the past year with intravitreal anti-VEGF drugs – up to 6 times per patient per year. • *One baseline OCT for patients starting treatment with hydroxychloroquine or*	**8 MSU**

Category	Code	Description	Base Units
		chloroquine • *After five years of hydroxychloroquine or chloroquine treatment, one OCT per year will be considered medically necessary.* • *For patients on hydroxychloroquine or chloroquine who have suspicious visual fields, clinical findings on examination of the retina, or are at high risk (dosing in excess of 5mg/kilo per day), OCT will be considered medically necessary up to twice a year.* **Eligible Diagnostic Codes** • 362.52 – Exudative Senile Macular Degeneration • 362.01 – Background Diabetic Retinopathy • 362.35 – Central Retinal Vein Occlusion • 362.36 – Venous Tributary Occlusion • 379.27 – Vitreomacular Adhesion • 365.9 – Unspecified Glaucoma • *362.10 – Background Retinopathy Unspecified (this is to be used for patients on hydroxychloroquine/chloroquine as there is no specific ICD9 code- see note below)* **Location** OFFC, HOSP **Note** Claims submitted with 362.10 ICD9 diagnostic code will require text stating the type of medication and any additional risk factors. These claims will be manually assessed.	

Effective April 6, 2019 the modifier (US=UNOF) has been removed from (PT=EXPT) claims.
By definition an urgent visit requires the physician to travel from one location to another in order to visit the patient, as outlined in Preamble 5.1.52. While an urgent visit is appropriate for the first patient seen at a facility, it does not apply to the second or subsequent patients seen at the same location as the physician is already physically in the facility and thus no travel occurred.

13.59L RO=HPV9 PT=RISK Age Restriction
High-Risk patients will only be eligible for this vaccination up to and including 45 years of age.

★ Fees New Fees and Highlighted Fees

NEW FEES

Effective April 6, 2019 the following health service code will be available for billing:

Category	Code	Description	Base Units
VEDT	**13.59O**	**Injection of onabotulinumtoxinA for the treatment of Chronic Migraine (Prior Approval)** 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.	**70 MSU**

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Category	Code	Description	Base Units
		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 8 service encounters for injection of ONA for Chronic Migraine may occur over that 24 month period • Services to be no more frequent than every 3 months • 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** NEUR **Location** OFFC	

Effective April 6, 2019 the following health service codes will be available for billing:

Category	Code	Description	Base Units
VEDT	**13.99F**	**Assessment and management of patient with Acute Stroke: From activation of Acute Stroke Protocol through completion of thrombolytic therapy (e.g. t-PA)** This HSC is specific for the assessment and management of a patient experiencing symptoms of acute stroke and for whom the Acute Stroke Protocol has been activated. The service includes ongoing evaluation, clinical monitoring, diagnostic evaluation, review of diagnostic imaging and completion of thrombolytic therapy (e.g. t-A) **Billing Guidelines** • Reportable by one physician per patient per day • Must complete thrombolytic therapy in order to report this HSC • If patient does not receive thrombolytic therapy, only the pertinent visit code is reportable **Location** HOSP (Provincial Stroke Centers only)	**130 MSU**
VEDT	**13.99G**	**Assessment and management of patient with Acute Stroke: From activation of Acute Stroke Protocol through receiving endovascular thrombectomy (EVT) with or without administration of thrombolytic therapy**	**170 MSU**

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Category	Code	Description	Base Units
		This HSC is specific for the assessment and management of a patient experiencing symptoms of acute stroke and for whom the Acute Stroke Protocol has been activated. The service includes ongoing evaluation, clinical monitoring, diagnostic evaluation, review of diagnostic imaging, with or without thrombolytic therapy, and supervision of patient receiving EVT. **Billing Guidelines** • Reportable by one physician per patient per day • Patient must undergo EVT in order to report this HSC **Specialty Restriction** NEUR **Location** HOSP (Halifax Infirmary only)	

NEW INTERIM FEES

Effective April 6, 2019 the following interim health service codes will be available for billing:

Category	Code	Description	Base Units
VADT	**13.59P**	**Insertion of Buprenorphine Implant (e.g. Probuphine) for the treatment of opioid use disorder** This HSC is for the insertion of the non-biodegradable buprenorphine delivery implant for the treatment of opioid use disorder	**20 MSU**
VADT	**13.59Q**	**Removal of Buprenorphine Implant (e.g. Probuphine)** This HSC is for the removal of the non-biodegradable buprenorphine delivery implant For removal and reinsertion of the non-biodegradable buprenorphine delivery implant, report the removal code at 100% and the insertion code at LV50. **Billing Guidelines** May not be claimed in addition to OAT1 or OAT2 by any physician for the same patient for 6 months following implantation. If the implant is removed early or there are special circumstances to consider the physician should add text to the OAT management claim explaining the circumstances.	**20 MSU**

Effective April 6, 2019 the following interim health service code will be available for billing:

Category	Code	Description	Base Units
VEDT	**50.0B**	**Endovascular Thrombectomy-Intracranial** 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. **Specialty Restriction** Neuroradiology (DIRD with subspecialty in neuroradiology) **Location** HOSP (QEII only)	**300 MSU**

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Effective April 6, 2019 the following interim health service code will be available for billing:

Category	Code	Description	Base Units
VIST	03.04I	**PSP Mental Health Comprehensive Visit to establish the PSP Mental Health Plan (PSP= Practice Support Program)** This code is for the complete assessment of the patient with a confirmed mental illness meeting the diagnostic criteria in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of sufficient severity and acuity to cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and warrant the development of a Mental Health care plan. This is not intended for patients with self-limited or short lived mental health symptoms. The assessment is to be performed by the PSP trained family physician most responsible for the patient's mental health care. The Mental Health Plan and start and stop times must be documented in the health record. This complete assessment is to include **all** of the following elements and be documented in the health record: • The patient's DSM diagnosis, psychiatric history and current mental state including suicide risk assessment as appropriate • Obtaining collateral history and information from caregivers as required • Performance of a complete medication review to include collateral information from pharmacy and assisted living facility as appropriate • Reviewing and documenting results of relevant validated assessment tools, laboratory, and other test results • Documentation of a clinical plan for the patient's care over the next year. Includes advanced care planning where appropriate • Outline of expected outcomes as a result of the treatment plan • Outline of linkages with other health care providers and community resources who will be involved in the patients care. • Confirmation that the plan has been created jointly and shared with the patient or their medical representative. The plan is to be shared with other care providers as appropriate • A documented care plan must be in place before access to additional counselling hours is provided It is recognized that the required elements may require more than one visit to complete. This health service code may be claimed at the final visit only when all of the information is complete and documented in the health record; other visits may be reported at the usual rate. **All** elements must be documented in the health record before reporting this PSP MHP visit service. **Billing Guidelines** • Reportable by the patient's PSP trained physician only • Not reportable with any other visit fee for the same physician, same patient, same day • Not reportable for services provided at walk-in clinics • Not to be used for patients living in nursing homes, residential care facilities or hospices • Reportable only once per patient per year • 50 MSU for first 30 minutes, 25 MSU for each additional 15 minutes, up to a maximum of 1 hour (5 multiples) • Start and stop times must be reported in the text field of the claim to MSI, as well as in the clinical record **Specialty Restriction** GENP with PSP Training **Location** OFFC, HOME	**50 MSU +MU**

PREAMBLE CHANGES

Counselling- Preamble 5.2.151

Current Definition	New Definition
The following services and restrictions apply to general practitioners only. *(5.2.152)* Counselling is a prolonged discussion directed at addressing problems associated with acute adjustment reactions or bereavement reactions. *(5.2.153)* Counselling may be claimed in 15 minute intervals. At least 80 percent of the time claimed must be spent in direct patient intervention. *(5.2.154)* Restrictions: Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, counselling may not be claimed for the following: – More than five hours per patient per physician per year. – More than one hour per patient per day. – A patient younger than four years old. – More than one general practitioner providing counselling to a particular patient. *(5.2.155)*	The following services and restrictions apply to general practitioners only. *(5.2.152)* Counselling is a prolonged discussion directed at addressing issues pertaining to the patient's underlying mental illness, acute adjustment disorder or bereavement. Counselling may be claimed by family physicians for patients who meet the current DSM (Diagnosis and Statistical Manual of Mental Disorders) diagnostic criteria for the diagnosis of a mental health disorder *(5.2.153)* Counselling may be claimed in 15 minute intervals. At least 80 percent of the time claimed must be spent in direct patient intervention. *(5.2.154)* Restrictions: Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, counselling may not be claimed for the following: – More than five hours per patient per physician per year. – More than one hour per patient per day. – A patient younger than four years old. – More than one general practitioner providing counselling to a particular patient. – Physicians who have completed training in the Practice Support Program Adult Mental Health Module may have access to an additional 4 hours of counselling per patient per year. The physician's name must be in the Nova Scotia Health Authority database confirming completion of training. *(5.2.155)*[1]
PSYC 08.49A Counselling.....12.7 per 15 min TI=GPEW.....15.88 per 15 min	PSYC 08.49A Counselling.....25.4 per 30 min. (12.7 units per 15 min. thereafter) TI=GPEW.....15.88 per 15 min.

[1] PSP Physicians who are billing above the 5 hour maximum per patient per year GP restriction must indicate in the text field of the claim that they are a PSP qualified physician. These physicians must be in the NSHA database to confirm completion of training.

BILLING REMINDERS

Meet and Greet

Preamble rules stipulate that all services billed to MSI must be medically necessary i.e. there must be a specific health related concern/ complaint that has led the patient to seek medical attention. It is not appropriate to bill MSI for a "meet and greet" encounter with a new patient unless a health related concern/complaint has been addressed during the encounter and the Preamble requirements for medically necessary visits have been satisfied.

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Unattached Patient Bonus Incentive (UPB1)

Physicians are reminded that this incentive may only be claimed for individuals they have agreed to take on as regular patients. The incentive may be claimed at the time of the first visit to the physician's office. The fee cannot be claimed in other circumstances such as placing the patient on a waiting list for the practice, when the patient is not being accepted into the practice, or is being directed to another physician for care.

The current guidelines for UPB1 were effective April 1, 2018

Category	Code	Description	Value
DEFT	**UPB1**	**Unattached Patient Bonus** This incentive is available for eligible general practitioners who take on a patient who does not have a family physician and meets the criteria indicated below **Billing Guidelines** • The GP has to have had at least one visit service with the patient prior to claiming the UPB1 fee. The UPB1 fee is billable in addition to the associated visit fee. • A GP can only claim UPB1 once per patient per lifetime. A physician cannot claim the unattached patient bonus more than once for the same patient. • An unattached patient is described as: patients taken from the 811 list, referred from an emergency department, patients who do not have a family physician, newborns and patients whose family physician is about to retire or relocate and does not have a new family physician to assume their practice. • 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 UPB1 cannot be claimed for walk-in clinics, for patients who already appear on a physician's patient list (physician validated), for patients who were taken off the 811 list before the establishment of this fee enhancement, or for new physicians who are building their practices until that point when their patient panel reaches 1350. • New Physicians must be practicing in the community for a minimum of two years, or have reached a patient panel of 1350 prior to claiming the UPB1. • Locum physicians are not eligible for this incentive. **Documentation** The GP must 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 encounter that resulted in the GP taking the Unattached Patient into his/her practice must also be recorded in the patient's record. This can be a patient from the 811 list, referral from the hospital emergency department, for enrolling patients who do not have a physician or are unattached at time of enrolment, for enrolling patients for whom un-attachment is imminent because their family practitioner is retiring/relocating and no new family physician is taking over the practice, an inpatient hospital report or other documentation. (Other documentation may include a note by the physician, documenting their discussion with the patient, confirming the prior hospital encounter.) **Specialty Restriction** GENP **Location** All Locations	**$150.00** (one time per patient)

BILLING REMINDERS (CONTINUED)

Consultations with unknown medical necessity

As outlined in Preamble 2.2.9, MSI will pay for a visit or consultation to determine if a treatment method is insured. This applies in circumstances in which the proposed procedure is sometimes, but not always insured. If the proposed procedure or treatment method is always uninsured, a visit or consultation may not be claimed.

Health Service Code 13.59N (Intravenous Infusion of Local Anaesthetic/Adrenergic Drugs for Chronic Pain Management)

The protocol required in order to claim Health Service Code 13.59N was originally outlined in the submission to the Fee Committee. In the performance of this procedure, patients are to be monitored with both an electrocardiogram and a pulse oximeter. An intravenous line is established and an infusion pump is used to deliver the drug. The physician must be in attendance or readily available to intervene to ensure that side effects do not occur and to make the necessary adjustments in the dosage of the medication. The patient also must be monitored for 10-15 minutes after the infusion is completed and then transferred to a 'post-recovery area' where they are continued to be monitored for a further 30 minutes before being discharged.

Imaging Studies Ordered by Chiropractors

Radiologists are reminded that they may only claim for imaging studies requested by physicians and nurse practitioners. They may not claim for studies requested by other health care providers, including chiropractors.

NEW EXPLANATORY CODES

Code	Description
AD083	SERVICE ENCOUNTER HAS BEEN REFUSED BASED ON THE AGE OF THE RECIPIENT
DE035	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS OAT1 AND OAT2 MAY NOT BE CLAIMED IN THE 6 MONTHS FOLLOWING AN INSERTION OF BUPRENOPHRINE IMPLANT FOR THE TREATMENT OF OPIOID USE DISORDER
MA076	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU ARE NOT PERMITTED TO CLAIM THIS FEE
VA094	SERVCE ENCOUNTER HAS BEEN REFUSED AS ELECTRONIC TEXT IS REQUIRED ON THE CLAIM STATING TYPE OF MEDICATION AND ANY ADDITIONAL RISK FACTORS
VA095	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF OCT FEES PER YEAR FOR THIS DIAGNOSIS HAVE PREVIOUSLY BEEN CLAIMED IN THE PAST YEAR
VE020	SERVICE ENCOUNTER HAS BEEN REFUSED AS AN INJECTION OF ONA FOR CHRONIC MIGRAINE HAS ALREADY BEEN APPROVED IN THE PREVIOUS 3 MONTHS
VE021	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 8 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
VE022	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR ASSESSMENT AND MANAGEMENT OF A PATIENT WITH ACUTE STROKE WAS PREVIOUSLY MADE FOR THIS PATIENT ON THIS DAY
VE023	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS FACILITY IS NOT AUTHORIZED TO CLAIM THE ACUTE STROKE PROTOCOL FEE
VE024	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE MAY ONLY BE CLAIMED FROM THE QEII

Code	Description
VT166	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS TEXT INDICATING THE STOP AND START TIMES FOR THIS SERVICE IS REQUIRED
VT167	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.04I IS NOT REPORTABLE WITH ANY OTHER VISIT FEES ON THE SAME DAY
VT168	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.04I MAY ONLY BE REPORTED ONCE PER PATIENT PER YEAR

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

UPDATED FILES

Updated files reflecting changes are available for download on Saturday April 6, 2019. The files to download are health service (SERVICES.DAT), health service description (SERV_DSC.DAT) and, explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

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

In partnership with

NOVA SCOTIA

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PHYSICIAN'S BULLETIN
March 27, 2019: Vol. LXIV, ISSUE 4

NOVA SCOTIA MEDICAL SERVICES INSURANCE

WCB CLAIMS PROCESSING – UPCOMING CHANGES

The target implementation date, for including the WCB claim number and/or the worker's injury date (month and year) when submitting claims to Medavie for WCB payment, is no longer April 18, 2019 as specified in the Physician's Bulletin dated January 21, 2019. The revised target date is June 27, 2019.

Accredited billing vendors have been contacted regarding the revised date. Please contact your vendor directly if you have any questions regarding the rollout of their software changes.

Ongoing updates will be provided via the MSI Physician's Bulletin. Relevant information will also be posted on the MSI website, https://msi.medavie.bluecross.ca. If you have any questions, please email msi_assessment@medavie.bluecross.ca or call 902-496-7011/toll-free 1-866-553-0585.

PHYSICIAN'S BULLETIN
March 1, 2019: Vol. LXIV, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

REQUEST FOR PROPOSALS – MEDICAL CONSULTANT

The Department of Health and Wellness is seeking the part time services of a Medical Consultant to provide support and advice on a range of policy issues related to physician services, Pharmacare, Children's Oral Health Program, and other extended health benefit programs.

A Request for Proposals (RFP) is posted in the Government Procurement site at:
https://novascotia.ca/tenders/tenders/tender-details.aspx?id=Doc208398473.
The RFP closes March 11, 2019, 2 PM.

PHYSICIAN'S BULLETIN

February 8th, 2019: Vol. LXIV, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

CHANGES TO NOVA SCOTIA HEALTH CARDS

Beginning February 11th 2019, Nova Scotia Residents will have the option to remove their sex designation from the front of their health card. A resident's sex designation will still be contained on the health card's magnetic stripe and in the MSI Registration files. A resident's sex designation is still required as part of the claims submission process. If you have any questions concerning the change or require assistance, please contact the MSI Resident Services Department at 902-496-7008 or 1-800-563-8880.

MSI DOCUMENTATION REMINDER

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribed, and start and stop times for time based codes.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptation's, or emotional problems, the physician "deliberately established a professional relationship with the patient for the purposes of removing, modifying or alleviating existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional wellbeing of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy," etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service on that date, then the service is not paid for or a lesser benefit is given. **When the clinical record does not support the service claimed, there will be a recovery to MSI at the time of audit.** Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

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HIGHLIGHTED FEES

The Master Agreement Management Group increased newborn and post-partum inpatient fees, applicable to all relevant providers. The following adjustments complete that increase, first published for family physicians in the November 30th 2018 bulletin. This increase for post-partum and newborn inpatient fees is interim, pending Fee Committee review of inpatient fees for all specialties: Effective February 8th, 2019 the adjusted MSU values apply to the following health service codes.

Category	Code	Description	Base Units
VIST	03.03	**Subsequent Care – Newborn Healthy Infant (LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS, SP=PEDI)** **Days 2, 3 (DA=DA23)** **Days 4-5 (DA=DA45)** **Description** These adjusted MSU values apply to the following health service codes: 03.03 LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS, SP=PEDI – Subsequent Care – Newborn Healthy Infant When the visit is provided to patients admitted to hospital where the pediatrician is the most responsible physician. **Billing Guidelines** May only be claimed once per patient per day by the most responsible physician (MRP) **Specialty Restriction** SP=PEDI **Location** LO=HOSP, FN=INPT **Notes:** First day out of ICU should be considered equivalent to day 2 and subsequent inpatient days as 3,4,5 for the purpose of reporting these increased code values.	 23 MSU 19 MSU

Category	Code	Description	Base Units
VIST	03.03	**Post-Partum Visit (LO=HOSP, FN=INPT, RO=PTPP, SP=OBGY)** **Days 2, 3 (DA=DA23)** **Days 4-7 (DA=DA47)** **Description** These adjusted MSU values apply to the following health service codes: 03.03 LO=HOSP, FN=INPT, RO=PTPP, SP=OBGY – Post-Partum Visit When the visit is provided to post-partum patients admitted to hospital where the obstetrician or gynecologist is the most responsible physician. **Billing Guidelines** May only be claimed once per patient per day by the most responsible physician (MRP). **Specialty Restriction** SP=OBGY **Location** LO=HOSP, FN=INPT **Notes:** First day out of ICU should be considered equivalent to day 2 and subsequent inpatient days as 3,4,5,6,7 for the purpose of reporting these increased code values.	 23 MSU 19 MSU

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FEE REVISIONS

As announced in the November 30, 2018 bulletin, HSC **78.39A – Interruption or removal of fallopian tubes for purposes of sterilization: abdominal, vaginal, laparoscopic-not hysteroscopic (unilateral or bilateral**) will now accept a Surgical Assistant modifier.
Effective February 8th, 2019, offices may now bill their Surgical Assist claims for services provided since November 30th, 2018.

Effective February 8th, 2019, HSC **03.03J, 03.03K, 03.03L** have been updated:

Category	Code	Description	Base Units
VIST	03.03J	**Initial Opioid Use Disorder Assessment for Initiation of Opioid Agonist Treatment (OAT) Community Primary Care Setting Only (30 minutes)**	50MSU + MU

Description
This is a time based fee for the complete assessment of the patient entering into opioid agonist treatment (OAT) for the first time as prescribed by their primary care provider. The required elements of this service are outlined below and must be documented in the patient's health record. Required elements include:

i. A complete substance use history including illicit, prescription and OTC medications with a risk of abuse and a DSM diagnosis for each problematic drug;
ii. A complete addiction treatment history;
iii. Past medical and surgical history;
iv. Family history;
v. Psychosocial history, including living situation, source of income and education;
vi. Review of systems;
vii. A focused physical examination;
viii. Review of treatment options;
ix. Formulation of a treatment plan;
x. Communication with the patient and/or family to obtain information for the assessment as well as with support staff working in the treatment environment;
xi. Communication with previous care providers, including family doctors, pharmacists, Mental Health and Addictions staff, etc. as necessary.
xii. Obtain a patient profile for the previous 12 months through the Nova Scotia Prescription Monitoring Program (NSPMP) or Drug Information System (DIS)
xiii. Obtain a urine drug screen;
xiv. The health care provider should request blood work serology (screening for HIV, and Hepatitis A, B, and C) if not done recently by a previous provider.
xv. Consider obtaining an ECG if indicated.

- Start and stop times are to be documented in the health record.
- It is recognized that the required elements may be gathered over several visits with the patient. This fee is for the initial visit only

Billing Guidelines

- Billable only by the health care provider who is most responsible for the patient's ongoing OAT in the community primary care setting.
- Not reportable for care provided in an Opioid Use Disorder Treatment Program
- Multiples of 15 minutes may be billed in addition to the base fee code to a maximum of 60 minutes in total.
- 80% of the time must be spent in face to face contact with the patient and/or family.
- If time less than 25 minutes, bill as regular visit.
- Once per health care provider per patient.

Specialty Restriction
SP=GENP

Premium
TI=GPEW

Location
LO=OFFC

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Category	Code	Description	Base Units
VIST	03.03K	**Initial Opioid Use Disorder Assessment for Opioid Agonist Treatment (OAT) – Transfer from Opioid Use Disorder Treatment Program to community Primary Care Provider**	50MSU

Description

This is a fixed fee for the complete assessment of the patient being transferred from an established Opioid Use Disorder Treatment Program to the primary health care provider who will be most responsible for that patient's ongoing OAT. The required elements of this service are outlined below and must be documented in the patient's health record. Required elements include:

i. A complete substance use history including illicit, prescription and OTC medications with a risk of abuse and a DSM diagnosis for each problematic drug;
ii. A complete addiction treatment history;
iii. Past medical and surgical history;
iv. Family history;
v. Psychosocial history, including living situation, source of income and education;
vi. Review of systems;
vii. A focused physical examination;
viii. Review of treatment options;
ix. Formulation of a treatment plan;
x. Communication with the patient and/or family to obtain information for the assessment as well as for support staff working in the treatment environment;
xi. Communication with previous care providers, including family doctors, pharmacists, Mental Health and Addictions staff, etc. as necessary;
xii. Obtain a patient profile for the previous 12 months through the Nova Scotia Prescription Monitoring Program (NSPMP) or Drug Information System (DIS);
xiii. Obtain a urine drug screen;
xiv. The physician should request blood work serology (screening for HIV, and Hepatitis A, B and C) if not done recently by a previous provider;
xv. Consider obtaining an ECG if indicated.

It is recognized that the required elements may be gathered over several visits with the patient. This fee is for the initial visit only.

Billing Guidelines

- Reportable only by the health care provider who is most responsible for the patient's ongoing OAT in the community primary care setting
- Once per patient per health care provider
- Applies only to patients transferred from a recognized Opioid Use Disorder Treatment Program
- Not reportable by health care providers who have previously seen the patient in a recognized Opioid Use Disorder Treatment Program

Specialty Restriction
SP=GENP

Premium
TI=GPEW

Location
LO=OFFC

Category	Code	Description	Base Units
VIST	03.03L	**Permanent Transfer of a patient on active Opioid Agonist Treatment (OAT) for opioid use disorder-Full acceptance of responsibility for ongoing care –Initial visit with accepting health care provider**	50MSU

Description

This is a fixed fee available to the primary care provider accepting full and ongoing responsibility for OAT for the patient's substance use disorder from the community health care provider currently providing care, due to a patient's relocation or desire for permanent change in health care provider. The required elements of this service are outlined below and must be documented in the patient's health record. Required elements include:

- A complete substance use history including illicit, prescription and OTC medications with a risk of abuse and a DSM diagnosis for each problematic drug;
- A complete addiction treatment history;
- Past medical and surgical history;
- Family history;
- Psychosocial history, including living situation, source of income and education;

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- Review of systems;
- A focused physical examination;
- Review of treatment options;
- Formulation of a treatment plan;
- Communication with the patient and/or family to obtain information for the assessment as well as for support staff working in the treatment environment;
- Communication with previous care providers, including family doctors, pharmacists, Mental Health and Addictions staff, etc. as necessary;
- Obtain a patient profile for the previous 12 months through the Nova Scotia Prescription Monitoring Program (NSPMP) or Drug Information System (DIS);
- Obtain a urine drug screen;
- The physician should request blood work serology (screening for HIV, and Hepatitis A, B and C) if not done recently by a previous provider;
- Consider obtaining an ECG if indicated.

It is recognized that the required elements may be gathered over several visits with the patient. This fee is for the initial visit only. Regular visit fees may be billed for subsequent visits.

Billing Guidelines

- Reportable only by the health care provider who is most responsible for the patient's ongoing OAT
- Once per patient per health care provider
- Reportable only by the accepting health care provider
- Not reportable for health care providers within the same group practice
- Not reportable by health care providers who have previously seen the patient in a recognized Opioid Use Disorder Treatment Program

Specialty Restriction
SP=GENP

Premium
TI=GPEW

Location
LO=OFFC

NEW FEES

Effective February 8th, 2019, HSC **MMM1 and MMM2** have been terminated and replaced with **OAT1 and OAT2**:

Category	Code	Description	Base Units
DEFT	OAT1	**Opioid Agonist Treatment (OAT) Monthly Management Fee for the Comprehensive Primary Care Provider Only** **ME=CARE**	60MSU

Description
This fee may be billed once per month by the comprehensive primary care provider, outside of the Opioid Use Disorder Treatment Program, who is most responsible for providing opioid agonist treatment (OAT) as defined by current DSM-criteria. The patient will be seen by the health care provider for a face to face visit or counselling session at least once per month (not including visits for urine drug screening alone). The following items are considered to be included in this service:

- All medication reviews and OAT dosage adjustments as required;
- Communicating on a regular timely basis with the pharmacy responsible for administering the patient's opioid agonist dose for the provision of safe and effective OAT: managing missed doses, checking on daily presentation at the pharmacy, helping coordinate prescriptions going to multiple pharmacies if there are Sunday or holiday closures or if a patient is travelling;
- Providing and/or coordinating care for the patient's concurrent physical and mental health conditions;
- Counselling the patient on issues related to their opioid use disorder;
- Connecting the patient to appropriate community resources;
- Providing case management and coordination of care functions, and facilitating connection with other addiction care providers;
- Arranging **random** point of care (POC) urine drug screening (UDS) appropriate to the patient's phase of treatment; To include generation of **random** UDS encounters, collection of urine, interpretation of results, documentation of the process of **randomization** and results of the screen in the health care record, and provision of feedback to the patient based on the results.
- A visit may not be claimed if the sole purpose of the patient's office encounter is to provide a urine sample.

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- An annual discussion of treatment options with rationale for continued OAT must be documented in the health record.

Billing Guidelines

- Only one claim per patient per month
- Billable only by the comprehensive primary care provider working outside of the Opioid Use Disorder Treatment Program who is most actively supervising/ responsible for the patient's use of OAT (ME=CARE)
- If there is no evidence to support randomization of the POC UDS then the fee will not be paid
- Not reportable for care provided in an Opioid Use Disorder Treatment Program.
- Payment stops when the patient stops OAT
- Will not be paid unless at least 1 face to face visit or counselling session has been reported for the same patient by the same health care provider in the previous 30 day period.

Specialty Restriction
RO=GENP

Location
LO=OFFC

Category	Code	Description	Base Units
DEFT	OAT2	**Opioid Agonist Treatment (OAT) Monthly Management Fee for provision of OAT only – patient referred by another health care provider with written progress updates supplied to the primary care provider at least quarterly.**	45MSU

Description
This fee may be billed once per month by the health care provider, outside of the Opioid Use Disorder Treatment Program, who is most responsible for providing opioid agonist treatment (OAT) as defined by current DSM-criteria. The patient will be seen by the health care provider for a face to face visit or counselling session at least once per month (not including visits for urine drug screening alone). The following items are considered to be included in this service:

- All medication reviews and OAT dosage adjustments as required;
- Communicating on a regular timely basis with the pharmacy responsible for administering the patient's opioid agonist dose for the provision of safe and effective OAT: managing missed doses, checking on daily presentation at the pharmacy, helping coordinate prescriptions going to multiple pharmacies if there are Sunday or holiday closures or if a patient is travelling;
- Providing and/or coordinating care for the patient's concurrent physical and mental health conditions;
- Counselling the patient on issues related to their opioid use disorder;
- Connecting the patient to appropriate community resources;
- Providing case management and coordination of care functions, and facilitating connection with other addiction care providers;
- Arranging **random** point of care (POC) urine drug screening (UDS) appropriate to the patient's phase of treatment; To include generation of **random** UDS encounters, collection of urine, interpretation of results, documentation of the process of **randomization** and results of the screen in the health care record, and provision of feedback to the patient based on the results.
- A visit may not be claimed if the sole purpose of the patient's office encounter is to provide a urine sample.
- An annual discussion of treatment options with rationale for continued OAT must be documented in the health record.
- Written progress updates will be supplied to the patient's comprehensive primary care provider at least quarterly and documented in the health record.

Billing Guidelines

- Only one claim per patient per month
- Billable only by the comprehensive primary care provider working outside of the Opioid Use Disorder Treatment Program who is most actively supervising/ responsible for the patient's use of OAT
- If there is no evidence to support randomization of the POC UDS then the fee will not be paid
- Not reportable for care provided in an Opioid Use Disorder Treatment Program.
- Payment stops when the patient stops OAT
- Will not be paid unless at least 1 face to face visit or counselling session has been reported for the same patient by the same health care provider in the previous 30 day period.

Specialty Restriction
N/A

Location
LO=OFFC

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Effective February 8th, 2019, HSC OFI1 is available for billing:

Category	Code	Description	Base Units
ADON	OFI1	**Incentive for use of Official Interpreter services when caring for a patient of limited English proficiency (LEP)**	5MSU

Description
This incentive is available to health care professionals who utilize the services of an official interpreter, as designated by the NSHA or IWK, when providing care to a patient of Limited English Proficiency (LEP). LEP refers to individuals who do not speak English as their primary language and have a limited ability to read, speak, write or understand English. This definition includes individuals who are deaf or hearing impaired and communicate using American Sign Language. Contact with the interpreter may be in person or via real time PHIA compliant technology. The interpreter's official identification must be documented in the patient's health record.

Billing Guidelines
This incentive may be added on to the appropriate visit code when the services of an official interpreter are required to facilitate a clinical encounter with a patient of Limited English Proficiency (LEP).
Available only for face to face or real time PHIA compliant technology encounters.

Documentation Requirements
The official identification number of the interpreter must be documented in the health record.

Specialty Restriction
N/A

Location
N/A

PREAMBLE CHANGES

GP EVENING AND WEEKEND INCENTIVE (5.1.188)

Current Definition	New Definition
GP EVENING AND WEEKEND INCENTIVE *(5.1.188)*	**GP ENHANCED HOURS PREMIUM**
This incentive program is intended to promote enhanced evening and weekend access to primary care services provided in the offices of fee-for-service family physicians who have an established practice and provide comprehensive and on-going care for their patients. *(5.1.189)* Billing Guidelines: • The eligible time periods for claiming the evening and weekend office visit incentive are 6 – 10p.m. during weekday evenings and 9 a.m. – 5 p.m. on weekends (Saturday and Sunday). • Physicians should offer and book appointments during these time periods in the same manner as they would for other (weekday) office hours. • Evening and weekend services eligible for incentive funding are office visit services provided in a community-based family practice in which the physician maintains a comprehensive patient chart to record all patient encounters, provides all necessary follow-up care for each encounter and takes responsibility for initiation and follow-up on all related referrals. • Eligible physicians may claim an incentive for evening and weekend office services provided for their own patients as well as for patients from the stable patient roster of other eligible physicians within the same practice location, providing the patient's record can be accessed and the encounter is recorded. • Services provided in walk-in clinics are not eligible for the evening and weekend office visit incentive funding program. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no	This premium in intended to promote enhanced patient access to comprehensive primary care outside of traditional office hours. This premium will be available only to physicians who have an ongoing clinical relationship with the patient and are practicing comprehensive and continuous primary care. Physicians working in a group or collaborative care setting may report this premium when providing care during the premium hours for patients of the practice if they have access to the patient's medical record. This premium is not available for unattached patients. This premium is not available for patients being seen in a walk in clinic where the care provided is episodic in nature. Billing Guidelines: • The eligible time periods are from 6a.m. to 8a.m. weekday mornings and 5p.m. to 10p.m. on weeknights where weekdays are defined as Monday through Friday. On Saturday, Sunday and Holidays (as defined by the MSI Physicians Bulletin) the eligible time period is from 9a.m. to 10p.m. • Physicians providing comprehensive and continuous primary care to patients (eligible for modifier ME=CARE only – see Physicians Bulletin May 17, 2018) should offer and book appointments during these time periods. • Services eligible for the Enhanced Hours Premium are office visit services provided by a practitioner providing comprehensive and continuous primary care and who maintains a comprehensive patient chart to record all patient encounters, provides all necessary follow-up care for each encounter and takes responsibility for the initiation of, and the follow-up on, all related referrals. • Eligible physicians may claim the premium for office services provided for their own patients as well as for patients from the registered patient panel of other eligible physicians within the same group practice, provided that the patient's health record can be accessed and the encounter is recorded. • Services provided in walk-in clinics are not eligible for the Enhanced Hours Premium. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no requirement for an appointment, and

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Current Definition	New Definition
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.*(5.1.190)*	episodic care with little or no follow-up. Walk in clinics have no standard patient panel and the patient list is constantly changing.
The following office services are eligible for the 25% evening and weekend incentive providing all other eligibility criteria are met. Only one incentive can be claimed per patient encounter regardless of the number of services provided during the encounter. Claims for eligible services should be submitted with the modifier TI =GPEW. *(5.1.191)* NOTE: For services where the evening and weekend incentive has been claimed, a record must be maintained and readily available to verify that the patient was booked for an appointment during an incentive-eligible time period. The appointment time should be recorded in the patient's record or office appointment books retained. *(5.1.192)* APP contract physicians can shadow bill the GP Evening and Weekend Office Visit Incentive (GPEW) *(5.1.193)* The evening and weekend office visit incentive should not be claimed in circumstances where the patient is booked for an appointment time that is not eligible for the incentive and then the physician "runs late". *(5.1.194)*	Refer to the MSI Physician's Bulletins for services eligible for the 25% Enhanced Hours Premium. Only one incentive can be claimed per patient encounter regardless of the number of services provided during the encounter. Claims for eligible services should be submitted with the modifier TI=GPEW NOTE: For services where the Enhanced Hours Premium has been claimed, a record must be maintained and readily available to verify that the patient was booked for an appointment during a premium -eligible time period. The appointment time should be recorded in the patient's record or office appointment books retained. APP contract physicians may shadow bill the GP Enhanced Hours Premium. The Enhanced Hours Premium should not be claimed in circumstances where the patient is booked for an appointment time that is not eligible for the premium and then the physician "runs late".

Time Period	Time	Payment Rate
Monday to Friday	6:00a.m – 8:00a.m	TI=GPEW (25% premium)
Monday to Friday	5:00p.m – 10:00p.m	TI=GPEW (25% premium)
Saturday and Sunday	9:00a.m – 10:00p.m	TI=GPEW (25% premium)
Recognized Holidays	9:00a.m – 10:00p.m	TI=GPEW (25% premium)

Billing Matters Billing Reminders, Updates, New Explanatory Codes

BILLING REMINDERS

Routine Prenatal Care 5.2.72
Physicians are reminded that any prenatal visit, limited or comprehensive, includes a Pap smear when medically indicated. However, a Pap smear is not required in order to bill a prenatal visit.

Hypnotherapy 5.2.145
Physicians practicing hypnotherapy must have at least 20 hours of training in clinical hypnotherapy and be an active member in good standing of a recognized Canadian Clinical Hypnosis society.

2019 Cut Off Dates
Please be advised there have been some adjustments made to the 2019 cut off dates. See attachment.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
VA093	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS IT IS INCLUDED IN THE REMUNERATION OF ANOTHER SERVICE RECENTLY BILLED FOR THIS PATIENT.

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Code	Description
AD082	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE INTERPRETER INCENTIVE MAY ONLY BE CLAIMED AFTER A VISIT OR CONSULT DURING THE SAME SERVICE OCCURRENCE.
DE034	SERVICE ENCOUNTER HAS BEEN REFUSED AS THERE HAVE BEEN NO SERVICES CLAIMED BY YOU FOR THIS PATIENT IN THE PREVIOUS 30 DAYS.
GN100	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST SUBMIT YOUR SIGNED PHYSICIAN CONFIRMATION LETTER IN ORDER TO BILL THE ENHANCED FEES FOR OFFICE AND GERIATRIC VISITS.
GN101	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE IS NOT BILLABLE FROM A HOSPICE FACILITY.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday February 8th, 2019. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT), modifiers (MODVALS.DAT) and, explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

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

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2019 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE	SALARY CONTRACT PAY PERIOD
December 19, 2018**	**December 24, 2018****	January 2, 2019	December 14-27, 2018
January 7, 2019	January 10, 2019	January 16, 2019	December 28, 2018-January 10, 2019
January 21, 2019	January 24, 2019	January 30, 2019	January 11-24, 2019
February 4, 2019	February 7, 2019	February 13, 2019	January 25-February 7, 2019
February 15, 2019**	February 21, 2019	February 27, 2019	February 8-21, 2019
March 4, 2019	March 7, 2019	March 13, 2019	February 22-March 7, 2019
March 18, 2019	March 21, 2019	March 27, 2019	March 8-21, 2019
April 1, 2019	April 4, 2019	April 10, 2019	March 22-April 4, 2019
April 12, 2019**	**April 17, 2019****	April 24, 2019	April 5-18, 2019
April 29, 2019	May 2, 2019	May 8, 2019	April 19-May 2, 2019
May 10, 2019**	**May 15, 2019****	May 22, 2019	May 3-16, 2019
May 27, 2019	May 30, 2019	June 5, 2019	May 17-30, 2019
June 10, 2019	June 13, 2019	June 19, 2019	May 31-June 13, 2019
June 21, 2019**	**June 26, 2019****	July 3, 2019	June 14-27, 2019
July 8, 2019	July 11, 2019	July 17, 2019	June 28-July 11, 2019
July 22, 2019	July 25, 2019	July 31, 2019	July 12-25, 2019
August 2, 2019**	August 8, 2019	August 14, 2019	July 26-August 8, 2019
August 19, 2019	August 22, 2019	August 28, 2019	August 9-22, 2019
August 30, 2019**	September 5, 2019	September 11, 2019	August 23-September 5, 2019
September 16, 2019	September 19, 2019	September 25, 2019	September 6-19, 2019
September 30, 2019	October 3, 2019	October 9, 2019	September 20-October 3, 2019
October 11, 2019**	October 17, 2019	October 23, 2019	October 4-17, 2019
October 28, 2019	October 31, 2019	November 6, 2019	October 18-31, 2019
November 8, 2019**	November 14, 2019	November 20, 2019	November 1-14, 2019
November 25, 2019	November 28, 2019	December 4, 2019	November 15-28, 2019
December 9, 2019	December 12, 2019	December 18, 2019	November 29-December 12, 2019
December 19, 2019**	**December 22, 2019****	December 31, 2019	December 13-26, 2019
January 6, 2020	January 9, 2020	January 15, 2020	December 27, 2019-January 9, 2020
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, Sessional Payments and Locum Claim Forms. 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

Please make a note in your schedule of the following dates MSI will accept as "Holidays".	
NEW YEAR'S DAY	TUESDAY, JANUARY 1, 2019
HERITAGE DAY	MONDAY, FEBRUARY 18, 2019
GOOD FRIDAY	FRIDAY, APRIL 19, 2019
EASTER MONDAY	MONDAY, APRIL 22, 2019
VICTORIA DAY	MONDAY, MAY 20, 2019
CANADA DAY	MONDAY, JULY 1, 2019
CIVIC HOLIDAY	MONDAY, AUGUST 5, 2019
LABOUR DAY	MONDAY, SEPTEMBER 2, 2019
THANKSGIVING DAY	MONDAY, OCTOBER 14, 2019
REMEMBRANCE DAY	MONDAY, NOVEMBER 11, 2019
CHRISTMAS DAY	WEDNESDAY, DECEMBER 25, 2019
BOXING DAY	THURSDAY, DECEMBER 26, 2019
NEW YEAR'S DAY	WEDNESDAY, JANUARY 1, 2020

PHYSICIAN'S BULLETIN
January 21, 2019: Vol. LXIV, ISSUE 2

NOVA SCOTIA MEDICAL SERVICES INSURANCE

WCB CLAIMS PROCESSING – UPCOMING CHANGES

As part of an overall modernization initiative, WCB Nova Scotia (WCB) is introducing improvements to how physicians' claims are processed for the care of work-related injuries and occupational disease, and how they communicate with physicians.

The target implementation date is April 18, 2019. At that time, you will need to include the WCB claim number and/or the worker's injury date (month and year) when submitting claims to Medavie for WCB payment.

Physicians should be already capturing this information as part of a patient visit as this information is currently required on the WCB Physician Report 8/10. Confirming whether the worker is eligible for benefits at the time the claim is submitted for payment will help prevent billing errors and the need for payment reversals.

Accredited billing vendors have been contacted regarding these new requirements. As a result, vendors have been updating their software to enable the submission of this additional information. Please contact your vendor directly, if you have any questions regarding the rollout of their software changes.

WCB is committed to improving communications with physicians as timely information is important to help you provide the best care to your patients. Therefore, beginning in spring 2019, WCB will notify you when there are eligibility changes related to a worker under your care. You will receive updates when coverage has been approved, denied, or closed, and if a worker moves into receiving long-term benefits from a return-to-work plan. This will further assist in preventing billing errors.

Ongoing updates including more details regarding claims submission will be provided via the MSI Physician's Bulletin. Relevant information will also be posted on the MSI website, https://msi.medavie.bluecross.ca. If you have any questions, please email msi_assessment@medavie.ca or call 902-496-7011/toll-free 1-866-553-0585.

PHYSICIAN'S BULLETIN
January 11, 2019: Vol. LXIV, ISSUE 1

NOVA SCOTIA MEDICAL SERVICES INSURANCE

PHYSICIAN CONFIRMATION LETTER REMINDER

Family physicians who are responsible for the comprehensive and continuous care of their patients are requested to forward a signed Physician Confirmation Letter to MSI by January 31, 2019. The enhanced fees for office and geriatric visits are only available to family physicians who attest that they are providing comprehensive and continuous care. As well, only those physicians having signed and returned the letter by January 31 will be eligible for the upcoming patient enrollment incentive. Additional information regarding this incentive will be sent to you in February, 2019.

If you have not already submitted your signed Physician Confirmation Letter, you can find the letter here. The signed letter can be emailed to: primary_care_investments@medavie.bluecross.ca

PHYSICIAN'S BULLETIN

December 14th, 2018: Vol. LXIII, ISSUE 21

NOVA SCOTIA MEDICAL SERVICES INSURANCE

PHYSICIAN CONFIRMATION LETTER REMINDER

Family physicians who are responsible for the comprehensive and continuous care of their patients are requested to forward a signed Physician Confirmation Letter to MSI by January 31, 2019. The enhanced fees for office and geriatric visits are only available to family physicians who attest that they are providing comprehensive and continuous care. As well, only those physicians having signed and returned the letter by January 31 will be eligible for the upcoming patient enrollment incentive. Additional information regarding this incentive will be sent to you in February, 2019.

You can find the Physician Confirmation Letter here. The signed letter can be emailed to: primary_care_investments@medavie.bluecross.ca

TI=GPEW

Fee Committee has made changes to the GP Evening Weekend (GPEW) modifier that will make it necessary to have a Physician Confirmation Letter on file for eligibility to claim the GPEW. Additional information regarding this change will be published upon implementation in February, 2019.

MSI ELINK UPGRADE REMINDER

MSIeLink, the internet gateway to Medavie for a range of network services related to medicare claims processing, is being upgraded. Accredited vendors have been notified of this upgrade. Effective December 15, 2018, all vendor software must be using a new MSIeLink client which has been distributed to accredited vendors. If your vendor does not make the required changes, you will not be able to submit claims as of December 15, 2018. If you have any questions regarding how your software will be impacted, we recommend that you contact your vendor.

PHYSICIAN'S BULLETIN
November 30th, 2018: Vol. LXIII, ISSUE 20

NOVA SCOTIA MEDICAL SERVICES INSURANCE

CONTENTS

MSI News

PRESCRIBING MEDICATION

AN ARTICLE BY DR. RHONDA CHURCH

It's a weekday afternoon. It's flu season. You have a waiting room full of patients and your assistant and two of the other physicians in your clinic are out sick. You're running almost an hour behind and have been fielding calls from the local nursing home about a number of ill residents there. You missed your son's last few basketball games because of work issues and you promised him you'd get to the one later today.

As you are attempting to sort out a complex, confused, and slightly hard of hearing elderly man who is short of breath, there is a knock at the exam room door.

"Call from the pharmacy on line 2. Question about a prescription you wrote this morning."

Sound familiar?

In addition to managing payments to physicians, Medavie Blue Cross also administers payments to pharmacists under the provincial Pharmacare Program. Recently, I met with members of our Pharmacare team who told me that one of the most frustrating aspects of a community pharmacist's job is having to call a physician for clarification on a busy day.

A great pharmacist is like a living, breathing CPS, with a tremendous depth of knowledge about medications we prescribe. Like physicians, they run small businesses, often employ staff and have practice standards in place to ensure safe and effective care of the people they serve. If they fill a prescription that contains incomplete information, there is a risk that they will fill the script in a way other than the physician intended. Not only can this lead to increased risk to the patient, filling such prescriptions can have significant financial implications for these small businesses as third party payers may not honour their fees.

MSI News continued

Here are the suggestions they had to reduce the number of calls:

- Include the patient's full name i.e. Walter White rather than Mr. White
- Include the name of the medication or product being prescribed rather than using nonspecific terms such as "ostomy supplies x 1 year"
- Include the dosage of the medication prescribed as well as the total number to dispense i.e. furosemide 20 mg once daily (90 tabs) rather than "furosemide as before" For individuals whose conditions are stable, three months' supply is generally the most cost effective option but if finances are tight, or the medication is new, a shorter duration may be appropriate.
- Include the size of the bottle or tube for liquids, ointments, etc. The pharmacist will only be able to fill this without clarifying it with you if the product comes in just one size.
- Include specific refill instructions i.e. "3 refills" rather than "as necessary" or "release with methadone."
- Sign the prescription.

A few extra seconds when prescribing can make a difference in the flow of you and your pharmacist's day and get you out the door and onto the bleachers.

★ Fees New Fees and Highlighted Fees

HIGHLIGHTED FEES

Effective November 30th, 2018 the adjusted MSU values apply to the following health service codes:

Category	Code	Description	Base Units
VIST	03.03	**Post-Partum Visit (LO=HOSP, FN=INPT, RO=PTPP)**	
		Days 2, 3 (DA=DA23)	23 MSU
		Days 4-7 (DA=DA47)	19 MSU
		Subsequent Care – Newborn Healthy Infant (LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS)	
		Days 2, 3 and (DA=DA23)	23 MSU
		Days 4-5 (DA=DA45)	19 MSU
		Description These adjusted MSU values apply to the following health service codes: 03.03 LO=HOSP, FN=INPT, RO=PTPP – Post-Partum Visit 03.03 LO=HOSP, FN=INPT, RO-NBCR, RP=SUBS – Subsequent Care, Newborn Healthy Infant. When the visit is provided to patients admitted to hospital where the family doctor is the most responsible physician. **Billing Guidelines** May only be claimed once per patient per day by the most responsible physician (MRP). **Specialty Restriction** SP=GENP **Location** LO=HOSP, FN=INPT	

As per the October 18th, 2017 bulletin, if a home visit occurs for a patient that is not considered homebound, then the visit is considered to be rendered at the home for convenience and may be claimed at the normal office rate. To facilitate this use, the new modifier ME=CONV (visit of convenience) has been added to the 03.03 home visit fee (effective November 30th, 2018), and will now pay at the correct normal office rate.

Category	Code	Description	Base Units
VIST	03.03	**ME=CONV, PT=FTPT, LO=HOME** **AG=OV65, ME=CONV, PT=FTPT, LO=HOME** **Description** This modifier is to be used when a visit outside of the office occurs for the convenience of either the patient or general practitioner. **Billing Guidelines** The modifier should be added to 03.03 home visit services for the first patient and the visit is for convenience. The modifier should also be added for 03.03 home visits for the first patient if they are 65 years of age or older and the visit is for convenience. If a home visit for convenience is claimed, the physician may not claim for mileage (HSC HOVM1). **Specialty Restriction** SP=GENP **Location** LO=HOME	13 MSU 16.5 MSU

NEW FEES

Effective November 30th, 2018 the following health service codes will be available for billing:

Category	Code	Description	Base Units	Anaes Units
MAAS IC	66.99B	**Cytoreductive Surgery with or without perioperative intraperitoneal chemotherapy (Sugarbaker Procedure)** This is a comprehensive fee based on the "skin to skin" operative time required to perform cytoreductive surgery with or without intraperitoneal chemotherapy (Sugarbaker). This procedure may include, but is not limited to, peritonectomy and multivisceral resections and may be followed by the infusion of intraperitoneal chemotherapy. **Billing Guidelines** • Surgical start and stop times must be reported in text with the claim and be verifiable by the record of operation in the patient's health record. • No other health service codes may be reported by the same physician, same patient, same service encounter, same day. **Specialty Restriction** SP=GNSG **Location** LO=HOSP	175MSU/Hour	12+T

Category	Code	Description	Base Units	Anaes Units
MASG	47.25A	**Aortic valve and ascending aorta replacement with reimplantation of coronary arteries (Bio-Bentall or Mechanical Bentall repair)** This is a comprehensive code for aortic root replacement with ascending aorta graft and valve conduit including coronary reimplantation. **Billing Guidelines** • Not reportable with: - 47.25 Other replacement of Aortic valve - 50.34B Excision of thoracic aorta aneurysm - 48.13 Aortocoronary bypass of two coronary vessels • May report, where clinically indicated, with: - ADON 51.61 Extracorporeal Circulation auxiliary to open heart surgery - ADON 49.99C Repeat open heart surgery **Specialty Restriction** SP=CASG **Location** LO=HOSP	1105MSU	35+T

Category	Code	Description	Base Units	Anaes Units
MASG	47.25B	**Valve sparing aortic root replacement or remodeling (David or Yacoub) with reimplantation of coronary arteries (VSR)** This is a comprehensive code for valve sparing aortic root replacement with graft, aortic valve suspension or remodeling, and coronary artery reimplantation. **Billing Guidelines** • Not reportable with: - 47.25 Other replacement of Aortic valve - 50.34B Excision of thoracic aorta aneurysm - 48.13 Aortocoronary bypass of two coronary vessels • May report, where clinically indicated, with: - ADON 51.61 Extracorporeal Circulation auxiliary to open heart surgery - ADON 49.99C Repeat open heart surgery **Specialty Restriction** SP=CASG **Location** LO=HOSP	1105 MSU	35+T

FEE REVISIONS

During the Province's March 2018 announcement of its $39.6 million investment in Primary Care simplification of the existing telephone health service codes was promised. The work of simplifying the documentation and billing guidelines has now finished and the following are the result of that work. Click here to go to the billing reminder in the September, 2018 bulletin

Category	Code	Description	Base Units
CONS	03.09K	**Specialist Telephone Advice – Consultant Physician – providing advice**	25 MSU
	03.09L	**Specialist Telephone Advice – Referring Physician – requesting advice**	11.5 MSU

Description

This health service code may be reported for a two-way telephone (or other synchronous electronic verbal communication) regarding the assessment and management of the patient but without the consulting physician seeing the patient. The referring physician may be a family physician or other specialist seeking an expert opinion from the consulting physician due to the complexity and severity of the case and with the intent of continuing to provide the patient's care closer to home. The consultant specialist may also receive requests for advice from a nurse practitioner.

The referring physician (or NP) must communicate to the specialist the reason for the consultation and relevant patient information through verbal, written or electronic communication, either before or within four business days after the telephone call. The referring physician must document that this information was supplied to the specialist. There must be a two-way verbal communication discussing the clinical situation followed by a management decision and a written report from the specialist to the referring provider.

The formal consultation report must be available in the patient's medical record, both the referring physician (or NP) and the specialist must maintain copies of this document, both medical records must include the date and time of the service and any contemporaneous notes, in addition to the written documents.

The service is reportable by the specialist for a new patient or an established patient with a new condition or an exacerbation of an existing condition.

Billing Guidelines

The HSC includes a review of the patient's relevant history, relevant family history and relevant history of present complaint, and a review of any laboratory data, PACS images, medical records or other data as needed to provide advice. The health service includes a discussion of the relevant physical findings as reported by the referring provider.

If subsequent phone calls are necessary within 14 days to complete the consultation they are considered included in the HSC for the telephone consultation.

The Consultant Physician HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.

The Referring Physician HSC may be reported when the telephone call for an urgent consultation occurs on the same day as the patient visit that generated the consultation.

The HSC is not reportable when the purpose of the communication is to:

- Arrange transfer
- Arrange a hospital bed for the patient
- Arrange a telemedicine consultation
- Arrange an expedited face to face consultation
- Arrange a laboratory, other diagnostic test or procedure
- Inform the referring physician of the results of diagnostic investigations
- Decline the request for a consultation or transfer the request to another physician

The service is not reportable for other forms of communication such as:

- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

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 health professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student

The service is not reportable by the consulting physician if the patient has had a face to face visit with the consultant or any member of his/her call group within the previous 14 days for the same condition or if the telephone consultation results in a face to face service within the next 14 days or the next available appointment of the consultant.
The service is not reportable for telephone calls of less than 5 minutes of two way medical discussion. The service is not reportable for calls between a referring provider and specialist in the same institution or practice location.

Documentation Requirements

- The referring physician must document that s/he has communicated the reason for the consultation and relevant patient information to the specialist
- Both the specialist consultant and the referring provider must document the patient name, identifying data, date and start and stop time of the call in their respective charts or EMRs.
- The names of the referring physician (or NP) and the consultant physician must be documented by both physicians.
- The diagnosis, reason for referral, elements of the history and physical as relayed by the referring provider, the opinion of the consultant physician and the plan for future management must be documented.
- A written report must be sent to the referring provider by the specialist consultant.
- The referring physician's billing number must be noted on the electronic claim.
- Both physicians must submit the start and stop time of the call in the text field on the MSI service report.

Specialty Restriction
N/A

Location
LO=OFFC

Category	Code	Description	Base Units
VIST	03.03Q	**Specialist Telephone Management/Follow Up with Patient** **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.	11.5 MSU

Billing Guidelines
This health service is reportable for a telephone (or synchronous electronic verbal communication) between the specialist physician and the patient, or the patient (or the patient's parent, guardian or proxy as established by written consent).
Telephone management requires 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 a management decision.
The specialist physician must have seen and examined the patient within the preceding 9 months.
The HSC is reportable 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
- 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 not reportable for other forms of communication such as:

- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

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 two way 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 content) 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 on the MSI service report

Specialty Restriction
N/A

Location
LO=OFFC

Category	Code	Description	Base Units
VIST	03.03R	**Family Physician Telephone Management/Follow Up with Patient**	11.5MSU

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 lace 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 an 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 of the patient 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.

Mental Illness is defined as;

- 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 telephone (or synchronous electronic verbal communication) between the family physician and the patient (or the patient's parent, guardian or proxy as established by written consent).
Telephone management requires 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 a management decision.
The family physician must have seen and examined the patient within the preceding 9 months.
The HSC is reportable a maximum of 4 times per patient per physician 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:

- Arrange a face to face appointment
- Notify the patient of an appointment
- Prescription renewal
- Arranging to provide a sick note
- Arrange a laboratory, other diagnostic test or procedure
- 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:

- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

The service is not 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 two way 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 content) understands and acknowledges the information provided.
- The start and stop time of the call must be included in the text field on the MSI service report

Specialty Restriction
N/A

Location
LO=OFFC

UPCOMING FEE REVISION

Physicians are advised that health service **code 78.39A – Interruption or removal of fallopian tubes for purposes of sterilization: abdominal, vaginal, laparoscopic-not hysteroscopic (unilateral or bilateral)** – will be revised to permit surgical assist claims as of November 30th, 2018. Any physicians providing surgical assistance should hold their claims for this procedure until MSI can update the billing system in early 2019.

Billing Matters Billing Reminders, Updates, New Explanatory Codes

BILLING REMINDERS

Facility Numbers
Physicians are reminded to ensure that when submitting claims they are using the correct facility number.

Pacemaker battery/leads replacement
Physicians are reminded that the health service codes for pacemaker battery change and leads replacement/adjustment include any necessary programming. It is not appropriate to make a separate claim for pacemaker programming.

After Hours Visits
When a physician is called urgently to a hospital, nursing home or the patient's home after hours, responds immediately because of the patient's condition, and travels to see the patient, the service may be claimed using an urgent modifier (US=UIOH and US=UNOF). As a reminder, use of an urgent modifier requires that the physician travel to see the patient and movement within a hospital or nursing home is not considered travel. Therefore, if additional patients are seen during the same trip, the visit must be claimed as an extra patient without an urgent modifier.

Confirmation Letter Notice
A reminder that to be eligible to use the modifier ME= CARE you must have submitted a Confirmation Letter attesting to your status as a primary care provider providing continuity care in the context of an ongoing relationship with your patients (see original notification here). Only physicians who have submitted said Confirmation Letter will have claims with the ME=CARE modifier processed. If you have not submitted the Confirmation Letter your claim should be submitted as an otherwise unmodified visit.

Click here to be taken to the updated FAQ on the Primary Care Investments.

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NEW AND UPDATED EXPLANATORY CODES

Code	Description
MJ065	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR PROGRAMMING TO A PACEMAKER WHICH IS PART OF THIS SERVICE HAS ALREADY BEEN CLAIMED ON THIS DAY.
NR089	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS PROCEDURE SHOULD ONLY BE BILLED FROM A HOSPITAL LOCATION. IF A VALID REASON EXISTS FOR BILLING THIS PROCEDURE FROM A LOCATION OTHER THAN HOSPITAL PLEASE RESUBMIT WITH SUPPORTING DOCUMENTATION.
VA092	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR EITHER BATTERY OR LEADS REPLACEMENT/ADJUSTMENT HAS ALREADY BEEN CLAIMED ON THIS DAY WHICH INCLUDES ANY NECESSARY PROGRAMMING.
MJ066	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR HEALTH SERVICE CODE 47.25, 48.13 OR 50.34B AT THE SAME ENCOUNTER.
MJ067	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR HEALTH SERVICE CODE 47.25A OR B AT THE SAME ENCOUNTER.
AD081	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC HOVM1 CANNOT BE CLAIMED ON HOME VISITS THAT OCCUR FOR PATIENT OR PHYSICIAN CONVENIENCE.
WBHUJ	FILE IS BEING ADJUDICATED FOR WORKERS COMPENSATION WITH A PROVINCE OTHER THAN NS.
WBHSD	SERVICE DATE NOT WITHIN WCB COVERAGE PERIOD.
WBHNC	INDIVIDUAL HAS NO WCB COVERAGE
WBHLT	HSC INVALID FOR WCB LTB CLAIM
WBHRT	HSC INVALID FOR WCB RTW CLAIM

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday November 30th, 2018. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT), modifiers (MODVALS.DAT) and, explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

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

In partnership with

PHYSICIAN'S BULLETIN
September 21st, 2018: Vol. LXIII, ISSUE 18

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

MSI ELINK PASSWORDS WILL EXPIRE OCTOBER 15TH 2018

Submitters will need to reset their current password prior to October 15, 2018, if they haven't already done so. If a submitter's password is not reset, the password will expire on October 15 and the submitter will not be able to submit claims.

If you have more than one individual in your office that uses the same Submitter ID to submit claims, please remember to provide the new password to them.

Vendors have been notified of these changes. In some cases, a vendor may make the required changes on your behalf. If you haven't heard from your vendor regarding this implementation, please contact your vendor for further direction.

Click here to go to the change instructions Q&A.

Physicians Moving out of Province

Physicians are reminded that it is important to call MSI and update their mailing and e-mail address for future correspondence when they move.

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Billing Matters Billing Reminders, Updates, New Explanatory Codes

BILLING REMINDERS

Tympanometry Only – 09.41H

Physicians are reminded that it is not appropriate to submit a claim for HSC 09.41H if another code was claimed during the same encounter that includes tympanometry.

Non-Face to face Health Service Codes

In the spring of 2017, four new health service codes were implemented for select services provided by physicians without face to face contact with patients. Since the time of implementation, MSI has been gathering information on the use of these health service codes through the service verification letter process. A number of concerns have been identified. The following are among the known incorrect applications of the Non-Face-to-Face Health Service Codes:

- Using these health service codes when the call to the patient is not made by the physician. As a reminder, these HSCs may only be claimed when the physician personally makes the call, and not when the call is made by office staff, nurse, nurse practitioner, or a medical trainee such as a medical student or resident;
- Claiming for a call when its purpose is to arrange or notify the patient of an appointment;
- Claiming for a call when its purpose is to arrange for a lab or other diagnostic test or a procedure;
- Claiming for a call when its purpose is to provide a sick note;
- Claiming for a call when its purpose is solely to notify a patient of test results; and
- Claiming for a call when its purpose is solely to renew a prescription.

These are all purposes which are identified as not reportable for this service in the existing Billing Guidelines.

Physicians are asked to carefully review the requirements for claiming these health service codes. A full description of the requirements can be found in the July 27th, 2018 bulletin by clicking here. Please note that the Non-Face-to-Face Health Service Codes have been approved for further changes. Please watch the November bulletin for the final wording.

Unattached Patients – UPB1

The unattached patient bonus is an incentive for family physicians who take on unattached patients and agree to become those patients' primary care provider. It is not available to physicians practicing in a walk-in setting. This fee should only be billed if all criteria are being met. Click here to be taken to the May 17th, 2018 bulletin where the billing guidelines are outlined.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
VA090	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PREVIOUSLY BILLED HSC 09.41E, F OR G INCLUDES TYMPANOMETRY.
VA091	SERVICE ENCOUNTER HAS BEEN REFUSED. HSC 09.41E, F, OR G CANNOT BE BILLED AT THE SAME ENCOUNTER AS HSC 09.41H AS THEY INCLUDE TYMPANOMETRY.

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UPDATED FILES

Updated files reflecting changes are available for download on Friday September 21st, 2018. The files to download are health service (SERVICES.DAT) and explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

Phone: 902-424-5818
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(in Nova Scotia)
TTY/TDD: 1-800-670-8888

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PHYSICIAN'S BULLETIN
September 13th, 2018: Vol. LXIII, ISSUE 17

NOVA SCOTIA MEDICAL SERVICES INSURANCE

MSI ELINK PASSWORD CHANGE

Passwords Will Expire October 15

Submitters will need to reset their current password prior to October 15, 2018, if they haven't already done so. If a submitter's password is not reset, the password will expire on October 15 and the submitter will not be able to submit claims.

If you have more than one individual in your office that uses the same Submitter ID to submit claims, please remember to provide the new password to them.

Vendors have been notified of these changes. In some cases, a vendor may make the required changes on your behalf. If you haven't heard from your vendor regarding this implementation, please contact your vendor for further direction.

MSI ELINK PASSWORD CHANGE INSTRUCTIONS Q & A

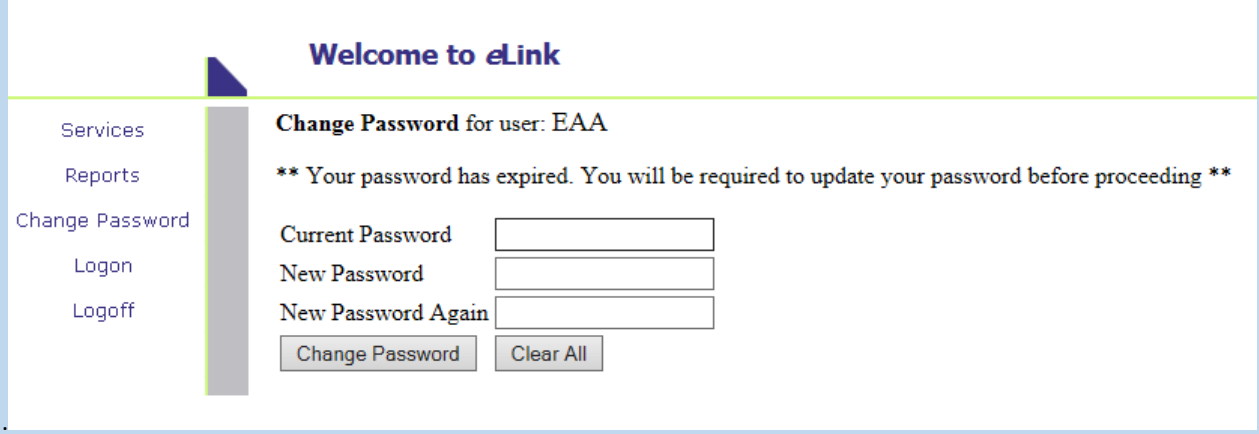
Effective July 15th, 2018, the current process of submitting a password change request via your claims submission software using the change password (/cp) service is no longer available. The current process has been replaced with a password change user interface.

How will I change my current password to a complex password to enable claims submission?

Please take the following steps, to change your current password to a new complex password:

1. Use your preferred browser to navigate to https://www.MSIeLink.ca.
2. Login using your Submitter ID (3 letters) as the User ID and your current password.
3. Select "Change Password" from the menu on the left side of the screen.
4. Using your current password, create a new password. The new password requirements are:
    - New password is not to match the current password.
    - Minimum password length is 14 and maximum length is 20.
    - Must contain at least 1 lowercase character, at least 1 uppercase character, at least 1 number, and at least 1 of the following special characters ! @ # $ * . , ? - = _
5. Cannot start with a special character.
6. Save the new password by selecting the **Change Password** button.

Note: The new password will not have an expiry date and can be changed whenever you choose, but you need to know your current password to change it to a new complex password.



If I am a new submitter, what will be my assigned password?

A temporary password will be assigned as, 'submitter id' || pass. For example, if your Submitter ID is 'zzz', the password will be 'zzzpass' (all lowercase). The password will only permit access to the MSIeLink website's change password functionality. Claims cannot be submitted using this password. This temporary password will have to be reset to a complex password before it can be used for this purpose. The steps described above will need to be followed to create a complex password that will allow for claims submission and file pick up.

If I forget my current password, what steps do I take to obtain a new password?

If you do not remember your current password, please do the following:

1. Contact Medavie's Provider Coordinators during regular business hours to have your password reset. They can be reached via email (msiproviders@medavie.ca) or phone (902-496-7011/toll-free 1-866-553-0585). Your password will be reset to the temporary password, 'submitter id' || pass, which will allow you to access the MSIeLink website.
2. Follow the process described above to create a new complex password that will allow for claim submission and file pick up.

PHYSICIAN'S BULLETIN

July 27th, 2018: Vol. LXIV, ISSUE 17

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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★ Fees New Fees, Fee Revisions, and Highlighted Fees

NEW FEES

Effective in the coming months, the following changes will be made to the Provincial Immunization Schedule:

HSC	Modifier	Description
13.59L	RO=HPV9	Human Papillomavirus - Requires PT=RISK when third dose is given - Requires text when claiming PT=RISK - **Available September 1st, 2018**
	RO=HDIN	High-dose-Influenza – Inactivated - Patient to be equal to or greater than 65 years of age. - Location Restricted to Long-Term Care Facility (i.e. Nursing Home or Residential Care Facility) only - **Available October 1st, 2018**

Please note as of August 1st, 2018 RO=TDAP (Tetanus Toxoid, Diphtheria, Acellular Pertussis) is available to female patients with each pregnancy. Physicians are reminded to bill as EC with explanatory text if the patient was previously incompletely immunized or pregnant.

FEE REVISIONS

Effective July 27th, 2018 the following billing guidelines changed to allow more than one physician to claim per patient (see underlined below). Physicians are asked that if they bill this health service code and receive explanation code AD068, they should rebill the claim as an EC for it to be manually processed. MSI will make the following billing changes in the near future.

Revised March 31, 2020 – See May 2020 Bulletin for updated information

Category	Code	Description
ADON	03.03P	**First Visit after In-Patient Hospital Discharge – Maternal and Newborn Care** 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 of discharge. • 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's 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 physician 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, HOME

Effective July 27th, 2018 the following billing guidelines for 03.03R have changed from requiring two or more chronic diseases, to at least one chronic disease. Please see the underlined change below.

Revised March 31, 2020 – See May 2020 Bulletin for updated information

Category	Code	Description	Base Units
VIST	03.03R	**Family Physician Telephone Management/Follow Up with Patient** 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 an 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 of the patient 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. Mental illness is defined as • 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.	11.5 MSU

Billing Guidelines

- This health service is reportable for a telephone (or synchronous electronic verbal communication) between the family physician and the patient (or the patient's parent, guardian or proxy as established by written consent).
- Telephone management requires 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 a management decision.
- The family physician must have seen and examined the patient within the preceding 9 months.
- The HSC is reportable a maximum of 4 times per patient per physician 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:
    - Arrange a face to face appointment
    - Notify the patient of an appointment
    - Prescription renewal
    - Arranging to provide a sick note
    - 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 not reportable for other forms of communication such as:
    - Written, e-mail or fax communication
    - Electronic verbal forms of communication that are not PHIA compliant
- 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 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.
- For patient initiated appointment requests that result in a telephone management service on the same day, the following text should be entered in the MSI text field:
    - Same day access
- The start and stop time of the call must be included in the text field on the MSI service report.
- There must be text on the MSI service report to indicate whether or not this service replaced a face to face service.

Location

LO=OFFC

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Effective July 27th, 2018 the below billing guidelines have been updated. Please note: work is continuing with the Nova Scotia Health Authority and the Fee Committee to review travel time compensation. Details to follow in a future MSI Physicians bulletin.

Category	Code	Description	Base Units
VIST	03.03M	**Medical assistance in dying – First physician assessor (first 15 minutes)** 30 MSU for first 15 minutes, 15 MSU for each additional 15 minutes up to a maximum of 4 hours Service may be provided via PHIA compliant, synchronous, virtual care platform. Modifier ME=VTCR is available for this service **Description** This fee is to compensate the first physician assessor for time spent providing MAiD services outlined in the College of Physicians and Surgeons of Nova Scotia Professional Standard Regarding Medical Assistance in Dying. It includes, but is not limited to, the time spent engaging the patient in a discussion of their diagnosis, prognosis, and treatment options, discussing the availability of palliative care for terminally ill patients, assessment of patient for MAiD criteria and arrangement for a second physician to assess the patient. **Billing Guidelines** Start and stop times must be recorded in the patient's medical record and on the MSI claim. Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family as required. Total duration of all components may be claimed. If the physician is a specialist and the patient has been formally referred the physician may bill the appropriate specialist prolonged consult fee with the same time documentation requirements as noted above. MAiD must be noted in the text on the MSI claim. **Premium** TI=MDNT for the hours of 0000-0800 TI=EVWH for evenings after 1800, weekends, and holidays **Location** OFFC, HOSP, HOME, CCNT, NRHM	30 MSU +MU

Category	Code	Description	Base Units
VIST	03.03O	**Medical assistance in dying – Second physician assessor (first 15 minutes)** 30 MSU for first 15 minutes, 15 MSU for each additional 15 minutes up to a maximum of 4 hours Service may be provided via PHIA compliant, synchronous, virtual care platform. Modifier ME=VTCR is available for this service **Description** This fee is to compensate the second physician assessor for time spent providing MAiD services outlined in the College of Physicians and Surgeons of Nova Scotia Professional Standard Regarding Medical Assistance in Dying. It includes, but is not limited to; the time spent conducting the subsequent assessment of the patient for MAiD criteria. **Billing Guidelines** Start and stop times must be recorded in the patient's medical record and on the MSI claim. Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family as required. Total Duration of all components may be claimed. **Premium** TI=MDNT for the hours of 0000-0800 TI=EVWH for evenings after 1800, weekends, and holidays **Location** OFFC, HOSP, HOME, CCNT, NRHM	30 MSU +MU

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Category	Code	Description	Base Units
VIST	03.03N	**Medical assistance in dying – Prescribing physician** **RO=FPHN** (30 MSU for the first 15 minutes, 15 MSU for each additional 15 minutes up to a maximum of 4 hours) **RO=SPHN** **Description** This fee is to compensate the prescribing physician for time spent providing MAiD services outlined in the College of Physicians and Surgeons of Nova Scotia Professional Standard Regarding Medical Assistance in Dying. It includes, but is not limited to, procuring the medication and administration at the patient's request. This physician must also be either the first physician or second physician assessor. **Billing Guidelines** Start and stop times must be recorded in the patient's medical record and on the MSI claim. Non face to face components include all documentation required by the pharmacist and the administration process. Total duration of all components may be claimed. FPHN must have previously claimed for a MAiD service with the same patient. When a second physician assists at the time of administering the medication, RO=SPHN may be claimed. This fee is not intended to compensate a second physician for administrative duties or procurement/return of medications as these activities are considered to be the responsibility of FPHN. **Premium** TI=MDNT for the hours of 0000-0800 TI=EVWH for evenings after 1800, weekends, and holidays **Specialty Restriction** None	30 MSU +MU 56 MSU

Billing Matters Billing Reminders, Updates, New Explanatory Codes

BILLING REMINDERS

Claiming for a General Anesthetic for Dental Surgery

If a general anesthetic is deemed medically necessary when providing a dental service, the anesthetic fee is payable whether the dental surgery is an insured or uninsured service. The anesthetist must indicate the medical necessity in the text segment of the service encounter. Examples of conditions where a general anesthetic might be medically necessary include, for example, an individual with a developmental delay or significant mental health issues.

Chronic Disease Management Incentive Program

Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year. The claim **must** be submitted to MSI no later than March 31st of that year in order to receive payment for that fiscal year.

Outdated Policy

All original claims must be submitted to MSI within 90 days from the date of service. Claims that are outside of the specified time limitations will only be considered if extenuating circumstances can be demonstrated for a late submission and are within a reasonable time frame past the 90 day limit. Request for an extension must be made to MSI in writing and will be approved on a case by case basis.

The time frame for submitting the request to MSI for late submission should be within one month following the 90 day limit. Examples of extenuating circumstances may include physical damage to office such as fire or flood and or a serious technical issue.

Service encounters submitted over the 90-day limitation will be adjudicated to pay "zero" with the following exceptions

- Reciprocal billing claims (out of province) must be submitted within 12 months of the date(s) of service.

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- Resubmission of refused claims or incorrect billings. These claims must be resubmitted to MSI within 185 days of the date of service. Each resubmission must contain an annotation in the text field of the service encounter submission referencing the previous service encounter number.

Circumstances relating to staffing issues/shortages and mislaid, misfiled, or lost claims cannot be accepted by MSI as valid explanations for a late submission.
Claims for registered hospital in-patients must also be submitted within the 90 day time limitation regardless if the patient has been discharged or continues on an in-patient basis. It is incumbent on the physician to obtain the required billing information for these patients and submit claims within the prescribed time limitations. Explanations relating to late discharge summaries, or facilities not consolidating the required information for the physician, cannot be accepted as a valid explanation for a late submission.
Please note: Failure to use a preauthorization code given by MSI and annotate the text field with the previous service encounter number will result in an adjudication paid at "zero".

Unbundling of claims
Preamble rules prohibit unbundling procedural codes into constituent parts and claiming for them separately as well as claiming for the means used to access the procedural or surgical site. Please note that payment rules are inserted into the MSI system periodically to allow MSI to confirm adherence to Preamble rules. In some circumstances, physicians may be requested to provide a copy of the clinical record in order to substantiate the claim for payment.
As per the Preamble:

- Procedural codes and their associated tariff are intended to remunerate the physician for all parts of the procedure that would normally be considered the defined technique for that procedure. It is not appropriate to deconstruct (unbundle) the procedure into constituent parts and bill MSI for these codes in addition to the procedural codes. (5.3.68).

NEW AND UPDATED EXPLANATORY CODES

Code	Description
AD077	SERVICE ENCOUNTER HAS BEEN REFUSED AS A THIRD INJECTION FOR RO=HPV9 REQUIRES PT=RISK. PLEASE RESUBMIT WITH THE APPROPRIATE MODIFIERS.
AD078	SERVICE ENCOUNTER HAS BEEN REFUSED AS PATIENT IS NOT 65 YEARS OF AGE OR OLDER.
AD079	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS RO=HDIN MAY ONLY BE CLAIMED FROM A LONG TERM CARE/RESIDENTIAL CARE FACILITY.
AD080	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF HPV9 INJECTIONS HAS BEEN REACHED.
VA089	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS HSC 50.99A REQUIRES TEXT INDICATING THE INTRAVENOUS WAS PERFORMED BY THE PHYSICIAN.
VA045	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS HSC 69.94 REQUIRES TEXT INDICATING WHY THE CATHETER INSERTION WAS PERFORMED BY THE PHYSICIAN.
VT164	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS MEDICAL ASSISTANCE IN DYING CLAIMS REQUIRE START AND STOP TIMES.
VT165	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.03N CANNOT BE CLAIMED UNLESS THE PROVIDER HAS PREVIOUSLY CLAIMED HSC 03.03M OR 03.03O FOR THIS PATIENT.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday July 27th, 2018. The files to download are health service (SERVICES.DAT), modifier values (MODVALS.DAT), health service description (SERV_DESC.DAT), diagnostic codes (DIAG_CD.DAT) and, explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

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

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NOVA SCOTIA

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PHYSICIAN'S BULLETIN
June 15th, 2018: Vol. LXII, ISSUE 15

NOVA SCOTIA MEDICAL SERVICES INSURANCE

MSI News

PRIMARY CARE INVESTMENTS UPDATE – COMPREHENSIVE AND CONTINUOUS CARE

In March 2018 the Department of Health and Wellness announced increased investment in services provided by family physicians that practice full scope family medicine and are responsible for the comprehensive and continuous care of their patients. This investment has necessitated that new fees be implemented. In follow up to the May 17th 2018 bulletin, the following fees are also included in that primary care investment (details below). The health service codes will be available as of June 15th, 2018. Once the health service codes become available we ask physicians to bill as usual. Any claims eligible for the enhanced fee value that were submitted between April 1st and June15th will later be identified, and a retroactive payment will be provided to physicians.

Category	Code	Description	Base Units
VIST	03.03	**Office Visit (Well Baby Care) – Comprehensive and Continuous Care** ME=CARE, RO=WBCR, (RF=REFD) ME=CARE, RO=WBCR, TI=GPEW, (RF=REFD)	 14.76 MSU 18.45 MSU
		Office Visit (Prenatal) – Comprehensive and Continuous Care ME=CARE, RO=ANTL, RP=SUBS (RF=REFD) ME=CARE, RO=ANTL, TI=GPEW, RP=SUBS (RF=REFD)	 14.76 MSU 18.45 MSU
		Extra Patient to: Urgent Care Codes – Comprehensive and Continuous Care ME=CARE, PT=EXPT, US=UNOF (RF=REFD)	 11.9 MSU

Billing Guidelines
By "full scope family medicine" it is meant that the physician has an ongoing relationship as a primary care provider to their patients and ensures their patients' continuity of care. These enhanced fees are not intended for episodic care provided to walk-in patients. The submission of a Physician Confirmation Letter is required to successfully use these enhanced fees.

Specialty Restriction
GENP

Location
OFFICE

PHYSICIAN'S BULLETIN
May 17, 2018: Vol. LXI, ISSUE 14

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

PRIMARY CARE INVESTMENTS

The investments represent a significant increase to the fees for services commonly provided by family physicians. With the input of Doctors Nova Scotia, the investments are structured with the intent that Nova Scotians will see an increase in physicians who are able to establish new relationships with patients who currently either do not have or are seeking a new family doctor. Highlights of the investment package include:

COMPREHENSIVE AND CONTINUOUS CARE

Effective April 1st, 2018 there is an increase of 13.5% to the fee paid for health service code 03.03 (office visit and geriatric office visit) for family physicians who are delivering comprehensive and continuous care to patients with whom they have an ongoing relationship. It does not include episodic care provided to walk-in patients. The enhanced fees are only available to family physicians who attest, via confirmation letter, that they are providing comprehensive and continuous care to patients. The MSI system will not be updated until May 17th. To claim the new enhanced fees, physicians should begin to use the new ME=CARE modifier on applicable claims submitted on May 17th or after, even if the service date was prior to May 17th. A confirmation letter must be filled out and returned directly to MSI no later than May 25th, 2018. Any claims eligible for the enhanced fee value that were submitted between April 1st and May 25th will later be identified, and a retroactive payment will be provided to physicians. Letters received after May 25th, 2018 will still be processed and eligibility will commence as of that date, no retroactive payments will be made for letters received after May 25th, 2018. All physicians who intend to use, or have been using, the enhanced fees, are required to submit the letter in order to continue to be eligible to bill these enhanced fees. The letter can be found here and must be sent to: primary_care_investments@medavie.bluecross.ca.

ENROLMENT FEE

Effective April 1st 2018, a one-time flat enrolment fee of $7.50 per current patient to enable family physicians to identify panels of patients for whom they are providing comprehensive and continuing care. However, it will take some time to define the enrolment process and for the initial/preliminary patient panel lists to be developed and distributed to family physicians for verification. Once these lists are received you will have the opportunity to add and/or remove names from the list based on your own charts. The $7.50 per patient will apply to the final approved and validated roster. More details on this fee, including the process will be shared in the coming weeks.

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UNATTACHED PATIENTS

Effective April 1st 2018, the rules for the $150 unattached patient bonus have been expanded. The fee will be available to APP, FFS, and eligible AFP family physicians for taking on patients from the 811 Find a Family Practice list as well as other patients who were previously unattached at the time they enrolled or who may become unattached, such as patients referred from the Emergency Department and patients from a practice where the physician is retiring or relocating and who no longer have a family physician. The criteria for the existing UPB1 will be broadened and the process for claiming the fee simplified. The fee should be billed at the time of your initial visit. You are required to keep the patient in your practice and to maintain an open chart for at least a year, but you should still bill the incentive at the time of the initial visit. (Note that this is a change from the instructions first communicated, which suggested that you should hold your billing until the unattached patient has been in your practice for a year.)

ALTERNATIVE PAYMENT PLAN (APP) CONTRACTS

Family practitioners compensated through APP contracts will have the opportunity to increase their compensation by 5.6%. It applies to APPs regardless of the full or part-time nature of the arrangement, based on volume of shadow billing. APP physicians who shadow bill a minimum 80% of their contract's payment will receive the 5.6% bonus.

Click here for FAQs regarding the Primary Care Investments.

TECHNOLOGY STIPEND - VIRTUAL CARE PILOT (MyHealthNS)

A working group, chaired by Dr. Stewart Cameron and with Doctors Nova Scotia representation, is working on the MyHealthNS Virtual Care Pilot criteria where physicians can receive up to $12,000 a year. This pilot will look at the benefits and impacts of using the secure e-messaging function and telephone to improve access to primary health care. When information is available, it will be added to the Physician's Bulletin. Meanwhile, to schedule a demo of MyHealthNS you can reach DHW at 902-424-3951 or email MyHealthNS@novascotia.ca.

ELECTRONIC MEDICAL RECORD (EMR) INCENTIVE TRUST AND SUPPORT

The DHW Migration Project Office will trigger payment of all incentives after the migration has been completed and all eligibility criteria have been met. Payments will be processed through MSI on a quarterly basis.

The following incentives and supports are available:

- **A one-time migration incentive of $2,300** will be paid to each physician in recognition for time spent by them and their staff to ensure migration of their patient records in accordance with provincial migration project standards, including testing and validating migrated data.

- ***A one-time incentive payment to expedite the required migration from Nightingale On Demand*** (NOD). Eligible physicians currently on Nightingale on Demand may also receive up to a maximum of $3,000 (one-time payment) to compensate them for migrating their patient records from Nightingale On Demand to a Certified EMR. Incentive amounts will be determined as follows:

    - Physicians who, between December 1, 2017 and October 31, 2018, secure a migration date with the vendor and DHW and submit their Consent to Grant Access Form to DHW, shall receive the maximum amount of the NOD Migration Incentive ($3,000). (Note that the migration date may be after October 31st, 2018, but it must be ***secured*** by October 31st, 2018)
    - Physicians who, between November 1, 2018 and March 31, 2019, secure a migration date with the vendor and DHW and submit their Consent to Grant Access Form to DHW, shall receive 75% of the maximum NOD Incentive (actual $2,250). (Note that the migration date may be after March 31, 2019, but it must be ***secured*** by March 31, 2019.)
    - Physicians who, between April 1, 2019 and October 31, 2019, secure a migration date with the vendor and DHW and submit their Consent to Grant Access Form to DHW, shall receive 50% of the maximum NOD Incentive (actual $1,500) (Note that the migration date may be after October 31, 2019, but it must be ***secured*** by October 31, 2019.)
    - Once a migration date is secured, it is expected that the physician will complete the migration as scheduled. If the scheduled migration date is changed by the DHW Migration Project Office, this will not negatively affect the amount of the incentive to be paid to the physician. If the scheduled migration date is changed by the physician, the new migration secured date will be used to determine eligibility for incentive payments.

- To qualify for compensation under the EMR Migration Incentive Program physicians are required to meet specific migration eligibility criteria and must have migrated from a provincial EMR to a Certified EMR between December 1, 2017 and December 31, 2019.

ELECTRONIC MEDICAL RECORD (*EMR) SUBSIDY*

To encourage ongoing EMR use, *existing* provincial EMR users (i.e. Practimax, Accuro and Med Access), who are receiving eResults from provincial information systems, will receive an EMR subsidy of $200 per month. The EMR Subsidy payment will be processed by DHW and paid through MSI on a quarterly basis. No action is required by physicians.

- Nightingale On Demand physicians will qualify for the subsidy in the month after they have completed their migration to a Certified EMR.
- For Accuro, Practimax and Med Access EMR users who meet the eligibility criteria (see FAQ), the subsidy is effective April 1, 2018.
- The end date for the EMR Subsidy is December 31, 2019 or earlier if a new Physician Master Agreement has been ratified.

Click here for the complete DHW EMR Communication and FAQ.

Fees New Fees, Fee Revisions, and Highlighted Fees

NEW FEES

Effective May 17th, 2018, the following health service code will be available for billing:

Category	Code	Description	Base Units
VIST	03.03V	**Medical Abortion/Termination of early Pregnancy** This comprehensive fee includes the assessment of the patient requesting termination of an early (first trimester) pregnancy, counselling, ordering and interpretation of laboratory tests and diagnostic imaging as required, prescription of the medication and telephone follow up. Administration/prescription of cytotoxic medication(s) and Rh immune globulin (where required) is included as are all verbal or electronic communications with the patient to relay results of follow up blood work and address questions or concerns. **Billing Guidelines** • May not be reported with any other consultation or visit service same patient same day. • Follow up visits are not included in the comprehensive HSC. **Premium** GPEW **Location** OFFICE	47.5 MSU

Effective April 1, 2018 the following health service premium is available for billing. Physicians holding claims from April 1st - May 16th have 90 days from the date of the bulletin to submit; please refer to this bulletin in electronic text for any claims submitted over 90 days from their date of service.

Category	Code	Description	Base Units	Anaes Units
ADON	AHSP1	**After Hours Service Premium (extended service hours)** This premium applies in circumstances where elective procedures are moved to an eligible premium time period due to factors beyond the control of the physician. The 35% after hours service premium is intended to compensate the physician for the disruption of their personal time while providing extended hours of service in addition to the scheduled workday. Eligible time periods are defined as: • Weekday evenings: Mon-Friday 17:00-23:59 • After midnight: Tuesday-Saturday 00:00-07:59 • Weekend day time: Saturday 08:00-16:59 • Weekend night time and Sunday all day: Saturday to Monday 17:00-07:59 • Official recognized holidays: 08:00-23:59 **Billing Guidelines** • May only be reported for scheduled electively booked interventional procedures that have been moved to a premium eligible time period due to factors beyond the control of the physician. • The premium does not apply to elective procedures that have been intentionally booked during premium hours ex: elective cases booked to start before 0800 hours, scheduled weekend joint replacement OR lists etc. **Specialty Restriction** Surgical specialties, endoscopies and interventional radiology **Location** LO=HOSP **Note** Only one claim for AHSP1 is required for all applicable services billed during the same occurrence. While not a billing requirement, physicians may reference in text the service encounter number(s) or health service code(s) the premium should apply to, as this may expedite processing and reduce wait times.	35% premium	35%

Effective April 1st 2018 the following enhanced office visit fees for GPs is available for billing:

Category	Code	Description	Base Units
VIST	03.03	**Office Visit – comprehensive and continuous care** A) ME=CARE, RP=SUBS (RF=REFD) B) ME=CARE, TI=GPEW, RP=SUBS (RF=REFD)	14.76 MSU 18.45 MSU
VIST	03.03A	**Geriatric Office Visit (for patients aged 65+)** A) ME=CARE, RP=SUBS (RF=REFD) B) ME=CARE, TI=GPEW, RP=SUBS (RF=REFD) The creation of these new enhanced fees will better remunerate full scope family medicine physicians for services provided, while also allowing physicians who provide episodic care to continue billing the current fees for normal and geriatric office visits. **Billing Guidelines** By "full scope family medicine" it is meant that the physician has an ongoing relationship as a primary care provider to their patients and ensures their patients' continuity of care. The enhanced fee is not intended for episodic care provided to walk-in patients. The submission of a Physician Confirmation Letter is required to successfully use this enhanced fee. **Specialty Restriction** GENP **Location** OFFICE	18.26 MSU 22.83 MSU

FEE REVISIONS

Effective April 1st, 2018 the billing guidelines associated with the following health service codes have been updated:

Category	Code	Description	Base Units
DEFT	UPB1	**Unattached Patient Bonus** On April 1st, 2018 the Department of Health and Wellness implemented revisions to the criteria for claiming HSC UPB1 — the unattached patient bonus fee. **Billing Guideline Updates** • The UPB1 service will be claimable from an office, nursing home, acute home care, or home location. Previously the service was limited to office claims. • The GP has to have had at least one visit service with the patient prior to claiming the UPB1 fee. This visit can occur at the same encounter in which UPB1 is claimed. • A GP can only claim UPB1 once per patient per lifetime. A physician cannot claim the unattached patient bonus more than once for the same patient. • The UPB1 cannot be claimed for walk-in clinics, for patients who already appear on a physician's patient list (physician validated), for patients who were taken off the 811 list before the establishment of this fee enhancement (i.e. retroactive payment before April 1st, 2018), or for new physicians who are building their practices until that point when their patient panel reaches 1350. **Documentation** The GP must 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 encounter that resulted in the GP taking the Unattached Patient into his/her practice must also be recorded in the patient's record. This can be a patient from the 811 list, referral from the hospital emergency department, for enrolling patients who do not have a physician or are unattached at time of enrolment, for enrolling patients for whom un-attachment is imminent because their family practitioner is retiring/relocating and no new family physician is taking over the practice, an inpatient hospital report or other documentation. (Other documentation may include a note by the physician, documenting their discussion with the patient, confirming the prior hospital encounter.) **Specialty Restriction** GENP **Location** All locations	$150.00 (one time per patient)

Revised march 31, 2020 – see May 2020 bulletin for updated information

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

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

Billing Guidelines

ADON Restricted to:
03.03 Office visit
03.03A Geriatric Office Visit (for patients age 65+)
03.03E Adults with Developmental Disabilities

- Reportable only if the visit occurs in the primary care physician's office or the patient's 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
GENP
Location
LO=OFFC, HOME

Revised march 31, 2020 – see May 2020 bulletin for updated information

Category	Code	Description	Base Units
ADON	03.03P	**First Visit after In-Patient Hospital Discharge – Maternal and Newborn Care** 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 communicatewith the patient and/or caregiver within 2 business days of discharge to better facilitate the patient being seen within 14 days of discharge. • 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's 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.	10 MSU

- 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, HOME

Please note the removal of the requirement for a written referral to be sent to the specialist and available in the patient's medical record only applies to the following health service codes:

Category	Code	Description	Base Units
VIST	03.09K	**Specialist Telephone Advice – Consultant Physician – Providing Advice**	25 MSU
VIST	03.09L	**Specialist Telephone Advice – Referring Physician – Requesting Advice**	11.5 MSU

This health service code may be reported for a telephone (or other synchronous electronic verbal communication) regarding the assessment and management of the patient but without the consulting physician seeing the patient.

The referring physician may be a family physician or other specialist seeking an expert opinion from the consulting physician due to the complexity and severity of the case and with the intent of continuing to provide the patient's care closer to home. The consultant specialist may also receive requests for advice from a nurse practitioner.
The referring physician (or NP) must communicate to the specialist the reason for the consultation and relevant patient information through verbal, written or electronic communication, either before or within four business days after the telephone call. The referring physician must document that this information was supplied to the specialist. There must be by a two-way verbal communication discussing the clinical situation followed by a management decision and a written report from the specialist to the referring provider.
The formal consultation report must be available in the patient's medical record; both the referring physician (or NP) and the specialist must maintain copies of this document. Both medical records must include the date and time of the service and any contemporaneous notes, in addition to the written documents.
The service is reportable by the specialist for a new patient or an established patient with a new condition or an exacerbation of an existing condition.

Billing Guidelines

The HSC includes a review of the relevant patient's history, relevant family history and relevant history of present complaint, and a review of any laboratory data, PACS images, medical records or other data as needed to provide advice.
The health service includes a discussion of the relevant physical findings as reported by the referring provider.
If subsequent phone calls are necessary within 14 days to complete the consultation they are considered included in the HSC for the telephone consultation.
The Consultant Physician HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.
The Referring Physician HSC may be reported when the telephone call for an urgent consultation occurs on the same day as the patient visit that generated the consultation.

The HSC is not reportable when the purpose of the communication is to:

- Arrange transfer
- Arrange a hospital bed for the patient
- Arrange a telemedicine consultation
- Arrange an expedited face to face consultation
- Arrange a laboratory, other diagnostic test or procedure
- Inform the referring physician of the results of diagnostic investigations
- Decline the request for a consultation or transfer the request to another physician

The service is not reportable for other forms of communication such as:

- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

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 health professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student

The service is not reportable by the consulting physician if the patient has had a face to face visit with the consultant or any member of his/her call group within the previous 14 days for the same condition or if the telephone consultation results in a face to face service within the next 14 days or the next available appointment of the consultant.
The service is not reportable for telephone calls of less than 5 minutes of two way medical discussion.

The service is not reportable for calls between a referring provider and specialist in the same institution or practice location.

Documentation requirements

- The referring physician must document that s/he has communicated the reason for the consultation and relevant patient information to the specialist
- Both the specialist consultant and the referring provider must document the patient name, identifying data and date and start and stop time of the call in their respective charts or EMRs.
- The names of the referring physician (or NP) and the consultant physician must be documented by both physicians.
- The diagnosis, reason for referral, elements of the history and physical as relayed by the referring provider, the opinion of the consultant physician and the plan for future management must be documented.
- A written report must be sent to the referring provider by the specialist consultant.
- The referring physician's billing number must be noted on the electronic claim.
- Both physicians must submit the start and stop time of the call in the text field on the claim.
- There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service.

Location
LO=OFFC

Category	Code	Description	Base Units
VIST	03.03Q	**Specialist Telephone Management/Follow Up with Patient** 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 lasts 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 telephone (or synchronous electronic verbal communication) between the specialist physician and the patient, or the patient (or the patient's parent, guardian or proxy as established by written consent). • Telephone management requires 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 a management decision. • The specialist physician must have seen and examined the patient within the preceding 9 months. • The HSC is reportable 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 for other forms of communication such as: • Written, e-mail or fax communication • Electronic verbal forms of communication that are not PHIA compliant 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 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 on the MSI service report. • There must be text on the MSI service report to indicate whether or not this service replaced a face to face service. **Location** LO=OFFC	11.5 MSU

Category	Code	Description	Base Units
VIST	03.03R	**Family Physician Telephone Management/Follow Up with Patient** 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 an 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 of the patient is not required. The patient population eligible must be either 65 years and older or be suffering from mental illness or multiple (two or more) chronic diseases. Mental illness is defined as • 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 telephone (or synchronous electronic verbal communication) between the family physician and the patient (or the patient's parent, guardian or proxy as established by written consent). • Telephone management requires 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 a management decision. • The family physician must have seen and examined the patient within the preceding 9 months. • The HSC is reportable a maximum of 4 times per patient per physician 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: - Arrange a face to face appointment - Notify the patient of an appointment - Prescription renewal - Arranging to provide a sick note - 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 not reportable for other forms of communication such as: - Written, e-mail or fax communication - Electronic verbal forms of communication that are not PHIA compliant • 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	11.5 MSU

The service is not reportable for telephone calls of less than 5 minutes of 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.
- For patient initiated appointment requests that result in a telephone management service on the same day, the following text should be entered in the MSI text field:
  - Same day access
- The start and stop time of the call must be included in the text field on the MSI service report.
- There must be text on the MSI service report to indicate whether or not this service replaced a face to face service.

Location

LO=OFFC

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Billing Matters Billing Reminders, Updates, New Explanatory Codes

BILLING REMINDERS

Travel for HSC HOVM1

Physicians are reminded that they cannot bill for travel from personal home location to patient home, only for travel from office to patient home (unless the physician has an at-home office registered with MSI).

UPDATES

Methadone Exemption

Effective May 2018 the federal government will permit health care practitioners to prescribe and administer methadone without requiring an exemption from federal law. Due to this policy change, physicians no longer need to provide proof of a valid Health Canada exemption to prescribe methadone in order to claim the following fees through MSI:

- **03.03J** – Initial Opioid Use Disorder Assessment in a community setting for initiation of Methadone Treatment
- **03.03K** – Initial Opioid Use Disorder Assessment for Methadone Treatment – Transfer from Methadone Maintenance Treatment Clinic to community physician
- **03.03L** – Permanent Transfer of patient on active Methadone Treatment for substance use disorder – Full acceptance of responsibility for ongoing care – Initial visit with accepting physician
- **MMM1** – Methadone Treatment Monthly Management fee: Intensive
- **MMM2** – Methadone Monthly Management Fee: Maintenance

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NEW AND UPDATED EXPLANATORY CODES

Code	Description
DE032	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED THE UNATTACHED PATIENT BONUS PAYMENT FOR THIS PATIENT.
DE033	SERVICE ENCOUNTER HAS BEEN REFUSED AS THERE HAVE BEEN NO VISIT SERVICES CLAIMED BY YOU FOR THIS PATIENT IN THE PREVIOUS 365 DAYS.
VT162	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.03V MAY NOT BE BILLED IN ADDITION TO OTHER SERVICES FOR THIS PATIENT ON THE SAME DAY.
VT163	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CONSULT MAY NOT BE BILLED IN ADDITION TO 03.03V FOR THIS PATIENT ON THE SAME DAY.

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 17, 2018. The files to download are health service (SERVICES.DAT), modifier values (MODVALS.DAT), health service description (SERV_DESC.DAT) and, explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

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

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PHYSICIAN'S BULLETIN
March 23, 2018: Vol. LX, ISSUE 13

NOVA SCOTIA MEDICAL SERVICES INSURANCE

CONTENTS

MSI News

MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT/ANAESTHESIA UNIT CHANGE

Effective April 1, 2018, the Medical Service Unit (MSU) value will be increased from $2.44 to $2.48 and the Anaesthesia Unit (AU) value will be increased from $20.76 to $21.07.

PSYCHIATRY FEES

Effective April 1, 2018 the hourly Psychiatry rate for General Practitioners will increase to $113.33 while the hourly rate for Specialists increases to $153.67 as per the tariff agreement.

SESSIONAL PAYMENTS

Effective April 1, 2018 the hourly Sessional rate for General Practitioners will increase to $148.80 while the hourly rate for Specialists increases to $173.60 as per the tariff agreement.

WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC

Effective April 1, 2018 the Workers' Compensation Board MSU Value will increase from $2.71 to $2.76 and the Workers' Compensation Board Anaesthetic Unit Value will increase from $23.07 to $23.41.

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NEW FEES

Effective April 1, 2018 the following health service premium will be available for billing. Physicians are asked to hold these premiums until notified that they may be submitted for payment.

Category	Code	Description	Base Units	Anaes Units
ADON		**After Hours Service Premium (extended service hours)** This premium applies in circumstances where elective procedures are moved to an eligible premium time period due to factors beyond the control of the physician. The 35% after hours service premium is intended to compensate the physician for the disruption of their personal time while providing extended hours of service in addition to the scheduled workday. Eligible time periods are defined as: a. Weekday evenings: Mon-Friday 17:00-23:59 b. After midnight: Tuesday-Saturday 00:00-07:59 c. Weekend day time: Saturday 08:00-16:59 d. Weekend night time and Sunday all day: Saturday to Monday 17:00-07:59 e. Official recognized holidays: 08:00-23:59 **Billing Guidelines** May only be reported for scheduled electively booked interventional procedures that have been moved to a premium eligible time period due to factors beyond the control of the physician. The premium does not apply to elective procedures that have been intentionally booked during premium hours ex: elective cases booked to start before 0800 hours, scheduled weekend joint replacement OR lists etc. **Specialty Restriction** Surgical specialties, endoscopies and interventional radiology **Location** HOSP	35% premium	35%

Effective March 23, 2018 the following health service codes will be available for billing:

Category	Code	Description	Base Units	Anaes Units
MASG	76.95B	**Insertion of semi-rigid or malleable penile prosthesis**	140 MSU	5+T
MASG	76.96B	**Removal with or without reinsertion of semi-rigid or malleable penile prosthesis** These HSCs are specific to the insertion, and/or removal, with or without re-insertion of a malleable or semi-rigid penile prosthesis to include any urethral dilation required to insert the device. **Billing Guidelines** Cystoscopy, when required, may be reported in addition to these HSCs. For the removal with or without reinsertion of semi-rigid or malleable penile prosthesis, IC will be paid at 125 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** UROL **Location** HOSP	IC @125MSU/hr	5+T

Revised March 31, 2020 – See May 2020 Bulletin for updated information

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 These HCSs are specific to the insertion, and/or removal, with or without reinsertion 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** UROL **Location** HOSP	IC @130MSU/hr	6+T

UPDATED FEES

Workers' Compensation Board Medical Service Unit Update

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been calculated for the listed WCB specific fees for fiscal year 2018-19.

Due to the increase in CPI for 2017, all of the WCB specific services listed below will have their values increased by 1.65% effective April 1st, 2018:

CODE	DESCRIPTION	NEW VALUE
WCB12	EPS physician assessment Service. Combined office visit and completion of Form 8/10 For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15 minute increments to a maximum of 1 additional hour	**Initial visit:** $180.03 + $51.61 per 15 minutes to a maximum 4x (RO=EPS1 and RP=INTL) **Subsequent visit:** $180.03 (RO=EPS1 and RP=SUBS)
WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable	GPs…….$43.97 per 15 min EPS(RO=EPS1) $52.61 per 15 min Specialists……..$59.17 per 15 min
WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable	GPs…….$43.97 per 15 min EPS(RO=EPS1)$52.61 per 15 min Specialists……..$59.17 per 15 min
WCB17	Photocopies of Chart Notes	10 pgs or less (ME=UP10)……..$26.33 11-25 pgs (ME=UP25)……..$52.61 26-50 pgs (ME=UP50)….. $105.16 Over 50 pgs (ME=OV50)……$157.71
WCB20	Carpal Tunnel Syndrome (CTS) Assessment Report	$67.48
WCB21	Follow-up visit report	$39.47
WCB22	Completed Mandatory Generic Exemption Request Form	$13.19 per form
WCB23	Completed Non-Opioid Special Authorization Request Form	$13.19 per form
WCB24	Completed Opioid Special Authorization Request Form	$44.22 per form
WCB25	Completed WCB Substance Abuse Assessment Form	$29.45
WCB26	Return to Work Report – Physician's Report Form 8/10	$67.48
WCB27	Eye Report	$59.17
WCB28	Comprehensive Visit for Work Related Injury or Illness	$67.90

BILLING REMINDERS

Text required on claims for removal of progestin contraceptive device (HSC 13.53C)

Physicians are reminded to include explanatory text on claims for removal of progestin contraceptive device. This health service code is for the removal of intradermal devices. Removal of intrauterine devices are to be claimed using visit codes.

Correct Location Code When Submitting Claim to MSI

Physicians are reminded to use the correct location and facility code when submitting claims to MSI. The location code to be used is the physical location of where the service was provided.

Elective Out of Province Services (within Canada)

Prior approval is required from the Nova Scotia Department of Health and Wellness before referring a patient out of province for insured health services unavailable in Nova Scotia if the patient wishes to be considered for travel and accommodation assistance. Approval must be sought through the Medical Consultant, MSI. The referral must be from a specialist registered in Nova Scotia, who is actively involved in the eligible resident's care. The referral must include the following:

- A description of the eligible resident's relevant medical history.
- A description of the health services requested as well as an estimation of the expected benefit to the patient.
- Confirmation that the health service(s) are provided in a publicly funded facility and are covered by the medical insurer in the proposed province
- Written confirmation of the medical evidence supporting the requested health service.
- When the proposed health service is a new or emerging health service, documentation must be included of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.
- Information on the available health services in Nova Scotia and an explanation of why these are not sufficient for the resident's needs.
- The contact information of the physician who will be treating the patient so a copy of the approval documentation can be forwarded to their office.
- A description of any follow-up requirements.
- A written recommendation in support of the out-of-province health services, confirming that this is the specialist's recommendation and that the referral is not being provided solely at the request of the patient.
- Written confirmation of, the patient's medical requirement for travel with an escort, if required.
- The costs for an escort will not be covered by DHW if there is no medical evidence to support the need for an escort. Evidence of medical need for an escort is not required if the resident is under 19 years of age.

MSI will review the application and provide a response to the appropriate specialist within 30 days of receiving a complete application.

Upon approval of the application, the Department of Health and Wellness will contact the eligible resident and provide the appropriate application forms for travel and accommodation assistance.

Elective out of Country Services

Individuals requiring elective, insured health services that are not available within Canada must be authorized by the DHW prior to making any medical and/or travel arrangement to ensure the service will be insured and in order for the DHW/MSI to negotiate a reasonable and fair compensation with out of country providers prior to the provision of services.

In order for a patient to be referred outside Canada for treatment, prior written approval is required from the Medical Consultant, MSI. The referral must be from a specialist registered in Nova Scotia, who is actively involved in the eligible resident's care. The referral must include the following:

- A description of the eligible resident's relevant medical history.
- A description of the health services requested as well as an estimation of the expected benefit to the patient.
- The contact information of the physician who will be treating the patient so a copy of the approval documentation can be forwarded to their office.

- Written confirmation of the medical evidence supporting the requested health service.
- When the proposed health service is a new or emerging health service, documentation must be included of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.
- Information on the available health services in Canada and an explanation of why these are not sufficient for the resident's needs.
- A description of any follow-up requirements.
- A written recommendation in support of the out-of-country health services, confirming that this is the specialist's recommendation and that the referral is not being provided solely at the request of the patient.
- Written confirmation of the patient's medical requirement for travel with an escort, if required.
- The costs for an escort will not be covered by DHW if there is no medical evidence to support the need for an escort. Evidence of medical need for an escort is not required if the resident is under 19 years of age.

MSI will review the application and provide a response to the appropriate specialist within 30 days of receiving a complete application.

Upon approval of the application, the Department of Health and Wellness will contact the eligible resident and provide the appropriate application forms for travel and accommodation assistance.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
MJ064	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR URETHRAL DILATION AT THE SAME ENCOUNTER. THIS SERVICE INCLUDES ANY URETHRAL DILATION REQUIRED TO INSERT THE DEVICE.
MN016	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR AN INSERTION OR REMOVAL WITH OR WITHOUT REINSERTION OF A PENILE PROSTHESIS AT THE SAME ENCOUNTER WHICH INCLUDES ANY URETHRAL DILATION REQUIRED TO INSERT THE DEVICE.
NR088	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR URETHRAL DILATION AT THE SAME ENCOUNTER. THIS SERVICE INCLUDES ANY URETHRAL DILATION REQUIRED TO INSERT THE DEVICE.
VA087	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR AN INSERTION OR REMOVAL WITH OR WITHOUT REINSERTION OF A PENILE PROSTHESIS AT THE SAME ENCOUNTER WHICH INCLUDES ANY URETHRAL DILATION REQUIRED TO INSERT THE DEVICE.
VA088	SERVICE ENCOUNTER HAS BEEN DISALLOWED. PLEASE RESUBMIT, INDICATING IN THE TEXT FIELD THIS CLAIM IS FOR THE REMOVAL OF AN INTRADERMAL DEVICE.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday March 23, 2018. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT) and, explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

CONTACT INFORMATION

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NOVA SCOTIA

PHYSICIAN'S BULLETIN

February 9, 2018: Vol. LIX, ISSUE 12

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

MSI DOCUMENTATION REMINDER

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribed, and start and stop times for time based codes.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptations, or emotional problems, the physician "deliberately established a professional relationship with the patient for the purposes of removing, modifying or alleviating existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional well being of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy," etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service on that date, then the service is not paid for or a lesser benefit is given. **When the clinical record does not support the service claimed, there will be a recovery to MSI at the time of audit.** Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

NEW FEES

Effective February 9, 2018 the following health service code will be available for billing:

Revised March 31, 2020 – See May 2020 Bulletin for updated information

Category	Code	Description	Base Units	Anaes Units
MASG	71.7F	**Cystoscopy with intravesicular injection(s) of chemodenervating agent** **Billing Guidelines** Not to be reported with other cystoscopy related HSCs. For example, do not report with HSC 01.34A, 01.34B, 01.34C, 01.34G **Specialty Restriction** UROL, OBGY **Location** HOSP	90 MSU	4+T

NEW INTERIM FEES (2015-2019 MASTER AGREEMENT)

Effective February 9, 2018 the following interim health service codes will be available for billing:

Category	Code	Description	Base Units
VIST		**Inpatient Trauma Service Leader Level I Trauma Centre**	
	03.04G	1. Inpatient Trauma Service Admission and Assessment Day 1	100 MSU(+MU)
	03.04H	2. Inpatient Trauma Service Tertiary survey Day 2	62 MSU(+MU)
	03.03T	3. Inpatient Trauma Service subsequent daily visit Day 3	23 MSU
	03.03U	4. Inpatient subsequent daily visit Day 4-7	19 MSU
		The Inpatient Trauma Service Leader HSC's are intended for the care and co-ordination of care for the patient on the inpatient trauma service in a level I trauma centre. Day 1 and Day 2 HSC's are time based codes intended for the first hour of care and coordination of care. The care is to include: Complete history and physical examination Documentation of all injuries in the health record Review of all formal radiological reports and laboratory tests results Ongoing and active daily medical and surgical management Co-ordination of care between specialty services	

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Category	Code	Description	Base Units

Billing Guidelines

1. Patient must have met the criteria for Trauma Team activation as set by Trauma Nova Scotia and been referred to the Trauma Service by the Trauma Team Leader in the ER.
2. Reportable only while an inpatient on the Trauma Service. Not reportable if the patient is admitted to ICU.
3. For Day 1 Admission and Assessment and Day 2 Tertiary Survey, **start and stop times** must be recorded in the health record.
4. Day 2 Tertiary Survey is only reportable by the same physician providing the admission assessment (same provider number) and is not reportable if Day 1 Admission and Assessment HSC has not been reported.
5. Reportable in addition to operative procedures by the same physician and/or physician of the same specialty (exempt from Preamble 5.3.52 and 5.3.55) if the visit is independent of the operative procedure performed.
6. Reportable by only one physician per patient.

Premium

Inpatient Trauma Service Admission and Assessment Day 1 is premium eligible.
Day 2 and subsequent daily visits are not premium eligible.

Specialty restriction

Inpatient Trauma Service physician members as designated by Trauma Nova Scotia.

Multiples

1. Inpatient Trauma Service Admission and Assessment Day 1 Per 15 minutes, maximum of 5 multiples (2 hours total time)
2. Inpatient Trauma Service Tertiary survey Day 2 Per 15 minutes, maximum of three multiples (90 minutes total time)

Location

HOSP

Preamble Reference:

SURGICAL SERVICES MAJOR (5.3.50)
Surgical procedures are described as major if they have a value in excess of 50 units: (5.3.51)
The procedure fee is intended to cover the operation and customary preoperative, operative and postoperative care by the surgeon or a designated covering physician. (5.3.52)

a) A consultation at any time prior to surgery may be claimed, even if the surgery is on the same day. A visit other than a consultation is not payable the same day as a major surgical procedure.(5.3.53)
b) Preoperative care includes:
   i. Comprehensive visit (the admission history and physical exam)
   ii. Hospital visits for up to two calendar days immediately prior to and including the day of surgery
   iii. Hospital visits in a preoperative period that extends beyond two days should be claimed using the appropriate visit codes (5.3.54)
c) Postoperative care includes care during the postoperative hospital stay up to 14 days. (5.3.55)
d) Urgent visits or emergency hospital visits (See Section 5 (5.1.52)) to attend the patient for an unrelated condition are not included in the surgical benefit and may be claimed accordingly. (5.3.56)
e) Hospital visits may be claimed starting on the 15th postoperative day for visits if the postoperative in hospital stay exceeds 14 consecutive calendar days. For the purpose of calculation, the day of the last operative procedure is considered day zero. Weekly routine visit maximums beyond 56 days apply starting from the date of admission. (5.3.57)
f) When a patient is readmitted to hospital during the first 14 days of the post-surgical period because of postoperative complications which do not require a surgical procedure, the surgeon or other physician attending this readmitted patient should claim hospital visits as for a new admission. (5.3.58)

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Note: There will be no reduction in the surgical payment when a service related to the surgery is claimed by another physician in the postoperative period. (5.3.59)

BILLING REMINDERS

Visit and Programming to a Pacemaker (HSC 49.83B and 49.83C)

Physicians are reminded that the visit and programming to a pacemaker health service codes include a visit in their description. It is inappropriate to make a separate claim for a visit or consult service at the same encounter.

MRI Guided Placement of MRI Compatible Clip (HSC 97.99A)

Physicians are reminded that health service code 97.99A MRI guided placement of MRI compatible clip to locate a breast abnormality, includes any related biopsy. It is inappropriate to report an additional breast biopsy code during the same encounter.

Visits to Pronounce Death

If a physician attends a patient to pronounce death, a limited visit may be claimed. However, this service may not be claimed using an urgent modifier. If another healthcare provider, such as a nurse, pronounces the patient, the physician may not claim a visit. It is not appropriate to claim a visit for filling out the death certificate or for telephone calls related to the death.

Insertion and Removal of Intradermal Progestin Contraceptive Device (HSC 13.53A and 13.53C)

Physicians are reminded that these HSCs are for the insertion or removal of intradermal progestin contraceptive devices only. They may not be used for insertion or removal of intrauterine progestin contraceptive devices.

Duplicate Services

Physicians are reminded that it is inappropriate for two physicians to claim the same service for the same patient on the same day.

Arthroscopic Debridement (HSC 92.89M)

Physicians are reminded that an arthroscopic debridement is tricompartmental, and thus should only be claimed for services on the knee.

Arthroscopy

Physicians are reminded that composite arthroscopy fees include the procedure and arthroscopy. As well, when other or multiple surgical procedures are performed through the arthroscope, only the major fee applies.

Pathology Interpretation

Physicians are reminded that pathology interpretation billing and service date must be the date the patient was seen in hospital and had specimens removed. The date the report was completed is not the correct service date. The only exception would be for consults or second opinion, which should be claimed for the date of service of the consult.

CLARIFICATION

Other incision with drainage of skin and subcutaneous tissue (HSC 98.03)

The October 18, 2017 bulletin reported that other incision with drainage of skin and subcutaneous tissue (AN = LOCL) (HSC 98.03), fell under category MISG. The correct category is VADT for this health service code.

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MSI HEALTH CARD RENEWAL

Revised Health card renewal form

Please be advised there is an updated version of the MSI Nova Scotia health card renewal form. This form should be used when a Nova Scotia resident's health card has expired. If the card has been expired for more than one year instruct the resident to contact our office to confirm eligibility.

This form cannot be used for new residents moving to Nova Scotia, to make changes to a residents file such as name, date of birth or gender changes and cannot be used to request duplicate or replacement cards if lost or stolen. This form cannot be used to renew cards for international students or foreign workers.

Helpful tips to ensure completeness of the renewal form and timely processing:

- Resident must sign the form to confirm they are ordinarily present in NS and to authorize the release of information for payment and audit purposes, this is mandatory to issue a health card
- Organ and/or tissue donation is optional and should only be signed if they wish to be a donor and should include their donor choice.
- A parent or guardian must sign for children under the age of 16

This form can also be found online at https://novascotia.ca/DHW/msi/docs/MSI-Health-Card-Renewal-Form.pdf. To ensure consistency with the renewal process, beginning **April 1, 2018** no other version of the renewal form will be accepted for processing.

For questions please contact the MSI Registration & Enquiry department at 902-496-7008 or toll free at 1-800-563-8880.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
MJ062	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED HSC 07.08A, B OR C AT THE SAME ENCOUNTER.
VA084	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED A MAJOR SURGERY PROCEDURE AT THE SAME ENCOUNTER.
VA085	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 97.99A AT THE SAME ENCOUNTER.
VA086	SERVICE ENCOUNTER HAS BEEN REFUSED AS A VISIT OR CONSULT HAS ALREADY BEEN CLAIMED AT THE SAME ENCOUNTER. HSC 49.83B AND 49.83C INCLUDE THE ACCOMPANYING VISIT IN THE HEALTH SERVICE DESCRIPTION.
VE019	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 66.89A AT THE SAME ENCOUNTER.
VT155	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR HSC 49.83B OR 49.83C HAS ALREADY BEEN CLAIMED AT THE SAME ENCOUNTER AND INCLUDES THE ACCOMPANYING VISIT IN THE HEALTH SERVICE DESCRIPTION.
MJ063	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED A CYSTOSCOPY RELATED SERVICE AT THE SAME ENCOUNTER.

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Code	Description
NR087	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 71.7F AT THE SAME ENCOUNTER.
VT156	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS START AND STOP TIMES FOR THIS SERVICE MUST BE INCLUDED IN TEXT.
VT157	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THERE IS NO CLAIM FOR 03.04G ADMISSION AND ASSESSMENT DAY 1 ON HISTORY BY THIS PROVIDER.
VT158	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE INPATIENT TRAUMA SERVICE TERTIARY SURVEY DAY 2 SHOULD ONLY BE BILLED BY THE PHYSICIAN THAT BILLS THE INITIAL DAY ONE ADMISSION AND ASSESSMENT.
VT159	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS INPATIENT TRAUMA SERVICE HAS ALREADY BEEN CLAIMED FOR THIS HOSPITAL ADMISSSION.
VT160	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.03U HAS ALREADY BEEN CLAIMED FOR THIS DAY.
VT161	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE HAS ALREADY BEEN CLAIMED FOR DAYS 4 THROUGH 7.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday February 9, 2018. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT) and, explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

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PHYSICIAN'S BULLETIN

November 17, 2017: Vol. LVIII, ISSUE 11

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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★ Fees New Fees and Highlighted Fees

NEW FEES

Effective November 17, 2017 the following health service code will be available for billing:

Category	Code	Description	Base Units
MAAS	50.77C	**Portal Vein Embolisation** Vascular embolization or occlusion of the portal vein (s), inclusive of percutaneous portal vein catheterization and all radiological supervision and interpretation, intra-procedural road mapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction. **Billing Guidelines** • Each case to be evaluated based on active physician skin to skin time defined as the time of first incision for placement of percutaneous catheter until the completion of embolization and removal of the venous catheter by the physician. • Time must be documented in the patient's health record. • Procedural time sheets to be submitted with claim. **Specialty Restriction** Interventional Radiology Fellowship with additional training in PVE **Location** HOSP	IC 140 MSU/hr

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The following codes were made effective November 1, 2017. Physicians were previously advised to hold these claims until November 17, 2017; codes are now available for billing.

Health Service Codes with fee value adjustments; physicians are asked to continue billing these codes, and a retroactive payment will be provided at a later date for claims billed between November 1, 2017 and November 17, 2017.

Category	Code	Description	Base Units
DEFT	CPO1	**Care Plan Oversight (CPO) Nursing Home, Residential Care Facility, or Hospice**	
		A)	15 MSU
		B)	30 MSU
		Supervision of care for a nursing home, residential care facility, or hospicepatient **Billing Guidelines** • Do not report with other telephone service or non face to face codes such as: o 13.99C Supervision of long-term anticoagulant therapy - in the same calendar month. o ENH1 Long Term Care Medication Review - in the same calendar year. **Specialty Restriction** GENP **Location** LO=NRHM, Residential Care Facility, or Hospice	

Revised March 31, 2020 – See April 2020 Bulletin for updated information

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

Category	Code	Description	Base Units
VIST	03.03	**Subsequent Daily Hospital Visit (LO=HOSP, FN=INPT, DA= DA23 or DA=DA47)** A) Days 2, 3, and first day out of ICU (DA=DA23) B) Days 4 – 7 (DA=DA47) These adjusted MSU values apply to health service code 03.03 LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, a subsequent limited visit provided to patients admitted to hospital where a family doctor is the most responsible physician. **Billing Guidelines** • May only be claimed once per patient per day by the most responsible physician (MRP). First day out of ICU should be considered equivalent to day 2 and subsequent inpatient days as 3,4,5,6,7 for the purpose of reporting these increased code values. **Specialty Restriction** GENP **Location** LO=HOSP, FN=INPT	 23 MSU 19 MSU

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

The comprehensive hospital discharge code is intended to be used whenservices provided on the day of discharge require greater than 30 minutes of the physician'stime. This HSC includes all services provided to the patient on the day of discharge from theacute care hospital. Every effort is to be made by the dischargephysician 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 careto 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 dischargeorder 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 reported 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 Most Responsible Physician (MRP) is defined as the physician in charge of the patient's care for any given day (24 hour period).
- May only be claimed 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 Free) A may not be claimed as the service is included in the Complex Comprehensive Acute Care Hospital Discharge Health Service Code.
- 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 performed after the patient physically leaves the hospital.

Specialty Restriction
GENP

Location
LO=HOSP, FN=INPT

Revised March 31, 2020 – See April 2020 Bulletin for updated information

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

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 must make every effort to communicate (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
- Not reportable in the walk-in clinic setting.

A complex care patient is defined as:

- A patient with multiple (two or more) chronic conditions

Billing Guidelines

ADON Restricted to:

03.03 Office visit
03.03A Geriatric Office Visit (for patients age 65+)
03.03E Adults with Developmental Disabilities

- Reportable only if the visit occurs in the primary care physician's office or the patient's 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.
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver by the physician or their office staff within 2 business days of discharge must be documented in the health record. If unsuccessful, the reason must be documented in the health record.
- 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 – Supervision of long-term anticoagulant therapy.
- Maximum of 4 claims per physician per patient per year.

Specialty Restriction
GENP
Location
LO=OFFC, HOME

Revised March 31, 2020 – See April 2020 Bulletin for updated information

Category	Code	Description	Base Units
ADON	03.03P	**First Visit after In-Patient Hospital Discharge – Maternal and Newborn Care** 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 must make every effort to communicate with the patient and/or caregiver within 2 business days of discharge. • 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's home within 14 calendar days after hospital discharge (consider discharge date as Day zero).Every effort to establish communication with the patient and/or caregiver by the physician ortheir office staff within 2 business days of dischargemust be documented in the health record. If unsuccessful, the reason must be documentedin the health record. 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** GENP **Location** LO=OFFC, HOME	10 MSU

Category	Code	Description	Base Units
ADON	HOVM1	**Blended Mileage and travel detention for Home Visits (1 multiple = 1 km)** This health service code is added on to a home visit health service code when the physician must travel to the patient's home in order to provide clinical services to a homebound patient. **Billing Guidelines** Text for the claim must include: • the start and finish time of the visit • point of origin • destination address • the distance in kilometers maximum MU=70 **Specialty Restriction** GENP **Multiples** 1 MU = 1 km, maximum multiples = 70 **Location** LO=HOME	0.46 MSU + MU

BILLING REMINDERS

Endoscopy transurethral electro-resection (HSC 72.1B)
Physicians are reminded that health service codes 69.0A cystoscopy with removal of foreign body/calculus, 01.34A cystoscopy with or without catheterization of ureters, and 01.34B cystoscopy with urethral dilation, cannot be claimed in the same encounter as 72.1B –endoscopy transurethral electro-resection, and vice versa.

Insertion of indwelling urinary catheter by Urologist
Health service code 69.94 – Insertion of indwelling urinary catheter performed by urologists cannot be claimed with any other procedures during the same encounter.

Clarification Health Service Codes 03.03Q Scheduled Specialist Telephone Management/Follow-up with Patient and 03.03R Scheduled Family Physician Telephone Management/Follow-Up with Patient

HSC 03.03Q and 03.03R were introduced earlier this year.

HSC 03.03Q may be reported for a scheduled 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 **for the same condition by the same provider or another provider within the same group practice**.

This service is not reported if the outcome of the scheduled 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.

A group practice is defined as the arrangement whereby two or more physicians are in practice, and each physician maintains and has access to medical records and histories of the patients.

HSC 03.03R may be reported for a scheduled 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 by the same provider or another provider within the same group practice.**

A group practice is defined as the arrangement whereby two or more physicians are in practice, and each physician maintains and has access to medical records and histories of the patients.

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 an 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 of the patient is not required.

The patient population eligible must be either 65 years and older or be suffering from mental illness or multiple (two or more) chronic diseases.

Chronic disease is defined as:
• A condition expected to last at least 12 months or until the death of the patient
• The chronic condition must place the patient at significant risk of acute exacerbation/decompensation, functional decline, or death

Mental illness is defined as:
• 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.

Both HSC 03.03Q and 03.03R have complex billing guidelines and documentation requirements and physicians are urged to review the May 18, 2017 MSI Bulletin to familiarize themselves with these before claiming these HSCs.

Scenarios:

Q: I am a cardiologist whose office practice is co-located with another cardiologist. My colleague saw Mrs. Green two days ago with increasing dyspnea due to congestive heart failure. May I claim HSC 03.03Q for a follow-up telephone call with her?
A: As noted above, you may only claim this HSC if she has not been seen by you or another physician in your group within the past 7 days. As your office colleague saw her two days ago, you may not claim HSC 03.03Q for a follow-up telephone call.

Q: I am a family physician. My longstanding patient, Mr. Blue, was recently admitted to our local hospital with pneumonia. I was away and one of my office colleagues cared for him and discharged him 5 days ago. Today, he has called looking to discuss some new GI symptoms. May I claim HSC 03.03R?
A: As this is a different problem from the one your office colleague provided care for 5 days ago, you may claim HSC 03.03R provided all other billing guidelines and documentation requirements have been satisfied.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
AD068	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE HSC 03.03P HAS PREVIOUSLY BEEN PAID.
AD069	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST CLAIM AN APPROPRIATE OFFICE VISIT BEFORE CLAIMING THIS ADD ON FEE FOR THE SAME ENCOUNTER.
AD070	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED THIS FIRST VISIT AFTER DISCHARGE ADD ON FEE FOR THIS PERIOD.
AD071	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED THIS FIRST VISIT AFTER DISCHARGE ADD ON FEE THE MAXIMUM OF FOUR TIMES IN THE PAST YEAR.
AD072	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED A MONTHLY CARE FEE IN THE SAME CALENDAR MONTH.
AD073	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED HSC 03.03S IN THE SAME CALENDAR MONTH.
AD076	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE HSC 03.03P CANNOT BE CLAIMED FOR PATIENT AGES 1-10.
DE029	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR CARE PLAN OVERSIGHT OR LONG TERM CARE CLINICAL GERIATRIC ASSESSMENT HAS PREVIOUSLY BEEN MADE FOR THIS PATIENT DURING THE SAME CALENDAR MONTH.
DE030	SERVICE ENCOUNTER HAS BEEN REFUSED A CLAIM FOR CARE PLAN OVERSIGHT HAS PREVIOUSLY BEEN MADE FOR THIS PATIENT DURING THE SAME CALENDAR MONTH.
DE031	SERVICE ENCOUNTER HAS BEEN DISALLOWED. WHEN BOTH A CLINICAL GERIATRIC ASSESSMENT AND CARE PLAN OVERSIGHT FEE HAVE BEEN CLAIMED FOR A PATIENT IN THE SAME CALENDAR YEAR, THE SECOND CGA FEE REQUIRES TEXT EXPLAINING NECESSITY. PLEASE RESUBMIT THIS CLAIM WITH TEXT REFERRING TO THE NECESSITY OF THIS SERVICE.

Code	Description
GN099	SERVICE HAS BEEN DISALLOWED, INSERTION OF THE INWELLING URINARY CATHETER CAN NOT BE CLAIMED WITH ANY OTHER PROCEDURE FEES DURING THE SAME ENCOUNTER
MJ060	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A CLAIM FOR CYSTOSCOPY HAS ALREADY BEEN SUBMITTED FOR THIS PATIENT AT THE SAME ENCOUNTER. IF AN ADDITIONAL CYSTOSCOPIC PROCEDURE IS REQUIRED PLEASE RESUBMIT WITH SUPPORTING TEXT.
MJ061	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED HSC 72.1B AT THE SAME ENCOUNTER. IF AN ADDITIONAL CYSTOSCOPIC PROCEDURE IS REQUIRED PLEASE RESUBMIT WITH SUPPORTING TEXT.
VA045	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS HSC 50.99A AND 69.94 REQUIRE TEXT INDICATING WHY THE INTRAVENOUS/CATHETER INSERTION WAS PERFORMED BY THE PHYSICIAN
VA082	SERVICE HAS BEEN DISALLOWED, INSERTION OF THE INWELLING URINARY CATHETER CAN NOT BE CLAIMED WITH ANY OTHER PROCEDURE FEES DURING THE SAME ENCOUNTER
VA083	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED HSC 72.1B AT THE SAME ENCOUNTER. IF AN ADDITIONAL CYSTOSCOPIC PROCEDURE IS REQUIRED PLEASE RESUBMIT WITH SUPPORTING TEXT.
VT142	SERVICE ENCOUNTER HAS BEEN REFUSED AS A DAILY HOSPITAL VISIT RATE FOR THE MOST RESPONSIBLE PHYSICIAN HAS ALREADY BEEN CLAIMED FOR THE PATIENT ON THIS DAY.
VT143	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE DA=DA23 MODIFIER MAY ONLY BE USED ON THE 2ND AND 3RD ADMISSION DATES (OR DAYS OUT OF ICU).
VT144	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE DA=DA47 MODIFIER MAY ONLY BE USED ON THE 4TH TO 7TH ADMISSION DATES (OR DAYS OUT OF ICU).
VT145	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED A VISIT SERVICE FOR THIS PATIENT ON THE SAME DAY.
VT146	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED THE ACUTE CARE HOSPITAL DISCHARGE DAY MANAGEMENT VISIT FEE FOR THIS PATIENT ON THE SAME DAY.
VT154	SERVICE HAS BEEN DISALLOWED, RESUBMIT AS A LIMITED VISIT, A SUBSEQUENT COMPREHENSIVE VISIT OR RESUBMIT PROVIDING ELECTRONIC TEXT EXPLAINING THE MEDICAL NECESSITY OF AN INITIAL COMPREHENSIVE VISIT WITHIN 30 DAYS OF A PREVIOUS VISIT

UPDATED FILES

Updated files reflecting changes are available for download on Friday November 17, 2017. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT), explanatory codes (EXPLAIN.DAT), and modified values (MODVALS.DAT).

HELPFUL LINKS

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2018 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE	SALARY CONTRACT PAY PERIOD
December 20, 2017**	**December 27, 2017****	January 3, 2018	December 15-28, 2017
January 8, 2018	January 11, 2018	January 17, 2018	December 29, 2017 – January 11, 2018
January 22, 2018	January 25, 2018	January 31, 2018	January 12-25, 2018
February 5, 2018	February 8, 2018	February 14, 2018	January 26-February 8, 2018
February 16, 2018**	February 22, 2018	February 28, 2018	February 9-22, 2018
March 5, 2018	March 8, 2018	March 14, 2018	February 23-March 8, 2018
March 19, 2018	March 22, 2018	March 28, 2018	March 9-22, 2018
April 2, 2018	April 5, 2018	April 11, 2018	March 23-April 5, 2018
April 16, 2018	April 19, 2018	April 25, 2018	April 6-19, 2018
April 30, 2018	May 3, 2018	May 9, 2018	April 20-May 3, 2018
May 11, 2018**	**May 16, 2018****	May 23, 2018	May 4-17, 2018
May 28, 2018	May 31, 2018	June 6, 2018	May 18-31, 2018
June 11, 2018	June 14, 2018	June 20, 2018	June 1-14, 2018
June 22, 2018**	**June 27, 2018****	July 4, 2018	June 15-28, 2018
July 9, 2018	July 12, 2018	July 18, 2018	June 29-July 12, 2018
July 23, 2018	July 26, 2018	August 1, 2018	July 13-26, 2018
August 3, 2018**	August 9, 2018	August 15, 2018	July 27-August 9, 2018
August 20, 2018	August 23, 2018	August 29, 2018	August 10-23, 2018
August 31, 2018**	September 6, 2018	September 12, 2018	August 24-September 6, 2018
September 17, 2018	September 20, 2018	September 26, 2018	September 7-20, 2018
September 28, 2018**	**October 3, 2018****	October 10, 2018	September 21-October 4, 2018
October 15, 2018	October 18, 2018	October 24, 2018	October 5-18, 2018
October 29, 2018	November 1, 2018	November 7, 2018	October 19-November 1, 2018
November 9, 2018**	November 15, 2018	November 21, 2018	November 2-15, 2018
November 26, 2018	November 29, 2018	December 5, 2018	November 16-29, 2018
December 10, 2018	December 13, 2018	December 19, 2018	November 30-December 13, 2018
December 19, 2018**	**December 24, 2018****	January 2, 2019	December 14-27, 2018
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, Sessional Payments and Locum Claim Forms. 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.

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PLEASE NOTE, THE ** INDICATES A DATE VARIATION

Please make a note in your schedule of the following dates MSI will accept as "Holidays".	
NEW YEAR'S DAY	MONDAY, JANUARY 1, 2018
HERITAGE DAY	MONDAY, FEBRUARY 19, 2018
GOOD FRIDAY	FRIDAY, MARCH 30, 2018
EASTER MONDAY	MONDAY, APRIL 2, 2018
VICTORIA DAY	MONDAY, MAY 21, 2018
CANADA DAY	MONDAY, JULY 2, 2018
CIVIC HOLIDAY	MONDAY, AUGUST 6, 2018
LABOUR DAY	MONDAY, SEPTEMBER 3, 2018
THANKSGIVING DAY	MONDAY, OCTOBER 8, 2018
REMEMBRANCE DAY	MONDAY, NOVEMBER 12, 2018
CHRISTMAS DAY	TUESDAY, DECEMBER 25, 2018
BOXING DAY	WEDNESDAY, DECEMBER 26, 2018
NEW YEAR'S DAY	TUESDAY, JANUARY 1, 2019

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Season's
Greetings
From the staff of MSI Programs

PHYSICIAN'S BULLETIN

October 18, 2017: Vol. LVII, ISSUE 10

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

This special bulletin is being issued in order to introduce the new Health Service Codes that will replace the Comprehensive Care Incentive Program (CCIP) which ends, as negotiated in the current Master Agreement, on October 31, 2017.

The purpose of the introduction of these new codes is to transition from an incentive based payment to a health service code based payment for primary care physicians.

Codes will be effective November 1, 2017, Physicians are asked to hold these claims until November 17, 2017 at which time the codes will be implemented into the MSI system and made available for billing.

In regard to the Health Service Codes with fee value adjustments, physicians are asked to continue billing these codes, and a retroactive payment will be provided at a later date for claims billed between November 1, 2017 and November 17, 2017.

NEW FEES

Effective November 17, 2017 the following health service codes will be available for billing:
Physicians are asked to hold these claims until November 17, 2017.

Revised March 31, 2020 – See future 2020 Bulletin for updated information

Category	Code	Description	Base Units
DEFT	CPO1	**CPO Nursing Home, Residential Care Facility, or Hospice** A) B) Supervision of care for a nursing home, residential care facility, or hospice patient **Billing Guidelines** • Do not report with other telephone service or non face to face codes such as: ○ 13.99C Supervision of long-term anticoagulant therapy - in the same calendar month. ○ ENH1 Long Term Care Medication Review - in the same calendar year. **Specialty Restriction** GENP **Location** LO=NRHM, Residential Care Facility, or Hospice	 15 MSU 30 MSU

Category	Code	Description	Base Units
VIST	03.03	**Subsequent Daily Hospital Visit (LO=HOSP, FN=INPT, DA= DA23 or DA=DA47)** A) Days 2, 3, and first day out of ICU (DA=DA23) B) Days 4 – 7 (DA=DA47) These adjusted MSU values apply to health service code 03.03 LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, a subsequent limited visit provided to patients admitted to hospital where the family doctor is the most responsible physician. **Billing Guidelines** • May only be claimed once per patient per day by the most responsible physician (MRP). First day out of ICU should be considered equivalent to day 2 and subsequent inpatient days as 3,4,5,6,7 for the purpose of reporting these increased code values. **Specialty Restriction** GENP **Location** LO=HOSP, FN=INPT	 23 MSU 19 MSU

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

The comprehensive 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. Every effort is to be 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 reported 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 Most Responsible Physician (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 Free) may not be claimed as the service is included in the Complex Comprehensive Acute Care Hospital Discharge Health Service Code.
- 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 performed after the patient physically leaves the hospital.

Specialty Restriction
GENP
Location
LO=HOSP, FN=INPT

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Category	Code	Description	Base Units
ADON	03.03S	**First Visit After Acute Care In-Patient Hospital Discharge – Complex Care** 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 must make every effort to communicate (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge. • Not reportable in the walk-in clinic setting. A complex care patient is defined as: • A patient with multiple (two or more) chronic conditions **Billing Guidelines** ADON Restricted to: 03.03 Office visit 03.03A Geriatric Office Visit (for patients age 65+) 03.03E Adults with Developmental Disabilities • Reportable only if the visit occurs in the primary care physician's office or the patient's 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. • Communication (direct contact, telephone, electronic) with the patient and/or caregiver by the physician or their office staff within 2 business days of discharge must be documented in the health record. If unsuccessful, the reason must be documented in the health record. • 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 – Supervision of long-term anticoagulant therapy. • Maximum of 4 claims per physician per patient per year. **Specialty Restriction** GENP **Location** LO=OFFC, HOME	10 MSU

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Category	Code	Description	Base Units
ADON	03.03P	**First Visit after In-Patient Hospital Discharge – Maternal and Newborn Care** 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 must make every effort to communicate with the patient and/or caregiver within 2 business days of discharge. • 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's home within 14 calendar days after hospital discharge (consider discharge date as Day zero). Every effort to establish communication with the patient and/or caregiver by the physician or their office staff within 2 business days of discharge must be documented in the health record. If unsuccessful, the reason must be documented in the health record. 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** GENP **Location** LO=OFFC, HOME	10 MSU

Category	Code	Description	Base Units
ADON	HOVM1	**Blended Mileage and travel detention for Home Visits (1 multiple = 1 km)** This health service code is added on to a home visit health service code when the physician must travel to the patient's home in order to provide clinical services to a homebound patient. **Billing Guidelines** Text for the claim must include: • the start and finish time of the visit • point of origin • destination address • the distance in kilometers maximum MU=70 **Specialty Restriction** GENP **Multiples** 1 MU = 1 km, maximum multiples = 70 **Location** LO=HOME	0.46 MSU + MU

*Refer to preamble change in relation to the definition of homebound patients and home visit travel fee

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FEE ADJUSTMENTS

Physicians are asked to continue billing these codes, and a retroactive payment will be provided at a later date for claims billed between November 1, 2017 and November 17, 2017.

Category	Code	Description	Base Units
VIST	Select 03.03 and 03.04 codes	**Fee Adjustments for Home Visits** These adjusted health service code values apply to a homebound patient where the physician must travel to the patient's home in order to provide the clinical service. **Adjusted Fee Values** 03.03 - Home Visit 0800-1700 03.03 - Home Visit 1701-2359, weekends and holidays 03.03 - Home Visit 0000-0800 03.03 - Home Visit emergency 03.03 - Home Visit extra patient 03.03 - Home Visit extra patient aged 65 years and older 03.04 - Home Complete examination **Specialty Restriction** GENP **Location** LO=HOME	 36 MSU 47.8 MSU 64.7 MSU 59.5 MSU 13 MSU 16.5 MSU 40.6 MSU

*Refer to preamble change in relation to the definition of homebound patients and home visit travel fee

Category	Code	Description	Base Units
VIST	03.04	**First Examination – Newborn Care Healthy Infant** This adjusted fee applies to health service code 03.04 LO=HOSP, FN=INPT, RO=NBCR, RP=INTL, an initial comprehensive visit provided to a healthy newborn in hospital by the family doctor. **Specialty Restriction** GENP **Location** LO=HOSP, FN=INPT	24 MSU

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Category	Code	Description	Base Units
MISG		These 3 adjusted fee values apply to health services provided by GENP only:	
	98.22	**Suture of skin and subcutaneous tissue of other sites**	20 MSU
	98.22A	**Suture of simple wounds or lacerations – child`s face**	25 MSU
	98.03	**Other incision with drainage of skin and subcutaneous tissue (AN = LOCL)**	10 MSU
		These 2 HSCs will be termed and other pre-existing HSC used:	
	98.04A	**Suture minor laceration with removal of foreign body**	Term
	98.22E	**Suture minor lacerations or simple wounds**	Term
		98.04A and 98.22E are replaced by: 98.22D Suture minor laceration or foreign body wound 20 MSU **Specialty Restriction** GENP	

PREAMBLE CHANGES

Definition of a Homebound Patient

Current Definition	New Definition
Rules Specific to Location (5.1.44) c) A Home Visit: Is a service rendered by a physician to a patient or patients following travel to the patient's home. The patient or patient's representative must request the physician to visit. A home visit may only be claimed when the patient's condition or situation justifies the service. If the nature of the patient's condition requires periodic scheduled home visits, a daily home visit can be claimed. (5.1.48)	**Rules Specific to Location (5.1.44)** c) A Home Visit: Is a service rendered by a physician to a **homebound** patient or patients following travel to the patient's home. The patient or patient's representative has requested a visit with the physician. A home visit may only be claimed when the patient's condition or situation justifies the service and the patient is homebound. A patient is considered to be homebound when one or more of the following conditions are met and documented in the health record: I. Leaving the home isn't recommended because of the patient's condition; II. The patient's condition keeps him or her from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person); III. Leaving home takes a considerable and taxing effort. If the patient is not considered homebound, the visit is considered to be rendered at home for convenience. In this situation, the visit may be claimed at the normal office visit rate and travel may not be claimed.

As per Preamble 1.1.36 "All claims submitted to MSI must be verifiable from the patient records associated with the services claimed and be billed in accordance with the Preamble." Therefore, physicians must document within the clinical record, e.g. in the CPP/Problem List the specific circumstances that have led to the patient being deemed homebound.

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Home Visit Travel Fee

Current Definition	New Definition
Services, supplies and other materials provided through the physician's office when such supplies are not normally considered part of office overhead (2.2.37) • Mileage or travelling time except as defined in (See Section 5(5.1.67)) relating to detention time or blended mileage/travel detention for acute home care home visits. (2.2.43) • For patients registered in acute home care, physicians may claim blended mileage/travel detention to compensate for travel expenses and time incurred for home visits. This fee does not apply to patients registered in the chronic home care program. Blended mileage/travel detention will be reimbursed only for those home visits initiated by the care coordinator or health care professionals of Home Care Nova Scotia. The mileage/travel detention fee is a blended rate based on kilometers travelled for the round trip. The distance in kilometers should be entered in the multiple field of the service encounter. A record should be kept in your office of the starting and destination points. (2.2.44)	• Mileage or travelling time except as defined in (See Section 5(5.1.67)) relating to detention time or blended mileage/travel detention for acute home care home visits, or for home visits. (2.2.43) • For patients registered in acute home care, physicians may claim blended mileage/travel detention to compensate for travel expenses and time incurred for home visits. This fee does not apply to patients registered in the chronic home care program. Blended mileage/travel detention will be reimbursed only for those home visits initiated by the care coordinator or health care professionals of Home Care Nova Scotia. • Mileage for home visits will be reimbursed only when a visit has been requested by the patient or patient's representative and the patient is considered homebound. The mileage/travel detention fee is a blended rate based on kilometers travelled for the round trip. Text for the claim must include: the start and finish time of the visit, point of origin, destination address, and the distance in kilometers. The distance in kilometers should be entered in the multiple field of the service encounter. A record should be kept in the physician's office of the starting and destination points. (2.2.44)

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

UPDATED FILES

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PHYSICIAN'S BULLETIN

September 22, 2017: Vol. LVI, ISSUE 9

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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★ Fees New Fees and Highlighted Fees

HIGHLIGHTED FEES

Provincial Immunization Changes

Effective September 22, 2017, the following immunization health service codes have been revised:

HSC	Modifier	Description
13.59L	RO=MMAR	MMR - Measles, Mumps, Rubella Vaccine Billing Guidelines This vaccine can only be billed if the first and second doses are given at least 4 weeks apart, and if the patient was born after January 1, 1970. If the 2nd injection is given within this 4 week period, the claim will be refused. Patient can only receive 2 doses per lifetime. Non-immune postpartum women are eligible to receive extra dose(s) as necessary. An explanation for the additional dose(s) must be added to the text field of the claim.
13.59L	RO=MENC	Men-C-C – Meningococcal conjugate Billing Guidelines This vaccine cannot be billed if the patient's birthdate is before January 1, 2004. Patients are eligible between 12 months to less than 5 years of age. An explanation for the addition of a high risk modifier must be added to the text field of the claim.

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BILLING REMINDERS

Catheter Insertion (HSC 69.94)

Physicians are reminded that HSC 69.94; insertion of indwelling urinary catheter, should only be claimed as a stand-alone procedure. Physicians may only claim for insertion of a catheter when they have personally performed the service. Preamble Rule 1.1.19 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. Text will be required on all claims explaining the reason why the physician had to personally perform the catheter insertion.

Electromyography or Nerve Conduction Studies (HSC 07.08A, 07.08B, 07.08C)

Physicians are reminded the above codes are used when the appropriate studies are performed as part of a diagnostic work-up. It is not appropriate to use these codes as proxies for intraoperative nerve integrity testing. Such testing is considered an integral part of surgical procedures performed near vital nerve structures.

Anaesthesia Modifier Clarification

Reminder on the intended use of Controlled Hypotension CO=CHYO:

The use of controlled hypotension is intended for longer cases with excessive bleeding to minimize blood loss and reduce the need for transfusions provided there are no contraindications for this technique. Also it is intended for specific cases in order to optimize surgical view. MSI requires explanatory text when claiming for controlled hypotension.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
AD074	SERVICE ENCOUNTER HAS BEEN REFUSED AS PATIENT IS 5 YEARS OF AGE OR OVER.
AD075	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS TEXT IS REQUIRED INDICATING THE NEED FOR ADDITIONAL DOSES OF THE MMAR VACCINE.
MA073	CLAIM FOR RADICAL NECK DISSECTION HAS BEEN REFUSED AS IT IS NOT PAYABLE AT THE SAME ENCOUNTER AS A GLOSSECTOMY, PAROTIDECTOMY OR FLOOR OF MOUTH TUMOUR CODES. COMPOSITE FEES EXIST THAT SHOULD BE USED INSTEAD.
MA074	CLAIM FOR GLOSSECTOMY, PAROTIDECTOMY OR FLOOR OF MOUTH TUMOUR HAS BEEN REFUSED AS IT IS NOT PAYABLE AT THE SAME ENCOUNTER AS A RADICAL NECK DISSECTION. COMPOSITE FEES EXIST THAT SHOULD BE USED INSTEAD.
MA075	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOUR SPECIALTY IS NOT APPROVED TO BILL THIS SERVICE. IF THE EXPLORATION OF A PERIPHERAL NERVE HAS BEEN DONE AS A SEPARATE AND DISTINCT PROCEDURE, THE SERVICE CAN BE SUBMITTED AS EC WITH TEXT AND INCLUDE THE OPERATIVE REPORT WHICH WILL BE REVIEWED PRIOR TO PAYMENT.
VT153	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS AN URGENT VISIT APPLIES WHEN A PHYSICIAN TRAVELS TO SEE A REGISTERED INPATIENT AT THE REQUEST OF HOSPITAL STAFF. PREAMBLE 5.1.54. RESUBMIT WITH TEXT STATING THE NECESSITY OF THE SERVICE AND TRAVEL DETAILS.

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PHYSICIAN'S BULLETIN

August 25, 2017: Vol. LV, ISSUE 8

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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★ Fees New Fees and Highlighted Fees

NEW INTERIM FEES (2015-2019 MASTER AGREEMENT)

Mindfulness-Based Cognitive Therapy (MBCT)

As of August 25, 2017 eligible services can now be submitted for dates of service July 28, 2017 onward. Physicians have 90 days from the date of this Bulletin to submit these claims. Please contact MSI directly for detailed instructions on how to submit these outdated eligible services.

PLEASE NOTE: **Physicians eligible to claim this code are restricted to PSYC trained in MBCT or GENP trained in group psychotherapy and MBCT.** Credentials must be submitted to MSI directly. Once MSI receives a physician's credentials and grants approval, the physician will be permitted to claim for this fee after the next system update. **Once the physician has contacted MSI with their credentials, the physician is advised to hold their claims until the next system update**.

Category	Code	Description	Base Units
PSYC	**08.44A**	**Mindfulness-Based Cognitive Therapy (MBCT)** **Group therapy fee per patient per two hour session (minimum 8 to maximum 12 patients per group)** MBCT is defined as a specific psychological intervention incorporating elements of cognitive behavioural therapy and mindfulness. This fee is for each two hour session of the eight week MBCT course provided for a group of 8 to 12 patients with recurrent episodes of depression. **Billing Guidelines** Fee is per patient, per two hour session. Session dates and start/stop times must be documented in the health record of each participant. One series of 8 sessions per patient per 365 days.	14.3MSU

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Category	Code	Description	Base Units
		Additional fees may be charged to the patient for non-billable services such as the provision of course materials and for the services of a privately paid non-MD therapist if applicable. **Specialty restriction** • GENP with approval from MSI. • PSYC with approval from MSI. Physicians approved to report this HSC will be required to provide proof that they have completed a minimum five day intensive training in MBCT for MBCT providers within the last five years (for example, a seven day retreat in Mind-Body Medicine from the Centre for Mindfulness in Medicine, Health Care and Society or equivalent), and attest to an ongoing personal mindfulness practice. GENP will, in addition to the above, need to provide evidence of training in the provision of group psychotherapy from a recognized training program and of ongoing practice in mental health and group therapy. PSYC are considered to have had training in the provision of group psychotherapy through their respective residency programs. Start and stop time to be documented in health record; however session outline and activities are standardized to be completed in 2 hours. **Location** LO=OFFC, HOSP, OTHR	

INTERIM FEES MADE PERMANENT

Effective August 25, 2017, the following interim fees have been made permanent.

Category	Code	Description	Base Units	Anaes Units
MASG	65.59D	**Total Abdominal Wall Reconstruction with myofascial advancement flaps** This is a comprehensive fee for the repair of a massive, complex abdominal wall hernia. The procedure includes the reduction of the hernia, all lysis of adhesions, and bowel resection as required, removal of pre-existing mesh as required, rectus muscle mobilization, fascial bipartition with component separation, with or without placement of mesh or biologic graft, and skin excision. Operative report and record of operation must be submitted with billing claim. **Billing Guidelines** Not to be billed with lysis of adhesions, bowel resection or any other intra-abdominal procedure same patient same day. Payment calculated based on “skin to skin” operating time as documented in the record of operation. **Please note** that as per the July 2014 bulletin, the operative report and record of operation must be submitted with the billing claim. **Specialty Restriction** GNSG, PLAS **Location** HOSP	IC at 130 MSU per hour	8+T

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NEW AND UPDATED EXPLANATORY CODES

Code	Description
AN006	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE CONSECUTIVE ANAESTHETIC HEALTH SERVICE CODE CLAIMED DOES NOT MATCH FIRST ANAESTHETIC HEALTH SERVICE CODED. PLEASE RESUBMIT USING THE CORRECT HEALTH SERVICE CODE.
GN096	PRE PAYMENT REVIEW. PLEASE SUBMIT DOCUMENTATION TO FURTHER ASSIST IN ASSESSING THIS CLAIM.
GN097	SERVICE ENCOUNTER HAS BEEN DISALLOWED. ENSURING THE FUNCTIONAL INTEGRITY OF VITAL STRUCTURES DURING A SURGICAL PROCEDURE IS INCLUDED IN THE SURGICAL HSC.
GN098	SERVICE ENCOUNTER HAS BEEN DISALLOWED. THERE WAS NO SEPARATE AND DISTINCT SURGICAL SERVICE. THE HSC CLAIMED WAS PART OF ANOTHER PAID SERVICE ENCOUNTER.
MA072	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.12 WAS BILLED AT THE SAME ENCOUNTER AND IS A COMPONENT OF THIS PROCEDURE.
NR086	REQUEST FOR READJUDICATION HAS BEEN REFUSED. DELETE THIS SUBMISSION AND SUBMIT A NEW SERVICE ENCOUNTER BASED ON THE INFORMATION YOU HAVE PROVIDED.
PC035	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM OF 8 SESSIONS FOR MINDFULNESS BASED COGNITIVE THERAPY IN A 365 DAY PERIOD HAS BEEN REACHED.
PP024	SERVICES PROVIDED BY A NON-PHYSICIAN ARE NOT INSURED. (EX. CHIROPRACTOR, PHYSIOTHERAPIST, PAC-PHYSICIANS ASSISTANT, PODIATRIST, NURSE PRACTITIONER).
VA080	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 27.72, 27.72B, 27.73, 27.73A OR 27.73B WAS BILLED AT THE SAME ENCOUNTER AND INCLUDES THIS PROCEDURE.
VA081	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A CLAIM FOR 51.95 RP=INTL HAS ALREADY BEEN CLAIMED FOR THIS PATIENT.
VT152	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THE TEXT DOES NOT WARRANT PAYMENT OF A COMPREHENSIVE VISIT, PLEASE RESUBMIT AS A LIMITED VISIT.

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

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UPDATED FILES

Updated files reflecting changes are available for download on Friday August 25, 2017. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT) and, explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

CONTACT INFORMATION

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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

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PHYSICIAN'S BULLETIN

August 4, 2017: Vol. LIV, ISSUE 6

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT UPDATE

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been applied to the listed WCB specific fees for fiscal years 2015-16 and 2016-17.

Due to the increase in CPI for fiscal year April 1st, 2015 - March 31st, 2016 any of the WCB specific services listed below provided over this time will have their values retroactively increased by 1.74%. Physicians will be remunerated for the outstanding value of any services rendered over this period via a onetime payment on August 2, 2017.

Also due to the further increase in CPI for fiscal year April 1st, 2016- January 26th, 2017 any of the WCB specific services listed below provided over this time will have their values retroactively increased by a cumulative 2.137% (1.74% for 2015-2016, 0.39% for 2016-2017). Physicians will also be remunerated for the outstanding value of any services rendered over this period via a one-time payment on August 2, 2017.

CODE	DESCRIPTION	VALUE
WCB12	EPS physician assessment Service. Combined office visit and completion of Form 8/10 For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15 minute increments to a maximum of 1 additional hour	**Initial visit:** $174.93 + $51.11 per 15 minutes to a maximum 4x (RO=EPS1 and RP=INTL) **Subsequent visit:** $174.93 (RO=EPS1 and RP=SUBS)
WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable	GPs.....$42.72 per 15 min EPS(RO=EPS1)$51.11 per 15 min Specialists.....$57.49 per 15 min
WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable	GPs.....$42.72 per 15 min EPS(RO=EPS1)$51.11 per 15 min Specialists.....$57.49 per 15 min
WCB17	Photocopies of Chart Notes	10 pgs or less (ME=UP10)..$25.56 11-25 pgs (ME=UP25).....$51.11 26-50 pgs (ME=UP50)..... $102.17 Over 50 pgs (ME=OV50)...$153.25
WCB20	Carpal Tunnel Syndrome (CTS) Assessment Report	$65.56
WCB21	Follow-up visit report	$38.33
WCB22	Completed Mandatory Generic Exemption Request Form	$12.80 per form
WCB23	Completed Non-Opioid Special Authorization Request Form	$12.80 per form
WCB24	Completed Opioid Special Authorization Request Form	$42.96 per form
WCB25	Completed WCB Substance Abuse Assessment Form	$28.62
WCB26	Return to Work Report – Physician's Report Form 8/10	$65.56
WCB27	Eye Report	$57.49
WCB28	Comprehensive Visit for Work Related Injury or Illness	$65.96

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MEDICAL ASSISTANCE IN DYING (MAID)

The MAID fees are currently interim while data is gathered. They are categorized as independent consideration (IC) and have no automatic MSU value in the system. Each claim submitted is held by MSI and manually adjudicated based on the information provided by the submitter in the claim text. As this is an interim fee the collection of data is important in considering a permanent fee in the future.

Claims will be processed independently of other physicians involved in the MAID services. This means that health service codes for the first, second and prescribing physicians will be reviewed as received and not held waiting for other MAID claims. All other applicable billing guidelines will apply in the processing of these health service codes.

Fees New Fees and Highlighted Fees

NEW INTERIM FEES (2015-2019 MASTER AGREEMENT)

Mindfulness-Based Cognitive Therapy (MBCT)

Physicians are asked to hold these claims until notified that they may be submitted for payment.

PLEASE NOTE: **Physicians eligible to claim this code are restricted to PSYC trained in MBCT or GENP trained in group psychotherapy and MBCT.** Credentials must be submitted to MSI directly. Once MSI receives a physician's credentials and grants approval, the physician will be permitted to claim for this fee after the next system update. **Once the physician has contacted MSI with their credentials, the physician is advised to hold their claims until the next system update**.

Category	Code	Description	Base Units
PSYC	**08.44A**	**Mindfulness-Based Cognitive Therapy (MBCT)** **Group therapy fee per patient per two hour session (minimum 8 to maximum 12 patients per group)** MBCT is defined as a specific psychological intervention incorporating elements of cognitive behavioural therapy and mindfulness. This fee is for each two hour session of the eight week MBCT course provided for a group of 8 to 12 patients with recurrent episodes of depression. **Billing Guidelines** Fee is per patient, per two hour session. Session dates and start/stop times must be documented in the health record of each participant. One series of 8 sessions per patient per 365 days. Additional fees may be charged to the patient for non-billable services such as the provision of course materials and for the services of a privately paid non-MD therapist if applicable.	14.3MSU

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Category	Code	Description	Base Units
		Specialty restriction • GENP with approval from MSI. • PSYC with approval from MSI. Physicians approved to report this HSC will be required to provide proof that they have completed a minimum five day intensive training in MBCT for MBCT providers within the last five years (for example, a seven day retreat in Mind-Body Medicine from the Centre for Mindfulness in Medicine, Health Care and Society or equivalent), and attest to an ongoing personal mindfulness practice. GENP will, in addition to the above, need to provide evidence of training in the provision of group psychotherapy from a recognized training program and of ongoing practice in mental health and group therapy. PSYC are considered to have had training in the provision of group psychotherapy through their respective residency programs. Start and stop time to be documented in health record and also in the text field of the claim to MSI. However session outline and activities are standardized to be completed in 2 hours. **Location** LO=OFFC, HOSP, OTHR	

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BILLING CLARIFICATIONS

The following communication is to clarify information published in the May 18, 2017 MSI Physicians Bulletin regarding Ophthalmology Services. As a reminder, the Preamble and related MSI Physicians Bulletins are the authority for the proper interpretation of the fee schedule. All inquiries on appropriate billing should be directed to MSI.

Vision Screening for Type 2 Diabetes

As per the Canadian Diabetes Association guidelines for vision screening, effective April 1 2017, residents with type 2 diabetes will only be eligible for a complete eye examination every 2 years. Residents with type 1 diabetes and residents with type 2 diabetes and retinopathy will be eligible for a complete eye examination every year. Diagnosis must be confirmed in the resident's medical chart.

Clarification: The information posted was to bring awareness to the Canadian Diabetes Association's vision screening guidelines which will be applied to Nova Scotia's optometry benefits. The change to Nova Scotia's optometry benefits was done in consultation with the Nova Scotia Association of Optometrists, the Diabetes Care Program of Nova Scotia and an Ophthalmologist practicing in Nova Scotia. There have been no changes applied to the policy for vision screening provided by physicians; physicians should continue to provide vision screening as medically required.

Cataract Surgery

Ophthalmologic surgeons are reminded that monitoring of intraocular pressure is a part of the customary operative or post-operative care when providing cataract surgery. Health Service Code 03.12 should not be reported in addition.

Clarification: This would apply only to the day of surgery and not over the remainder of the postoperative period.

Trabeculectomy and Trabeculoplasty

Health service codes for Trabeculectomy (HSC 26.25, 26.25B, 26.25C and 26.25D) and trabeculoplasty (HSC 26.29D and 26.29E) are for invasive major surgical procedures and as such may only be claimed for services provided in an operating room.

Clarification: Physicians may continue to bill HSC 26.29D Trabeculoplasty in an office or hospital setting. The May bulletin reminder still applies to the Trabeculectomy codes. These procedures must be performed in an operating room.

BILLING REMINDERS

Complete care codes

As per Physician's Manual Preamble section 7.4.1, 'Complete care codes are minor surgical procedures, which include the visit the same day and related visits by the same physician for 14 days following the procedure'.
Counselling related to the procedure cannot be claimed during this period.

Other repair and plastic operations on trachea, tracheal splint, transthoracic

HSC 43.69 other repair and plastic operations on trachea, tracheal splint, transthoracic may only be claimed by GNSG and THSG.

Exploration of peripheral nerve

17.5A – Exploration of peripheral nerve transplant or nerve transposition with or without neurolysis (excluding median nerve at carpal tunnel) is only to be claimed when the surgery is performed on peripheral nerves. This code may not be used for operations on cranial nerves.

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Surgical access

Physicians are reminded that procedures used to provide the surgical exposure (e.g.-laparoscopy, sinusoscopy, cystoscopy, etc.) necessary to perform a definitive procedure are included in the surgical HSC and may not be claimed separately. As per Physician's Manual Preamble section 5.3.71, '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; e.g. a laparotomy is not to be claimed to provide access to the abdominal cavity except when no definitive procedure is performed within the abdomen. When one physician provides surgical exposure for a procedure performed by a physician in another specialty, the exposure and definitive procedures may be claimed separately by the respective physicians.'

Surgical procedure claims

Physicians are reminded that it is not appropriate to claim for parts of a procedure that would normally be considered the defined technique. Procedures such as ligation of blood vessels to prevent hemorrhage, that are performed as preventative measures are considered to be part of the defined technique. As per Physician's Manual Preamble section 5.3.68, 'Procedural codes and their associated tariff are intended to remunerate the physician for all parts of the procedure that would normally be considered the defined technique for that procedure. It is not appropriate to deconstruct (unbundle) the procedure into constituent parts and bill MSI for these codes in addition to the procedural codes.'

Composite fee

Physicians are reminded to use composite fees that were devised to encompass several procedures that are commonly performed together rather than claiming the procedures separately. As per Physician's Manual Preamble section 5.3.68, 'Procedural codes and their associated tariff are intended to remunerate the physician for all parts of the procedure that would normally be considered the defined technique for that procedure. It is not appropriate to deconstruct (unbundle) the procedure into constituent parts and bill MSI for these codes in addition to the procedural codes.'

Example:

When a partial glossectomy is accompanied by a radical neck dissection the code that should be claimed is 37.1A-hemiglossectomy plus radical neck dissection.

It is not appropriate to claim code 37.1 and in addition claim one of the following codes; 52.32, 52.32A, 52.33, 52.33A.

Comprehensive visits

Comprehensive Visits (HSC 03.04) may be claimed when medical necessity exists for a physician to conduct an in-depth evaluation of a patient due to the seriousness, complexity or obscurity of the patient's complaints or medical condition. It includes ensuring a complete history is recorded in the medical record and performing a physical examination appropriate to the physician's specialty and the working diagnosis.

As has been outlined in previous Bulletins, documentation of **all** of the following provides a clear indication that a comprehensive visit has taken place:

1. A detailed patient history including:
    - Relevant history of presenting complaint
    - Relevant past medical and surgical history
    - Medication list
    - Allergies
    - Family history, as appropriate
    - Social history, as appropriate

2. A complete physical exam including:
    - A complete physical examination, appropriate to the physician's specialty and relevant to the presenting complaint.
    - Documentation describing the pertinent positive and negative findings of the physical examination. It is not adequate to indicate that the "physical exam is normal" without indicating what was examined.

In situations in which these criteria are not met, it would be appropriate to claim the visit as a limited visit i.e. HSC 03.03.

Preamble rules also stipulate that a comprehensive visit may not be claimed within 30 days of a previous limited or comprehensive visit. However, a subsequent comprehensive visit service may be claimed by the specialties of internal medicine, neurology, and paediatrics.

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These three specialties – internal medicine, neurology and paediatrics – have two types of comprehensive visits available to them for services provided in the office i.e. Initial and Subsequent. An Initial Comprehensive Visit may be claimed provided **all** of the above requirements above are met, **and** the patient is being seen for a new condition or complication of an existing condition. If the patient is not being seen for a new condition or complication of an existing condition, an initial visit may not be claimed and either a subsequent 03.04 or 03.03 should be claimed, depending on whether the requirements above have been satisfied.

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It is not appropriate to claim either an initial or subsequent 03.04 for all follow-up visits after 30 days have passed; the requirements noted above must be satisfied

Non-Face to Face Health Service Codes (HSCs 03.09K, 03.09L, 03.03Q, 03.03R)

Upon review of the new non-face to face HSCs which were implemented April 1, 2017 MSI has noted that some claims were for services ineligible to be claimed using these HSCs. Common errors included the following:

- The telephone call was not scheduled;
- The purpose of the call was to provide a prescription renewal;
- The purpose of the call was to inform the patient of the results of diagnostic investigations with no change in management plan.
- The service was claimed when the decision is to see the patient at the next available appointment in the office.

The requirements for claiming these HSCs were outlined in previous MSI Bulletins. Once again, physicians are asked to carefully review these requirements to be sure they are in compliance. If services have been claimed that are not in compliance, please delete these claims.

Physicians and their billing clerks are asked to carefully review the requirements for these new Health Service codes before submitting them.

QUESTION AND ANSWER

New Non-Face to Face Health Service Codes (HSCs 03.09K, 03.09L, 03.03Q, 03.03R)

Q: I am a specialist in a tertiary care centre. A family physician phones me to discuss a patient with an urgent problem but there was no written request. Does this mean I cannot claim HSC 03.09K Specialist Telephone Advice (Consultant Physician)?

A: Provided the family physician sends the written request before or on the day of the call – including after the telephone call – you may claim this service using HSC 03.09K. As a reminder, the telephone call needs to be scheduled.

Q: I regularly speak by telephone with the radiologists at my local hospital to discuss my patients' imaging results and obtain advice on planning future imaging studies. Can HSCs 03.09K/03.09L be used for these calls?

A: Telephone calls with radiologists may not be claimed using these HSCs. The intent of the telephone consultation HSCs is to replace an in-person consultation with the specialist and calls to relay the results of imaging studies or plan future studies do not satisfy that intent.

Q: Can I claim HSC 03.09K/03.09L for providing advice to a psychologist or if I ask a psychologist for advice?

A: HSCs 03.09K and 03.09L are for telephone consultations between physicians. The only exception is that a Nurse Practitioner may also request consultation advice from a specialist physician. Telephone consultations with psychologists may not be claimed.

Q: When claiming HSC 03.03Q Scheduled Specialist Telephone Management/Follow-up with Patient or 03.03R Scheduled Family Physician Telephone Management/Follow-Up with Patient do I need to inform the patient of the scheduled time of the call?

A: Yes, you need to schedule the call with the patient and advise them of the time of the call just as you would for an in-person appointment.

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Q: I am a specialist in a tertiary care centre. Because of the nature of my subspecialty, I look after patients from other Maritime provinces. Can I claim HSCs 03.09K and 03.03Q for these patients?

A: Yes, you may claim these HSCs for these patients. However, in the case of the consultation codes, the referring physician or Nurse Practitioner in the other province cannot claim the referring practitioner code i.e. HSC 03.09L.

Q: A referral arrived from a family physician asking me to see a patient. After reviewing the referral, I was certain that I could sort out the questions the family physician had over the phone, saving the patient a two hour drive. Can I claim 03.09K in these circumstances or does the family physician have to have requested a telephone rather than an in-person consultation?

A: You may claim 03.09K under these circumstances, provided you've met the other requirements for the HSC, including scheduling the call with the family physician.

Q: I am a family physician. I referred my patient to a specialist several months ago. However, his clinical condition has worsened and he needs to be seen by the specialist urgently. Can I claim 03.09L if I call the specialist to ask for a sooner appointment?

A: HSCs 03.09K and 03.09L cannot be claimed when the purpose of the call is to expedite an in-person assessment; the intent of the telephone consultation is to replace an in-person consultation.

Q: I am a billing clerk for a family doctor. How do I claim for calling a patient with their test results?

A: When calling patients concerning the results of diagnostic investigations HSC 03.09R (and 03.09Q for specialists) may only be claimed when there is a change in the management plan for the patient. As a reminder, the call must be made by the physician personally and not delegated to neither office staff nor medical trainees such as residents.

Q: Can 03.09K be used when a specialist is requesting advice from a GP?

A: HSC 03.09K requires the physician providing the advice to be a specialist. A specialist is defined as one whose name appears in the specialist register of the College of Physicians & Surgeons of Nova Scotia.

Q: As a family physician, can I claim both 03.03 and 03.09L on the same day for the same patient?

A: Yes, it's recognized that in some circumstances you will see a patient with an urgent problem who requires a consultation with a specialist the same day. In those circumstances, you may claim for your visit with the patient and additionally for a scheduled telephone consultation with the specialist that day. As a reminder, you are required to send a written referral to the specialist for the consultation service.

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HELPFUL LINKS

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PHYSICIAN'S BULLETIN
July 18, 2017: Vol. LIII, ISSUE 5

NOVA SCOTIA MEDICAL SERVICES INSURANCE

ELIGIBLE MASTER AGREEMENT PAYMENTS

Canadian Medical Protective Association ("CMPA") Assistance Payment and Other Eligible Master Agreement Related Payments

Canadian Medical Protective Association ("CMPA") Assistance Payment

The Department of Health and Wellness (through MSI) will provide reimbursement of all eligible CMPA premium fees, directly to eligible physicians. This is a new process, as in the past, reimbursement was provided from Doctors Nova Scotia.

Reimbursement of eligible CMPA premium fees for the period covering January 1, 2017 up to and including June 30, 2017 will be deposited through an electronic funds transfer on the next regularly scheduled MSI payment date – July 19, 2017.

Should you have any questions regarding this payment, please send them to masteragreement@novascotia.ca.

PHYSICIAN'S BULLETIN

May 18, 2017: Vol. LII, ISSUE 4

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

VISION SCREENING FOR TYPE 2 DIABETES

As per the Canadian Diabetes Association guidelines for vision screening, effective April 1 2017, residents with type 2 diabetes will only be eligible for a complete eye examination every 2 years. Residents with type 1 diabetes and residents with type 2 diabetes and retinopathy will be eligible for a complete eye examination every year. Diagnosis must be confirmed in the resident's medical chart.

INTERPROVINCIAL RECIPROCAL BILLING

Service providers may be required to render medical services to patients from other provinces within Canada who are visiting or travelling within Nova Scotia. Effective April 1, 1988, all provinces and territories, except Quebec, agreed to participate in a reciprocal billing agreement under which a service provider would submit service encounters directly to their own provincial medical plan for eligible Canadian patients. Attached is a sample of Valid Insured Health Services Plan Cards for Reciprocal Billing. Please see Preamble section 2.4.0 for detailed Reciprocal Billing Agreement information, including eligibility criteria.

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INTERIM FEES MADE PERMANENT

Effective May 18, 2017, the following interim fees have been made permanent.

Category	Code	Description	Base Units
CONS	03.09I	**Anatomic Pathology Consultation** **Diagnostic Consultation, with review of records and specimens, with report on referred material prepared elsewhere.**	45 MSU
CONS	03.09J	**Anatomic Pathology Consultation** **Special Diagnostic Consultation, with review of records and specimens, with report on referred material and requiring preparation of additional slides, and/or ordering and interpretation of special tests.**	60 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.**	20 MSU
VEDT	03.38C	**Interpretation of Spirometry Pre and Post Bronchodilator** *(Revised March 31,2020 – See May 2020 Bulletin for updated information)*	10 MSU
VEDT	03.38D	**Six Minute Walk Test, interpretation, when this is the sole procedure.**	2 MSU
VEDT	05.99A	**Immunofluorescence, interpretation of any and all markers required for diagnosis; any method.**	30 MSU
VEDT	05.99B	**Molecular testing, interpretation of any and all analyses/tests required for diagnosis; any method.**	40 MSU

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NEW INTERIM FEES (2015-2019 MASTER AGREEMENT)

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New Health Service Codes for Non-Face to Face Services

Eligible services can now be submitted for dates of service April 1, 2017 onward. Physicians have 90 days from the date of this Bulletin to submit these claims. Please contact MSI directly for detailed instructions on how to submit these outdated eligible services.

Physicians and their billing clerks are asked to carefully review the requirements for these new Health Service codes before submitting them.

The new non face-to-face HSCs will replace HSCs 03.03F, 03.03I, 03.09D, 03.09E and 03.09F and therefore physicians should, effective March 31, 2017, cease using them. Services that would have been submitted using these discontinued HSCs should be held and claimed using the new HSCs.

Category	Code	Description	Base Units
CONS	**03.09K**	**Specialist Telephone Advice – Consultant Physician – Providing Advice**	25 MSU
CONS	**03.09L**	**Specialist Telephone Advice – Referring Physician – Requesting Advice**	11.5 MSU

This health service code may be reported for a two-way telephone (or other synchronous electronic verbal communication) regarding the assessment and management of the patient but without the consulting physician seeing the patient.

The referring physician may be a family physician or other specialist seeking an expert opinion from the consulting physician due to the complexity and severity of the case and with the intent of continuing to provide the patient's care closer to home. The consultant specialist may also receive requests for advice from a nurse practitioner.

The referring physician (or NP) must submit a written request for an elective consultation to the specialist. The specialist will schedule a 15 minute telephone call with the referring provider. There must be by a two-way verbal communication discussing the clinical situation followed by a management decision and a written report from the specialist to the referring provider.

For urgent consultations that do not result in transfer of the patient, the telephone call and the written request to the specialist may occur on the same day.

The written referral and the formal consultation report must be available in the patient's medical record; both the referring physician (or NP) and the specialist must maintain copies of both documents. Both medical records must include the date and time of the service and any contemporaneous notes, in addition to the written documents.

The service is reportable by the specialist for a new patient or an established patient with a new condition or an exacerbation of an existing condition.

Billing Guidelines
The HSC includes a review of the patient's history, family history and history of present complaint, and a review of any laboratory data, PACS images, medical records or other data as needed to provide advice.

The health service includes a discussion of the physical findings as reported by the referring provider.

If subsequent phone calls are necessary within 14 days to complete the consultation they are considered included in the HSC for the telephone consultation.

The Consultant Physician HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.

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Category	Code	Description	Base Units

The Referring Physician HSC may be reported when the telephone call for an urgent consultation occurs on the same day as the patient visit that generated the consultation.

The HSC is not reportable when the purpose of the communication is to:

- Arrange transfer
- Arrange a hospital bed for the patient
- Arrange a telemedicine consultation
- Arrange an expedited face to face consultation
- Arrange a laboratory, other diagnostic test or procedure
- Inform the referring physician of the results of diagnostic investigations
- Decline the request for a consultation or transfer the request to another physician

The service is not reportable for other forms of communication such as:

- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

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 health professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student

The service is not reportable by the consulting physician if the patient has had a face to face visit with the consultant or any member of his/her call group within the previous 14 days for the same condition or if the telephone consultation results in a face to face service within the next 14 days or the next available appointment of the consultant.

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

The service is not reportable for calls between a referring provider and specialist in the same institution or practice location.

Documentation Requirements

- A written referral must be sent to the specialist and be available in the patient's medical record.
- Both the specialist consultant and the referring provider must document the patient name, identifying data and date and start and stop time of the call in their respective charts or EMRs.
- The names of the referring physician (or NP) and the consultant physician must be documented by both physicians.
- The diagnosis, reason for referral, elements of the history and physical as relayed by the referring provider, the opinion of the consultant physician and the plan for future management must be documented.
- A written report must be sent to the referring provider by the specialist consultant.
- The referring physician's billing number must be noted on the electronic MSI service Report (claim).
- The specialist must enter the date of the receipt of the referral in the text field on the MSI service report (claim).
- Both physicians must submit the start and stop time of the call in the text field on the MSI service report (claim).
- There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service.

Location
LO=OFFC

Note
As these codes replace HSCs 03.09E, 03.09F, 03.09D these three codes will be termed on implementation of these health services codes.

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Category	Code	Description	Base Units
VIST	**03.03Q**	**Scheduled Specialist Telephone Management/Follow-up with Patient** This health service code may be reported for a scheduled 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 scheduled 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 scheduled telephone (or 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 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 a management decision. The HSC is reportable for scheduled telephone appointments only. The specialist physician must have seen and examined the patient within the preceding 9 months. The HSC is reportable 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 • Provide a prescription renewal • 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 not reportable for other forms of communication such as: • Written, e-mail or fax communication • Electronic verbal forms of communication that are not PHIA compliant 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 two way 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 understands and acknowledges the information provided.	11.5 MSU

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Category	Code	Description	Base Units
		• 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 on the MSI service report (claim). • There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service. **Location** LO=OFFC **Note** As this HSC replaces HSCs 03.03F and 03.03I these will be termed on implementation of this health service code.	

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Revised March 31, 2020 – See May 2020 Bulletin for updated information

Category	Code	Description	Base Units
VIST	**03.03R**	**Scheduled Family Physician Telephone Management/Follow-Up with Patient** This health service code may be reported for a scheduled 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 an 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 of the patient is not required. The patient population eligible must be either 65 years and older or be suffering from mental illness or multiple (two or more) chronic diseases. Chronic disease is defined as: Mental illness is defined as: • 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 scheduled telephone (or synchronous electronic verbal communication) between the family physician and the patient (or the patient's parent, guardian or proxy as established by written consent). Telephone management requires 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 a management decision. The HSC is reportable for scheduled telephone appointments only. The family physician must have seen and examined the patient within the preceding 9 months. The HSC is reportable a maximum of 4 times per patient per physician 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.	11.5 MSU

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Category	Code	Description	Base Units

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
- Arranging to provide a sick note
- 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 not reportable for other forms of communication such as:

- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant
-

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 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.
- For patient initiated appointment requests that result in a telephone management service on the same day, the following text should be entered in the MSI text field:
  Same day access
- The start and stop time of the call must be included in the text field on the MSI service report (claim).
- There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service.

Location
LO=OFFC

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BILLING REMINDERS

Methadone Management Health Service Codes

Physicians are reminded that methadone treatment and management health service codes are reportable only by the physician most responsible for the ongoing care of the patient inclusive of the patient's substance use disorder and concurrent medical conditions. These health service codes are not reportable by physicians providing methadone management alone.

Cataract Surgery

Ophthalmologic surgeons are reminded that monitoring of intraocular pressure is a part of the customary operative or post-operative care when providing cataract surgery. Health Service Code 03.12 should not be reported in addition.

Percutaneous Ureteroscopy with ultrasonic lithotripsy and/or ureteroscopy with electrohydraulic lithrotripsy (HSC 68.95B)

Procedural codes remunerate physicians for all aspects of the procedure that would normally be considered part of the defined technique for that procedure. Preamble rules prohibit unbundling procedural codes into constituent parts and claiming for them separately.

HSC 68.95B Percutaneous ureteroscopy with ultrasonic lithotripsy and/or ureteroscopy with electrohydraulic lithotripsy should not be claimed with any of the following as all are inherent parts of this procedure:

- HSC 68.95C ureteroscopy plus basket,
- HSC 68.99A removal of J-stent including cystoscopy, or
- HSC 68.99C calibration and/or dilation of ureter – one/both sides

Trabeculectomy and Trabeculoplasty

Health service codes for Trabeculectomy (HSC 26.25, 26.25B, 26.25C and 26.25D) and trabeculoplasty (HSC 26.29D and 26.29E) are for invasive major surgical procedures and as such may only be claimed for services provided in an operating room.

Suture of Lacerations (HSC's 98.22, 98.22A, 98.22B, 98.22D and 98.22E)

These health service codes may be claimed when suturing of lacerations is provided as a stand-alone procedure. These HSCs may not be claimed where skin suturing is an integral aspect of another procedure such as removal of a cutaneous lesion.

Multiples for these HSCs may only be claimed when multiple lacerations are sutured. It is not appropriate to claim multiples for each suture.

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NEW AND UPDATED EXPLANATORY CODES

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Code	Description
GN092	SERVICE ENCOUNTER HAS BEEN REFUSED AS TEXT IS REQUIRED FOR NON FACE TO FACE SERVICES.
GN093	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY BILLED A NON FACE TO FACE SERVICE FOR THIS PATIENT ON THE SAME DAY.
GN094	YOU HAVE BILLED FOR A NON FACE TO FACE SERVICE AND WE ARE REQUESTING THE SUPPORTING DOCUMENTATION TO AID IN THE EVALUATION OF THIS CLAIM.
GN095	SERVICE ENCOUNTER HAS BEEN REDUCED TO THE APPROPRIATE FEE FOR THE SERVICE PROVIDED.
MA072	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 27.72, 27.72B, 27.73, 27.73A, OR 27.73B HAS ALREADY BEEN BILLED AT THE SAME ENCOUNTER AND IS A COMPONENT OF THIS PROCEDURE.
VA080	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.12 IS A COMPONENT OF THIS PROCEDURE.
VT147	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PATIENT MUST HAVE PREVIOUSLY BEEN SEEN FOR A FACE TO FACE ENCOUNTER BY THIS PROVIDER WITHIN THE LAST 9 MONTHS.
VT148	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.09K MAY NOT BE BILLED IN ADDITION TO ANY OTHER SERVICE FOR THIS PATIENT ON THE SAME DAY.
VT149	SERVICE ENCOUNTER HAS BEEN REFUSED AS CALLS BETWEEN A REFERRING PROVIDER AND SPECIALIST IN THE SAME INSTITUTION OR PRACTICE LOCATION ARE NOT PERMITTED FOR THIS SERVICE.
VT150	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED FOR SPECIALIST TELEPHONE ADVICE FOR THIS PATIENT WITHIN THE PREVIOUS 14 DAYS WHICH INCLUDES ANY SUBSEQUENT CALLS NECESSARY TO COMPLETE THE CONSULTATION.
VT151	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE ALREADY BILLED A FACE TO FACE VISIT FOR THIS PATIENT IN THE PREVIOUS 14 DAYS.

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UPDATED FILES

Updated files reflecting changes are available for download on Thursday May 18, 2017. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT) and, explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

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

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NOVA SCOTIA

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PHYSICIAN'S BULLETIN

March 24, 2017: Vol. LII, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT/ANAESTHESIA UNIT CHANGE

Effective April 1, 2017, the Medical Service Unit (MSU) value will be increased from $2.42 to $2.44 and the Anaesthesia Unit (AU) value will be increased from $20.55 to $20.76.

PSYCHIATRY FEES

Effective April 1, 2017 the hourly Psychiatry rate for General Practitioners will increase to $111.66 while the hourly rate for Specialists increases to $151.40 as per the tariff agreement.

SESSIONAL PAYMENTS

Effective April 1, 2017 the hourly Sessional rate for General Practitioners will increase to $146.40 while the hourly rate for Specialists increases to $170.80 as per the tariff agreement.

WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC

Effective April 1, 2017 the Workers' Compensation Board MSU Value will increase from $2.69 to $2.71 and the Workers' Compensation Board Anaesthetic Unit Value will increase from $22.83 to $23.07.

WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT UPDATE

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been calculated to the listed WCB specific fees for fiscal year 2017-18.

Due to the increase in CPI for 2016, all of the WCB specific services listed below will have their values increased by 1.24% effective April 1st, 2017:

CODE	DESCRIPTION	NEW VALUE
WCB12	EPS physician assessment Service. Combined office visit and completion of Form 8/10 For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15 minute increments to a maximum of 1 additional hour	**Initial visit:** $177.10 + $51.76 per 15 minutes to a maximum 4x(RO=EPS1 and RP=INTL) **Subsequent visit:** $177.10 (RO=EPS1 and RP=SUBS)
WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable	GPs……$43.25 per 15 min EPS(RO=EPS1)……..$51.76 per 15 min Specialists……$58.21 per 15 min
WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable	GPs……$43.25 per 15 min EPS(RO=EPS1)……..$51.76 per 15 min Specialists……$58.21 per 15 min
WCB17	Photocopies of Chart Notes	10 pgs or less (ME=UP10)……....$25.88 11-25 pgs (ME=UP25)……$51.76 26-50 pgs (ME=UP50)……$103.44 Over 50 pgs (ME=OV50).....$155.15
WCB20	Carpal Tunnel Syndrome (CTS) Assessment Report	$66.37
WCB21	Follow-up visit report	$38.81
WCB22	Completed Mandatory Generic Exemption Request Form	$12.98 per form
WCB23	Completed Non-Opioid Special Authorization Request Form	$12.98 per form
WCB24	Completed Opioid Special Authorization Request Form	$43.50 per form
WCB25	Completed WCB Substance Abuse Assessment Form	$28.97
WCB26	Return to Work Report – Physician's Report Form 8/10	$66.37
WCB27	Eye Report	$58.21
WCB28	Comprehensive Visit for Work Related Injury or Illness	$66.80

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NEW FEES

Effective March 24, 2017 the following health service code will be available for billing:

Category	Code	Modifier	Description	Base Units
VADT	03.19H	**RO=INTP**	**Corneal Topography of both eyes for corneal disease (not refractive eye surgery)** Physician interpretation of computerised corneal topography for; • Central corneal ulcer • Corneal dystrophy, bullous keratopathy, and complications of transplanted cornea • Diagnosis and monitoring of keratoconus and pellucid marginal corneal degeneration • Corneal astigmatism **Billing Guidelines** • Post corneal transplant-maximum 6 per patient per year. • Fee includes both eyes, whether one at a time or on two separate visits • For keratoconus and pellucid degeneration where progressive changes greater than 1 diopter in a year has been documented this HSC is payable twice per year per patient. • Not payable for pre or postoperative cataract patients except where there is evidence of irregular astigmatism • Not payable when done in association with laser refractive surgery or the pre or postoperative care of these patients with laser refractive surgery **Specialty Restriction** OPHT With Fellowship in Corneal Disease **Location** LO=OFFC, LO=HOSP	5.8 MSU

Effective March 24, 2017 the following health service code will be available for billing:

Category	Code	Description	Base Units	ANAES Units
MASG	97.79A	**Masculinization of the Female Chest** Complete masculinization of the chest wall for the surgical treatment of gender dysphoria to include bilateral subcutaneous mastectomy, nipple-areolar repositioning, chest contouring and initial scar camouflage as required. **Billing Guidelines** • Must have prior approval by MSI. • Not to be billed with any other mastectomy, nipple or breast reconstruction or tissue shift codes. **Specialty Restriction** PLAS **Location** LO=HOSP	IC at 110MSU/hr	4+T

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Effective March 24, 2017 the following health service code will be available for billing:

Revised March 31, 2020 – See May 2020 Bulletin for updated information

Category	Code	Modifier	Description	Base Units	ANAES Units
MASG	57.6D	**RO=FPHN** **RO=SPHN**	**Total proctocolectomy with ileostomy and abdominal perineal resection** 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. * This fee is replacing health service code 57.6A - Enterectomy with colostomy, caecostomy or ileostomy, which was termed for March 23, 2017. **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 Colostomy • 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: • 1.24C 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 **Premium** No – but may submit OR Report and Record of Operation for manual assessment if service is provided in premium time for medical necessity **Assistant** Reportable only when RO=SPHN is not reported **Specialty Restriction** GNSG, RO=SPHN also restricted to GNSG **Location** LO=HOSP	550MSU 400MSU	8+T

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NEW INTERIM FEES (2015-2019 MASTER AGREEMENT)

New Health Service Codes for Non-Face to Face Services

In the coming weeks, a number of new Health Service Codes will be available to physicians for select non-face to face services rendered on or after April 1, 2017. Physicians are asked to hold these claims until notified that they may be submitted for payment. An update regarding submission dates will be published in the next MSI Physician's Bulletin on May 18, 2017.

Physicians and their billing clerks are asked to carefully review the requirements for these new Health Service codes before submitting them.

The new non face-to-face HSCs will replace HSCs 03.03F, 03.03I, 03.09D, 03.09E and 03.09F and therefore physicians should, effective March 31, 2017, cease using them. Services that would have been submitted using these discontinued HSCs should be held and claimed using the new HSCs.

Category	Code	Description	Base Units
VIST	**03.09K**	**Specialist Telephone Advice – Consultant Physician – Providing Advice**	25 MSU
VIST	**03.09L**	**Specialist Telephone Advice – Referring Physician – Requesting Advice**	11.5 MSU

This health service code may be reported for a two-way telephone (or other synchronous electronic verbal communication) regarding the assessment and management of the patient but without the consulting physician seeing the patient.

The referring physician may be a family physician or other specialist seeking an expert opinion from the consulting physician due to the complexity and severity of the case and with the intent of continuing to provide the patient's care closer to home. The consultant specialist may also receive requests for advice from a nurse practitioner.

The referring physician (or NP) must submit a written request for an elective consultation to the specialist. The specialist will schedule a 15 minute telephone call with the referring provider. There must be by a two-way verbal communication discussing the clinical situation followed by a management decision and a written report from the specialist to the referring provider.

For urgent consultations that do not result in transfer of the patient, the telephone call and the written request to the specialist may occur on the same day.

The written referral and the formal consultation report must be available in the patient's medical record; both the referring physician (or NP) and the specialist must maintain copies of both documents. Both medical records must include the date and time of the service and any contemporaneous notes, in addition to the written documents.

The service is reportable by the specialist for a new patient or an established patient with a new condition or an exacerbation of an existing condition.

Billing Guidelines
The HSC includes a review of the patient's history, family history and history of present complaint, and a review of any laboratory data, PACS images, medical records or other data as needed to provide advice.

The health service includes a discussion of the physical findings as reported by the referring provider.

If subsequent phone calls are necessary within 14 days to complete the consultation they are considered included in the HSC for the telephone consultation.

The Consultant Physician HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.

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The Referring Physician HSC may be reported when the telephone call for an urgent consultation occurs on the same day as the patient visit that generated the consultation.

The HSC is not reportable when the purpose of the communication is to:

- Arrange transfer
- Arrange a hospital bed for the patient
- Arrange a telemedicine consultation
- Arrange an expedited face to face consultation
- Arrange a laboratory, other diagnostic test or procedure
- Inform the referring physician of the results of diagnostic investigations
- Decline the request for a consultation or transfer the request to another physician

The service is not reportable for other forms of communication such as:

- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

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 health professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student

The service is not reportable by the consulting physician if the patient has had a face to face visit with the consultant or any member of his/her call group within the previous 14 days for the same condition or if the telephone consultation results in a face to face service within the next 14 days or the next available appointment of the consultant.

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

The service is not reportable for calls between a referring provider and specialist in the same institution or practice location.

Documentation Requirements

- A written referral must be sent to the specialist and be available in the patient's medical record.
- Both the specialist consultant and the referring provider must document the patient name, identifying data and date and start and stop time of the call in their respective charts or EMRs.
- The names of the referring physician (or NP) and the consultant physician must be documented by both physicians.
- The diagnosis, reason for referral, elements of the history and physical as relayed by the referring provider, the opinion of the consultant physician and the plan for future management must be documented.
- A written report must be sent to the referring provider by the specialist consultant.
- The referring physician's billing number must be noted on the electronic MSI service Report (claim).
- The specialist must enter the date of the receipt of the referral in the text field on the MSI service report (claim).
- Both physicians must submit the start and stop time of the call in the text field on the MSI service report (claim).
- There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service.

Location
LO=OFFC

Note
As these codes replace HSCs 03.09E, 03.09F, 03.09D these three codes will be termed on implementation of these health services codes.

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Category	Code	Description	Base Units
VIST	**03.03Q**	**Scheduled Specialist Telephone Management/Follow-up with Patient** This health service code may be reported for a scheduled 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 scheduled 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 scheduled telephone (or 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 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 a management decision. The HSC is reportable for scheduled telephone appointments only. The specialist physician must have seen and examined the patient within the preceding 9 months. The HSC is reportable 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 • Provide a prescription renewal • 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 not reportable for other forms of communication such as: • Written, e-mail or fax communication • Electronic verbal forms of communication that are not PHIA compliant 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 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 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 on the MSI service report (claim). • There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service. **Location** LO=OFFC **Note** As this HSC replaces HSCs 03.03F and 03.03I these will be termed on implementation of this health service code.	11.5 MSU

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Category	Code	Description	Base Units
VIST	**03.03R**	**Scheduled Family Physician Telephone Management/Follow-Up with Patient**	11.5 MSU

This health service code may be reported for a scheduled 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 an 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 of the patient is not required.
The patient population eligible must be either 65 years and older or be suffering from mental illness or multiple (two or more) chronic diseases.

Mental illness is defined as:
- 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 scheduled telephone (or synchronous electronic verbal communication) between the family physician and the patient (or the patient's parent, guardian or proxy as established by written consent).
Telephone management requires 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 a management decision.
The HSC is reportable for scheduled telephone appointments only. The family physician must have seen and examined the patient within the preceding 9 months.
The HSC is reportable a maximum of 4 times per patient per physician 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:
- Arrange a face to face appointment
- Notify the patient of an appointment
- Prescription renewal
- Arranging to provide a sick note
- 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 not reportable for other forms of communication such as:
- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

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 medical discussion.

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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.
- For patient initiated appointment requests that result in a telephone management service on the same day, the following text should be entered in the MSI text field:
  Same day access
- The start and stop time of the call must be included in the text field on the MSI service report (claim).
- There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service.

Location
LO=OFFC

Billing Matters Billing Reminders, New Explanatory Codes

BILLING REMINDERS

Complete Hearing Tests
Physicians are reminded that health service code 09.41D complete hearing testing includes pure tone audiometry (air and bone), tympanometry, and a speech test, and all components must be performed to claim this fee.

Laser Treatment of Malignant Neoplasms of Esophagus, Bronchi, etc. in Addition to Scope
Physicians are reminded that health service code 44.0A laser treatment of malignant neoplasms of esophagus, bronchi, etc. in addition to scope is an add-on fee and should only be claimed after an appropriate base fee for bronchoscopy or esophagoscopy is paid.

Pap Smears
Physicians are reminded that health service code 03.26A pap smear may not be claimed in addition to a visit, consultation or procedure for a gynaecological or obstetrical diagnosis, nor is it payable in addition to a complete physical exam.

Hemodialysis
Physicians providing dialysis services are reminded that only one claim per patient may be made for initial hemodialysis i.e. HSC 51.95 RP=INTL

Clinical Records Supporting Claims to MSI
On occasion, MSI requires physicians to provide supporting clinical documentation to verify claims made to MSI. As per Preamble 1.1.36 "All claims submitted to MSI must be verifiable from the patient records associated with the services claimed and be billed in accordance with the Preamble."

Medical Assistance in Dying (MAID)
Physicians are reminded that time spent discussing MAID with legal representatives, the College of Physicians and Surgeons of Nova Scotia, the Canadian Medical Protective Association or other associations not involved in direct patient care cannot be claimed.

The health service code for the second physician (03.03O) cannot be processed if a claim has not been submitted for the role of first physician (03.03M).

The health service code for the prescribing physician (03.03N) cannot be processed if claims have not been made for first and second physician.

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Canadian Medical Protective Association ("CMPA") Assistance Payment and other eligible Master Agreement related payments

*****If you have already taken action, please disregard this communication*****

The 2015-2019 Physician Master Agreement provides funding for reimbursement of eligible physician fees paid to The Canadian Medical Protective Association. As of September 9, 2016, the Department of Health and Wellness (through MSI) will provide compensation directly to all eligible physicians. This is a new process, as in the past, reimbursement was provided from Doctors Nova Scotia. All physicians registered with MSI have been mailed a package on February 15, 2017 to coordinate this process.

To ensure receipt of eligible reimbursement, all physicians are required to complete and submit the business arrangement form. The original deadline was March 17, 2017, but if you have not submitted, please submit as soon as possible. This new business arrangement will be used to process your CMPA payments as well as all other contractual incentive payments under the current Master Agreement. This new process, including the submission of required information to MSI, will allow for a transition away from a cheque based payment to an electronic funds transfer in the near future. You will continue to receive any/all eligible incentive based payments by cheque while we transition to electronic funds transfer.

Should you have any questions, please contact the MSI Provider Coordinators at msiproviders@medavie.bluecross.ca or by telephone 902-496-7011 (toll free: 1-866-553-0585).

Documentation Reminder

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribed, and start and stop times for time based codes.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptions, or emotional problems, the physician "deliberately established a professional relationship with the patient for the purposes of removing, modifying or alleviating existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional well being of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy," etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service on that date, then the service is not paid for or a lesser benefit is given. When the clinical record does not support the service claimed, there will be a recovery to MSI at the time of audit. Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

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NEW EXPLANATORY CODES

Code	Description
AD067	SERVICE ENCOUNTER HAS BEEN REFUSED. RESUBMIT USING THE APPROPRIATE HEALTH SERVICE CODE AND MODIFIER COMBINATION WITH THE PT=RISK MODIFIER AND TEXT EXPLAINING HIGH RISK.
BK060	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE FOLLOWING HSCS I1310, I1312, AND I1313 MAY ONLY BE BILLED ONCE PER PATIENT PER DAY.
GN028	SERVICE ENCOUNTER HAS BEEN DISALLOWED. RESUBMIT INDICATING DURATION OF SERVICE.
GN043	SERVICE ENCOUNTER HAS BEEN DISALLOWED. RESUBMIT INDICATING THE START AND FINISH TIME FOR THE PROCEDURE PERFORMED.
GN088	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR HSC 57.6D HAS BEEN APPROVED ON THIS DAY.
GN089	SERVICE ENCOUNTER HAS BEEN DISALLOWED. PLEASE RESUBMIT WITH TEXT INDICATING SPECIFIC AREAS INVOLVED.
GN090	SERVICE ENCOUNTER HAS BEEN DISALLOWED BECAUSE THE PROCEDURE IS NECESSARY TO ALLOW ACCESS/VISUALIZATION TO PERFORM THE SURGERY.
GN091	SERVICE ENCOUNTER HAS BEEN REFUSED. PLEASE RESUBMIT USING THE APPROPRIATE MODIFIER(S).
MI007	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 03.03, 09.02C OR 09.02F ON THIS DAY.
MJ018	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THIS SERVICE REQUIRES ELECTRONIC TEXT OR A PRIOR APPROVAL NUMBER.
MJ021	SERVICE ENCOUNTER HAS BEEN DISALLOWED. RESUBMIT WITH A COPY OF THE OUT PATIENT REPORT TO AID IN THE ADJUDICATION OF YOUR SERVICE ENCOUNTER.
MJ058	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 29.94A, 29.94B AND 29.94C MAY NOT BE CLAIMED TOGETHER AT THE SAME ENCOUNTER.
MJ059	DATE OF SERVICE ON CLAIM DOES NOT MATCH DATE OF SERVICE ON OPERATIVE REPORT.
NR006	SERVICE ENCOUNTER HAS BEEN DISALLOWED. INDICATE ACTUAL PROCEDURE PERFORMED WHEN RESUBMITTING.
NR014	SERVICE ENCOUNTER HAS BEEN DISALLOWED. RESUBMIT WITH A COPY OF THE PATHOLOGY REPORT TO AID IN THE ADJUDICATION OF YOUR SERVICE ENCOUNTER.
NR085	SERVICE ENCOUNTER HAS BEEN PAID AS THE RESULT OF A PRE-PAYMENT ASSESSMENT REVIEW.
OP033	SERVICE ENCOUNTER HAS BEEN REFUSED AS ONE OF THE REQUIRED DIAGNOSTIC CODES (37160,37148,37171,V425) WAS NOT INCLUDED ON THE SERVICE ENCOUNTER.
OP042	SERVICE ENCOUNTER HAS BEEN REFUSED AS AN INITIAL VISIT HAS ALREADY BEEN CLAIMED FOR THIS DIAGNOSIS.
OP043	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS AN ADDITIONAL COMPLETE EXAM HAS ALREADY BEEN APPROVED IN THE PAST YEAR.
OP044	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THIS FEE IS ONLY PAYABLE ONCE EVERY 2 YEARS FOR THE DIAGNOSIS SPECIFIED.

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Code	Description
OP045	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED CORNEAL TOPOGRAPHY THE MAXIMUM OF SIX TIMES FOR THIS PATIENT WITHIN THE PAST YEAR.
OP046	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A PREVIOUS OPTOMETRIC VISION ANALYSIS HAS BEEN APPROVED WITHIN THE PREVIOUS 2 YEARS.
OP047	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED CORNEAL TOPOGRAPHY FOR KERATOCONUS AND PELLUCID DEGENERATION THE MAXIMUM OF TWO TIMES FOR THIS PATIENT WITHIN THE PAST YEAR.
VA047	SERVICE ENCOUNTER HAS BEEN REFUSED. HSC 03.26A AND 03.26C ARE INCLUDED IN THE COMPLETE CARE CODE 81.8 WHICH WAS PREVIOUSLY BILLED FOR THIS PATIENT ON THIS DAY.
VA077	SERVICE ENCOUNTER HAS BEEN DISALLOWED, PLEASE RESUBMIT WITH DOCUMENTATION INDICATING THAT THE SERVICE WAS PROVIDED BY THE PHYSICIAN, NOT ANOTHER PROFESSIONAL.
VA078	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY BILLED AN ESOPHAGOGASTRODUODENOSCOPY CODE AT THE SAME ENCOUNTER.
VA079	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST BILL THE APPROPRIATE BASE FEE FOR BRONCHOSCOPY OR ESOPHAGOSCOPY
VT100	SERVICE ENCOUNTER HS BEEN REFUSED AS A 03.26A OR 03.26C HAS PREVIOUSLY BEEN BILLED FOR THIS PATIENT ON THE SAME DAY.
VT138	SERVICE ENCOUNTER HAS BEEN REFUSED AND CANNOT BE PROCESSED UNTIL AFTER THE FIRST PHYSICIAN CLAIM HAS BEEN RECEIVED AND PROCESSED.
VT139	SERVICE ENCOUNTER HAS BEEN REFUSED AS MSI REQUIRES FIRST AND SECOND PHYSICIAN CLAIMS TO PROCESS THE PRESCRIBING PHYSICIAN CLAIM.
VT140	SERVICE ENCOUNTER HAS BEEN REFUSED AS A MINIMUM OF ONE HALF HOUR MUST BE SPENT FOR MAID FEES TO BE PAYABLE.
VT141	SERVICE ENCOUNTER HAS BEEN REDUCED AS A MAXIMUM OF 2 HOURS IS PAYABLE PER PATIENT FOR THIS HEALTH SERVICE CODE.

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UPDATED FILES

Updated files reflecting changes are available for download on Friday March 24, 2017. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT) and, explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

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

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PHYSICIAN'S BULLETIN
February 16, 2017: Vol. LII, ISSUE 2

NOVA SCOTIA MEDICAL SERVICES INSURANCE

ELIGIBLE MASTER AGREEMENT PAYMENTS

Canadian Medical Protective Association ("CMPA") Assistance Payment and Other Eligible Master Agreement Related Payments

Canadian Medical Protective Association ("CMPA") Assistance Payment and other eligible Master Agreement related payments

The 2015-2019 Physician Master Agreement provides funding for reimbursement of eligible physician fees paid to The Canadian Medical Protective Association. As of September 9, 2016, the Department of Health and Wellness (through MSI) will provide compensation directly to all eligible physicians. This is a new process, as in the past, reimbursement was provided from Doctors Nova Scotia. All physicians registered with MSI will be receiving a package in the mail to coordinate this process.

To ensure receipt of eligible reimbursement, all physicians are required to complete and submit the attached business arrangement form no later than March 17, 2017. This new business arrangement will be used to process your CMPA payments as well as all other contractual incentive payments under the current Master Agreement. This new process, including the submission of required information to MSI, will allow for a transition away from a cheque based payment to an electronic funds transfer in the near future. You will continue to receive any/all eligible incentive based payments by cheque while we transition to electronic funds transfer.

Should you have any questions, please contact the MSI Provider Coordinators at msiproviders@medavie.bluecross.ca or by telephone 902-496-7011 (toll free: 1-866-553-0585).

NOVA SCOTIA MEDICAL SERVICES INSURANCE
P.O. BOX 500 HALIFAX, N.S. B3J 2S1

NOVA SCOTIA

MSI PROVIDER BUSINESS ARRANGEMENT (BA) FORM

(Please complete and return to MSI)

PROVIDER INFORMATION

Service Provider Number (If known): _____ **MSI USE ONLY** *LICENSE No: (NEW PHYSICIAN)* _____

Service Provider Name: _____

Incorporated Name (If applicable): _____

Email Address: _____

Service Provider Address: _____

_____

Phone Number: _____ Fax Number: _____

Please indicate which of the following applies:

☐ 1. **New / Additional Business Arrangement - Same Bank Account

☐ 2. *New Bank Account / New Business Arrangement

BANKING INFORMATION

ONLY BANKING FROM CANADIAN INSTITUTIONS WILL BE ACCEPTED

A LINE OF CREDIT ACCOUNT WILL NOT BE ACCEPTED

Name of Financial Institution: _____

Address: _____

_____

Phone Number: _____

BANK ACCOUNT INFORMATION

Bank Number: _____ Branch: _____ Account: _____

PLEASE ENCLOSE A VOID CHEQUE (COPIES ACCEPTED)

I/We hereby authorize Nova Scotia Medical Services Insurance to make deposits to my/our account at the financial institution described above. I/We will advise MSI of any changes in my/our account information.

Signature: _____ **Please Print Name:** _____

PHYSICIAN'S BULLETIN

January 27, 2017: Vol. LII, ISSUE 1

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT UPDATE

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been applied to the listed WCB specific fees for fiscal years 2015-16 and 2016-17.

Due to the increase in CPI for fiscal year April 1st, 2015 - March 31st, 2016 any of the WCB specific services listed below provided over this time will have their values retroactively increased by 1.74%. Physicians will be remunerated for the outstanding value of any services rendered over this period via a onetime payment in Spring 2017.

Also due to the further increase in CPI for fiscal year April 1st, 2016- January 26th, 2017 any of the WCB specific services listed below provided over this time will have their values retroactively increased by a cumulative 2.137% (1.74% for 2015-2016, 0.39% for 2016-2017). Physicians will also be remunerated for the outstanding value of any services rendered over this period via a one-time payment in Spring 2017.

CODE	DESCRIPTION	VALUE
WCB12	EPS physician assessment Service. Combined office visit and completion of Form 8/10 For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15 minute increments to a maximum of 1 additional hour	**Initial visit:** $174.93 + $51.11 per 15 minutes to a maximum 4x (RO=EPS1 and RP=INTL) **Subsequent visit:** $174.93 (RO=EPS1 and RP=SUBS)
WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable	GPs……..$42.72 per 15 min EPS(RO=EPS1)$51.11 per 15 min Specialists……..$57.49 per 15 min
WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable	GPs……..$42.72 per 15 min EPS(RO=EPS1)$51.11 per 15 min Specialists……..$57.49 per 15 min
WCB17	Photocopies of Chart Notes	10 pgs or less (ME=UP10)..$25.56 11-25 pgs (ME=UP25)……..$51.11 26-50 pgs (ME=UP50)….. $102.17 Over 50 pgs (ME=OV50)...$153.25
WCB20	Carpal Tunnel Syndrome (CTS) Assessment Report	$65.56
WCB21	Follow-up visit report	$38.33
WCB22	Completed Mandatory Generic Exemption Request Form	$12.80 per form
WCB23	Completed Non-Opioid Special Authorization Request Form	$12.80 per form
WCB24	Completed Opioid Special Authorization Request Form	$42.96 per form
WCB25	Completed WCB Substance Abuse Assessment Form	$28.62
WCB26	Return to Work Report – Physician's Report Form 8/10	$65.56
WCB27	Eye Report	$57.49
WCB28	Comprehensive Visit for Work Related Injury or Illness	$65.96

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NON-RESIDENT PHYSICIAN LICENSE

Physicians licensed in Nova Scotia as "non-resident physicians" are asked to notify the MSI Provider Coordinators (msiproviders@medavie.ca) when they return to ensure all billing arrangement numbers are active. This will avoid delay in processing their billings while working in Nova Scotia. MSI will no longer be notified by the College when a physician holding a non-resident license returns to Nova Scotia to provide medical services through MSI

Fees New Fees and Highlighted Fees

FEE CHANGES

Effective January 27, 2017 the following health service code will no longer be active:

Category	Code	Description	Base Units
VADT	09.01B	Ophthalmic tests – plus multiples, if applicable	1 MSU

Billing Matters Billing Reminders, New Explanatory Codes

BILLING REMINDERS

MRI Repeat Sequence

Physicians are reminded that a repeat sequence code cannot be submitted until after the matching base MRI code has been submitted.

Hypnotherapy

Effective April 1, 2017 physicians practicing hypnotherapy must provide proof of current Full Membership in the Canadian Federation of Clinical Hypnosis (CFCH) to bill hypnotherapy. These credentials can be forwarded to MSI_Assessment@medavie.bluecross.ca for review. It has been a longstanding requirement that physicians practicing hypnotherapy require appropriate training equivalent to that provided by the Nova Scotia Society of Clinical Hypnosis. This society no longer exists and membership in the CFCH ensures practitioners are appropriately trained to provide this service.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
AN005	CONSECUTIVE ANAESTHETIST CLAIMS CANNOT BE PROCESSED UNTIL AFTER THE FIRST ANAESTHETIST CLAIM HAS BEEN SUBMITTED. AS PER PREAMBLE 5.2.52
BK053	SERVICE ENCOUNTER HAS BEEN REFUSED AS A REPEAT SEQUENCE CAN ONLY BE CLAIMED AFTER THE MATCHING BASE MULTISECTION MRI FEE IS CLAIMED FOR THE SAME OCCURRENCE. PLEASE CLAIM THE BASE FEE FOR THIS MRI BEFORE SUBMITTING THE REPEAT SEQUENCE CLAIM.
GN051	SERVICE ENCOUNTER HAS BEEN REFUSED AS A SERVICE OCCURRENCE ONE (1) HAS NOT BEEN CLAIMED FOR THIS DAY BY THIS PHYSICIAN.
GN087	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 68.95B AT THE SAME ENCOUNTER.
MA071	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 01.34A, 68.83A, 68.95C, 68.99A OR 68.99C HAS ALREADY BEEN BILLED AT THE SAME ENCOUNTER.
MJ056	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED HEALTH SERVICE CODE 68.95B FOR THIS PATIENT AT THE SAME ENCOUNTER. PLEASE SUBMIT A REASSESS (ACTION CODE R) ALONG WITH THE OR REPORT TO AID IN THE ASSESSMENT OF YOUR CLAIM.
MJ057	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED HEALTH SERVICE CODE 68.0A FOR THIS PATIENT AT THE SAME ENCOUNTER. PLEASE SUBMIT A REASSESS (ACTION CODE R) ALONG WITH A COPY OF THE OPERATIVE REPORT TO AID IN THE ASSESSMENT OF YOUR CLAIM
PC034	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU DO NOT HAVE APPROVAL TO BILL FOR THIS SERVICE. PLEASE SUBMIT YOUR QUALIFICATIONS TO PROVIDE HYPNOTHERAPY TO MSI.
RF006	SERVICE ENCOUNTER HAS BEEN REFUSED. CLAIMED UNIT VALUE IS NOT PAYABLE RE AGE OF PATIENT, RESUBMIT WITH CORRECT UNIT AMOUNT.
VA074	SERVICE ENCOUNTER HAS BEEN REFUSED AS ONLY ONE FEE FOR EITHER HSC 09.41E, 09.41F OR 09.41G SHOULD BE CLAIMED PER PATIENT PER DAY.
VA075	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 09.41D AT THE SAME ENCOUNTER WHICH INCLUDES THIS PROCEDURE.
VA076	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 09.41A, 09.41B OR 09.41H HAS ALREADY BEEN BILLED AT THE SAME ENCOUNTER AND IS A COMPONENT OF THIS PROCEDURE.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday January 27, 2017. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT) and, explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

CONTACT INFORMATION

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TTY/TDD: 1-800-670-8888

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* Please note that the 2017 cut-off dates have been updated.

2017 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE	SALARY CONTRACT PAY PERIOD
December 21, 2016**	**December 28, 2016****	January 4, 2017	December 16-29, 2016
January 9, 2017	January 12, 2017	January 18, 2017	December 30-January 12, 2017
January 23, 2017	January 26, 2017	February 1, 2017	January 13-26, 2017
February 6, 2017	February 9, 2017	February 15, 2017	January 27-February 9, 2017
February 17, 2017**	February 23, 2017	March 1, 2017	February 10-23, 2017
March 6, 2017	March 9, 2017	March 15, 2017	February 24-March 9, 2017
March 20, 2017	March 23, 2017	March 29, 2017	March 10-23, 2017
April 3, 2017	April 6, 2017	April 12, 2017	March 24-April 6, 2017
April 17, 2017	April 20, 2017	April 26, 2017	April 7-20, 2017
May 1, 2017	May 4, 2017	May 10, 2017	April 21-May 4, 2017
May 12, 2017**	**May 17, 2017****	May 24, 2017	May 5-18, 2017
May 29, 2017	June 1, 2017	June 7, 2017	May 19-June 1, 2017
June 12, 2017	June 15, 2017	June 21, 2017	June 2-15, 2017
June 26, 2017	**June 28, 2017****	July 5, 2017	June 16-29, 2017
July 10, 2017	July 13, 2017	July 19, 2017	June 30-July 13, 2017
July 24, 2017	July 27, 2017	August 2, 2017	July 14-27, 2017
August 4, 2017	August 10, 2017	August 16, 2017	July 28-August 10, 2017
August 21, 2017	August 24, 2017	August 30, 2017	August 11-24, 2017
September 1, 2017**	September 7, 2017	September 13, 2017	August 25-September 7, 2017
September 18, 2017	September 21, 2017	September 27, 2017	September 8-21, 2017
September 29, 2017*	**October 4, 2017****	October 11, 2017	September 22-October 5, 2017
October 16, 2017	October 19, 2017	October 25, 2017	October 6-19, 2017
October 30, 2017	November 2, 2017	November 8, 2017	October 20-November 2, 2017
November 13, 2017	November 16, 2017	November 22, 2017	November 3-16, 2017
November 27, 2017	November 30, 2017	December 6, 2017	November 17-30, 2017
December 11, 2017	December 14, 2017	December 20, 2017	December 1-14, 2017
December 20, 2017**	**December 27, 2017****	January 3, 2018	December 15-28, 2017
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, Sessional Payments and Locum Claim Forms. 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 2017

Please make a note in your schedule of the following dates MSI will accept as "Holidays."	
NEW YEAR'S DAY	MONDAY, JANUARY 2, 2017
HERITAGE DAY	MONDAY, FEBRUARY 20, 2017
GOOD FRIDAY	FRIDAY, APRIL 14, 2017
EASTER MONDAY	MONDAY, APRIL 17, 2017
VICTORIA DAY	MONDAY, MAY 22, 2017
CANADA DAY	MONDAY, JULY 3, 2017
CIVIC HOLIDAY	MONDAY, AUGUST 7. 2017
LABOUR DAY	MONDAY, SEPTEMBER 4, 2017
THANKSGIVING DAY	MONDAY, OCTOBER 9, 2017
REMEMBRANCE DAY	MONDAY, NOVEMBER 13, 2017
CHRISTMAS DAY	MONDAY, DECEMBER 25, 2017
BOXING DAY	TUESDAY, DECEMBER 26, 2017
NEW YEAR'S DAY	MONDAY, JANUARY 1, 2018

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PHYSICIAN'S BULLETIN
November 18, 2016: Vol. LI, ISSUE 17

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

IMPORTANT UPDATE

Canadian Medical Protective Insurance (CMPA) Assistance

Effective January 1, 2017, the Department of Health and Wellness will be responsible for the coordination and processing of all eligible CMPA reimbursement, as per the 2015-2019 Master Agreement.

CMPA premium reimbursement to eligible physicians will be facilitated by MSI, through a bottom line adjustment to the physician's preferred business arrangement in place with MSI. Semi-annual payments will be made based on the following payment schedule:

- June 2017
- December, 2017
- June, 2018
- December, 2018
- June, 2019
- December, 2019

Early in the New Year you will receive a package from MSI requesting completion of a Business Arrangement form and supporting banking documentation. A new business arrangement will be set up by MSI for each physician specifically for the Canadian Medical Protective Insurance (CMPA) Assistance reimbursement.

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NEW FEES

Methadone Management

Effective November 18, 2016 the following 5 new health services codes will be available for reporting methadone management.

PLEASE NOTE: **Physician's wishing to claim these 5 codes must be registered with the College of Physicians and Surgeons of Nova Scotia (CPSNS) as having a current valid Health Canada exemption to prescribe methadone for dependency *AND* must contact CPSNS to give them permission to release their name to MSI**. MSI cannot directly request this information for privacy reasons. Once MSI receives a physician's name from CPSNS the physician will be permitted to claim for these fees after the next system update. **Once the physician has contacted CPSNS to release their name, the physician is advised to hold their claims until the next system update**.

Category	Code	Description	Base Units
VIST	03.03J	**Initial Opioid Use Disorder Assessment in a community setting for initiation of Methadone Treatment – (30 minutes)** This is a time based fee for the complete assessment of the patient entering into opioid agonist treatment (OAT) with methadone for the first time. The required elements of this service are outlined in the College of Physicians and Surgeons of Nova Scotia (CPSNS) Methadone Maintenance Treatment (MMT) Handbook and must be documented in the patient's health record. Required elements include: i. A complete substance use history including illicit, prescription and OTC medications with a risk of abuse and a DSM diagnosis for each problematic drug ii. A complete addiction treatment history; iii. Past medical and surgical history; iv. Family history; v. Psychosocial history, including living situation, source of income and education; vi. Review of systems; vii. A focused physical examination, when indicated; viii. Review of treatment options; ix. Formulation of a treatment plan; x. Communication with the patient and/or family to obtain information for the assessment as well as for support staff working in the treatment environment; xi. Communication with previous care providers, including family doctors, pharmacists, addiction services staff, etc. as necessary. xii. Obtain a patient profile for the previous 12 months through the Nova Scotia Prescription Monitoring Program (NSPMP) and register the patient in the NSPMP Methadone Program Monitoring Service. xiii. Obtain a urine drug screen xiv. The physician should request blood work serology (screening for HIV, and Hepatitis A, B and C) during initiation or within a reasonable amount of time after initiation of OAT (not required if patient is a transfer from another physician or from a specialized treatment program unless blood serology has not previously been completed). xv. Consider obtaining an ECG if indicated. Start and stop times are to be documented in the health record. It is recognized that the required elements may be gathered over several visits with the patient. This fee is for the initial visit only. Regular visit fees may be billed for subsequent visits. **Billing Guidelines** • Billable only by the physician working outside of the Provincial Methadone Treatment Clinic who is most actively supervising/responsible for the patient's use of methadone. • Multiples of 15 minutes may be billed in addition to the base fee code to a maximum of 2 • 80% of the time must be spent in face to face contact with the patient and/or family. • If time less than 25 minutes, bill as regular visit. • Once per physician per patient. **Specialty restriction** Physicians registered with the CPSNS as having a current valid Health Canada exemption to prescribe methadone for dependency. **Location** OFFC	50 MSU + MU (1 MU/15min = 25 MSU)

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Category	Code	Description	Base Units
VIST	03.03K	**Initial Opioid Use Disorder Assessment for Methadone Treatment – Transfer from Methadone Maintenance Treatment Clinic to Community Physician** This is a fixed fee for the complete assessment of the patient being transferred from an established Methadone Maintenance Treatment (MMT) Clinic to the care of the physician who will be most responsible for that patient's ongoing OAT with methadone. The required elements of this service are outlined in the College of Physicians and Surgeons of Nova Scotia (CPSNS) MMT Handbook and must be documented in the patient's health record. Required elements include: i. A complete or updated substance use history including illicit, prescription and OTC medications with a risk of abuse and a DSM diagnosis for each problematic drug ii. A complete or updated addiction treatment history; iii. A complete or updated past medical and surgical history; iv. A family history; v. A psychosocial history, including current living situation, source (s) of income and education; vi. Review of systems; vii. A focused physical examination, when indicated; viii. Review of treatment options; ix. Formulation of a treatment plan; x. Communication with the patient and/or family to obtain information for the assessment as well as for support staff working in the treatment environment; xi. Communication with previous care providers, including family doctors, pharmacists, addiction services staff, etc. as necessary. xii. Obtain a patient profile for the previous 12 months through the Nova Scotia Prescription Monitoring Program (NSPMP) and register the patient in the NSPMP Methadone Program Monitoring Service. xiii. Obtain a urine drug screen xiv. The physician should request blood work serology (screening for HIV, and Hepatitis A, B and C) if not done recently by the previous provider. xv. Consider obtaining an ECG if indicated It is recognized that the required elements may be gathered over several visits with the patient. This fee is for the initial visit only. Regular visit fees may be billed for subsequent visits. **Billing Guidelines** • Billable only by the physician who is most responsible for the patient's ongoing methadone treatment. • Once per physician per patient. **Specialty Restriction** Physicians registered with the CPSNS as having a current valid Health Canada exemption to prescribe methadone for dependency. **Location** OFFC	50 MSU

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Category	Code	Description	Base Units
VIST	03.03L	**Permanent Transfer of patient on active Methadone Treatment for substance use disorder – Full acceptance of responsibility for ongoing care - Initial Visit with accepting physician** This is a fixed fee available to the physician accepting full and ongoing responsibility for OAT with methadone for the patient's substance use disorder from the community physician currently providing care due to a patient's relocation or desire for permanent change in care provider. The required elements of this service are outlined in the College of Physicians and Surgeons of Nova Scotia (CPSNS) MMT Handbook and must be documented in the patient's health record. Required elements include: i. A complete or updated substance use history including illicit, prescription and OTC medications with a risk of abuse and a DSM diagnosis for each problematic drug ii. A complete or updated addiction treatment history; iii. A complete or updated past medical and surgical history; iv. A family history; v. A psychosocial history, including current living situation, source (s) of income and education; vi. Review of systems; vii. A focused physical examination, when indicated; viii. Review of treatment options; ix. Formulation of a treatment plan; x. Communication with the patient and/or family to obtain information for the assessment as well as for support staff working in the treatment environment; xi. Communication with previous care providers, including family doctors, pharmacists, addiction services staff, etc. as necessary. xii. Obtain a patient profile for the previous 12 months through the Nova Scotia Prescription Monitoring Program (NSPMP) and register the patient in the NSPMP Methadone Program Monitoring Service. xiii. Obtain a urine drug screen xiv. The physician should request blood work serology (screening for HIV, and Hepatitis A, B and C) if not done recently by the previous provider. xv. Consider obtaining an ECG if indicated It is recognized that the required elements may be gathered over several visits with the patient. This fee is for the initial visit only. Regular visit fees may be billed for subsequent visits. **Billing Guidelines** • Billable only by the physician who is assuming responsibility for the patient's ongoing OAT with methadone. • Billable once per physician per patient. • Billable only by the accepting physician. **Specialty Restriction** Physicians registered with the CPSNS as having a current valid Health Canada exemption to prescribe methadone for dependency. **Location** OFFC	50 MSU

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Category	Code	Description	Base Units
DEFT	MMM1	**Methadone Treatment Monthly Management Fee: Intensive** For physicians working in a primary care setting who are managing patients in the induction and stabilization phase of OAT with methadone. These patients will be seen by the physician for a visit at least twice per month (not including visits for urine drug screening alone) for support and dose adjustments. These visits may be billed in addition to the management fee. **Description** This fee may be billed once per month by the physician, outside of the Methadone Treatment Clinic, who is most responsible for the care of the patient in the induction and initial stabilization phase of opioid agonist treatment (OAT) with methadone for a substance use disorder as defined by DSM V criteria. The patient will be seen by the physician at least twice per month in their general practice (not including visits for urine drug screening alone). The following items are considered to be included in this service: • All medication reviews and methadone dosage adjustments as required; • Communicating on a regular and timely basis with the pharmacy responsible for administering the patient's opioid agonist (methadone) dose for the provision of safe and effective OAT: managing missed doses, checking on daily presentation at the pharmacy, helping coordinate prescriptions going to multiple pharmacies if there are Sunday or holiday closures or if a patient is travelling; • Coordinating care for the patient's concurrent medical conditions; • Counseling the patient on issues related to their substance use disorder; • Connecting the patient to appropriate community resources; • Providing case management and coordination of care functions, and facilitating connection with other addiction care providers; • Arranging random point of care (POC) urine drug screening (UDS) as required by the College of Physicians and Surgeons of Nova Scotia Methadone Maintenance Treatment guidelines appropriate for the patient's phase of treatment; To include generation of random UDS encounters, collection of urine, interpretation of results, documentation of process of randomization and results of the screen in the health care record, and provision of feedback to the patient based on the results. • A visit may not be claimed if the sole purpose of the patient's office encounter is to provide a urine sample. **Billing Guidelines** • Only one claim per patient per month. Maximum six per patient per year. • Regular visit fees may be billed in addition to the monthly fee. • Billable only by the physician working outside of the Provincial Methadone Treatment Clinic who is most actively supervising/responsible for the patient's use of methadone. • If there is no evidence to support randomization of the point of care urine drug screen then the fee will not be paid. • Payment stops when the patient stops methadone or moves to the maintenance phase of treatment. **Specialty restriction** Physicians registered with the CPSNS as having a current valid Health Canada exemption to prescribe methadone for dependency. **Location** OFFC	125 MSU

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Category	Code	Description	Base Units
DEFT	MMM2	**Methadone Treatment Monthly Management Fee: Maintenance** For physicians working in a primary care setting who are managing patients in the maintenance phase of OAT with methadone. These patients will be seen by the physician for a visit at least once per month (not including visits for urine drug screening alone) for support and dose adjustments. These visits may be billed in addition to the management fee. **Description** This fee may be billed once per month by the physician, outside of the Methadone Treatment Clinic, who is most responsible for the care of the patient in the maintenance phase of opioid agonist treatment (OAT) with methadone for a substance use disorder as defined by DSM V criteria. The patient will be seen by the physician at least once per month in their general practice (not including visits for urine drug screening alone). The following items are considered to be included in this service: • All medication reviews and methadone dosage adjustments as required; • Communicating on a regular and timely basis with the pharmacy responsible for administering the patient's opioid agonist (methadone) dose for the provision of safe and effective OAT: managing missed doses, checking on daily presentation at the pharmacy, helping coordinate prescriptions going to multiple pharmacies if there are Sunday or holiday closures or if a patient is travelling; • Coordinating care for the patient's concurrent medical conditions; • Counseling the patient on issues related to their substance use disorder; • Connecting the patient to appropriate community resources; • Providing case management and coordination of care functions, and facilitating connection with other addiction care providers; • Arranging random point of care (POC) urine drug screening (UDS) as required by the College of Physicians and Surgeons of Nova Scotia Methadone Maintenance Treatment guidelines appropriate for the patient's phase of treatment; To include generation of random UDS encounters, collection of urine, interpretation of results, documentation of process of randomization and results of the screen in the health care record, and provision of feedback to the patient based on the results. • A visit may not be claimed if the sole purpose of the patient's office encounter is to provide a urine sample. **Billing Guidelines** • Only one claim per patient per month. • May bill for visits in addition to the monthly fee. • Billable only by the physician working outside of the Provincial Methadone Treatment Clinic who is most actively supervising/responsible for the patient's use of methadone. • If there is no evidence to support randomization of the POC UDS then the fee will not be paid. • Payment stops when the patient stops methadone. **Specialty restriction** Physicians registered with the CPSNS as having a current valid Health Canada exemption to prescribe methadone for dependency. **Location** OFFC	68 MSU

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BILLING REMINDERS

Echocardiograms Reminder

When submitting claims for echocardiograms, physicians may claim either I1312 (Doppler – quantitative) or I1313 (Doppler – qualitative), but not both. A quantitative study includes the elements of a qualitative study.

Premiums for Radiology Services Reminder

MSI has had a number of inquiries from radiologists concerning the use of premium fees (i.e. services claimed with the modifiers US=PREM and US=PR50). As per Preamble section 5.1.82, premium fees may be claimed for certain services provided on an emergency basis during designated time periods. An emergency basis is defined as services that must be performed without delay because of the medical condition of the patient.

Premium fees may be claimed for eligible diagnostic imaging services when the patient's condition requires that the imaging service be done without delay during a designated time period and the interpretation by the radiologist and the formal report are completed during the same designated time period.

Services of a non-emergency nature provided during premium hours do not qualify for premium rates.
It is not appropriate for radiologists to claim services using premium modifiers in the following circumstances:

- during times the radiologist or resident he/she is supervising is scheduled to be onsite in the radiology department
- for non-emergent studies

Additionally, radiologists are reminded that they may only claim for the services provided by a resident if they, as the attending, are onsite. A physician may claim either for the resident's procedure or for his or her own services, but not both, when they are performed at the same time. (Preamble (5.2.9))

At the time of implementation of premium fees for radiology in 2002, radiologists were advised that they must maintain a log of bulk billed services that were submitted with premium codes. Although services are no longer bulk billed, all physicians claiming premium fees are required to be able to provide documentation that verifies Preamble requirements for these services have been met.

Services Related to Research Studies Reminder

Physicians are reminded that costs of medical services that are primarily related to research or experimentation are not the responsibility of the patient or MSI. (*Preamble 2.2.25*).

Audiometry Reminder

09.41E - Impedance audiometry including tympanometry, static compliance, multiple frequency acoustic reflex and/or reflex decay testing including interpretation
09.41F - Impedance audiometry interpretation only of tympanogram, impedance/compliance and stapedial reflex tests
09.41G - Impedance audiometry including tympanometry, static compliance, single frequency acoustic reflex and/or reflex decay testing including interpretation

HSC 09.41E or G should only be claimed when the physician personally performs and interprets the test. HSC 09.41F should only be claimed when the physician personally interprets either of the tests (09.41E or G). Only one of these HSCs may be claimed per patient per day.

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Medical Assistance in Dying (MAID) Fee Summary

The following new interim visit Health service codes were introduced in September 2016 to reimburse physicians for MAID services provided:

03.03M - Medical assistance in dying – First physician

This fee is to reimburse the first physician for time spent providing MAID services outlined in the CPSNS Professional Standard Regarding Medical Assistance in Dying. It includes, but not limited to, the time spent engaging the patient in a discussion of their diagnosis, prognosis, and treatment options, discussing the availability of palliative care for terminally ill patients, assessment of patient for MAID criteria, and arrangement for a second physician to assess the patient.

03.03O - Medical assistance in dying – Second physician

This fee is to reimburse the second physician for time spent providing MAID services outlined in the CPSNS Professional Standard Regarding Medical Assistance in Dying. It includes, but not limited to, the time spent conducting the subsequent assessment of the patient for MAID criteria.

03.03N - Medical assistance in dying – Prescribing physician

This fee is to reimburse the prescribing physician for time spent providing MAID services outlined in the CPSNS Professional Standard Regarding Medical Assistance in Dying. It includes, but not limited to, procuring the medication and administration at the patient's request.

More detail on the services required for medical assistance in dying can be found on the CPSNS website at http://www.cpsns.ns.ca/Standards-Guidelines/Medical-Assistance-in-Dying

Each code pays at 30 MSU for the first 30 minutes and 15 MSU per 15 minutes thereafter to a maximum of 2 hours.

The MAID fees are currently interim while billing information is gathered. They are also categorized as independent consideration (IC) and have no automatic MSU value in the system. Each claim submitted is held by MSI and manually adjudicated based on the information provided by the submitter in the claim text.

Billing Guidelines:

Physicians must document in the patient's medical record all steps described in the CPSNS Professional Standard Regarding Medical Assistance in Dying. The physician must also record the start and stop times for the face to face component of the service and the start and stop times for the non-face to face components in the patient's medical record. Both of these times must be submitted in the text field on the electronic claim made to MSI for proper claim assessment.

Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family if required, and administration process where applicable. The total duration of all components may be claimed. Physicians may not claim for services provided by non-medical personnel such as nurses and nurse practitioners nor for the services of medical trainees such as residents.

If the first or second physician is a specialist and the patient has been formally referred the physician may bill the appropriate specialist prolonged consult fee with the same time documentation requirements as noted above. MAID must be noted in text on the MSI claim form. If the prescribing or administering physician is a specialist the 03.03N code noted above will apply.

Physicians are permitted to claim the MAID fees across multiple encounters and should submit a separate claim for each day the service was provided. Each daily service must meet the minimum 30 minute requirement; shorter encounters should be claimed as a normal visit. Beyond the first 30 minutes, payment for each claim will be rounded down to the nearest 15 minute increment. The maximum of two hours per MAID code per patient applies to each encounter.

Long Term Care Fees Reminder

As per the Homes for Special Care Regulations "Every resident of a nursing home or a home for the aged shall be personally seen by a qualified medical practitioner at least once every six months and the medical practitioner shall examine the medical records of the resident and determine on each occasion whether the resident requires a physical examination."

Physicians are reminded that they may report CGA1, which includes at least one visit with the patient, twice per fiscal year following the billing guidelines listed in Preamble section 5.1.168. Physicians may also report additional visits when required by medical necessity (or necessity for follow up of an ongoing medical problem) and there has been a request from the patient, their family or nursing home staff for the visit.

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NEW AND REVISED EXPLANATORY CODES

Code	Description
DE024	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE HAS ALREADY BEEN APPROVED FOR THIS MONTH.
DE025	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR MMM2 (MAINTENANCE) HAS ALREADY BEEN BILLED FOR THIS PATIENT.
DE026	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MMM1 FEE HAS ALREADY BEEN CLAIMED THE MAXIMUM OF SIX TIMES FOR THIS PATIENT DURING THIS CALENDAR YEAR.
DE027	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR MMM2 HAS ALREADY BEEN BILLED FOR THIS PATIENT DURING THIS MONTH.
DE028	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR MMM1 HAS ALREADY BEEN BILLED FOR THIS PATIENT DURING THIS MONTH.
GN082	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU ARE NOT CURRENTLY PERMITTED TO BILL THIS SERVICE. PLEASE CONTACT CPSNS TO REGISTER. REFER TO NOVEMBER 2016 PHYSICIANS BULLETIN.
VT134	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE INITIAL OPIOID USE DISORDER ASSESSMENT HAS BEEN PREVIOUSLY PAID
VT135	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE INITIAL OPIOID USE DISORDER ASSESSMENT FOR METHADONE TREATMENT - TRANSFER FROM CLINIC TO PHYSICIAN HAS BEEN PAID
VT136	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PERMANENT TRANSFER OF PATIENT ON ACTIVE METHADONE TREATMENT FOR SUBSTANCE USE DISORDER - INITIAL VISIT WITH ACCEPTING PHYSICIAN HAS BEEN PREVIOUSLY PAID
BK058	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED FOR A QUANTITATIVE OR QUALITATIVE DOPPLER INTERPRETATION ON THE SAME DAY. PLEASE RESUBMIT THIS CLAIM WITH ELECTRONIC TEXT EXPLAINING THE NECESSITY OF THE 2ND INTERPRETATION.
PR014	SERVICE ENCOUNTER HAS BEEN REFUSED AS A MAXIMUM FOR THIS CODE HAS ALREADY BEEN REACHED.
GN083	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THE DOCUMENTATION DOES NOT INCLUDE A DESCRIPTION OF THE CLAIMED PROCEDURE.
GN084	SERVICE ENCOUNTER HAS BEEN DISALLOWED BECAUSE THE PROCEDURE IS A NECESSARY PART OF ANOTHER PAID SERVICE ENCOUNTER.
GN085	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS ASSISTANT FEES CANNOT BE CLAIMED IN THESE CIRCUMSTANCES.
GN086	FOR ATTENDANCE ON THE PATIENT FOR THE PURPOSE OF PRONOUNCEMENT OF DEATH, A LIMITED VISIT ONLY MAY BE CLAIMED, PER PREAMBLE 5.3.223.
VT137	IT IS NOT APPROPRIATE TO BILL MSI FOR A MEET AND GREET VISIT WITH A NEW PATIENT UNLESS A HEALTH RELATED CONCERN/COMPLAINT HAS BEEN ADDRESSED AT THE VISIT.
AD066	SERVICE ENCOUNTER HAS BEEN REFUSED AS A COLONOSCOPY ADD ON FEE MAY ONLY BE CLAIMED AFTER A COLONOSCOPY IS BILLED FOR THE SAME OCCURRENCE
OP041	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE DIAGNOSTIC CODE BILLED IS NOT VALID FOR THIS SERVICE
MJ055	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS MSI REQUIRES THE START AND END TIMES OF THIS PROCEDURE TO ASSESS. PLEASE RESUBMIT THIS CLAIM WITH THE START AND END TIMES IN THE TEXT FIELD
VA073	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR DIALYSIS HAS ALREADY BEEN BILLED FOR THIS PATIENT ON THIS DAY
PP023	YOUR CLAIM FOR DENTAL SERVICES HAS BEEN FORWARDED TO GREEN SHIELD FOR REVIEW.

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UPDATED FILES

Updated files reflecting changes are available for download on Friday November 18, 2016. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT) and, explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

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

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2017 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE	SALARY CONTRACT PAY PERIOD
December 21, 2016**	**December 28, 2016****	January 4, 2017	December 16-29, 2016
January 9, 2017	January 12, 2017	January 18, 2017	December 30-January 12, 2017
January 23, 2017	January 26, 2017	February 1, 2017	January 13-26, 2017
February 6, 2017	February 9, 2017	February 15, 2017	January 27-February 9, 2017
February 17, 2017**	February 23, 2017	March 1, 2017	February 10-23, 2017
March 6, 2017	March 9, 2017	March 15, 2017	February 24-March 9, 2017
March 20, 2017	March 23, 2017	March 29, 2017	March 10-23, 2017
April 3, 2017	April 6, 2017	April 12, 2017	March 24-April 6, 2017
April 17, 2017	April 20, 2017	April 26, 2017	April 7-20, 2017
May 1, 2017	May 4, 2017	May 10, 2017	April 21-May 4, 2017
May 12, 2017**	**May 17, 2017****	May 24, 2017	May 5-18, 2017
May 29, 2017	June 1, 2017	June 7, 2017	May 19-June 1, 2017
June 12, 2017	June 15, 2017	June 21, 2017	June 2-15, 2017
June 26, 2017	**June 28, 2017****	July 5, 2017	June 16-29, 2017
July 10, 2017	July 13, 2017	July 19, 2017	June 30-July 13, 2017
July 24, 2017	July 27, 2017	August 2, 2017	July 14-27, 2017
August 4, 2017	August 10, 2017	August 16, 2017	July 28-August 10, 2017
August 21, 2017	August 24, 2017	August 30, 2017	August 11-24, 2017
September 1, 2017**	September 7, 2017	September 13, 2017	August 25-September 7, 2017
September 18, 2017	September 21, 2017	September 27, 2017	September 8-21, 2017
September 29, 2017*	**October 4, 2017****	October 11, 2017	September 22-October 5, 2017
October 16, 2017	October 19, 2017	October 25, 2017	October 6-19, 2017
October 30, 2017	November 2, 2017	November 8, 2017	October 20-November 2, 2017
November 13, 2017	November 16, 2017	November 22, 2017	November 3-16, 2017
November 27, 2017	November 30, 2017	December 6, 2017	November 17-30, 2017
December 11, 2017	December 14, 2017	December 20, 2017	December 1-14, 2017
December 20, 2017**	**December 27, 2017****	January 3, 2018	December 15-28, 2017
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, Sessional Payments and Locum Claim Forms. 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 2017

Please make a note in your schedule of the following dates MSI will accept as "Holidays."	
NEW YEAR'S DAY	MONDAY, JANUARY 2, 2017
HERITAGE DAY	MONDAY, FEBRUARY 20, 2017
GOOD FRIDAY	FRIDAY, APRIL 14, 2017
EASTER MONDAY	MONDAY, APRIL 17, 2017
VICTORIA DAY	MONDAY, MAY 22, 2017
CANADA DAY	MONDAY, JULY 3, 2017
CIVIC HOLIDAY	MONDAY, AUGUST 7. 2017
LABOUR DAY	MONDAY, SEPTEMBER 4, 2017
THANKSGIVING DAY	MONDAY, OCTOBER 9, 2017
REMEMBRANCE DAY	MONDAY, NOVEMBER 13, 2017
CHRISTMAS DAY	MONDAY, DECEMBER 25, 2017
BOXING DAY	TUESDAY, DECEMBER 26, 2017
NEW YEAR'S DAY	MONDAY, JANUARY 1, 2018

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PHYSICIAN'S BULLETIN
November 10, 2016: Vol. LI, ISSUE 16

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

PHYSICIAN STATMENTS

MSI is aware that some statement files from the November 9th, 2016 payment are not accessible via elink.

We are working to make these statements available.

In the interim, if you require your payment totals please contact us at (902) 496-7342 or email the assessment department at MSI_Assessment@medavie.bluecross.ca with a contact name, the business arrangement number, group name, provider id, and a phone or fax number we may contact with the requested information.

We apologize for any inconvenience this may cause and thank you for your patience.

PHYSICIAN'S BULLETIN
September 23, 2016: Vol. LI, ISSUE 16

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

UNIT VALUES AND PAYMENT RATES

MEDICAL SERVICE UNIT/ANAESTHESIA UNIT VALUE

Effective April 1, 2016, the Medical Service Unit (MSU) value will remain at $2.42 and the Anaesthesia Unit (AU) value will remain $20.55.

WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC

Effective April 1, 2016 the Workers' Compensation Board MSU value will remain $2.69 and the Workers' Compensation Board Anaesthetic Unit value will remain $22.83.

SESSIONAL PAYMENTS

Effective April 1, 2016 the Sessional payment rates for General Practitioners will remain at 60 MSUs and the rate for Specialists will remain at 70 MSUs.

PSYCHIATRY FEES

Effective April 1, 2016 the hourly Psychiatry rate for General Practitioners will remain $110.55 and the hourly rate for Specialists will remain $146.96 as per the tariff agreement.

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FEE REVISIONS

Effective September 23, 2016 the following health services codes are no longer active.

Category	Code	Description	Base Units
MAAS	67.02A	**Percutaneous nephrostomy and stent insertion**	IC
MAAS	67.02B	**Percutaneous nephrostomy and ureteric dilatation**	IC

INTERIM FEES

Effective September 22, 2016 the following interim health service codes are available for billing.

Category	Code	Description	Base Units
VIST	03.03M	**Medical assistance in dying – First physician** This fee is to reimburse the first physician for time spent providing MAID services outlined in the CPSNS Professional Standard Regarding Medical Assistance in Dying. It includes, but not limited to, the time spent engaging the patient in a discussion of their diagnosis, prognosis, and treatment options, discussing the availability of palliative care for terminally ill patients, assessment of patient for MAID criteria, and arrangement for a second physician to assess the patient. **Billing Guidelines** Start and stop times must be recorded in the patient's medical record for the face to face component of the service and on the MSI claim. Similarly start and stop times for the non-face to face components must be documented in the patient's medical record and on the MSI claim. Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family if required. Total duration of all components may be claimed. If the physician is a specialist and the patient has been formally referred the physician may bill the appropriate specialist prolonged consult fee with the same time documentation requirements as noted above. MAID must be noted in text on the MSI claim.	IC (30 MSU for first ½ hour, 15 MSU for each additional 15 minutes up to a maximum of 2 hours)

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VIST	03.03N	**Medical assistance in dying – Prescribing physician** This fee is to reimburse the prescribing physician for time spent providing MAID services outlined in the CPSNS Professional Standard Regarding Medical Assistance in Dying. It includes, but not limited to, procuring the medication and administration at the patient's request. This physician must be either the first physician or the second physician. **Billing Guidelines** Start and stop times must be recorded in the patient's medical record for the face to face component of the service and on the MSI claim. Similarly start and stop times for the non-face to face components must be documented in the patient's medical record and on the MSI claim. Non face to face components include all documentation required by the pharmacist and the administration process. Total duration of all components may be claimed.	IC (30 MSU for first ½ hour, 15 MSU for each additional 15 minutes up to a maximum of 2 hours)
VIST	03.03O	**Medical assistance in dying – Second physician** This fee is to reimburse the second physician for time spent providing MAID services outlined in the CPSNS Professional Standard Regarding Medical Assistance in Dying. It includes, but not limited to, the time spent conducting the subsequent assessment of the patient for MAID criteria. **Billing Guidelines** Start and stop times must be recorded in the patient's medical record for the face to face component of the service and on the MSI claim. Similarly start and stop times for the non-face to face components must be documented in the patient's medical record and on the MSI claim. Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family if required. Total duration of all components may be claimed.	IC (30 MSU for first ½ hour, 15 MSU for each additional 15 minutes up to a maximum of 2 hours)

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Billing Matters Billing Reminders, New Explanatory Codes

BILLING REMINDERS

Reminder – Immunizations Administered by Pharmacists

Over the past few years, MSI Audit has identified numerous instances in which a physician has claimed for an immunization administered by a pharmacist. With the upcoming launch of this year's influenza immunization program, physicians are again reminded that they may not claim for these immunizations.

Reminder – Phototherapy Services for Dermatologic Conditions

A visit may only be claimed at the time a patient attends for phototherapy for a dermatologic condition if Preamble requirements for a visit are met. This means that the physician must personally render the visit (Preamble section 1.4) and document history and physical findings in the clinical record (Preamble section 7.)

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BILLING REMINDERS CONTINUED

Reminder – Release of Tongue Tie in Newborn

Physicians are reminded that release of newborn tongue tie has been an uninsured service since 1997. Therefore, physicians may not claim visit or procedural HSCs related to this.

Reminder – Colonoscopy Add On Fees

Health service code 01.22B - polypectomy is an add on code for the removal of colonic polyps, and should only be claimed with a colonoscopy fee. It should not be claimed for the removal of polyps found during other endoscopic procedures such as a gastroscopy. Likewise, health service codes 01.22A - colonoscopy with one/more biopsies, and 01.22F - Balloon dilation of colonic stricture, are also add on fees specific to a colonoscopy.

UPDATE

Remote Practice on Call - Funding Update

As per the new Master Agreement, effective September 9, 2016 the Remote Practice on call stipend has been reduced from $28,217 to $20,000 pro-rated annually for the remainder of the 2016/17 fiscal year. For all physicians receiving remote practice on call funding, you will see the change reflected on the September 28, 2016 payment date.

NEW EXPLANATORY CODES

Code	Description
GN081	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE HOSPITAL ADMIT DATE IS BEFORE THE DATE OF BIRTH

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday Sept 23, 2016. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT), explanatory codes (EXPLAIN.DAT), and modifier values (MODVALS.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

CONTACT INFORMATION

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TTY/TDD: 1-800-670-8888

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PHYSICIAN'S BULLETIN
July 28, 2016: Vol. LI, ISSUE 14

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

PHYSICIAN REGISTRATION PROCESS FOR THE INTERIM FEDERAL HEALTH PROGRAM

The Interim Federal Health Program (IFHP) provides limited, temporary coverage of health-care benefits to people in the following groups who are not eligible for provincial or territorial health insurance:

- protected persons, including resettled refugees;
- refugee claimants; and
- certain other groups.

Basic coverage (similar to health-care coverage provided by provincial/territorial health insurance plans)

- in-patient and out-patient hospital services
- services provided by medical doctors, registered nurses and other health-care professionals licensed in Canada, including pre- and post-natal care
- laboratory, diagnostic and ambulance services

Physicians interested in registering to direct bill for services through this program must register with Medavie Blue Cross to provide services and products to Interim Federal Health Program (IFHP) beneficiaries. To access the provider registration form, please visit: https://provider.medavie.bluecross.ca/.

There is an information handbook for health care professionals available on the Government of Canada website. Please visit: http://www.cic.gc.ca/english/refugees/outside/arriving-healthcare/practitioners.asp for more information.

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FEE REVISIONS

Effective July 28, 2016 the billing guidelines associated with the following health service code have been updated to include R1213 and R1264.

Category	Code	Modifiers	Description	Base Units
ADON	02.89C		**Ultrasound performed by radiologist during premium time** This add-on fee is to be used when an ultrasound must be performed directly by the radiologist due to the absence of an ultrasound technologist, and when it must be done without delay due to the medical condition of the patient during designated times where premium fees may be claimed (Preamble 5.1.84). Each ultrasound must be performed directly by the radiologist (not the resident or fellow) and must include archived diagnostic ultrasound images, a written permanent report, and a verbal report when requested. **Billing Guidelines** Add on to the following HSC's only when US=PREM, or US=PR50: R1205 Ultrasound Abdomen General 25.39 R1212 Ultrasound Appendix 18.75 R1220 Ultrasound Pelvis 18.75 R1225 Endovaginal 26.95 R1226 Endovaginal with pelvic 38.70 R1275 Ultrasound Scrotum 25.45 R1345 Doppler – extremities 18.75 **R1213 Ultrasound Kidneys 18.75** **R1264 Cerebral 33.49 (IWK Only)** Not to be billed when the scan is performed by the radiology resident or fellow. **Specialty Restriction** DIRD, RADI **Location** HOSP	30 MSU

Effective April 1, 2016 the surgical assist modifier has been added to the following health service code.

Category	Code	Modifiers	Description	Base Units
MAAS	98.11	**RO=SRAS**	**Debridement of wound or infected tissue**	IC

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FEE REVISIONS CONTINUED

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Effective April 1, 2016 premium modifiers US=PREM and US=PR50 have been added to the following health service code.

Category	Code	Modifiers	Description	Base Units
BULK	R1264	US=PREM US=PR50	**Cerebral Ultrasound** In specific clinical circumstances at the IWK Health Centre a cerebral ultrasound and interpretation may be required without delay due to the medical condition of the patient, such as an emergency procedure for neonates with suspected intracranial haemorrhage. In these cases it would be appropriate for the radiologist to claim premium time on the interpretation. **Billing Guidelines** Premiums on R1264 may only be claimed from the IWK **Specialty Restriction** DIRD, RADI **Location** HOSP	33.49 MSU

INTERIM BILLING PROCESS

Medical Assistance in Dying (MAID)

Physicians providing MAID are now able to bill MSI for providing this service. New health service codes are being created for this purpose. In the interim, physicians may bill EC for the following:

First physician:
EC - 30 MSU for the first 30 mins and 15 MSU per 15 mins thereafter to a maximum of 2 hours.
Start and stop times must be recorded in the patient's medical record for the face to face component of the service and on the MSI claim form. Start and stop times for the non-face to face components must also be documented in the patient's medical record and on the MSI claim form. Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family if required. Total duration of all face-to-face and non-face-to face components of the patient's care may be claimed. Physicians may not claim for services provided by non-medical personnel such as nurses and nurse practitioners nor for the services of medical trainees such as residents.

Second Physician:
EC - 30 MSU for the first 30 mins and 15 MSU per 15 mins thereafter to a maximum of 2 hours.
Start and stop times must be recorded in the patient's medical record for the face to face component of the service and on the MSI claim form. Start and stop times for the non-face to face components must also be documented in the patient's medical record and on the MSI claim form. Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family if required. Total duration of all face-to-face and non-face-to face components of the patient's care may be claimed. Physicians may not claim for services provided by non-medical personnel such as nurses, nurse practitioners and pharmacists nor for the services of medical trainees such as residents.

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INTERIM BILLING PROCESS CONTINUED

Prescribing or Administering Physician:
This physician must be either the first physician or the second physician.
EC - 30 MSU for the first 30 mins and 15 MSU per 15 mins thereafter to a maximum of 2 hours.
Start and stop times must be recorded in the patient's medical record for the face to face component of the service and on the MSI claim form. Start and stop times for the non-face to face components must also be documented in the patient's medical record and on the MSI claim form. Non face to face components include all documentation required by the pharmacist and the administration process. Total duration of all face-to-face and non-face-to face components of the patient's care may be claimed. Physicians may not claim for services provided by non-medical personnel such as nurses, nurse practitioners and pharmacists nor for the services of medical trainees such as residents.

If the first or second physician is a specialist and the patient has been formally referred the physician may bill the appropriate specialist prolonged consult fee with the same time documentation requirements as noted above.

If the prescribing or administering physician is a specialist the same EC code noted above will apply.

MAID must be noted in text on the MSI claim form.

PROVINCIAL IMMUNIZATION CORRECTION

Please disregard the fee revision notification of RO=ADPO, which was included in the May 19, 2016 Physician's Bulletin. This modifier has been replaced by RO=TDPP.

Billing Matters Billing Reminders, New Explanatory Codes

BILLING REMINDERS

Reminder – Pathology Consultations

MSI has received a number of queries from pathologists concerning how to claim for review of material submitted by another institution for a second opinion.

Effective April 1, 2016 MSI implemented two interim health service codes for anatomical pathology consultations. These were communicated in the March, 2016 Bulletin and are as follows:

Category	Code	Description	Base Units
CONS	03.09I	**Anatomic Pathology Consultation** **Diagnostic Consultation, with review of records and specimens, with report on referred material prepared elsewhere.** This is a comprehensive, diagnostic consultation on materials prepared in a separate licensed pathology laboratory. The service includes: a review of the consultation documents submitted by the referring physician, including clinical reports and laboratory data, discussion with the referring pathologist, as appropriate, literature review, and generation of the report to the referring physician. **Billing Guidelines** May not be billed with any other diagnostic tests on the same case. **Specialty Restriction** PATH **Location** HOSP	45 MSU

Category	Code	Description	Base Units
CONS	03.09J	**Anatomic Pathology Consultation** **Special Diagnostic Consultation, with review of records and specimens, with report on referred material and requiring preparation of additional slides, and/or ordering and interpretation of special tests.** This is a comprehensive, special diagnostic consultation on materials prepared in a separate licensed pathology laboratory that require the ordering and interpretation of additional slides and routine staining (e.g. H&E), and/or the ordering and interpretation of special diagnostic tests such as electron microscopy, immunohistochemistry, and molecular tests. The service includes: a review of the consultation documents submitted by the referring physician, including clinical reports and laboratory data, discussion with the referring pathologist, as appropriate, ordering and interpretation of additional slides and routine staining (e.g. H&E), literature review, and generation of the report to the referring physician. The following special tests maybe reported in addition to the consultation: electron microscopy, immunohistochemistry, and molecular tests. **Billing Guidelines** The interpretation of the following special tests: • Electron Microscopy • Immunohistochemistry • Molecular Tests May be billed in addition to the consultation, as required, using the same service date as the consultation. **Specialty Restriction** PATH **Location** HOSP	60 MSU

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These HSCs are for use when a pathologist has been asked to review material sent by an outside institution or when a second opinion is medically necessary from a pathologist who has additional training/expertise in the area of concern. They may not be claimed for quality assurance activities. When claiming these HSCs the date of service on the claim should reflect the date the pathologist has rendered the opinion.

Reminder – Botox Guidelines

MSI insures the injection of Botox by physicians for the following clinical indications only:

- focal spasticity related to stroke, multiple sclerosis, spinal cord or traumatic brain injury
- laryngeal dystonia
- equinus foot deformity in cerebral palsy patients 2 years of age and older
- cervical dystonia
- blepharospasm, hemifacial spasm (VII nerve disorder) or strabismus in patients 12 years of age and older
- achalasia
- urinary incontinence due to neurogenic detrusor overactivity resulting from neurogenic bladder associated with multiple sclerosis (MS) or subcervical spinal cord injury (SCI) in patients who have failed to respond to behavioural modification and anticholinergics and/or are intolerant to anticholinergics
- idiopathic overactive bladder unresponsive to behaviour modification, medications and peripheral nerve stimulation

Reminder - Storage and Maintenance of Clinical Records

As per Preamble section 1.1.40, physicians are required to maintain records supporting services claimed to MSI for a period of five years in order to substantiate claims submitted. When implementing business practices at the time of entering into a group practice or locum tenens, or when winding down a practice, physicians should confirm that their records will be easily retrievable if they are required to substantiate claims to MSI.

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Reminder – Psychotherapy and Counselling Services

Physicians are reminded that the following services require a minimum of two time intervals/three multiples be claimed (i.e. a minimum of 30 minutes):

HSC 08.19A Child Psychiatric Assessment
HSC 08.43A Behavioural Management
HSC 08.49B Psychotherapy
HSC 08.44 Group Psychotherapy
HSC 08.45 Family Therapy
HSC 08.41 Hypnotherapy
HSC 08.5B Psychiatric Care by a Psychiatrist

HSC 08.5A Clinical Psychiatry by a Psychiatrist requires a minimum of four time intervals/five multiples (i.e. 60 minutes) be claimed.

As always, start and finish times must be recorded on the patient record and additionally in the text field in the claim. Physicians must spend at least 80% of the time claimed in direct intervention with the patient(s).

Reminder – Comprehensive Visits

Physicians are reminded that health service codes exist for both comprehensive and limited visit services. Health service code 03.04 is an un-referred comprehensive visit and health service code 03.03 is an un-referred limited visit.

The referred equivalents are health service codes 03.08 (comprehensive consultation) and 03.07 (limited consultation).

Comprehensive visits may be claimed when necessitated by the seriousness, complexity or obscurity of the patient's complaint(s) or medical condition and ensuring a complete history is recorded and a physical examination appropriate to the physician's specialty and working diagnosis are documented. This is outlined in Preamble sections 5.1.7 and 5.1.8.

Documentation of all of the following provide a clear indication that a comprehensive visit or comprehensive consultation has taken place:

A detailed patient history including:

- Relevant history of presenting complaint
- Relevant past medical and surgical history
- Medication list
- Allergies
- Family history, as appropriate
- Social history, as appropriate

As well as a physical exam including:

- A complete physical examination, appropriate to the physician’s specialty and relevant to the presenting complaint.
- Documentation describing the pertinent positive and negative findings of the physical examination. It is not adequate to indicate that the “physical exam is normal” without indicating what was examined.

In situations in which these criteria are not met, it would be appropriate to claim the visit as a limited visit or limited consultation.

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BILLING REMINDERS CONTINUED

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Reminder – Telemedicine Fees

Physicians are reminded that the modifier ME=TELE is to be used to indicate telemedicine consultation when using the provincial telehealth network. It cannot be used when providing services utilizing other platforms, such as Skype, email or telephone.

Reminder – The "Meet and Greet"

Physicians are reminded that Preamble rules stipulate that all services billed to MSI must be medically necessary i.e. there must be a specific health related concern/complaint that has led the patient to seek medical attention. It is not appropriate to bill MSI for a "meet and greet" visit with a new patient unless a health related concern/complaint has been addressed at the visit. Similarly, it is not appropriate to bill a comprehensive visit or counselling for such encounters unless the visit is medically necessary and Preamble requirements for these codes have been satisfied.

Reminder – HLA Typing and HLA Identification/Crossmatch

HLA typing (04.49A) is a service provided for a patient awaiting a transplant, HLA identification/crossmatch is conducted on the potential donor. A patient should not receive both of these services on the same day as an individual cannot be both a donor and a recipient at the same time.

NOTICE

Payment Statement Recreation

During the period of December 23, 2015 – April 13, 2016 it was identified that reversed claims were not represented on the pay statements accessed via your software vendor.
Upon request, MSI will begin regenerating statements for the following payment dates:

December 23, 2015
January 6, 2016
January 20, 2016
February 3, 2016
February 17, 2016
April 13, 2016

Please note, if you have already made a request for a corrected statement, you do not need to send in your request a second time. We have all requests on file and will begin the process of sending these statements out effective immediately. We appreciate your patience during this time while we work through the back log.

For any physicians who have not yet made a request for a regenerated statement, you can do so by sending a fax to MSI at 902-490-2275. Please send the fax on letter head and include the provider number, business arrangement, contact number and payment date for which you require the statement regenerated.

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NEW EXPLANATORY CODES

Code	Description
VE017	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 04.49B HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY.
VE018	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 04.49A HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY.
BK057	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE CANNOT BE BILLED FROM THIS FACILITY.
GN080	MSI RESULT

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

UPDATED FILES

Updated files reflecting changes are available for download on Thursday, July 28, 2016. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT), explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

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PHYSICIAN'S BULLETIN

May 19, 2016: Vol. LI, ISSUE 13

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

NEW PHYSICIAN WEBSITE LOCATION

The platform that the MSI Physician's Website is housed on has been upgraded to more current technology. In doing so, we have updated the URL. The Website can now be found at http://msi.medavie.bluecross.ca/

The former URL (www.medavie.bluecross.ca/msiprograms) remains active and will redirect to the current site. For efficiency, it would be advisable to update any saved bookmarks and favourites.

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FEE REVISIONS

Effective May 20, 2016 the following health service codes have been revised to allow for 5 multiples to be claimed.

Category	Code	Description	Value
DEFT	WCB22	Completed Mandatory Generic Exemption Request Form	$12.50
DEFT	WCB23	Completed Non-Opioid Special Authorization Request Form	$12.50
DEFT	WCB24	Completed Opioid Special Authorization Request Form	$42.00

PROVINCIAL IMMUNIZATION CHANGES

Effective May 19, 2016 the following new immunization is available for billing:

HSC	Modifier	Description	Base Units
13.59L	RO=IPVV	IPV-Inactivated Polio Vaccine Billing Guidelines May only be claimed once per lifetime. If the patient was previously incompletely immunized, the physician may bill EC with explanatory text.	6 MSU

Effective May 19, 2016 the following billing guidelines will be implemented:

HSC	Modifier	Description
13.59L	RO=MMAR	MMR - Measles, Mumps, Rubella Vaccine Billing Guidelines This vaccine cannot be billed if the first and second doses are not given at least 4 weeks apart, if patient was born on January 1, 1970 or later. If the 2nd injection is given within this 4 week period, the claim will be refused.
13.59L	RO=TDAP	Tdap - Tetanus, Toxoid, Diphtheria, Acellular Pertussis Vaccine Billing Guidelines This vaccine cannot be claimed if the same immunization was previously billed while the patient was 18 years of age or older.
13.59L	RO=TEDV	Td - Tetanus Toxoid, Diphtheria Vaccine Billing Guidelines This vaccine cannot be claimed if the same immunization was previously given to the patient within the previous 10 years unless the new claim also has the high risk modifier (PT=RISK). If the claim has the high risk modifier it will require explanatory text and will be manually assessed.

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FEE REVISIONS CONTINUED

Effective May 19, 2016 the following billing guideline has been modified:

HSC	Modifier	Description
13.59L	RO=ADPO	Adacel-Polio (Tdap-IPV) Billing Guideline The previous restriction, if patient has already had the injection for diptheria, pertussis, tetanus and poliomyelitis (RO=QUAD) has been removed.

Billing Matters Billing Reminders, New Explanatory Codes

BILLING REMINDERS

Reminder - Claims for Pathology Interpretation of Surgical Specimens (Gross and Microscopic)

When more than one surgical specimen is received from a patient, the following rules apply:

- P2325 may be claimed for each specimen taken from anatomically distinct surgical sites.
- P2345 may be claimed when three or more separate surgical specimens are taken from the same anatomic site.
- P2346 may be claimed when a single large complex cancer specimen, which includes lymph nodes, is examined for the purposes of providing a pathologic cancer staging.

For the purposes of correctly interpreting anatomic pathology fee code P2325 and P2345, the body is considered to be divided into the following distinct anatomical areas:

- head and neck
- upper limbs
- lower limbs
- trunk anterior and posterior

The following organ systems are also considered to be distinct surgical sites:

- upper GI tract
- lower GI tract
- female reproductive system
- male reproductive system
- separate organs within the abdominal or thoracic cavities may be claimed as distinct sites

For example:

P2325

- two colonic polyps from the transverse and descending colon are to be claimed as HSC P2325 (no multiples) as both come from the lower GI tract
- examination of tissue from the colon (two specimens) and liver (two specimens) are claimed as P2325 with two multiples as the colon and liver are anatomically distinct sites.

P2345

- three colonic polyps from the ascending, transverse and descending colons are to be claimed using HSC P2345 (no multiples)
- examination of tissue from four cervical biopsy sites and a single endocervical curettage sample should be claimed as HSC P2345 (no multiples) as all specimens are from the female reproductive system

P2325 + P2345

- examination of tissue from the colon (three specimens) and liver (two specimens) are to be claimed as P2345 (for the three colonic specimens) and P2325 (for the two liver specimens)

P2346

- a single complex gynaecologic cancer specimen which includes lymph nodes is to be claimed as HSC P2346 and not as multiples or second service occurrences using HSCs P2325 and/or P2345

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Reminder - Sleep Studies

Health Service Codes exist in Nova Scotia for Level 1, Level 2 and Level 3 Sleep Studies. When claiming these studies, the following requirements apply:

HSC 03.19C - Sleep Studies (Level 1)

HSC 03.19C is for a Level 1 study (overnight polysomnography) a full sleep study in a hospital sleep laboratory with a sleep technologist in attendance.
At a minimum all of the following must be recorded:

- 2-3 leads of electroencephalogram
- 2 leads of electrooculogram
- submental EMG
- ECG
- airflow nose and mouth by thermistor or nasal pressure cannulae
- respiratory effort
- oxygen saturation
- snoring
- anterior tibialis electromyogram
- body position

Physicians must have formal fellowship level training and be credentialed to interpret Level 1 sleep studies by the Nova Scotia Health Authority in order to claim this health service code.

HSC 03.19F - Level 2 Sleep Apnea Testing

At a minimum all of the following parameters must be measured:

- electrooculogram
- heart rate
- air flow
- respiratory effort
- oxygen saturation
- anterior tibialis EMG
- body position

Physicians must have completed fellowship level training including interpretation of sleep studies

HSC 03.19G - Level 3 Sleep Apnea Testing

All of the following parameters must be measured:

- heart rate
- air flow
- respiratory effort
- oxygen saturation
- body position

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Physicians must have completed fellowship level training including interpretation of sleep studies.

Physicians claiming these services are asked to review their billing practices to confirm that they are selecting the appropriate health service code.

NEW EXPLANATORY CODES

Code	Description
AD060	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE SECOND DOSE OF THE MEASLES, MUMPS, AND RUBELLA VACCINE CANNOT BE ADMINISTERED WITHIN 28 DAYS OF THE FIRST DOSE.
AD061	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE TETANUS TOXOID, DIPHTHERIA, AND ACELLULAR PERTUSSIS IMMUNIZATION HAS PREVIOUSLY BEEN CLAIMED FOR THIS PATIENT WHILE OVER 18 YEARS OF AGE.
AD062	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF IPVV INJECTIONS HAS BEEN REACHED.
AD063	SERVICE ENCOUNTER HAS BEEN REFUSED AS A TETANUS TOXOID, DIPTHERIA INJECTION HAS ALREADY BEEN APPROVED IN THE PREVIOUS 10 YEARS.
MA019	SERVICE ENCOUNTER HAS BEEN REFUSED. WHEN A BLEPHAROPLASTY IS PERFORMED FOR A DIAGNOSIS OF BLEPAROCHALASIS OR DERMATOCHALASIS, CODE 22.5C SHOULD BE USED, NOT A LID PTOSIS CODE. PRIOR TO SUBMITTING 22.5C, PLEASE CONTACT THE ASSESSMENT DEPT FOR A PA NUMBER.
WBPPC	PHYSICIAN COMPLIANCE. FEES ADJUSTED OR REVERSED DUE TO NON-COMPLIANCE OF THE DOCS NS CONTRACT.

In every issue Helpful links, contact information, updated files

UPDATED FILES

Updated files reflecting changes are available for download on Thursday, May 19, 2016. The files to download are health service (SERVICES.DAT), explanatory codes (EXPLAIN.DAT) and modifier values (MODVALS.DAT).

HELPFUL LINKS

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www.novascotia.ca/dhw/

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PHYSICIAN'S BULLETIN

March 24, 2016: Vol. LI, ISSUE 12

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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★ Fees New Fees and Fee Revisions

NEW INTERIM FEES

Effective April 1, 2016 the following interim health service codes will be available for billing.

Category	Code	Description	Base Units
CONS	03.09I	**Anatomic Pathology Consultation** **Diagnostic Consultation, with review of records and specimens, with report on referred material prepared elsewhere.** This is a comprehensive, diagnostic consultation on materials prepared in a separate licensed pathology laboratory. The service includes: a review of the consultation documents submitted by the referring physician, including clinical reports and laboratory data, discussion with the referring pathologist, as appropriate, literature review, and generation of the report to the referring physician. **Billing Guidelines** May not be billed with any other diagnostic tests on the same case. **Specialty Restriction** PATH **Location** HOSP	45 MSU

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NEW INTERIM FEES CONTINUED

Effective April 1, 2016 the following interim health service codes will be available for billing.

Category	Code	Description	Base Units
CONS	03.09J	**Anatomic Pathology Consultation** **Special Diagnostic Consultation, with review of records and specimens, with report on referred material and requiring preparation of additional slides, and/or ordering and interpretation of special tests.** This is a comprehensive, special diagnostic consultation on materials prepared in a separate licensed pathology laboratory that require the ordering and interpretation of additional slides and routine staining (e.g. H&E), and/or the ordering and interpretation of special diagnostic tests such as electron microscopy, immunohistochemistry, and molecular tests. The service includes: a review of the consultation documents submitted by the referring physician, including clinical reports and laboratory data, discussion with the referring pathologist, as appropriate, ordering and interpretation of additional slides and routine staining (e.g. H&E), literature review, and generation of the report to the referring physician. The following special tests maybe reported in addition to the consultation: electron microscopy, immunohistochemistry, and molecular tests. **Billing Guidelines** The interpretation of the following special tests: • Electron Microscopy • Immunohistochemistry • Molecular Tests May be billed in addition to the consultation, as required, using the same service date as the consultation. **Specialty Restriction** PATH **Location** HOSP	60 MSU
VEDT	05.99A	**Immunofluorescence, interpretation of any and all markers required for diagnosis; any method.** This code is used to reflect the physician's work in reviewing slides stained with a fluorescent dye under a fluorescent microscope, recording the results, photographing the results, downloading the images, re-reviewing the images when performing the final review of the case, recording the results in the final report, and integrating the results when making a final diagnosis. **Billing Guidelines** Once per case. Case is defined as "all specimens gathered at one clinical encounter." **Specialty Restriction** Anatomical Pathology **Location** HOSP	30 MSU

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NEW INTERIM FEES CONTINUED

Effective April 1, 2016 the following interim health service codes will be available for billing.

Category	Code	Description	Base Units
VEDT	05.99B	**Molecular testing, interpretation of any and all analyses/tests required for diagnosis; any method.** This code is used to reflect the physician's work in selecting the appropriate tissue block and test (s) to be performed, interpretation of the results/analyses, and generating the report. **Billing Guidelines** Once per case no matter how many analyses or tests are performed. Case is defined as "all specimens gathered at one clinical encounter." **Specialty Restriction** Anatomical Pathology **Location** HOSP	40 MSU

FEE REVISIONS

Effective March 24, 2016 the following health service code will be paid according to Independent Consideration (IC).

Category	Code	Description	Base Units	Anaes Units
MASG	65.59D	**Total Abdominal Wall Reconstruction with myofascial advancement flaps** This is a comprehensive fee for the repair of a massive, complex abdominal wall hernia. The procedure includes the reduction of the hernia, all lysis of adhesions, and bowel resection as required, removal of pre-existing mesh as required, rectus muscle mobilization, fascial bipartition with component separation, with or without placement of mesh or biologic graft, and skin excision. Operative report and record of operation must be submitted with billing claim. **Billing Guidelines** Not to be billed with lysis of adhesions, bowel resection or any other intra-abdominal procedure same patient same day. Payment calculated based on "skin to skin" operating time as documented in the record of operation. **Please note** that as per the July 2014 bulletin, the operative report and record of operation must be submitted with the billing claim. **Specialty Restriction** GNSG, PLAS **Location** HOSP	IC at 130 MSU per hour	8+T

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BILLING REMINDERS

HSC 26.52 – Iridotomy

The fee for iridotomy (HSC 26.52) should only be used when treating glaucoma. It is not appropriate to bill iridotomy when the procedure is solely used as a means of access for another procedure.

As per section 5.3.71 of the Preamble

"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."

EXPLANATORY CODES

Code	Description
BK056	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THIS ECHOCARDIOGRAPH SERVICE HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY. PLEASE RESUBMIT WITH ELECTRONIC TEXT EXPLAINING THE REASON FOR THE SUBSEQUENT SERVICE.
ED106	PAYMENT RESPONSIBILITY IS INCORRECT FOR THE HEALTH CARD NUMBER PROVIDED
MA070	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED ANOTHER SURGERY ON THIS EYE DURING THE SAME ENCOUNTER. THE FEE FOR IRIDOTOMY SHOULD ONLY BE USED WHEN IT IS A STAND ALONE PROCEDURE.
VE016	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PATIENT REQUIRES ONE PREVIOUSLY BILLED CATARACT SURGERY IN THE PAST YEAR TO CLAIM FOR THE THIRD EXAMINATION IN A YEAR, OR TWO CATARACT SURGERIES FOR THE FOURTH EXAMINATION.

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

UPDATED FILES

Updated files reflecting changes are available for download on Thursday, March 24, 2016. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT), explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

www.medavie.bluecross.ca\msiprograms

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

CONTACT INFORMATION

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January 29, 2016: Vol. LI, ISSUE 11

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

MSI DOCUMENTATION REMINDER

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribed, and start and stop times for time based codes.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptions, or emotional problems, the physician "deliberately established a professional relationship with the patient for the purposes of removing, modifying or alleviating existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional well being of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy," etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service on that date, then the service is not paid for or a lesser benefit is given. **When the clinical record does not support the service claimed, there will be a recovery to MSI at the time of audit.** Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

INTERIM FEES - REVISED

The effective date of the following interim health services codes have been extended to March 1, 2015. These codes were originally introduced in the October 2015 bulletin with an effective date of April 1, 2015.

Note: Physicians holding eligible services must submit their claims from the month of March 2015 within 90 days of the date of this bulletin. Please ensure previously paid claims for these services are deleted prior to resubmitting a new claim. Please contact MSI directly for detailed instructions on how to submit these outdated eligible services.

Revised March 31, 2020 – See May 2020 Bulletin for updated information

Category	Code	Description	Base Units
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.** This code is used to report the interpretation of all spirometry, flow/volume loops, oximetry, and bronchodilation responsiveness, as required, to properly assess the response of the patient to exercise. **Billing Guidelines** Only for 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** RSMD, INMD **Location** HOSP	20 MSU

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INTERIM FEES - REVISED CONTINUED

Revised March 31, 2020 – See May 2020 Bulletin for updated information

Category	Code	Description	Base Units
VEDT	03.38C	**Interpretation of spirometry Pre and Post Bronchodilator** This code is used to report the interpretation of spirometry 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 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** RSMD, INMD **Location** HOSP	10 MSU
VEDT	03.38D	**Six Minute Walk Test, interpretation, when this is the sole procedure.** For the interpretation of the results of the six minute walk test when this is the only pulmonary function test performed for that patient that day. Results must include: the distance walked, pulse oximetry readings, heart rate, and subjective exertion. **Billing Guidelines** Only for interpretation of tests performed in a hospital pulmonary function laboratory (Preamble 5.3.190). Do not report with: • Any other pulmonary function tests same patient same day. **Specialty Restriction** RSMD, INMD **Location** HOSP	2 MSU

FEE REVISIONS

Please visit the Bulk Billing Transition section of the MSI website for updates to the Radiology Rules Communication document.

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BILLING REMINDERS

WCB Physician Report Form 8/10s

The Workers' Compensation Board continues to monitor the submission of Physician Report Form 8/10s for quality, completeness and legibility and for inappropriate submission of reports in Long Term Benefits cases. The WCB will reverse the report portion of the fee ($64.16) if the contract conditions are not met. The WCB 28 (visit) will continue be paid in these instances.

HSC 13.53A and 13.53C Insertion and Removal of Intradermal Progestin Contraceptive Device

Physicians are reminded that these HSCs are for the insertion or removal of intradermal progestin contraceptive devices only. They may not be used for insertion or removal of intrauterine progestin contraceptive devices.

MRI Interpretation-Repeat Sequence

The claim for a MRI interpretation repeat sequence fee should only be made after the matching base spin echo or inversion recovery MRI interpretation has been claimed and accepted at the same occurrence. All interpretation requests generated from the same encounter should be claimed using the same service occurrence number.

NEW EXPLANATORY CODES

Code	Description
BK052	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED THIS MRI INTERPRETATION SERVICE FOR THE SAME PATIENT ON THE SAME DAY.
BK053	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A REPEAT SEQUENCE CAN ONLY BE CLAIMED AFTER THE MATCHING BASE MULTISECTION MRI FEE IS CLAIMED FOR THE SAME OCCURRENCE. PLEASE CLAIM THE BASE FEE FOR THIS MRI BEFORE SUBMITTING A RE-ADJUDICATE FOR THIS CLAIM.
BK054	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED THIS SERVICE FOR THE SAME PATIENT ON THE SAME DAY.
BK055	SERVICE ENCOUNTER HAS BEEN REFUSED AS A FEE FOR GATING MAY ONLY BE CLAIMED AFTER A MRI THORAX WITH MULTIPLE SEQUENCES HAS BEEN CLAIMED DURING THE SAME ENCOUNTER.
MJ054	HSC 46.41 DECORTICATION OF LUNG MAY NOT BE BILLED WITH ANY OTHER MAJOR SURGERY.
WB004	WCB HAS ADJUSTED THIS CLAIM BASED ON AN AUDIT OF THE FORM 8/10 FOR LEGIBILITY, COMPLETENESS OR QUALITY AS PER CONTRACT CONDITIONS. THE VISIT FEE ONLY (WCB28) WILL BE PAID ON THIS CLAIM.
WB024	WCB HAS ADJUSTED THIS CLAIM TO THE APPROPRIATE VISIT FEE AS THE CLIENT IS ON LONG TERM BENEFITS AND FORM 8/10 IS ONLY NECESSARY WHEN THERE IS A CHANGE IN CONDITION OR TREATMENT AS PER CONTRACT CONDITIONS.
MA069	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PATIENT IS OVER 6 MONTHS OLD.
VA072	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THERE IS ALREADY A CLAIM AT THE SAME ENCOUNTER FOR A PROCEDURE THAT INCLUDES INTRAVENOUS INSERTION.
GN079	SERVICE ENCOUNTER HAS BEEN DISALLOWED. IV INSERTION IS CONSIDERED A PART OF THIS PROCEDURE AND IT HAS ALREADY BEEN CLAIMED AT THE SAME SERVICE ENCOUNTER.
VT133	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC WCB28 FOR THIS PATIENT ON THE SAME DAY.

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In every issue Helpful links, contact information, updated files

UPDATED FILES

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HELPFUL LINKS

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CONTACT INFORMATION

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PHYSICIAN'S BULLETIN
November 25, 2015: Vol. LI, ISSUE 10

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

MSI TECHNOLOGY TRANSITION AND IMPORTANT CHANGE TO CUT-OFF TIME

Medavie Blue Cross, as the administrator of the MSI Program is in the process of transitioning to a new corporate claims system.

As part of the roll-out of this new system MSI will require sufficient time to process claims on the old system prior to switching over to the new claims system.

In order to eliminate risk during this process we will require the cut-off time to be 11:29pm on December 3, 2015 instead of the usual time of 11:59pm.

Should you have any enquiries you can contact MSI:

Local Phone: 902-496-7011
Toll-Free Phone: 1-866-553-0585
Email: MSI_Assessment@medavie.ca
Available 8:00am to 5:00pm Monday to Friday (excluding holidays)

PHYSICIAN'S BULLETIN
October 23, 2015: Vol. LI, ISSUE 9

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

NEW MSI CLAIMS PROCESSING AND PAYMENT SYSTEM

In the coming months, MSI will be transitioning to a new claims processing system. While physicians will not see a change in the way their claims are processed once the transition is complete in early December, there are a number of items related to submission of claims that we would like to make physicians and billing clerks aware of.

1. In order to maintain the claims history of Nova Scotia residents in the MSI database, it is important that an individuals' claims history be stable over a period of time during the transition. This means that between November 20 and December 3, 2015 physicians will be required to hold all deletions and readjudications of claims. New claims will be able to be processed in the usual manner; only deletions and readjudications will be impacted.
2. During the transition dates above, there will be a delay in sending adjudication responses. When the transition to the new claims system is complete at midnight on December 3, the system will be fully functional and deletions and readjudications will be able to be processed. However, adjudication responses will not be available from December 4th – 6th. **As the November 20th date approaches, we ask that all physician offices and billing clerks work to review any outstanding claims requiring deletion and/or re-adjudication to minimize the impact during the technology transition.**
3. The Preamble to the MSI Physician's Manual stipulates that claims must be submitted within 90 days of the date of service. Effective December 3, 2015, this 90-day rule will be enforced for **both fee for service and shadow-billed services** with the following exceptions only:
    - Reciprocal billing claims (out of province) must be submitted within 12 months of the date of service.
    - Resubmission of refused claims or incorrect billings must be resubmitted to MSI within 185 days of the date of service. Each resubmission must contain an annotation in the text field of the Service Encounter submission referencing the previous Service Encounter Number.

Physicians who shadow bill and have outstanding claims that have not yet been submitted are asked to work with their billing clerk to ensure compliance with the 90 day limit. Effective December 3, all claims outside this window will be adjudicated as "pay at zero" and returned to the provider. Shadow claims that are submitted more than 90 days from the date of service will fall under the purview of the Outdated Claims Policy which states:

Outdated claims will only be considered by MSI if extenuating circumstances can be demonstrated for a late submission and are within a reasonable time frame past the 90 day limit. Requests for an extension must be made to MSI in writing and will be approved on a case by case basis. The time frame for submitting the request to MSI for late submission should be within one month following the 90 day limit.

MSI News continued

Claims for registered hospital in-patients must also be submitted within the 90-day time limit whether the patient has been discharged or continues as an in-patient.

MSI is committed to a smooth transition with minimal impact on physicians during our technology transition. Should you have any questions or concerns we may be reached as follows between 8 a.m. and 5 p.m. Monday through Friday.

Local Phone: 902-496-7011
Toll-Free Phone: 1-866-553-0585
Email: MSI_Assessment@medavie.ca

Fees New Fees and Highlighted Fees

INTERIM FEES

Note: Physicians holding eligible services must submit their claims from April 1, 2015 onward within 90 days of the date of this bulletin. Please ensure previously paid claims for these services are deleted prior to resubmitting a new claim. Please contact MSI directly for detailed instructions on how to submit these outdated eligible services.

Effective April 1, 2015 the following interim health service codes are available for billing.
Revised March 31, 2020 – See May 2020 Bulletin for updated information

Category	Code	Description	Base Units
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.** This code is used to report the interpretation of all spirometry, oximetry, and bronchodilation responsiveness, as required, to properly assess the response of the patient to exercise. **Billing Guidelines** Only for 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** RSMD, INMD **Location** HOSP	20 MSU

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Revised March 31, 2020 – See May 2020 Bulletin for updated information

Category	Code	Description	Base Units
VEDT	03.38C	**Interpretation of Spirometry Pre and Post Bronchodilator** This code is used to report the interpretation of spirometry, 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 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** RSMD, INMD **Location** HOSP	10 MSU
VEDT	03.38D	**Six Minute Walk Test, interpretation, when this is the sole procedure.** For the interpretation of the results of the six minute walk test when this is the only pulmonary function test performed for that patient that day. Results must include: the distance walked, pulse oximetry readings, heart rate, and subjective exertion. **Billing Guidelines** Only for interpretation of tests performed in a hospital pulmonary function laboratory (Preamble 5.3.190). Do not report with: • Any other pulmonary function tests same patient same day. **Specialty Restriction** RSMD, INMD **Location** HOSP	2 MSU

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FEE REVISIONS

Effective April 1, 2015 the following health service code has been revised to allow for two multiples to be claimed.

Radiologists looking to claim two tomographies on prior submitted encounters are asked to submit a delete for the previously paid single multiple service before resubmitting a new claim with a multiple of two. Physicians must submit their claims from April 1, 2015 onward within 90 days of the date of this bulletin. Please contact MSI directly for detailed instructions on how to submit these outdated eligible claims.

Category	Code	Group	Description	Base Units
BULK	R1950	Nuc. Med.	**Tomography (add on)**	12.50 MSU

Effective October 22, 2015 the following health services code is no longer active.

Category	Code	Description	Base Units
DEFT	WCB10	**WCB completion of Form 10 in conjunction with an expedited non-emergency Orthopaedic Major Surgical Procedure**	IC

Billing Matters Billing Reminders, New Explanatory Codes

BILLING REMINDERS

Claims for HSC R403 – Fluoroscopy

As per Preamble section 5.3.149, this health service code may only be used when the radiologist is not claiming another procedure. For example, it may be used when a radiologist personally provides fluoroscopy support for another physician who is doing a procedure such as a hysterosalpingogram, bronchoscopy or ERCP. It cannot be claimed when the radiologist has claimed another procedure such as insertion of a PICC line, abscess drainage or gastrostomy tube insertion either as part of the same service encounter or a subsequent service encounter.

ADDITIONAL BILLING INFORMATION

Optic Nerve Imaging HSC 02.02B Diagnostic Codes

Please see the current list of acceptable diagnostic codes that may be used when claiming Optic Nerve Imaging (02.02B):

36252 - Exudative Senile Macular Degeneration
36201 - Background Diabetic Retinopathy
36235 - Central Retinal Vein Occlusion
36236 - Venous Tributary Occlusion
37927 - Vitreomacular Adhesion
3659 - Unspecified Glaucoma

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NEW EXPLANATORY CODES

Code	Description
AN004	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE FIRST ANAE START TIME SPECIFIED ON THIS CLAIM DOES NOT MATCH THE TIME PROVIDED ON THE PREVIOUSLY SUBMITTED CLAIM FOR THE FIRST ANAESTHESIOLOGIST SERVICE.
BK050	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.38B OR 03.38C HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY
CR020	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A CLAIM FOR DIRECTIVE CARE OR CONTINUING CARE HAS ALREADY BEEN APPROVED FOR THIS PATIENT ON THE SAME DAY.
GN076	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE ALREADY BILLED A VISIT AT THE SAME ENCOUNTER. PLEASE SUBMIT A DELETE FOR THE VISIT BEFORE RESUBMITTING FOR THE CGA1.
GN077	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE ALREADY CLAIMED A SERVICE THAT INCLUDES SUTURING AT THE SAME ENCOUNTER.
GN078	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PROVIDER NUMBER IS NOT VALID FOR THIS SERVICE.
MN015	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU PREVIOUSLY BILLED AT THE SAME ENCOUNTER A SERVICE WHERE SUTURING OF THE SKIN IS INCLUDED IN THE PROCEDURE.
VE013	SERVICE ENCOUNTER HAS BEEN REFUSED AS A PHYSICIAN HAS PREVIOUSLY BILLED ANOTHER PULMONARY FUNCTION TEST FOR THIS PATIENT ON THE SAME DAY.
VE014	SERVICE ENCOUNTER HAS BEEN REFUSED AS A PHYSICIAN HAS PREVIOUSLY BILLED FOR STAND ALONE FEE 03.38D FOR THIS PATIENT ON THE SAME DAY.
VE015	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU CANNOT BILL 03.38B AND 03.38C ON THE SAME DAY
VT132	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A CLAIM FOR CRITICAL CARE HAS ALREADY BEEN APPROVED FOR THIS PATIENT ON THE SAME DAY.
WB035	SERVICE ENCOUINTER HAS BEEN REFUSED AS A CLAIM FOR WCB17 HAS ALREADY BEEN APPROVED FOR THIS DATE.

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UPDATED FILES

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2016 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE
December 23, 2015**	**December 30, 2015****	January 6, 2016
January 11, 2016	January 14, 2016	January 20, 2016
January 25, 2016	January 28, 2016	February 3, 2016
February 5, 2016**	**February 10, 2016****	February 17, 2016
February 22, 2016	February 25, 2016	March 2, 2016
March 7, 2016	March 10, 2016	March 16, 2016
March 18, 2016**	**March 23, 2016****	March 30, 2016
April 4, 2016	April 7, 2016	April 13, 2016
April 18, 2016	April 21, 2016	April 27, 2016
May 2, 2016	May 5, 2016	May 11, 2016
May 13, 2016**	**May 18, 2016****	May 25, 2016
May 30, 2016	June 2, 2016	June 08, 2016
June 13, 2016	June 16, 2016	June 22, 2016
June 24, 2016**	**June 29, 2016****	July 6, 2016
July 11, 2016	July 14, 2016	July 20, 2016
July 22, 2016**	**July 27, 2016****	August 3, 2016
August 08, 2016	August 11, 2016	August 17, 2016
August 22, 2016	August 25, 2016	August 31, 2016
September 2, 2016**	September 08, 2016	September 14, 2016
September 19, 2016	September 22, 2016	September 28, 2016
September 30, 2016**	**October 5, 2016****	October 12, 2016
October 17, 2016	October 20, 2016	October 26, 2016
October 31, 2016	November 3, 2016	November 09, 2016
November 14, 2016	November 17, 2016	November 23, 2016
November 28, 2016	December 1, 2016	December 7, 2016
December 12, 2016	December 15, 2016	December 21, 2016
December 21, 2016**	**December 28, 2016****	January 4, 2017
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, Sessional Payments and Locum Claim Forms. 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 2016

Please make a note in your schedule of the following dates MSI will accept as "Holidays."	
NEW YEAR'S DAY	FRIDAY, JANUARY 1, 2016
HERITAGE DAY	MONDAY, FEBRUARY 15, 2016
GOOD FRIDAY	FRIDAY, MARCH 25, 2016
EASTER MONDAY	MONDAY, MARCH 28, 2016
VICTORIA DAY	MONDAY, MAY 23, 2016
CANADA DAY	FRIDAY, JULY 1, 2016
CIVIC HOLIDAY	MONDAY, AUGUST 1. 2016
LABOUR DAY	MONDAY, SEPTEMBER 5, 2016
THANKSGIVING DAY	MONDAY, OCTOBER 10, 2016
REMEMBRANCE DAY	FRIDAY, NOVEMBER 11, 2016
CHRISTMAS DAY	MONDAY, DECEMBER 26, 2016
BOXING DAY	TUESDAY, DECEMBER 27, 2016
NEW YEAR'S DAY	MONDAY, JANUARY 2, 2017

MEDICAL CONSULTANT JOB POSTING

Job Title: Medical Consultant
Internal/External: Internal/External
Department: Medicare Programs
Competition: 2015-543
Employment Type: Consultant Position – 3 year contract
Location(s): Dartmouth, NS
Salary: Competitive Compensation
Reports to: Team Leader
Closing Date: November 1, 2015

"We care about the work we do-and we're looking for new colleagues who do, too."

The Company:

For over 70 years, and across six provinces we've been a leading diversified health services partner for individuals, plan sponsors, plan advisors and governments across Canada. We are proud to be a not-for-profit organization committed to giving back to the communities where we live and work. We support the health and wellness of our employees and their families with various wellness programs and resources to support their personal and professional growth.

We're a team of 1,900 colleagues dedicated to collaboration, innovation, customer service, and committed to work-life balance, community involvement and career development which is why Medavie Blue Cross is recognized as one of Canada's 10 Most Admired Corporate Cultures. We care about the work we do-and we're looking for new colleagues who do, too.

Role Summary:

We are currently accepting applications for a part time Medical Consultant. The successful candidate will work onsite with the Medicare Programs team in our Dartmouth office and will be responsible for providing professional medical guidance in support of the MSI assessment and audit functions. In this role, the successful candidates will be responsible for providing a professional link between physicians, government and patients.

As a Medical Consultant, your key responsibilities will include:

- Providing direction and guidance to the Claims Assessment team regarding claims adjudication and payment.
- Reviewing requests for pre-authorization of in-province physician services; out-of- province/country physician services or hospitalization and retroactive payment of out- of-province/country physician services or hospitalization claims.
- Ensuring all administrative processes are followed for out-of-province/country referrals for addiction and mental health services.
- Providing or assisting in the first level of appeals for citizen/provider complaints regarding issues of medical insurability, medical necessity and treatment not normally insured as well as provider appeals regarding claims payment.
- Conduct fee for service and shadow billing audits in collaboration with the Medicare 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 pre and post payment monitoring operations, and the development of risk analysis strategies to utilize departmental resources efficiently.
- Providing assistance to the Department of Health and Wellness Medical Consultant to support medical policy, medical tariff development and activities related to claims assessment
- 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.

- Responding to enquiries from patients, physicians, Doctors NS, Nova Scotia College of Physicians and Surgeons, Medical Directors and the Department of Health and Wellness with respect to individual patient claims and the insurability of specific services for an individual according to Department of Health and Wellness policy.

As the ideal candidate, you possess the following qualifications:

Education: University degree with a Doctorate in Medicine.

Work Experience: Ten to 15 years' experience as a physician in a range of practice settings. Surgical and administrative experience would be an asset.

Other Qualifications: Strong interpersonal skills and the ability to resolve conflicts and deal with stressful situations.

Computer Skills: General computer knowledge.

Communication Skills: Excellent written and verbal communication skills are fundamental to the position.

You also demonstrate the following core competencies:

Knowledge: Uses knowledge and industry best practices to provide guidance and/or advice to leaders and coworkers on key issues in own area of expertise. Demonstrates a specialized knowledge of all processes, policies and precedents to do the job and solve day to day issues independently.

Analytical Thinking: Uses knowledge and experience to solve a variety of routine and complex technical problems. Identifies the cause of problems and implements the most appropriate solution.

Communication: Able to communicate complex information effectively through both oral and written means. Demonstrates the full range of effective verbal communication skills in a variety of settings such as formal meetings, presentations, and any one on one situation.

Customer Orientation: Independently processes many unusual and demanding customer requests. Maintains library/database/network of all customer information and materials to meet both routine and complex customer needs.

Execution and Organization Skills: Exceptional organizational and time-management skills. Able to prioritize work within in a changing work environment under the pressure of deadlines.

Team Work: Provides professional advice and direction to team members and leads work processes and proactively searches for ways to improve team effectiveness and performance.

If you are interested in working with a team of professionals in a challenging role and you possess the necessary qualifications, please follow the instructions for applying online via the Medavie Blue Cross Corporate website by clicking on the link below.

Apply Now

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

Canadian Citizenship - 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.

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August 14, 2015: Vol. LI, ISSUE 8

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

NEW MSI CLAIMS PROCESSING AND PAYMENT SYSTEM

Medavie Blue Cross, as the administrator of the MSI program, has undertaken a technology transition to a new corporate claims system. The implementation of this new corporate claims system is scheduled for fall 2015. **Physicians will see no changes in the claims submission or payment processing as a result of this technology project.** As part of the roll-out of this new system MSI will need to convert claims history from the old system to the new system. During this conversion period, MSI will require a period of time where the Medicare history is stable with no changes.

During the claims history conversion, physicians will be required to hold all deletions and re-adjudicates of claims for a period of time. The length of time physicians will be required to hold all deletions and re-adjudicates will be minimal and result in the least disruption for physicians. New claims will continue to be accepted. Further information, including specific dates for conversion, will be communicated via mail as we near the implementation date.

In the meantime, it is important for offices to re-adjudicate claims in a timely manner to minimize the impact during the conversion period.

Important Shadow Billing Information

All physicians must submit original claims to MSI within 90 days of the date of service. This includes physicians who shadow bill.

With the implementation of the new corporate claims system the 90 day time limit for shadow claims will be enforced. Effective fall 2015 shadow claims over the 90-day time limit will be considered outdated claims. These claims will be adjudicated and processed as 'paid as zero' with the following exceptions:

- Reciprocal billing claims (out of province) must be submitted within 12 months of the date of service.
- Resubmission of refused claims or incorrect billings must be resubmitted to MSI within 185 days of the date of service. Each resubmission must contain an annotation in the text field of the Service Encounter submission referencing the previous Service Encounter Number.

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MSI News continued

Important Shadow Billing Information - continued

Shadow claims that are greater than 90 days of the date of service will fall under the purview of the Outdated Claims Policy. Outdated claims will only be considered by MSI if extenuating circumstances can be demonstrated for a late submission and are within a reasonable time frame past the 90-day limit. Request for an extension must be made to MSI in writing and will be approved on a case by case basis.
The time frame for submitting the request to MSI for late submission should be within one month following the 90-day limit. Examples of extenuating circumstances may include physical damage to office, such as fire or flood and/or a serious technical issue.

Circumstances relating to staffing issues/shortages and mislaid, misfiled, or lost claims cannot be accepted by MSI as valid explanations for a late submission.

Claims for registered hospital in-patients must also be submitted within the 90-day time limit regardless of the patient having been discharged or continuing on an in-patient basis. It is incumbent on the physician to obtain the required billing information for these patients and submit claims within the prescribed time limit.
Explanations relating to late discharge summaries, or facilities not consolidating the required information for the physician, cannot be accepted as a valid explanation for a late submission.

All physicians who submit shadow claims will receive direct communication in the mail notifying them of the implementation date.

Fees New Fees and Highlighted Fees

NEW FEES

Effective June 15, 2015 the following health service code is available for billing:

Category	Code	Description	Value
DEFT	WCB28	**Comprehensive Visit for Work Related Injury or Illness** Please note: The WCB28 should be billed with the WCB26 (the report)	$64.56

The following health service code has been reinstated effective May 22, 2015.

Category	Code	Description	Base Units
VADT	03.26C	**Female Pelvic Examination with Speculum**	10.5 MSU

NEW FEES CONTINUED

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Effective August 14, 2015 the following new health service codes are available for billing:

Category	Code	Description	Base Units
VADT	02.02B	**Optic Nerve Imaging** Optic Nerve Imaging by any means (e.g. OCT, HRT) for patients with a diagnosis of glaucoma, wet AMD, retinal vein occlusion, diabetic macular edema. This fee is for the interpretation of scanning computerized ophthalmic diagnostic imaging, with interpretation and written report, unilateral or bilateral, of the optic nerve and/or retina regardless of the technology used to perform the imaging. Not to be used for glaucoma screening. **Billing Guidelines** Billable: 1. Glaucoma diagnosis - once per year. 2. Diabetic macular edema, retinal vein occlusion or wet age related macular degeneration having been treated once in the past year with intravitreal anti-VEGF drugs - up to 6 times per year **Specialty Restriction** OPTH **Location** OFFC, HOSP	8 MSU
VEDT	09.02H	**Comprehensive Eye Examination of both eyes including refraction** This fee is for the comprehensive examination of the entire visual system to diagnose or obtain information to allow proper ongoing care of more complex conditions and includes history, general medical observation with sensorimotor examination, external and ophthalmoscopic examinations, refraction, and testing with analysis of non-automated visual fields. It may include biomicroscopic examination with mydriasis or cycloplegia, tonometry, retinoscopy, manual keratometry, gonioscopy, colour vision testing, ocular alignment using prisms, indirect ophthalmoscopic examination of the fundus, axial length measurement, and corneal pachymetry as required. Auto or manual refraction for diagnostic purposes (not simply writing a prescription) is included. This examination will result in a diagnosis and initiation of treatment program with follow up arrangements. Specific treatment interventions such as laser coagulation, intravitreal injection, or removal of a foreign body are billable in addition to the comprehensive eye examination. **Billing Guidelines** Billable to a maximum of two times per year, unless for pre and post cataract surgery, then can be billed as required to a maximum of four times in one year if the patient has cataract surgery on both eyes during that year. May be billed per eye when performed pre and post	29 MSU

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Category	Code	Description	Base Units
		cataract surgery. Restricted to patients with a diagnosis of retinal vascular conditions including, but not limited to, diabetes, glaucoma, uveitis, retinopathy of prematurity outside of the NICU, and paediatric strabismus/amblyopia treatment. When performed in conjunction with cataract surgery, the post surgical exam must be at least 30 days after the surgery. Not to be billed with: VADT 03.12 Tonometry VADT 09.01A Gonioscopy VADT 09.05 Visual field study VADT 09.13B Axial length measurement by ultrasound Corneal pachymetry Automated or manual keratometry **Specialty Restriction** OPTH **Location** OFFC, HOSP	

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Effective August 14, 2015 the following health service codes have been revised to include specialty and location restrictions, which align the payment system with existing policy.

Category	Code	Description	Base Units
VADT	03.19C	**Sleep Studies** **Specialty Restriction** NEUR, RESP **Location** HOSP	60 MSU
VADT	03.19F	**Level II Sleep Apnea Testing Interpretation** **Specialty Restriction** NEUR, INMD, OTOL, RESP **Location** OFFC, HOSP	35 MSU
VADT	03.19G	**Level III Sleep Apnea Testing Interpretation** **Specialty Restriction** NEUR, INMD, OTOL, RESP **Location** OFFC, HOSP	25 MSU

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Effective August 13, 2015 the following health service code will no longer be active:

Category	Code	Description	Base Units
VADT	02.02A	**Optical Coherence Tomography**	8 MSU

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PROVINCIAL IMMUNIZATION CHANGES

Effective July 31, 2015 the following immunizations are available for billing:

HSC	Modifier	Description
13.59L	RO=MENB (PT=RISK)	MenB - Meningococcal B vaccine (high risk patient) Billing Guidelines For post exposure prophylaxis, outbreaks, and those with high risk conditions.
13.59L	RO=MENQ	Men-C-ACYW-135- Meningococcal Conjugate Quadrivalent vaccine Billing Guidelines Grade 7 students only
13.59L	RO=GAIG (PT=RISK)	GAIg - Measles Immunoglobulin (high risk patient)
13.59L	RO=HAIG (PT=RISK)	HAIg - Hepatitis A Immunoglobulin (high risk patient)
13.59L	RO=HAVV (PT=RISK)	HA - Hepatitis A vaccine (high risk patient)
13.59L	RO=MENC (PT=RISK)	Men-C-C- Meningococcal conjugate (high risk patient)

Effective July 31, 2015 the following provincial immunization description has changed:

Modifier	Old Description	New Description
RO=MMRT	MMRV - Measles, Mumps, Rubella and Varicella for travel only to areas of risk for Measles.	MMR- Measles, Mumps and Rubella for travel only to areas of risk for Measles.

* This is a description change only; the original intent for this immunization is to vaccinate children between 6 months and within one week of 12 months of age, against Measles for travel to high risk areas with the MMR (Measles, Mumps and Rubella) vaccine.

Please note that effective August 14, 2015 the following billing guidelines will be enforced:

HSC	Modifier	Billing Guideline
13.59L	RO=HPV4	PT=RISK modifier will be required when a 3rd dose of RO=HPV4 is given
13.59L	RO=MMRV	Maximum of two injections per patient per lifetime Only allowed if patient is at least 12 months or within 1 week of 12 months
13.59L	RO=PNEU	Only one injection to be billed if the patient is greater than or equal to 65 years of age

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PROVINCIAL IMMUNIZATION CHANGES CONTINUED

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Please note that effective August 14, 2015 the following billing guidelines have been modified:

HSC	Modifier	Billing Guideline
13.59L	RO=PNEU	Maximum of three injections per patient per lifetime (previous guideline only allowed two)
13.59L	RO=HPV4	Previous gender restrictions removed

Please note a communication change. MMRV and MMAR Vaccines are to be given at 12 months and again between 18 months and 6 years of age. (This is a change from the previously published 12 months and 4-6 years).

The Nova Scotia Immunization Schedules are attached in the appendices section of this bulletin.

The NS Publicly Funded Vaccine/Immunoglobulin Eligibility Policy (July 2015), the NS Publicly Funded Vaccine Eligibility for Individuals at High Risk of Acquiring Vaccine Preventable Diseases Policy Version 2.0 (July 2015) and the NS Routine Childhood Immunization Schedule Poster (July 2015) can be found at:
http://novascotia.ca/dhw/CDPC/info-for-professionals.asp

Billing Matters Billing Reminders, New Explanatory Codes

BILLING REMINDERS

Pathology: Health Service Codes P2345 and P2325

P2325 (Surgicals, gross and microscopic) may be claimed for each specimen taken from anatomically distinct surgical sites. The following is a list of anatomically distinct surgical sites:

- head and neck
- upper limbs
- lower limbs
- trunk anterior and posterior
- upper GI tract
- female reproductive system
- male reproductive system
- separate organs within the abdominal or thoracic cavities may be claimed as distinct sites

P2345 (Surgicals, gross and microscopic – three or more separate surgical specimens) may be claimed when three of more separate surgical specimens are taken from the same anatomic site.

Examples: two separate skin specimens from the right and left arms are considered one site, specimens from the uterus and ovary are one site, specimens from the colon and liver are two sites.

Note: The multiples permitted for HSC P2345 or P2325 may not be the same as the number of specimens received and examined. Please ensure the multiples claimed are submitted correctly.

Pathology: Second Opinion Consults

Pathologists are reminded that they may not bill second opinion consults for cases that are part of a Quality Assurance program.

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BILLING REMINDERS CONTINUED

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Pathology: Cytology Screener and Interpretation

In the May 22nd 2015 Bulletin there was a reminder that HSC P2330 (cytology with a screener) is not to be claimed with HSC P2331 (interpretation and report – GYN slides) for the same specimen. To accommodate for reviews done by screeners claimed prior to an interpretation MSI will now accept claims for the interpretation (P2331) for a previously paid review by a screener (P2330). However, the payment amount for interpretation (P2331) will be reduced by the value of the previously paid screener review (P2330). Deleting the screener code (P2330) claim is no longer necessary.

Bulk Billing Transition Updated Documentation

Please visit the **Bulk Billing Transition section** of the MSI website for updated rules.

Physician Claims for Vaccines Administered by Pharmacists

It has come to MSI's attention that some family physicians claimed for influenza vaccinations administered by pharmacists during last year's influenza vaccination program. Family physicians may claim only for vaccines they have either personally administered or those administered by nurses under direct supervision and employment of the physician. In the latter circumstance, the physician may only claim for the procedure if the physician is personally on the premises when the nurse administers the vaccine. Physicians may not claim for vaccines administered by pharmacists.

Comprehensive Prenatal Visits (HSC 03.04)

MSI has received a number of complaints from family physicians who are asked to follow antenatal patients of colleagues who do not provide obstetrical services. The concern raised is that the referring physician is claiming a comprehensive antenatal visit without meeting Preamble requirements for a comprehensive visit which includes conducting and documenting a complete history and physical. For antenatal patients, this includes conducting a gynaecologic examination and documenting full details of the history and physical on the standardized Nova Scotia prenatal record form. As only one comprehensive antenatal visit is payable per pregnancy, the receiving physician who conducts and documents a complete history and physical cannot claim a comprehensive visit if one has been claimed by the regular family physician prior to referring the patient for obstetrical care. As a reminder, this health service code should be claimed only after all the Preamble requirements have been met. It is the responsibility of the coordinating physician to also coordinate billing with the receiving physician.

Second and Subsequent Service Occurrences

MSI has noted instances in which previously bulk billed codes are being incorrectly submitted using second or subsequent service occurrence numbers. As a reminder, second and subsequent service occurrences may only be submitted for separate and distinct episodes of care.

For example, if a patient has an ECG done in the cardiac investigation unit in the morning that is read by an internist and the same internist sees the patient in consultation later that day in the emergency department the consultation should be claimed as service occurrence #2.

However, if a patient attends the pulmonary function lab and has both spirometry and plethysmography carried out and reported by a respirologist, both health service codes should be submitted in the same service occurrence.

Similarly, if a patient has both a chest CT and an abdominal CT scan carried out in a single visit to the diagnostic imaging department and reported by the same radiologist one service occurrence should be submitted for the two studies. However, if the patient has a chest radiograph done and returns later in the day for a follow-up study these should be reported as separate service occurrences.

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BILLING REMINDERS CONTINUED

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Pulmonary Function Tests

As per MSI's previous communication, if a physician has interpreted two or more pulmonary function studies that meet the definition of multiple service encounters as outlined above and these have not been paid the claims should be submitted with action code 'R' (readjudication) together with a copy of the clinical record.

In the fall new health service codes will be implemented for the following studies:

- Pulmonary function studies to assess bronchodilator responsiveness
- Six minute walk test, interpretation, when this is the sole procedure
- Exercise induced asthma assessment, interpretation

Physicians are requested to hold claims for these studies until the new health service codes are implemented. These codes will be retroactive to April 1, 2015.

NEW EXPLANATORY CODES

Code	Description
AD038	SERVICE ENCOUNTER HAS BEEN REFUSED AS A MAXIMUM OF THREE 13.59L RO=PNEU IMMUNIZATIONS HAVE BEEN PREVIOUSLY PAID
AD056	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED HSC 95.94A AT THE SAME ENCOUNTER.
AD057	SERVICE ENCOUNTER HAS BEEN REFUSED AS AN INFLUENZA INJECTION HAS ALREADY BEEN APPROVED IN THE PREVIOUS 6 MONTHS.
AD058	SERVICE ENCOUNTER HAS BEEN REFUSED AS A THIRD INJECTION FOR RO=HPV4 REQUIRES MODIFIER PT=RISK
AD059	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF HPV4 INJECTIONS HAS BEEN REACHED
BK043	SERVICE ENCOUNTER HAS BEEN ACCEPTED AT A REDUCED VALUE AS A CLAIM FOR CYTOLOGY SCREENER CODE P2330 HAS PREVIOUSLY BEEN MADE FOR THIS SPECIMEN.
BK044	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM HAS PREVIOUSLY BEEN MADE FOR THE INTERPRETATION AND REPORT OF THESE GYN CYTOLOGY SLIDES (HSC P2331).
BK045	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR A DOPPLER QUANTITATIVE INTERPRETATION AT THE SAME ENCOUNTER.
BK046	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR A DOPPLER QUALITATIVE INTERPRETATION AT THE SAME ENCOUNTER.
BK047	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR A GENETIC SONOGRAM AT THE SAME ENCOUNTER. A GENETIC SONOGRAM INCLUDES ALL NECESSARY IMAGING.
BK048	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED A CRITICAL OR COMPREHENSIVE CARE FEE FOR THE PATIENT ON THIS DAY WHICH INCLUDES ALL EKG INTERPRETATION PERFORMED.
BK049	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED AN EKG INTERPRETATION FEE FOR THE PATIENT ON THIS DAY. PLEASE SUBMIT A DELETE FOR THE EKG INTERPRETATION BEFORE MAKING A SUBMISSION FOR A CRITICAL OR COMPREHENSIVE CARE FEE.
GN070	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE CAN NOT BE BILLED FROM THIS FACILITY
GN071	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED FOR SOLE OPERATIVE PROCEDURE FEE 90.69D AT THE SAME ENCOUNTER.

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Code	Description
GN072	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED ANOTHER SERVICE AT THE SAME ENCOUNTER. HSC 90.69D CAN ONLY BE BILLED IF THE REMOVAL OF FIXATION DEVICE IS THE SOLE OPERATIVE PROCEDURE.
GN073	PLEASE SUBMIT DOCUMENTATION TO FURTHER ASSIST IN ASSESSING THIS CLAIM
GN074	THE INFORMATION PROVIDED ON YOUR CLAIM DOES NOT MATCH THE SURGEONS SUBMISSION
GN075	PLEASE PROVIDE TEXT INDICATING APPROVAL WAS GIVEN BY PUBLIC HEALTH
VA067	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 09.02H AT THE SAME ENCOUNTER
VA068	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED HSC 13.59L AT THE SAME ENCOUNTER.
VA069	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR AN ULTRASOUND FEE AT THE SAME ENCOUNTER. GENETIC SONOGRAM INCLUDES ALL NECESSARY IMAGING. PLEASE SUBMIT A DELETE FOR ORIGINAL INTERPRETATION BEFORE RESUBMITTING GENETIC SONOGRAM.
VA070	SERVICE ENCOUNTER HAS BEEN REFUSED AS ONLY ONE OPTIC NERVE IMAGING FEE CAN BE BILLED PER YEAR FOR THIS DIAGNOSIS
VA071	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM OF 6 CLAIMS ALLOWED PER YEAR FOR THIS SERVICE HAVE BEEN APPROVED
VE011	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED ONE OF THE FOLLOWING SERVICES AT THE SAME ENCOUNTER 03.12, 09.01A, 09.05 OR 09.13B
VE012	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THE MAXIMUM LIMIT PER YEAR HAS ALREADY BEEN APPROVED FOR THIS SERVICE

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In every issue Helpful links, contact information, updated files

UPDATED FILES

Updated files reflecting changes are available for download on Friday, August 14, 2015. The files to download are health service (SERVICES.DAT), health service description (SERVDSC.DAT), explanatory codes (EXPLAIN.DAT) and modifier values (MODVALS.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

www.medavie.bluecross.ca\msiprograms

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

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

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Routine Childhood Immunization Schedule

Childhood immunizations have changed in the past few years. This schedule reflects these changes and may be different from what you or your children may have received in the past.

The immunizations shown on this schedule are those that are given **free of charge**.

High-risk children may be eligible for additional vaccines. For more information, talk to your health care provider or call your local Public Health Services office.

VACCINES	SCHEDULE					
	2 months	4 months	6 months	12 months	18 months	4-6 years
DTaP-IPV-Hib Diphtheria, tetanus, acellular pertussis (whooping cough), polio, and Haemophilus influenzae type b vaccine	✓	✓	✓		✓	
Pneumo Conj. Pneumococcal conjugate vaccine	✓	✓		✓		
Men C Conj. Meningococcal group C conjugate vaccine				✓		
MMRV* Measles, mumps, rubella and varicella vaccine				✓	✓*	✓*
Tdap-IPV Tetanus, diphtheria, acellular pertussis (whooping cough), and polio vaccine						✓

**The second dose of MMRV can be given only once between 18 months and 6 years of age.*

Seasonal Flu Vaccines

- Seasonal flu vaccines are free for all Nova Scotians. They are recommended for all adults and children EXCEPT for babies under 6 months.
- Seasonal flu vaccines are strongly recommended for anyone who lives with or takes care of a child under 5 years, and for anyone living in a home where a newborn is expected during influenza season (October to April). This includes both adults and older children.
- Seasonal flu vaccines are also strongly recommended for children with a health condition that places them at high risk and for anyone who lives with or takes care of these children.
- Children under 9 years old getting their first flu vaccine need 2 doses.

For more information about seasonal flu vaccines, see: novascotia.ca/DHW/CDPC/flu.asp

Aussi disponible en français

NOVA SCOTIA

13151/APR15 REV15-16

Nova Scotia Routine Childhood Immunization Schedule

Publicly Funded Vaccines: Information for Health Professionals

Age	Vaccine	Site	Route	Needle Size *(based on assessment of child)*
2 months	DTaP-IPV-Hib	vastus lateralis (thigh)	I/M	25g 1 inch
	Pneumococcal	vastus lateralis (thigh)	I/M	25g 1 inch
4 months	DTaP-IPV-Hib	vastus lateralis (thigh)	I/M	25g 1 inch
	Pneumococcal	vastus lateralis (thigh)	I/M	25g 1 inch
6 months	DTaP-IPV-Hib	vastus lateralis (thigh)	I/M	25g 1 inch
12 months	MMRV	upper arm	S/C	25g 5/8 inch
	Meningococcal C	vastus lateralis (thigh)	I/M	25g 1 inch
	Pneumococcal	vastus lateralis (thigh)	I/M	25g 1 inch
18 months	DTaP-IPV-Hib	deltoid	I/M	25g 1 inch
	(MMRV)[1]	upper arm	S/C	25g 5/8 inch
4-6 years *(before starting school)*	Tdap-IPV	deltoid	I/M	25g 1 inch
	(MMRV)[1]	upper arm	S/C	25g 5/8 inch

[1] *(MMRV): The second dose of MMRV can be given only once between 18 months and 6 years of age.*

Seasonal Influenza Vaccine

- The influenza vaccine is recommended annually for all children 6 months and older.
- Children under 9 years old getting their first influenza vaccine need 2 doses at least 4 weeks apart.

School-based Program

- Hepatitis B, Tetanus, Diphtheria and Acellular Pertussis (Tdap), Meningococcal Quadrivalent (A, C, Y, W 135) and Human Papillomavirus (HPV) vaccines are offered in the school-based immunization program.
- Please call Public Health if you have any questions about the school-based immunization program.

Information for the Unimmunized or Partially Immunized Child

- In relation to the publicly funded program, for information on the number of doses and timing of vaccine administration for the **unimmunized child 1-6 years of age** please consult the Canadian Immunization Guide: **phac-aspc.gc.ca/publicat/cig-gci/p01-12-eng.php**
- In relation to the publicly funded program, for information on the number of doses and timing of vaccine administration for the **unimmunized child 7-17 years of age** please consult the Canadian Immunization Guide: **phac-aspc.gc.ca/publicat/cig-gci/p01-12-eng.php**
- In relation to the publicly funded program, for information on the number of doses and timing of vaccine administration for the **partially immunized child** please consult the Canadian Immunization Guide: **phac-aspc.gc.ca/publicat/cig-gci/p01-12-eng.php**
- Interruption of a vaccine schedule does not require restarting the series, regardless of length of time since last dose.
- **MMRV** is indicated for use in children less than 13 years of age. **Eligible individuals** ages 13 years and older should receive **MMR and Varicella vaccines separately.**

Other Important Information

- For children **medically at high risk of acquiring vaccine-preventable diseases** please refer to Vaccine Eligibility for High Risk Conditions: **novascotia.ca/dhw/CDPC/info-for-professionals.asp**
- Record date given, vaccine name, lot number, site and route of administration, and vaccine provider's name on reciprocal form or into PHIM.
- Use only the specific diluents provided for each vaccine to reconstitute the vaccine. Diluents are not interchangeable.
- For unusual or serious **adverse reactions** to vaccines, complete AEFI form: **phac-aspc.gc.ca/im/aefi-form-eng.php** and submit to Public Health.
- **Cold chain:** Vaccines must be kept at a temperature of +2 to +8°C. In the event of a fridge failure, keep vaccine refrigerated and contact Public Health immediately for advice on vaccine use.
- **Immunization Resources / Websites:**
  - Nova Scotia Department of Health and Wellness: **novascotia.ca/dhw/cdpc/info-for-professionals.asp**
  - Public Health Agency of Canada: **phac-aspc.gc.ca/im/index-eng.php**
  - Immunize Canada: **immunize.ca**
  - Canadian Paediatric Society: **cps.ca**

Public Health Contact Information

Amherst
Tel: 902-667-3319

Antigonish
Tel: 902-867-4500
ext. 4800

Bridgewater
Tel: 902-543-0850

Dartmouth
Tel: 902-481-5800

New Glasgow
Tel: 902-752-5151

Sydney
Tel: 902-563-2400

Truro
Tel: 902-893-5820

Wolfville
Tel: 902-542-6310

Yarmouth
Tel: 902-742-7141

NOVA SCOTIA

13078/MAY15 REV15-16

School Immunization Schedule

The immunizations shown on this schedule are those that are given **free of charge.**

Children at high risk may be eligible for additional vaccines. For more information, talk to your health care provider or talk to your local Public Health Office.

		School Year
		Grade 7
VACCINES	**HPV (for both boys and girls)** Human papillomavirus vaccine (2 doses)	✓
	Hepatitis B (HB) Hepatitis B vaccine (2 doses)	✓
	Tdap Tetanus, diphtheria, and acellular pertussis (whooping cough) vaccine	✓
	Meningococcal Quadrivalent Meningococcal Quadrivalent vaccine (Groups A, C, Y and W 135)	✓

13153 /APR15 REV15-16

PHYSICIAN'S BULLETIN
June 24, 2015: Vol. LI, ISSUE 7

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians WCB interim change in billing process

INTERIM BILLING PROCESS

In the June 5, 2015 Physician's Bulletin, physicians were advised to bill Health Service Code 03.04 plus WCB26 for an injured worker visit and Form 810 report, in place of the former WCB11. We are aware of a current issue that is preventing some claims from processing.

In the interim please bill former WCB11 claims as follows:

- Health Service Code **EC (Exceptional Circumstances)** plus **WCB26** for the visit and report. When billing **EC**, please request **24 units** and ensure that an annotation **"Interim code for Comprehensive WCB visits"** is made in the "text" field.

If you have eligible rejected claims, you may resubmit them now according to the instructions above.

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PHYSICIAN'S BULLETIN
June 5, 2015: Vol. LI, ISSUE 6

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians WCB fee revisions

NEW FEES

Effective June 15, 2015 the following new health service codes will be available for billing for services on or after June 15, 2015. For further details on WCB billing see the Physician's WCB Reference Guide at www.wcb.ns.ca/physicians.

Code	Description	Value
WCB26	**Return to Work Report – Physician's Report Form 8/10** **Billing Guidelines** Can be billed with 03.04, comprehensive office visit, same service date for Return to Work Services. **Can be billed as Long Term Benefits (LTB) Follow-up Report.** Only required if there is a change in medical status or treatment. Not required for changes in medication. Can be billed with 03.03 or 03.03A office visit, same service date. **Specialty Restriction** GENP, EMMD	$64.16
WCB27	**Eye Report** **Billing Guidelines** Only to be used on request of the WCB. Can be billed with an office visit, if needed, same service date. **Specialty Restriction** OPTH	$56.25

MODIFIED FEES

Effective June 15, 2015 the following fees will be modified with the following information.

Code	Description	Modification
WCB12	**Enhanced Physician Services (EPS) Return to Work Office Visit & Report.** **Billing Guidelines** Can be billed with other WCB codes on the same service date. Multiples on initial visit only, max of 4 multiples paid at $50 each. **Specialty Restriction** Can only be billed by EPS physician (RO=EPS1).	Added the following modifiers and updated the fees. RO=INTL……..$171.24+MU RO=SUBS……..$171.24

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MODIFIED FEES CONTINUED

Code	Description	Modification
WCB13	**WCB Requested Reports** **Billing Guidelines** Only to be used on request of the WCB. Can be billed with other WCB codes on the same service date.	Updated to include different fee depending on type of physician. GPs……..$41.82 per 15 min EPS (RO=EPS1)……$50.00 per 15 min Specialists……...$56.25 per 15 min
WCB15	**Case conference and teleconferencing** **Billing Guidelines** Can be billed with other WCB codes on the same service date. WCB case worker or medical advisor must be in attendance unless otherwise approved.	Updated to include different fee depending on type of physician. GPs……..$41.82 per 15 min EPS (RO=EPS1)……$50.00 per 15 min Specialists……...$56.25 per 15 min
WCB17	**Photocopies of chart notes** **Billing Guidelines** Only to be used on request of the WCB. Can be billed with other WCB codes on the same service date.	Updated to include different fee depending on the size of the chart to be copied. 10 pages or less (ME=UP10).....$25.00 11-25 pages (ME=UP25)……..$50.00 26-50 pages (ME=UP50)…….$100.00 Over 50 pages (ME=OV50)…...$150.00
WCB20	**Carpal Tunnel Syndrome (CTS) Assessment Report** **Billing Guidelines** Only to be used upon request of the WCB. Can be billed with an office visit if needed, same service date. **Specialty Restriction** GENP	Updated value to……$64.16

DISCONTINUED FEES

Effective June 14, 2015 the following fees will be discontinued.

Code	Description
WCB11	**Physician Assessment Service** (replaced by 03.04 and WCB26)
WCB14	**Chart Summaries / Written Reports** (replaced by WCB13)
WCB16	**Case Conferencing and Teleconferencing (EPS Physician)** (replaced by WCB15)
WCB98	**Second Opinion Consultation Specifically requested by WCB Regarding Back Surgery**

PHYSICIAN'S BULLETIN
May 22, 2015: Vol. LI, ISSUE 4

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

BILLING UPDATE

Claiming a consultation at the time of colonoscopy for FIT positive Colon Cancer Prevention Program (CCPP) patients

Prior to April 1, 2015, physicians providing colonoscopy services to FIT positive CCPP patients booked for colonoscopy by the Program could not claim a consultation fee at the time of the procedure.

Effective April 1, 2015, DHW has agreed that the CCPP Medical Director will formally refer these patients through the district screening nurses. When a patient is referred from the Colon Cancer Prevention Program for a colonoscopy with a formal referral from the Program's Medical Director, a limited consultation HSC 03.07 may be billed at the time of the colonoscopy procedure, in accordance with the Preamble rules, if the patient has not previously been seen in consultation.

When a patient is referred from the CCPP with a formal referral from the Program's Medical Director for a medical assessment prior to booking a colonoscopy a comprehensive (HSC 03.08) or limited (HSC 03.07) consultation may be billed depending on the situation, in accordance with the Preamble rules.

See March 27, 2015 Bulletin for details on the requirements for a comprehensive consult claim.

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NEW FEES

Effective May 22, 2015 the following new health service code is available for billing:

Category	Code	Modifiers	Description	Base Units	Anaes Units
MASG	60.59B		**Proctectomy with rectal mucosectomy, ileoanal anastomosis, and creation of ileal reservoir (Ileal Pouch Anal Anastomosis)** This is a comprehensive fee for a partial proctectomy, with rectal mucosectomy, ileoanal anastomosis, and creation of an ileal reservoir. Includes sigmoidoscopy when performed. **Billing Guidelines** May not be billed with: 1.24C Sigmoidoscopy May be billed with (usual surgical rules apply): 58.21A Ileostomy (LV50) 57.6B Colectomy (LV 50) **Specialty Restriction** Colorectal surgeon, Surgical oncologist **Location** HOSP	630 MSU	8+T

FEE REVISIONS

Effective May 22, 2015 the following health service code will no longer be active.

Category	Code	Modifiers	Description	Base Units	Anaes Units
VADT	03.26C*		**Female pelvic examination with speculum**	10.5 MSU	
MASG	60.31A		**Proctectomy - mucosectomy, ilio-anal anastomosis and ileal pouch**	500 MSU	8+T
		RO=ABAS		135 MSU	
		RO=ABDM	*Replaced by HSC 60.59B	400 MSU	
		RO=PEAS		68 MSU	
		RO=PRIN		200 MSU	

* MSI Physician's Bulletin Update – May 27, 2015*
The terming of HSC 03.26C Female pelvic examination with speculum, on May 22, 2015 was an error.
In the interim, please submit claims using exceptional circumstances (HSC EC).
Please ensure that an annotation is made in the "text" field indicating: 'as per HSC 03.26C'.

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NEW DIAGNOSTIC CODE

New Diagnostic Code for Vitreomacular Adhesion

A new diagnostic code 37927 for vitreomacular adhesion (VMA) will be added to the list of approved "specified retinal diseases" when billing for:

- HSC 02.02A – Optical Coherence Tomography for Macular Analysis in specific retinal diseases
- HSC 28.73F - Intravitreal injection of a pharmacologic agent for the treatment of specific retinal diseases.

The addition of this diagnostic code is being implemented to accommodate the DHW Pharmacare decision to include Jetrea® (ocriplasmin), as an Exception Status Benefit. Please refer to the January 2015 Pharmacare News, Physicians' Edition Bulletin for details on the Exception Status Criteria.

BILLING CLARIFICATION

Please see the following codes that have expanded descriptions to assist with billing the appropriate code:

Category	Code	Modifiers	Description	Base Units	Anaes Units
MASG	97.14	ME=RADI	**Unilateral extended simple mastectomy** This code applies to both radical and modified radical mastectomies. • **Radical mastectomy**: Excision of breast (skin, parenchyma, nipple and areola), the pectoralis major and minor including axillary lymph nodes • **Modified radical mastectomy**: Excision of breast (skin, parenchyma, nipple and areola), the fascia overlying the pectoralis major with or without the pectoralis minor muscle, including axillary lymph nodes. Removal of axillary lymph nodes includes formal axillary node dissection or lymph node sampling or sentinel node dissection for staging. ***Billing Guidelines** This code may not be billed with: • 52.89E Sentinel Lymph Node Biopsy for cancer • 52.42 Radical excision of axillary lymph nodes	280 MSU	

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BILLING CLARIFICATION CONTINUED

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Category	Code	Modifiers	Description	Base Units	Anaes Units
MASG	97.15	ME=RADI	**Bilateral extended simple mastectomy** This code applies to both radical and modified radical mastectomies. • Radical mastectomy: Bilateral excision of breast (skin, parenchyma, nipple and areola), the pectoralis major and minor including axillary lymph nodes • Modified radical mastectomy: Bilateral excision of breast (skin, parenchyma, nipple and areola), the fascia overlying the pectoralis major with or without the pectoralis minor muscle, including axillary lymph nodes. Removal of axillary lymph nodes includes formal axillary node dissection or lymph node sampling or sentinel node dissection for staging. ***Billing Guidelines** This code may not be billed with: • 52.89E Sentinel Lymph Node Biopsy for cancer • 52.42 Radical excision of axillary lymph nodes	420 MSU	

* In addition HSC 97.27A Quadrant resection, lumpectomy, radical mastectomy with axillary dissection may not be billed with the following codes:

- 52.89E Sentinel Lymph Node Biopsy for cancer
- 52.42 Radical excision of axillary lymph nodes

BILLING REMINDERS

Consecutive Anaesthetists

As per Preamble section 5.2.51 where one anaesthetist starts a procedure and is replaced by another during an anaesthetic procedure, the first anaesthetist should claim the appropriate basic fee plus time units for the time he/she is present and the second anaesthetist should claim the time units for which he or she is present. The start time of the first anaesthetist shall dictate when double time units begin, for either and both anaesthetists. Services may only be claimed by a physician if they have personally rendered the service (see Preamble section 1.1.6). Anaesthetists are therefore reminded that when consecutive anaesthetists are used each must claim for his/her own anaesthetic time. This applies to both fee-for-service and shadow-billed claims.

Echocardiograms Reminder

When submitting claims for echocardiograms, physicians may claim either I 1312 (Doppler - quantitative) or I1313 (Doppler - qualitative), but not both. A quantitative study includes the elements of a qualitative study.

Cytology Codes

Pathologists are reminded that they may claim either HSC P2330 (cytology with a screener) or P2331 - (interpretation and report - GYN cytology slides) but not both for the same specimen. If a pathologist claims a P2330, then later signs out the case and wishes to change the claim to a P2331, he/she must delete the claim for the P2330 first.

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BILLING REMINDERS CONTINUED

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Billing of Radiology Services with Premium Fees

MSI has had a number of inquiries from radiologists concerning the use of premium fees (i.e. services claimed with the modifiers US=PREM and US=PR50).

As per Preamble section 5.1.81, premium fees may be claimed when a service (i.e. interpretation of an imaging study), must be performed without delay during designated time periods because of the medical condition of the patient. Premium fees can, therefore, be claimed in situations in which there has been a direct request made to a radiologist for an emergency interpretation of a specific study because of the condition of the patient and the radiologist responds without delay to the request. Services of a non-emergency nature or services of an emergency nature but not performed without delay during these times do not qualify for premium rates. This includes booked procedures performed during premium hours and interpretations done after hours for which there has not been a specific request made to the radiologist about a specific imaging study. If a study has been ordered but the radiologist has not been specifically contacted by the attending physician and requested to provide an emergency interpretation, a premium cannot be claimed.

At the time of implementation of premium fees for radiology in 2002, radiologists were advised that they must maintain a log of bulk billed services that were submitted with premium codes. Although services are no longer bulk billed, all physicians claiming premium fees are required to be able to provide documentation that verifies Preamble requirements for these services have been met.

Intensive Care Units *(5.1.122)*

Intensive care unit (ICU) services refers to services rendered in ICUs approved by the Department of Health and Wellness by physicians who have been assigned by a hospital to the ICU staff by reason of special training or experience. *(5.1.123)*

b) There should only be one day 1 (first day) claimed during the same ICU admission even if the patient's status changes. Day 1 is normally the date of admission to the ICU. However, if the physician does not actually see the patient until the next day, e.g. because a resident is covering, then day 1 can be the date when the patient is first seen by the physician. Day 1 can only be claimed again if the patient is readmitted to the ICU at least 24 hours after discharge. This does not preclude ventilatory care day 1 and critical care day 1 being claimed on the same day. *(5.1.126)*

NEW AND UPDATED EXPLANATORY CODES

Code	Description
CN020	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS AN 03.09B HAS PREVIOUSLY BEEN APPROVED FOR THIS DAY.
CR019	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THE DAY ONE FEE HAS ALREADY BEEN CLAIMED FOR THIS PATIENT DURING THE SAME ICU ADMISSION. PLEASE SUBMIT A NEW CLAIM WITH THE APPROPRIATE DAILY MODIFIER.
GN069	SERVICE ENCOUNTER HAS BEEN DISALLOWED (REFUSED) AS THE SERVICE DATE IS NOT WITHIN THE APPROVED DATE RANGE.
MA061	SERVICE ENCOUNTER HAS BEEN DISALLOWED. PLEASE SUBMIT A REASSESS (ACTION CODE R) ALONG WITH A COPY OF THE OPERATIVE REPORT, AND INDICATE SKIN TO SKIN TIME IN TEXT TO AID IN THE ASSESSMENT.
MJ053	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 01.24C AT THE SAME ENCOUNTER.
VA066	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 60.59B AT THE SAME ENCOUNTER.
VT131	CLAIM HAS BEEN DISALLOWED AS THIS SERVICE SHOULD BE BILLED IN GROUPS OF 3. IF 4 OR MORE ARE NECESSARY, SUBMIT AN ADDITIONAL SERVICE OCCURRENCE FOR EACH ADDITIONAL GROUP OF 3 WITH TEXT.

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UPDATED FILES

Updated files reflecting changes are available for download on Friday, May 22, 2015. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanatory codes (EXPLAIN.DAT), modifier values (MODVALS.DAT) and diagnostic codes (DIAG_CD.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

www.medavie.bluecross.ca\msiprograms

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

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

In partnership with

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May 8, 2015: Vol. LI, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

WCB SPECIAL AUTHORIZATION

In order to accommodate the WCB Special Authorization process the following new health service codes will be available for billing effective May 11, 2015.

Category	Code	Description	Value
DEFT	WCB22	Completed Mandatory Generic Exemption Request Form	$12.50
DEFT	WCB23	Completed Non-Opioid Special Authorization Request Form	$12.50
DEFT	WCB24	Completed Opioid Special Authorization Request Form	$42.00
DEFT	WCB25	Completed WCB Substance Abuse Assessment Form	$28.00

For further information please refer to the toolkit that was mailed to you or visit www.wcb.ns.ca/formulary

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PHYSICIAN'S BULLETIN
March 27, 2015: Vol. LI, ISSUE 2

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

BULK BILLING TRANSITION PROJECT

CLAIMS SYSTEM UNDERGOING MODERNIZATION – AN ARTICLE BY DR. RHONDA CHURCH

Historically, many hospital based services provided by some specialties such as pathology, radiology and internal medicine have had a unique payment system known as bulk billing. Physicians submit claims for services based on the number of services provided. MSI is in the process of transitioning to the standard patient-specific claims system for these services. Rather than these claims being submitted as the total number of services provided, a standard claim which includes information such as the patient's name, health card number, and date of service will be needed.

The primary reasons why this transition is taking place are as follows:

- The current bulk billing structure creates critical information gaps, most notably in patient history. The move to patient specific billing will result in improvements to the longitudinal patient record.
- Under the current bulk-billed system, the Department of Health and Wellness cannot reciprocally bill for services provided to out of province residents. The transition to an electronic claims submission system remedies that situation, as this method requires patient specific details with each billing code.

Transition timeline
A detailed communications package was mailed (September 2014) to physicians who will be affected by this change. Internal Medicine services successfully transitioned from bulk billing to electronic claims on March 1, 2015. Pathology and Radiology services will transition on April 1, 2015.

New health codes
Billing rules as established in the Preamble, Physician's Manual and Bulletins remain unchanged. However, some existing health service codes have been deleted and replaced with modifiers to allow claims for 35% and 50% premium modifiers.

Service date requirement
One other notable requirement is that the date of service on the claim must reflect the date the patient received the service rather than the date the physician interpreted the study or signed the final report. For example, if a chest radiograph or a surgical biopsy is taken on April 5th but the study was reported on the April 6th and the report signed on the April 7th, the date on the claim should be April 5th. This will provide consistency in billing practices and assist in retrieval of the clinical record, should it be required to substantiate the claim.

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Medavie Blue Cross, as the administrator of the MSI program, is committed to a smooth transition for all Internal Medicine, Pathology and Radiology physicians and stakeholders. As we continue with the transition to electronic billing, we will continue the important dialogue with all stakeholders that has already begun.

Project news and changes will continue to be shared with all affected specialties through the various documents on MSI Website, emails and official bulletin updates. For up-to-date information, please visit the Bulk Billing Transition page on the MSI website.

The following documents are a few of the important information documents that have been published on the MSI Website for your reference:

Internal Medicine Rules Communication

Radiology Rules Communication

Pathology Rules Communication

Questions concerning new or existing business arrangements may be directed to msiproviders@medavie.ca and those concerning the claims submission process to MSI_Assessment@medavie.ca

Rhonda Church, MD,
Medical Consultant, MSI Programs, Medavie Blue Cross

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NEW FEES

Effective April 1, 2015 the following new health service code is available for billing:

Category	Code	Modifiers	Description	Base Units	Anaes Units
ADON	02.89C		**Ultrasound performed by radiologist during premium time** This add-on fee is to be used when an ultrasound must be performed directly by the radiologist due to the absence of an ultrasound technologist, and when it must be done without delay due to the medical condition of the patient during designated times where premium fees may be claimed (Preamble 5.1.84). Each ultrasound must be performed directly by the radiologist (not the resident or fellow) and must include archived diagnostic ultrasound images, a written permanent report, and a verbal report when requested. **Billing Guidelines** Add on to the following HSC's only when US=PREM, or US=PR50: R1205 Ultrasound Abdomen General 25.39 R1212 Ultrasound Appendix 18.75 R1220 Ultrasound Pelvis 18.75 R1225 Endovaginal 26.95 R1226 Endovaginal with pelvic 38.70 R1275 Ultrasound Scrotum 25.45 R1345 Doppler – extremities 18.75 Not to be billed when the scan is performed by the radiology resident or fellow. **Specialty Restriction** DIRD, RADI **Location** HOSP	30 MSU	

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PREAMBLE REVISIONS

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PREMIUM FEES

Effective March 27, 2015, select interventional cardiology procedures will be eligible for premium fees, when performed in a cardiac catheterization laboratory.

Eligible interventional cardiology procedures:

Category	Code	Description
VADT	49.96B	Left heart catheterization with angiograms and selective coronary arteriogram
VADT	48.0A	Percutaneous coronary angioplasty (including selective coronary arteriography and right heart catheterization)
VADT	48.0F	Insertion of intracoronary stent - includes one angiogram When a stentor is called in to place a stent during angioplasty by another interventional cardiologist, only 50 units is payable to the stentor. When three or more stents are placed, an additional 25 units is payable regardless of the number of additional stents) - plus multiples, if applicable

Note: Documentation of the time of the procedure and the reason for it being performed during premium hours must appear on the health record for audit purposes. Electively booked procedures do not qualify for premium billing.

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BILLING CLARIFICATION

Non-insured Services - Psychotherapy

Effective April 1, 2015 the following are excluded from the definition of insured psychotherapy and will be added to the list of services not insured by MSI:

- Mindfulness, movement therapy, energy therapy, and other types of alternative or integrative treatments.

BILLING REMINDERS

Immunizations Given by Pharmacists

Beginning in 2013, Nova Scotia pharmacists have been authorized to provide some immunizations to Nova Scotia residents. It has come to MSI's attention that some physicians are claiming for vaccines administered by pharmacists. A physician cannot claim for vaccines administered by a pharmacist.

Synoptic Reporting

This is a reminder that no matter how a patient health record is reported (dictation, synoptic reporting, hand written, etc.) all elements associated with an appropriate claim are still required. Physicians are responsible for ensuring that an appropriate medical record is maintained for all services claimed to MSI (Preamble Section 1.1.33), regardless of the reporting method. In particular, where a procedural code is claimed, the patient record of that procedure must contain information that is sufficient to verify the type and extent of the procedure according to the fees claimed (Preamble Section 1.1.35). While we recognize the potential benefits of synoptic reporting, physicians need to ensure the report is complete. Synoptic reporting software used should enable free text to assist physicians to tailor the information in the medical report, as needed, to reflect the services provided to the patient. If a free text option is not available, it is the physician's responsibility to ensure supporting documentation is incorporated into the medical report as required.

Shadow Billing

All Physicians must submit original claims to MSI within 90 days of the date of service. This includes physicians who shadow bill.

Claims for registered hospital in-patients must also be submitted within the 90-day time limitation regardless if the patient has been discharged or continues on an in-patient basis. It is incumbent on the physician to obtain the required billing information for these patients and submit claims within the prescribed time limitations. Explanations relating to late discharge summaries, or facilities not consolidating the required information for the physician, cannot be accepted as a valid explanation for a late submission.

Service Encounters submitted over the 90-day time limitation will be adjudicated to pay "zero" with the following exceptions:

- Reciprocal billing claims (out of province) must be submitted within 12 months of the date of service.
- Resubmission of refused claims or incorrect billings. These claims must be resubmitted to MSI within 185 days of the date of service. Each resubmission must contain an annotation in the text field of the Service Encounter submission referencing the previous Service Encounter Number.

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BILLING REMINDERS CONTINUED

Comprehensive Visit Services

Health service codes exist for both comprehensive and limited visit services. Health service code 03.04 is an unreferred comprehensive visit and health service code 03.03 is an unreferred limited visit. The referred equivalents are health service codes 03.08 (comprehensive consultation) and 03.07 (limited consultation).

Comprehensive visits may be claimed when necessitated by the seriousness, complexity or obscurity of the patient's complaint(s) or medical condition and ensuring a complete history is recorded and a physical examination appropriate to the physician's specialty and working diagnosis are documented. This is outlined in Preamble sections 5.1.7 and 5.1.8.

Documentation of all of the following provide a clear indication that a comprehensive visit or comprehensive consultation has taken place:

A detailed patient history including:

- Relevant history of presenting complaint
- Relevant past medical and surgical history
- Medication list
- Allergies
- Family history, as appropriate
- Social history, as appropriate

As well as a physical exam including:

- A complete physical examination, appropriate to the physician's specialty and relevant to the presenting complaint.
- Documentation describing the pertinent positive and negative findings of the physical examination. It is not adequate to indicate that the "physical exam is normal" without indicating what was examined.

In situations in which these criteria are not met, it would be appropriate to claim the visit as a limited visit or limited consultation.

Services Not Insured by MSI

Services available to residents of Nova Scotia under the Workers' Compensation Act or through the Department of Veterans Affairs are not insured by MSI. Please refer to Preamble sections 2.2.1 and 2.2.2. The physician must determine who has responsibility for payment, if any.

For example:

- Physician services related to a Workers' Compensation Board (WCB) covered work injury. WCB claims are to be billed to WCB, these services are not insured by MSI.
- Physician services related to a Veterans Affairs Canada (VAC) recognized service disability. These claims are to be billed to VAC, they are not insured by MSI.

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NEW AND UPDATED EXPLANATORY CODES

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New explanatory codes effective March 27, 2015

Code	Description
AD055	SERVICE ENCOUNTER HAS BEEN REFUSED AS THERE IS NO CLAIM FOR AN ELIGIBLE PREMIUM SERVICE BILLED AT THE SAME ENCOUNTER.
BK041	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS FACILITY IS NOT PERMITTED TO CLAIM FOR THESE MAMMOGRAM FEES.
BK042	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR RENAL STATIC IMAGING AT THE SAME ENCOUNTER.

Below is an explanatory code that will be updated effective March 27, 2015 to state the following:

Code	Description
GN064	SURGICAL ASSIST CLAIMS (RO=SRAS) CANNOT BE CLAIMED UNTIL AFTER THE SURGEONS CLAIM HAS BEEN RECEIVED AND PROCESSED. ONCE THIS IS COMPLETE, YOU MAY RESUBMIT USING THE SAME HSC AS THE SURGEON.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday, March 27, 2015. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanatory codes (EXPLAIN.DAT), modifier values (MODVALS.DAT) and diagnostic codes (DIAG_CD.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

www.medavie.bluecross.ca\msiprograms

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

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NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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PHYSICIAN'S BULLETIN

January 30, 2015: Vol. LI, ISSUE 1

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

BULK BILLING TRANSITION PROJECT

IMPORTANT DATE CHANGES

The Department of Health and Wellness and MSI have undertaken a project to align physician billing across Nova Scotia. This will move all physicians to electronic claims submissions.

This project involves key physician groups (Radiology, Internal Medicine and Pathology) who are receiving direct communications on the project. There will be, from time to time, important project updates shared in the MSI Bulletin & on the MSI website.

www.medavie.bluecross.ca/msiprograms

Important update:

Throughout the Bulk Billing Transition project rollout, stakeholders have raised concerns regarding implementation timelines and technical requirements. Ongoing discussions have led to an agreement to extend the transition timelines for all groups.

The aim is to provide physicians with additional time to update and/or modify billing systems to meet the technical requirements for patient specific billing. It is the responsibility of the physician to determine the business process they will implement to submit claims in the required MSI patient specific format.

New transition dates:

Internal Medicine – new go live date March 1, 2015
Radiology – new go live date April 1, 2015
Pathology – new go live date April 1, 2015

As we continue with the transition to electronic billing, we will continue this important dialogue with all stakeholders. Project news and changes will continue to be shared with all impacted groups through the FAQ, emails and official bulletin updates.

There will be an opportunity in the coming weeks to engage in dialogue and address questions. Additional information on the stakeholder discussions will be shared soon.

We would welcome the opportunity to address any and all questions. Your questions can be forwarded by telephone 1-902-496-7011 or via e-mail at MSI_Assessment@medavie.bluecross.ca

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MSI News Internal Medicine Health Services Codes and Rules

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Effective March 1, 2015 the health service codes & MSU values used to bulk bill Internal Medicine services will remain the same for the switch to electronic billing.

CATEGORY	HEALTH SERVICE CODE	DESCRIPTIONS/MODIFIERS	BASE UNITS
BULK	I1168	Electrocardiogram – interpretation LO=HOSP	4.60
BULK	I1171	Electroencephalogram - interpretation only LO=HOSP	10.50
BULK	I6208	Holter monitoring - interpretation only LO=HOSP	25.00
BULK	I1110	Simple spirometry LO=HOSP	5.00
BULK	I1140	Flow / volume loops LO=HOSP	5.00
BULK	I1210	Helium dilution LO=HOSP	5.00
BULK	I1410	Carbon monoxide single breath LO=HOSP	5.00
BULK	I1710	Pulmonary stress test LO=HOSP	20.00
BULK	I1120	Bedside spirometry LO=HOSP	5.00
BULK	I1230	Body plethysmography LO=HOSP	5.00
BULK	I1311	M – mode LO=HOSP	25.44
BULK	I1310	Two dimensional LO=HOSP	47.56
BULK	I1312	Doppler – quantitative LO=HOSP	30.45
BULK	I1313	Doppler – qualitative LO=HOSP	15.23

Billing Tips:

- The service date for electronic claims should be the date the patient had the procedure conducted and not the date the interpretation was completed (if they differ). The fee is for the interpretation. Examples would include echocardiograms, electrocardiograms and pulmonary function tests.
- When a clinical service is provided by a physician to a patient this is referred to as a service occurrence. If the patient had a single encounter with the physician on a specific day for a specific clinical service, then the service occurrence would be set as one. If a second encounter occurred at a later time on the same day for a similar clinical service it would be submitted as service occurrence two. An example would be if a patient has spirometry performed at 10:00am, clinically deteriorates and has another medically necessary spirometry performed at 8:00 pm on the same day. For claims related to the second and subsequent encounters, text is required in order for those claims to be paid. This text must indicate the medical necessity of the subsequent service as well as the time of the occurrence. Any claims submitted with an occurrence number greater than one without text will be paid at zero. The only exemption to this will be claims for electrocardiograms, these will not require text.
- Location HOSP is required for all the above health service codes.
- Normally the payment responsibility for most services is entered as MSI. However, there are instances where the payment responsibility will change, for example; service encounters under Workers' Compensation Board (WCB) and Out of Province (OOP). If the service encounter is for a service provided to a non-resident registered with another provincial health plan except Quebec the home province code is entered in this field, e.g. NB, ON, PE. The service also requires a person data record for the non-resident. More information can be found in the Physician's Manual under section 3.2.115.
- Workers' Compensation Board service encounters for a non‐resident cannot be submitted electronically to MSI for payment. Service encounters for services provided, as a result of an on the job injury, to a non‐resident temporarily working for a Nova Scotia company, should be submitted directly to the Nova Scotia Workers' Compensation Board. More information can be found in the Physician's Manual under section 2.5.6.

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NEW FEES

Effective January 30, 2015 the following new health service codes are available for billing:
revised Mar 31, 2020 - see May 2020 bulletin for updated information

Category	Code	Modifiers	Description	Base Units	Anaes Units
MASG	57.59B	RO=FPHN RO=SPHN	**Colectomy, partial with coloproctostomy (low pelvic anastomosis)** 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 **Specialty Restriction** RO=FPHN restricted to GNSG RO=SPHN restricted to GNSG **Location:** HOSP	405 MSU 300 MSU	8+T
ADON	58.01A	RO=SPHN	**Ileostomy (loop or defunctioning)** ADON to HSC 57.59B and 60.52B	90 MSU 67.50 MSU	

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Category	Code	Modifiers	Description	Base Units	Anaes Units
MASG	60.4C	RO=FPHN RO=SPHN	**Open Abdominoperineal resection; complete proctectomy with colostomy** This fee is for the complete resection of the distal sigmoid colon, rectum, and anus with creation of end sigmoid colostomy and perineal dissection to remove the appropriate segment of bowel along with the anal sphincter. Includes mobilization of colon, identification of ureter, dissection of mesocolic vessels, division of colon, excision of rectum and delivery of sigmoid colon, rectum, and anus through the perineal incision. 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 of bowel or formation of colostomy or ileostomy on the same patient same day. Not to be billed with: 01.24C Sigmoidoscopy 58.11 Colostomy 58.21 Ileostomy for ulcerative colitis 58.39A Ileostomy with tube **Specialty Restriction** RO=FPHN restricted to GNSG RO=SPHN restricted to GNSG **Location** HOSP	550 MSU 400 MSU	8+T
MISG	23.99B	AG=CH03	**Chemodenervation of extraocular muscle(s) for strabismus** Botulinum toxin injections of the extraocular muscle(s) for strabismus, unilateral or bilateral, in patients up to three years of age. **Billing Guidelines** This fee is for the injection of one or more extraocular muscles in one or both eyes, same patient, same physician, same day. **Specialty Restriction** Paediatric OPHT **Location** HOSP	25 MSU	4+T

revised March 31, 2020 - see May 2020 bulletin for updated information

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Category	Code	Modifiers	Description	Base Units	Anaes Units
MASG	82.64D		**Abdominal Sacral Colpopexy** This fee is for the repair of a post-hysterectomy vaginal vault prolapse via the abdominal approach. This comprehensive fee includes lysis of adhesions, exposure of the ureter(s) as required, the attachment of mesh to the vaginal vault apex and suspension to the anterior sacrum, any enterocele repair, and cystoscopy if performed. **Billing Guidelines** May not be billed with: 1.34 Cystoscopy 71.02 Ureterolysis 82.7 Enterocele repair 68.98A Exploration of ureter **Specialty Restriction** OBGY **Location** HOSP	350 MSU	6+T
MASG	82.64E		**Laparoscopic Sacral Colpopexy** This is a comprehensive, time-based fee for the laparoscopic repair of a post-hysterectomy vaginal vault prolapse. This comprehensive fee includes all procedures performed during the operative period on the same patient, same day. In order to bill this HSC the entire abdominal portion of the procedure must be performed laparoscopically. **Billing Guidelines** No other HSC's may be billed same physician, same patient, same service encounter. **Specialty Restriction** OBGY **Location** HOSP	IC at 140MSU/hr	6+T
MASG	82.64F		**Colpopexy, vaginal; fixation to sacrospinous ligament(s)** This fee is for the vaginal approach to vaginal vault suspension post-hysterectomy via attachment to the sacrospinous ligament(s) either unilateral or bilateral. **Billing Guidelines** Not to be billed with any other enterocele repair: HSC 82.7 HSC 82.64B **Specialty Restriction** OBGY **Location** HOSP	200 MSU	6+T

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FEE REVISIONS

Effective January 30, 2015 the following health service code has been revised.

Category	Code	Modifiers	Description	Base Units	Anaes Units
MASG	60.52B	RO=FPHN RO=SPHN	**Laparoscopically Assisted Anterior Resection** Laparoscopic resection of the appropriate segment of colon with coloproctostomy (low pelvic anastomosis). Includes mobilisation of colon, identification of the ureter, dissection of mesocolic vessels, division of colon, delivery of colon through the extraction site, with intra- or extra-corporeal anastomosis of bowel (including EEA stapling), to include all stapling, and closure of the extraction site. 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** This is intended to be a comprehensive fee for the entire procedure. Not to be billed with: 1.24C Sigmoidoscopy 58.11 Colostomy 58.21 Ileostomy for ulcerative colitis 58.39A Ileostomy with tube 66.19 Other Laparotomy, 66.83 Laparoscopy, 60.52A Lower anterior Resection where EEA stapler is used. **Specialty Restriction** Primary surgeon: Minimally Invasive Surgeon MIS RO=SPHN restricted to GNSG **Location** HOSP	420 MSU 315 MSU	8+T

Effective January 29, 2015 the following health service code will no longer be active

Category	Code	Modifiers	Description	Base Units	Anaes Units
MASG	60.4A		**Abdominal-perineal resection plus colostomy**	450 MSU	8+T

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BILLING REMINDERS

Surgeon and Surgical Assistant Claims

As outlined in the July 18, 2014 and November 21, 2014 Physician's Bulletin, surgical assistants are remunerated at 33.8% of the fee paid to the surgeon and the health service codes claimed for surgical assistant services are expected to align with those submitted by the primary surgeon and must adhere to Preamble rules. If a claim for a surgical assistant fee is received in the absence of a claim from the surgeon, the claim will be returned with explanatory code GN064 indicating that the claim cannot be paid as no claim has been submitted by a surgeon for this service. It is therefore important that the surgeon's claims are submitted to MSI in a timely manner and within the 90 day time frame to allow the surgical assistant to also be paid for these services. This includes billings from all revenue streams including shadow claims.

NEW EXPLANATORY CODES

Code	Description
GN055	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED THE SURGEON / SURGICAL ASSIST FEE FOR THIS SERVICE.
GN067	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 82.64D AT THE SAME ENCOUNTER.
GN068	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY BILLED HSC 82.64E AT THE SAME ENCOUNTER.
MA064	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR A SIGMOIDOSCOPY, COLOSTOMY, OR ILEOSTOMY AT THE SAME ENCOUNTER.
MA065	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR 57.59B, 60.4C OR 60.52B AT THIS ENCOUNTER. IF YOU ARE ATTEMPTING TO CLAIM AN ILEOSTOMY WITH THIS PROCEDURE PLEASE USE THE ADDON HSC 58.01A
MA066	SERVICE ENCOUNTER HAS BEEN REFUSED AS A SECOND PHYSICIAN CLAIM EXISTS FOR THIS ENCOUNTER. A SURGICAL ASSIST CANNOT ALSO BE CLAIMED.
MA067	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 60.52B CANNOT BE CLAIMED WITH HSC 66.19, 66.83 OR 60.52A AT THE SAME ENCOUNTER
MA068	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 66.19 OR 66.83 CANNOT BE CLAIMED WITH HSC 60.52B AT THE SAME ENCOUNTER
MJ050	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED ONE OF THE FOLLOWING HSCS 01.34A, B, C, D, E, F, G, H, 71.02, 82.7, OR 68.98A AT THE SAME ENCOUNTER.
MJ051	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY BILLED AN ENTEROCELE REPAIR (HSC 82.7 OR 82.64B) AT THE SAME ENCOUNTER.
MJ052	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY BILLED HSC 82.64F AT THE SAME ENCOUNTER.
MN012	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE ALREADY CLAIMED THIS SERVICE FOR THIS PATIENT ON THE SAME DAY.
MN014	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 60.52A CANNOT BE CLAIMED WITH 60.52B AT THE SAME ENCOUNTER
VA065	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR A COLECTOMY WITH COLOPROCTOSTOMY AT THIS ENCOUNTER
VT129	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 82.64E IS A COMPREHENSIVE SERVICE AND YOU HAVE ALREADY CLAIMED ANOTHER SERVICE AT THE SAME ENCOUNTER.
VT130	SERVICE ENCOUINTER HAS BEEN REFUSED. THE DOCUMENTATION PROVIDED SUPPORTS AN INITIAL VISIT WITH COMPLETE EXAMINATION, NOT A CONSULT (SEE PREAMBLE 5.1.7). PLEASE RESUBMIT WITH THE APPROPRIATE HSC.
WB033	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE REQUIRED WCB FORM WAS NOT RECEIVED WITHIN THE APPROPRIATE TIME.

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UPDATED FILES

Updated files reflecting changes are available for download on Friday, January 30, 2015. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanatory codes (EXPLAIN.DAT), and modifier values (MODVALS.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

www.medavie.bluecross.ca\msiprograms

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

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November 21, 2014: Vol. L, ISSUE 6

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

PREPAYMENT ASSESSMENT CHANGES

FALL 2014

The team working on implementing the recommendations in John Carter's Physician Audit and Appeal Practices Report has reached a significant milestone. The threshold for pre-payment assessment of multiple claims in major surgery cases on the same patient, same day by the same provider has been increased from two to four.

MSI will implement the revised thresholds in the computer system effective November 21, 2014. Prepayment assessments will still be conducted on claims with less than four health service codes on a random basis.

Doctors Nova Scotia, Department of Health and Wellness (DHW) and MSI have been working to address the recommendations in John Carter's Physician Audit and Appeal Practices report. As recommended by the Carter report, DHW has reviewed the results of prepayment assessment and based on this review, the thresholds have been raised.

BULK BILLING TRANSITION PROJECT

FALL 2014

The Department of Health and Wellness and MSI have undertaken a project to align physician billing across Nova Scotia. It is titled **The Bulk Billing Transition Project.** This will move all physicians to electronic claims submissions by the end of 2015.

This project impacts key physician groups who are receiving direct communications on the project. There will be, from time to time, important project updates shared in the MSI Bulletin. These updates apply only to those impacted physician groups.

About the project:

Currently the majority of Radiology, Pathology and some Internal Medicine claims are submitted to MSI under a bulk billing method which consists of manual, non-patient specific claims. By contrast, electronic claim submission, which is used for all other physician billing in the province, provide detailed patient information on every digital claim. This difference between billing systems creates a number of challenges (including incomplete MSI patient histories and an inability to reciprocally bill for non-resident procedures) that can be remedied by moving all billing to an electronic system.

Update to impacted physician groups:

Since the Bulk Billing Transition project implementation began, there have been concerns raised around potential impacts of the new electronic billing requirements, specifically the timing of the transitions.

MSI is committed to working with all stakeholders to ensure a smooth transition we recognize that changes come with challenges. There have been recent discussions between the Department of Health and Wellness, Doctors Nova Scotia, MSI and a number of impacted physician groups regarding project timelines and logistical requirements.

In response to those concerns, and to better assist physicians with their transitions to the new electronic billing system, we are **moving all go-live dates from December 1, 2014 to February 1, 2015.**

This is a new date change for Internal Medicine physicians. This does not impact Radiology or Pathology physicians as the go-live date for both groups was February 1, 2015 prior to this notice.

As we continue with the transition to electronic billing, we will continue this important dialogue with all stakeholders. Project news and changes will be shared in a timely manner with all impacted groups through the FAQ, emails and official bulletin updates.

If you have questions at any time, please contact us at 1-902-496-7011 or visit us online.
www.medavie.bluecross.ca/msiprograms

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NEW FEES

Effective November 21, 2014 the following new health service codes are available for billing:
Updated March 31, 2020 – See May 2020 Bulletin for updated information

Category	Code	Modifiers	Description	Base Units	Anaes Units
MASG	60.55C		**Closure of Enterostomy, large or small intestine; with resection and colorectal/ileorectal anastomosis (eg, closure of Hartmann type procedure)** This comprehensive fee includes all of the procedures required to perform the closure of an existing enterostomy including mobilization of the intestine, resection of bowel to remove the enterostomy site, lysis of adhesions, pelvic dissection, exploration and identification of ureter, mobilization of the rectum with resection of the upper rectum as required, and repair of any existing parastomal or incisional hernia. Open, laparoscopic, or combined approach. **Billing Guidelines** Not to be billed with: MASG 57.59 Other partial excision of large intestine MASG 60.52 Other anterior resection **Specialty Restriction:** GNSG **Location:** HOSP	390 MSU	8+T
VEDT	03.38A	RO=INTP	**Bronchial Challenge Testing with methacholine or similar compounds – includes baseline spirometry and all spirometric determinations post administration of agent(s)** This fee is for the interpretation of the testing and a 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 only 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 the testing is done in the hospital based pulmonary function laboratory. **Specialty Restriction:** INMD, PEDI **Location:** HOSP	19 MSU	

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FEE REVISIONS

Effective November 21, 2014 the following health service code will have a specialty restriction of UROL.

Category	Code	Modifiers	Description	Base Units	Anaes Units
MASG	71.02		**Ureterolysis with freeing or repositioning of ureter for peri-ureteral fibrosis (Regions required)** **Specialty Restriction:** UROL **Location:** HOSP	215 MSU	6+T

Effective November 20, 2014, the following health service codes will no longer be active:

Category	Code	Modifiers	Description	Base Units	Anaes Units
MASG	60.55A		**Colon/rectal reanastomosis after segmental resection where mucus fistula or Hartman procedure exists**	250 MSI	8+T

PROVINCIAL IMMUNIZATION CHANGES

Effective November 20, 2014 the following immunizations are termed:

HSC	Modifier
13.59L	RO=HAHB
13.59L	RO=MENQ
13.59L	RO=MMRT
13.59L	RO=RABI
13.59L	RO=RABV
13.59L	RO=TEIG
13.59L	RO=VAIG

These immunizations are to be administered in high risk/post exposure situations only (as communicated through Public Health). Therefore, the base fee codes (without the high risk modifier) have been termed and replaced by the equivalent with the high risk modifier.

Effective November 21, 2014 the following immunizations are effective:

HSC	Modifier
13.59L	RO=HAHB with PT=RISK (previously implemented in September)
13.59L	RO=MENQ with PT=RISK
13.59L	RO=MMRT with PT=RISK
13.59L	RO=RABI with PT=RISK
13.59L	RO=RABV with PT=RISK
13.59L	RO=TEDV with PT=RISK
13.59L	RO=TEIG with PT=RISK (previously implemented in September)
13.59L	RO=VAIG with PT=RISK (previously implemented in September)

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Immunization Information - Clarification

After release of the last Bulletin, MSI staff received inquiries about criteria for eligibility of some vaccines.

We have been advised by Public Health of the following:

Hepatitis B vaccine is covered for Nova Scotia residents under the following circumstances only:

- Grade 7 students when provided through the school based immunization program
- Post exposure prophylaxis for Hepatitis B
- *Pre-exposure prophylaxis for the following high risk groups:
    - Chronic liver disease
    - Chronic renal disease and dialysis
    - Congenital immunodeficiency
    - Hematopoietic stem cell transplant (HSCT)
    - HIV
    - Illicit drug use
    - High risk sexual practices
    - Solid organ transplant
    - Hemophiliacs and other people receiving repeated infusions of blood or blood products e.g. sickle cell disease.

Rabies vaccine and immunoglobulin are covered for post-exposure prophylaxis only.

Further information may be found at the following site: http://novascotia.ca/dhw/cdpc/documents/Immunization-Manual.pdf

Billing Matters Billing Reminders, New Explanatory Codes

BILLING REMINDERS

Health Service Codes 28.73F (Intravitreal injection of a pharmacologic agent for the treatment of specific retinal diseases) and 02.02A (Optical Coherence Tomography)

Effective November 12, 2013, changes were made to billing rules concerning health service code 28.73F (intravitreal injection of a pharmacologic agent for the treatment of specific retinal diseases) such that this health service code could be claimed for patients with wet age-related macular degeneration (AMD), diabetic macular edema (DME) or retinal vein occlusion (RVO) when treating with an appropriate pharmacologic agent (i.e. intravitreal drugs).

Health service code 02.02A (Optical Coherence Tomography) may be claimed by the ophthalmologist treating a patient with one of these pharmacologic agents for one of the conditions listed above. The OCT may only be billed in association with the injection or to guide whether an injection is required. OCT may be claimed to a maximum of six times per patient per year and a written report of the image interpretation is to be recorded in the clinical record.

Surgical Assistant Claims

As outlined in the July 18, 2014 Physician's Bulletin, surgical assistants are remunerated at 33.8% of the fee paid to the surgeon and the health service codes claimed for surgical assistant services are expected to align with those submitted by the primary surgeon and must adhere to Preamble rules. If a claim for a surgical assistant fee is received in the absence of a claim from the surgeon, the claim will be returned with explanatory code GN064 indicating that the claim cannot be paid as no claim has been submitted by a surgeon for this service.

ICU Day 1

If a patient is transferred from one ICU to a second ICU within the same facility, both physicians may claim ICU codes on the day of transfer but the physician attending the patient in the receiving ICU cannot claim another Day 1. However, if a patient is transferred to a new facility i.e., another hospital, a new ICU day 1 may be claimed.

Within the same facility, a second ICU Day 1 may only be claimed if the patient is discharged from the ICU and readmitted at least 24 hours after the ICU discharge.

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BILLING REMINDERS CONTINUED

MSI Documentation Reminder

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribe, and start and stop times if applicable.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptions, or emotional problems, the physician "deliberately established a professional relationship with the patient for the purposes of removing, modifying or alleviating existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional well being of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy," etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service on that date, then the service is not paid for or a lesser benefit is given. **When the clinical record does not support the service claimed, there will be a recovery to MSI at the time of audit.** Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

NEW EXPLANATORY CODES

Code	Description
AD054	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 90.09G FOR THIS PATIENT ON THIS DAY.
BK017	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR AN ULTRASOUND OF THE AORTA, APPENDIX, KIDNEYS, OR PYLORUS AT THE SAME ENCOUNTER. THESE ARE MEANT TO BE INCLUDED IN THE ABDOMEN GENERAL ULTRASOUND FEE.
BK018	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR AN ABDOMEN GENERAL ULTRASOUND AT THE SAME ENCOUNTER. AN ULTRASOUND OF THE AORTA, APPENDIX, KIDNEYS, OR PYLORUS IS MEANT TO BE INCLUDED IN THE ABDOMEN GENERAL ULTRASOUND FEE.
BK019	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR AN U/S OF THE AORTA, APPENDIX, KIDNEYS, OR PYLORUS AT THE SAME ENCOUNTER. THESE FEES ARE NOT CUMULATIVE. AN ABDOMINAL GENERAL U/S (HSC R1205) IS THE COMPOSITE FEE FOR THESE SERVICES.
BK020	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS FEE IS CONSIDERED TO BE AN ADD ON CODE AND MAY ONLY BE CLAIMED AFTER A BASE SERVICE HAS BEEN BILLED.

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BK021	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR AN ENDOVAGINAL U/S (R1225) AT THE SAME ENCOUNTER. TO CLAIM FOR BOTH, PLEASE SUBMIT A DELETE FOR THE ENDOVAGINAL U/S AND CREATE A NEW CLAIM FOR ENDOVAGINAL WITH PELVIC (R1226).
BK022	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR AN PELVIC ULTRASOUND (R1220) AT THE SAME ENCOUNTER. TO CLAIM FOR BOTH, PLEASE SUBMIT A DELETE FOR THE PELVIC ULTRASOUND AND CREATE A NEW CLAIM FOR ENDOVAGINAL WITH PELVIC (R1226).
BK023	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR THE ENDOVAGINAL AND PELVIC ULTRASOUND COMBINATION FEE AT THE SAME ENCOUNTER.
BK024	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED A CLAIM FOR EITHER THE STAND ALONE PELVIS ULTRASOUND OR ENDOVAGINAL ULTRASOUND FEE.
BK025	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED FOR ANOTHER CODE AT THE SAME ENCOUNTER. WHEN THE INTRAOPERATIVE CODE IS USED, NO OTHER CODE MAY BE CLAIMED FOR THAT EXAMINATION.
BK026	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED FOR AN INTRAOPERATIVE ULTRASOUND FEE AT THE SAME ENCOUNTER. WHEN THE INTRAOPERATIVE CODE IS USED, NO OTHER CODE MAY BE CLAIMED FOR THAT EXAMINATION.
BK027	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.38A HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY.
BK028	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED THE BILATERAL FEE CODE FOR THIS SERVICE AT THE SAME ENCOUNTER.
BK029	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED THE UNILATERAL FEE CODE FOR THIS SERVICE AT THE SAME ENCOUNTER. PLEASE SUBMIT A DELETE FOR THE UNILATERAL SERVICE BEFORE CLAIMING THE BILATERAL FEE.
BK030	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED A VENOGRAM EXTREMITY CLAIM AT THE SAME ENCOUNTER. THE VENOGRAM EXTREMITY FEE INCLUDES THE CENTRAL FILM.
BK031	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED A CENTRAL FILM CLAIM AT THE SAME ENCOUNTER. A VENOGRAM EXTREMITY FEE INCLUDES THE CENTRAL FILM. PLEASE SUBMIT A DELETE FOR HSC R605 BEFORE RESUBMITTING THE VENOGRAM EXTREMITY FEE.
BK032	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED A RENAL SCAN AND RENOGRAM CLAIM AT THE SAME ENCOUNTER.
BK033	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED AN A.C.E. RENAL SCAN CLAIM AT THE SAME ENCOUNTER.
BK034	SERVICE ENCOUNTER HAS BEEN DISALLOWED. PLEASE RESUBMIT, INDICATING IN THE TEXT FIELD WHO PERFORMED THE INJECTION.
BK035	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS FEE IS CONSIDERED TO BE AN ADD ON CODE AND MAY ONLY BE CLAIMED AFTER A RENAL SCAN (R1875, R1880, OR R1881) HAS BEEN BILLED.
BK036	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR THE MULTIPLE AREAS FEE AT THE SAME ENCOUNTER.
BK037	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR THE SINGLE AREA FEE AT THE SAME ENCOUNTER.
BK038	SERVICE ENCOUNTER HAS BEEN REFUSED AS AN AUTOPSY HAS ALREADY BEEN CLAIMED FOR THIS INDIVIDUAL.
BK039	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED A VISIT FOR THIS INDIVIDUAL AT THE SAME ENCOUNTER.
BK040	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED A CONSULT FOR THIS INDIVIDUAL AT THE SAME ENCOUNTER.
MJ047	SERVICE ENCOUINTER HAS BEEN REFUSED AS HSC 57.59 OR 60.52 HAS PREVIOUSLY BEEN BILLED FOR THIS PATIENT ON THE SAME DAY.

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MJ048	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 60.55C HAS PREVIOUSLY BEEN BILLED FOR THIS PATIENT ON THE SAME DAY.
MJ049	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 90.06B FOR THIS PATIENT ON THIS DAY.
VE009	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THE SAME DAY.
VE010	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC I 1110 OR I 1140 HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday, November 21, 2014. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanatory codes (EXPLAIN.DAT), and modifier values (MODVALS.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

www.medavie.bluecross.ca\msiprograms

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

CONTACT INFORMATION

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2015 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE
December 23, 2014 **	**December 31, 2014****	January 7, 2015
January 12, 2015	January 15, 2015	January 21, 2015
January 26, 2015	January 29, 2015	February 4, 2015
February 6, 2015**	**February 11, 2015****	February 18, 2015
February 23, 2015	February 26, 2015	March 4, 2015
March 9, 2015	March 12, 2015	March 18, 2015
March 23, 2015	March 26, 2015	April 1, 2015
April 6, 2015	April 9, 2015	April 15, 2015
April 20, 2015	April 23, 2015	April 29, 2015
May 4, 2015	May 7, 2015	May 13, 2015
May 15, 2015**	May 21, 2015	May 27, 2015
June 1, 2015	June 4, 2015	June 10, 2015
June 15, 2015	June 18, 2015	June 24, 2015
June 26, 2015**	July 2, 2015	July 8, 2015
July 13, 2015	July 16, 2015	July 22, 2015
July 24, 2015**	**July 29, 2015****	August 5, 2015
August 10, 2015	August 13, 2015	August 19, 2015
August 24, 2015	August 27, 2015	September 2, 2015
September 4, 2015**	September 10, 2015**	September 16, 2015
September 21, 2015	September 24, 2015	September 30, 2015
October 2, 2015**	**October 7, 2015****	October 14, 2015
October 19, 2015	October 22, 2015	October 28, 2015
October 30, 2015**	**November 4, 2015****	**November 10, 2015****
November 16, 2015	November 19, 2015	November 25, 2015
November 30, 2015	December 3, 2015	December 9, 2015
December 14, 2015	December 17, 2015	December 23, 2015
December 23, 2015**	**December 30, 2015****	January 6, 2016
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, Sessional Payments and Locum Claim Forms. 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 2015

Please make a note in your schedule of the following dates MSI will accept as "Holidays."	
NEW YEAR'S DAY	THURSDAY, JANUARY 1, 2015
HERITAGE DAY	MONDAY, FEBRUARY 16, 2015
GOOD FRIDAY	FRIDAY, APRIL 3, 2015
EASTER MONDAY	MONDAY, APRIL 6, 2015
VICTORIA DAY	MONDAY, MAY 18, 2015
CANADA DAY	WEDNESDAY, JULY 1, 2015
CIVIC HOLIDAY	MONDAY, AUGUST 3. 2015
LABOUR DAY	MONDAY, SEPTEMBER 7, 2015
THANKSGIVING DAY	MONDAY, OCTOBER 12, 2015
REMEMBRANCE DAY	WEDNESDAY, NOVEMBER 11, 2015
CHRISTMAS DAY	FRIDAY, DECEMBER 25, 2015
BOXING DAY	MONDAY, DECEMBER 28, 2015
NEW YEAR'S DAY	FRIDAY, JANUARY 1, 2016

PHYSICIAN'S BULLETIN
SEPTEMBER 26, 2014: Vol. L, ISSUE 5

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

PHYSICIAN'S MANUAL UPDATE

2014

The Department of Health and Wellness in collaboration with Medavie Blue Cross and Doctors Nova Scotia are pleased to announce that the MSI Physician's Manual has undergone an update as result of the Nova Scotia Physician's Manual Modernization Project (NS PMMP). This newly updated Physician's Manual is a significant deliverable of the NS PMMP. A key goal of the NS PMMP is to prepare and sustain accurate and supporting documentation. As a result of this, the NS PMMP Steering Committee recommended that one of the first activities be to improve existing documentation for physicians and billing clerks.

The most significant change physicians and their billing clerks will notice is that the new manual merges the content of the previous Physician's Manual and the Billing Instructions Manual. Policy changes made from January to December 2013 including those approved by the Master Agreement Steering Group has been included in this version; however it may be necessary to refer to Bulletins for additional detailed information.

The work completed to achieve this goal included:

- Simplifying the document layout to improve readability.
- Analyzing and merging the content of the NS MSI Physician's Manual 2012 and the NS MSI Billing Instructions Manual 2012 in logical order.
- Critical appraisal to ensure the merging did not affect the content meaning.
- NS PMMP Working Group and Steering Committee review of the document structure, layout and content changes required to address duplication.
- Formal tracking of the content of each document as the merged Nova Scotia Medical Services Insurance Physician's Manual 2014 was created.
- Integrating policy changes made from January to December - 2013 including those approved by the Master Agreement Steering Group.

Other changes that have been made to the new version of the Physician's Manual are as follows:

- The introductory page to each section provides an overview of the content of the section and includes the definitions of key terms.
- Italicized numeric paragraph identifiers (e.g. 1.0.2) are included at the end of all headings and paragraphs in Section 1 to 7. These identifiers can be used when needing to refer to a specific item, for example when a billing clerk is contacting MSI with a question.
- There are more cross‐references across Sections.
- Linked table of contents, updated index, and overall updated look & formatting changes

We are very pleased about the achievement of this deliverable and would like to thank everyone who contributed. The 2014 MSI Physician's Manual is now available at www.medavie.bluecross.ca/msiprograms

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MSI News

BULLETIN REDESIGN

NEW THIS ISSUE!

The Department of Health and Wellness, in collaboration with Medavie Blue Cross and Doctors Nova Scotia is very pleased to announce the launch of the new redesigned Physician's Bulletin.

This critical document, which communicates key information on physician billing, now has a full table of contents that is web enabled for easy navigation. With a mouse click or a tap, readers will be able to swiftly navigate to content of interest or back to the main page. This front page contains an MSI news section to keep physicians and billing staff informed on latest developments. MSI's contact information is easily found on each page and content is grouped in categories making the flow of the document better and more intuitive.

Physician feedback has helped form the new design. Before the redesign began, physicians were surveyed for opportunities to improve the bulletin. Based on that feedback, a sample bulletin was created and the physicians were asked to test it. They were specifically asked to find key information, report the information and rate the ease with which they found the answers. They were also asked to provide additional thoughts on the new design.

The MSI Physician's Bulletin is only available electronically; physicians and billing staff must subscribe to receive the bulletin to ensure they are billing with the most up-to-date information.

Click here to subscribe

★ Fees New fees and highlighted fees

PROVINCIAL IMMUNIZATION CHANGES

Changes have been made to the immunization modifiers and descriptions to align them more closely with national standards. This will assist with the production of provincial immunization coverage rates. Schedule of Provincial Immunizations is attached in Appendix A.

Effective September 25, 2014, the following provincial immunization modifiers have been termed:

HSC	Modifier
13.59L	RO=ADAC
13.59L	RO=ADPO
13.59L	RO=BOTR
13.59L	RO=HPVV
13.59L	RO=PAND
13.59L	RO=TEDI
13.59L	RO=VARI

Effective September 26, 2014, the following new provincial immunization codes are available for billing:

HSC	Modifier	Description
13.59L	RO=HAHB	HAHB - Hepatitis A and B Vaccine
13.59L	RO=HAHB(PT=RISK)	HAHB - Hepatitis A and B Vaccine (high risk patient)
13.59L	RO=HBIG(PT=RISK)	HBIg - Hepatitis B Immunoglobulin (high risk patient)
13.59L	RO=HBVV	HB - Hepatitis B Vaccine
13.59L	RO=HBVV(PT=RISK)	HB - Hepatitis B Vaccine (high risk patient)
13.59L	RO=HIBV	Hib - Haemophilus Influenzae Type B Vaccine
13.59L	RO=HIBV(PT=RISK)	Hib - Haemophilus Influenzae Type B Vaccine (high risk patient)
13.59L	RO=HPV4	HPV -4 - Human Papillomavirus Vaccine
13.59L	RO=PNEC(PT=RISK)	Pneu-P-13 - Pneumococcal-conjugate-valent Vaccine (high risk patient)
13.59L	RO=PNEU(PT=RISK)	Pneu-P-23 - Pneumococcal-Polysaccharide-valent Vaccine (high risk patient)
13.59L	RO=RABI	RabIg - Rabies Immunoglobulin
13.59L	RO=RABV	Rab - Rabies Vaccine
13.59L	RO=TDAP	Tdap - Tetanus, Toxoid, Diphtheria, Acellular Pertussis Vaccine
13.59L	RO=TDPP	Tdap-IPV - Tetanus toxoid, Diphtheria, Acellular Pertussis, Polio
13.59L	RO=TEDV	Td - Tetanus Toxoid, diphtheria Vaccine
13.59L	RO=TEIG	Tetanus Immunoglobulin
13.59L	RO=VAIG	VarIg - Varicella-Zoster Immunoglobulin
13.59L	RO=VARV	Var - Varicella vaccine
13.59L	RO=VARV(PT=RISK)	Var - Varicella vaccine (high risk patient)

Effective September 26, 2014, the following provincial immunization descriptions have been changed:

Modifier	Old Description	New Description
RO=INFL	Injection for various strains of Influenza	Inf – Influenza-Inactivated Vaccine
RO=MENC	Meningococcal type C Conjugate Vaccine	Men-C-C - Meningococcal conjugate Vaccine
RO=MENQ	Meningococcal Quadrivalent	Men-C-ACYW-135 - Meningococcal conjugate quadrivalent Vaccine
RO=MMAR	Injection for Measles, Mumps and Rubella	MMR - Measles, Mumps, Rubella Vaccine
RO=MMRT	Injection for Measles, Mumps and Rubella for travel only to areas of risk for Measles	MMRV - Measles, Mumps, Rubella and varicella for travel only to areas of risk for Measles
RO=MMRV	MMAR/VARI Injections	MMRV - Measles, Mumps, Rubella and Varicella Vaccine
RO=PENT	Injection for Diphtheria, Pertussis, Tetanus, Poliomyelitis and Haemophilus	DTaP-IPV-Hib - Diphtheria, Tetanus, Acellular Pertussis, Polio, Haemophilus Influenzae Type B Vaccine
RO=PNEC	Pneumococcal Conjugate vaccine (Prevnar)	Pneu-P-13 - Pneumococcal-conjugate-valent Vaccine
RO=PNEU	Injection for Pneumococcal Pneumonia, Bacteraemia and Meningitis	Pneu-P-23 - Pneumococcal-Polysaccharide-valent Vaccine

Please note that effective September 26, 2014, the following billing guidelines will be enforced:

HSC	Modifier	Billing Guideline
13.59L	Any with high risk modifier (PT=RISK)	Modifier PT=RISK requires text stating the patient's clinical high risk diagnosis and reasoning for administration
13.59L	RO=PENT	Not to be billed before 6 weeks of age, the same immunization cannot be claimed within 4 weeks of each other
13.59L	RO=PNEC	Not to be billed before 6 weeks of age

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Examples of Provincial Immunization Schedules:

Childhood Vaccine Schedule:

Vaccine	Modifier	2 months	4 months	6 months	12 months	18 months	4-6 years
DTaP-IPV-Hib *Diphtheria, Tetanus, Acellular Pertussis, Polio, Haemophilus influenzae type b vaccine*	RO=PENT	✓	✓	✓		✓	
Pneu-P-13 *Pneumococcal-conjugate-valent vacccine*	RO=PNEC	✓	✓		✓		
Men-C-C *Meningococcal conjugate vaccine*	RO=MENC				✓		
MMRV *Measles, Mumps, Rubella and Varicella vaccine*	RO=MMRV				✓		✓
Tdap - IPV *Tetanus Toxoid, Diphtheria, Acellular Pertussis, Polio vaccine*	RO=TDPP						✓

School Vaccine Schedule:

Vaccine	Modifier	Grade 7
HPV-4 *Human Papillomavirus vaccine (3 doses)*	RO=HPV4	✓
HB *Hepatitis B vaccine*	RO=HBVV	✓
Tdap *Tetanus Toxoid, Diphtheria, Acellular Pertussis*	RO=TDAP	✓
Men-C-C *Meningococcal conjugate*	RO=MENC	✓

Adult Vaccine Schedule:

Vaccine	Modifier	Adults to age 64	Adults 65 and older
Inf *Influenza Vaccine (every flu season)*	RO=INFL	✓	✓
Td Td - Tetanus Toxoid, diphtheria Vaccine *(every 10 year)*	RO=TEDV	✓	✓

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Vaccine	Modifier	Adults to age 64	Adults 65 and older
Pneu-P-23 *Pneumococcal-Polysaccharide-valent (1 dose)*	RO=PNEU	✓ (high risk only)	✓
MMR *Measles, Mumps, Rubella Vaccine (2 doses)*	RO=MMAR	✓ (adults born in 1970 or later)	

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FEE REVISIONS

Effective September 26, 2014, Pre-Authorization will be required for the following health service code:

Category	Code	Description	Unit Value
MISG	98.12R	DESTRUCTION (DERMABRASION) OF SINGLE AREA (E.G. TRAUMA SCAR)	35 4+T

Effective September 25, 2014, the following health service codes will no longer be active:

Category	Code	Description	Unit Value
DEFT	WCB9	EXPEDITED NON-EMERGENCY ORTHOPAEDIC CONSULTATIONS	30.43
MASG	71.4A*	COMBINED ABDOMINAL VAGINAL FASCIAL SLING PROCEDURE	
		RO=ABDO	300 6+T
		RO=VGSG	150 6+T

*Replaced by MASG 71.4D – Pubo-vaginal sling with autologous fascia for female urinary incontinence, includes cystoscopy as required, 350 MSU, 6+T (as outlined on page 4 of the July 18, 2014 MSI Bulletin.)

Billing Matters Billing Reminders, New Explanatory Codes

NEW EXPLANATORY CODES

Code	Description
AD051	SERVICE ENCOUNTER HAS BEEN DISALLOWED. WHEN CLAIMING FOR HIGH RISK PATIENTS (PT=RISK), TEXT IS REQUIRED. PLEASE RESUBMIT WITH THE APPROPRIATE TEXT.
AD052	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PATIENT IS LESS THAN 6 WEEKS OLD
AD053	SERVICE ENCOUNTER HAS BEEN REFUSED AS A PENT INJECTION HAS BEEN PREVIOUSLY APPROVED IN THE PREVIOUS 4 WEEKS
BK001	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE NOT INCLUDED TEXT REFERRING TO THE ANATOMICAL SITE SPECIMEN WAS TAKEN FROM. PLEASE RESUBMIT WITH APPROPRIATE TEXT.
BK002	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR AN ABDOMINAL SURVEY FILM AT THE SAME ENCOUNTER.
BK003	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR AN INTRAVENOUS UROGRAM (IVP) AT THE SAME ENCOUNTER.
BK004	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS AT THE SAME ENCOUNTER YOU HAVE CLAIMED FOR AN INTRAVENOUS UROGRAM (IVP), WHICH CANNOT BE CLAIMED WITH ROUTINE TOMOGRAPHY. IF TOMOGRAPHY WAS NOT ROUTINE, PLEASE RESUBMIT WITH TEXT INDICATING THE SITUATION.
BK005	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR A SERVICE IN WHICH FLUOROSCOPY IS INCLUDED FOR THE SAME ENCOUNTER.
BK006	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR A FLUOROSCOPY DURING THE SAME ENCOUNTER.

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NEW EXPLANATORY CODES CONTINUED

Code	Description
BK007	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE IS NOT YET ELIGIBLE FOR ELECTRONIC BILLING.
BK008	SERVICE ENCOUNTER FOR FLUOROSCOPY HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR ANOTHER SERVICE AT THE SAME ENCOUNTER.
BK009	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR A STAND ALONE FLUOROSCOPY FEE AT THE SAME ENCOUNTER.
BK010	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PATIENT IS OVER 12 YEARS OLD. PLEASE SUBMIT A CLAIM FOR THE APPLICABLE NON PAEDIATRIC CODE FOR PAYMENT.
BK011	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR AN UPPER G.I. SERIES FOR THIS PATIENT AT THE SAME ENCOUNTER.
BK012	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR A COLON G.I. SERIES FOR THIS PATIENT AT THE SAME ENCOUNTER.
BK013	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR A CYSTOGRAPHY OR CYSTOURETHROGRAM FOR THIS PATIENT AT THE SAME ENCOUNTER.
BK014	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED A CT FEE FOR THE SAME REGION DURING THIS ENCOUNTER. WHEN A CT EXAMINATION IS PERFORMED WITH AND WITHOUT CONTRAST, THE COMBINED CODE SHOULD BE USED.
BK015	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED A SEPARATE CLAIM FOR THIS CT WITH OR WITHOUT CONTRAST AT THE SAME ENCOUNTER. PLEASE SUBMIT A DELETE FOR THE INDIVIDUAL FEE BEFORE CLAIMING THIS COMBINED CODE.
BK016	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED A CLAIM FOR THIS CT WITH AND WITHOUT CONTRAST COMBINATION CODE AT THE SAME ENCOUNTER.
CS007	SERVICE ENCOUNTER HAS BEEN DISALLOWED. WHEN A VISIT AND CAST AND/OR SPLINT ARE PERFORMED AT THE SAME SERVICE ENCOUNTER, ONLY ONE IS APPROVED.
GN064	SURGICAL ASSIST CLAIMS (RO=SRAS) CANNOT BE CLAIMED UNTIL AFTER THE SURGEON HAS CLAIMED FOR THE SURGICAL SERVICES. PLEASE ENSURE THE PRIMARY SURGEON HAS SUBMITTED CLAIMS FOR THE SAME HSC AND RESUBMIT.
GN065	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE HAS ALREADY BEEN CLAIMED BY ANOTHER PROVIDER ON THIS DAY.
M0J46	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS SURGICAL ASSIST CLAIMS FOR HSC 98.49C OR 98.49D CANNOT BE CLAIMED UNTIL THE SURGEON HAS CLAIMED FOR THE SURGICAL SERVICES.

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UPDATED FILES

Updated files reflecting changes are available for download on Friday, September 26th, 2014. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanatory codes (EXPLAIN.DAT), and modifier values (MODVALS.DAT).

HELPFUL LINKS

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APPENDIX A

SCHEDULE OF PROVINCIAL IMMUNIZATIONS

Refer to the following fee schedule when claiming for individual immunization(s) not billed in conjunction with an office visit or a single immunization billed in conjunction with an office visit:

IMMUNIZATION	HEALTH SERVICE CODE	MODIFIER	MSUs	DIAGNOSTIC CODE
HAHB *Hepatitus A and B vaccine*	13.59L	RO=HAHB*	6.0	*See below
HBIg *Hepatitus B Immunoglobulin*	13.59L	RO=HBIG*	6.0	*See below
HB *Hepatitis B vaccine*	13.59L	RO=HBVV	6.0	V069
Hib *Haemophilus influenzae type b vaccine*	13.59L	RO=HIBV*	6.0	*See below
HPV-4 *Human Papillomavirus vaccine*	13.59L	RO=HPV4	6.0	V069
Inf *Infuenza-Inactivated vaccine*	13.59L	RO=INFL	6.0	V069
Influenza - Pregnant	13.59L	RO=INFL	6.0	V221
Influenza - Males and non-pregnant females	13.59L	RO=INFL	6.0	V048
Men-C-C *Meningococcal conjugate vaccine*	13.59L	RO=MENC	6.0	V069
Men-C-ACYW-135 *Meningococcal conjugate quadrivalent vaccine*	13.59L	RO=MENQ*	6.0	*See below
MMR *Measles, Mumps, Rubella vaccine*	13.59L	RO=MMAR	6.0	V069
MMRV *Measles, Mumps, Rubella and Varicella vaccine for travel only to areas of risk for Measles*	13.59L	RO=MMRT*	6.0	*See below
MMRV *Measles, Mumps, Rubella and Varicella vaccine*	13.59L	RO=MMRV	6.0	V069
DTaP-IPV-Hib *Diphtheria, Tetanus, Acellular Pertussis, Polio, Haemophilus influenzae type b vaccine*	13.59L	RO=PENT	6.0	V069
Pneu-P-13 *Pneumococcal-conjugate-valent vaccine*	13.59L	RO=PNEC	6.0	V069
Pneu-P-23 *Pneumococcal-Polysaccharide-valent vaccine*	13.59L	RO=PNEU**	6.0	V066
RabIg *Rabies Immunoglobulin*	13.59L	RO=RABI*	6.0	*See below
Rab Rabies vaccine	13.59L	RO=RABV*	6.0	*See below

Tdap *Tetanus Toxoid, Diphtheria, Acellular Pertussis vaccine*	13.59L	RO=TDAP	6.0	V069
Tdap-IPV *Tetanus toxoid, Diptheria, Acellular Pertussis, Polio vaccine*	13.59L	RO=TDPP	6.0	V069
Td *Tetanus Toxoid, diphtheria vaccine*	13.59L	RO=TEDV	6.0	V069
TIG *Tetanus Immunoglobulin*	13.59L	RO=TEIG*	6.0	*See below
VarIg *Varicella-Zoster Immunoglobulin*	13.59L	RO=VAIG*	6.0	*See below
Var *Varicella*	13.59L	RO=VARV	6.0	V069

When claiming immunization with a visit, the visit will be paid in full at 100%. The first inoculation will be paid in full at 6.0 MSU and all subsequent inoculations will be paid at 3.0 MSU or 50%. If the purpose of the visit is for immunization only, then the first two inoculations will be paid at 100% and all subsequent inoculations at 50% of the specified MSU.

Refer to the following table when claiming for a provincial immunization tray fee:

HEALTH SERVICE CODE	DESCRIPTION	MSUs
13.59M	Provincial Immunization Tray Fee	1.5 per multiple (Max 4)

* Refer to the following diagnostic code table, when claiming for **at risk immunizations**:

PATIENT'S CONDITION	DIAGNOSTIC CODE
At risk irrespective of age	Diagnostic code applicable to condition, e.g. 25000 diabetes mellitus
Close contact of at risk individual	V018
Well Senior	V069

** Refer to the following diagnostic code table, when claiming for **pneumococcal and varicella immunizations**:

PATIENT'S CONDITION	DIAGNOSTIC CODE
At risk irrespective of age	Diagnostic code applicable to condition, e.g. 25000 diabetes mellitus
Close contact of at risk individual	V018
Well Senior	V066

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

July 18, 2014 Volume L #4

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NEW FEES

Note: Physicians holding eligible services must submit their claims from April 1, 2014 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.

Effective April 1, 2014 the following new health service codes are available for billing:

Category	Code	Description	Unit Value
MASG	17.5C	**Nerve Transfer with Microneural Coaptation for the treatment of proximal 3rd, 4th, or 5th degree nerve injury to the brachial plexus or other major peripheral nerve:** This is a time-based, comprehensive fee for nerve transfer using microneural coaptation, with the surgical microscope, of a healthy donor nerve (distal) to the injured recipient nerve (proximal). This procedure is for proximal 3rd, 4th, or 5th degree nerve injury to the brachial plexus or other major peripheral nerve. The fee includes all nerve dissection, nerve stimulation, incisions, tendon transfers and repairs required to accomplish the repair. No other HSC's may be billed during the skin-to-skin time period used to calculate the surgical fee. Operative report and record of operation must be submitted for billing. **Billing Guidelines** No other HSC's to be billed during the skin-to-skin surgical time used to calculate the surgical fee. **Specialty Restriction** PLAS **Location** HOSP **Regions** Right, left, bilateral	IC at 130 MSU/hr 4+T

Note: Physicians holding eligible services must submit their claims from June 1, 2014 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.

Effective June 1, 2014 the following new health service codes are available for billing:

Category	Code	Description	Unit Value	
MASG	65.59D	**Total Abdominal Wall Reconstruction with myofascial advancement flaps (Interim Fee):** This is a comprehensive fee for the repair of a massive, complex abdominal wall hernia. The procedure includes the reduction of the hernia, all lysis of adhesions, bowel resection as required, removal of pre-existing mesh as required, rectus muscle mobilization, fascial bipartition with component separation, with or without placement of mesh or biologic graft, and skin excision. Operative report and record of operation must be submitted with billing claim. **Billing Guidelines** Not to be billed with lysis of adhesions, bowel resection or any other intra-abdominal procedure same patient same day. Physician must document skin-to-skin operating time in the claim as well as in the record of operation. In the event that skin-to-skin time exceeds 5 hours and 30 minutes, the physician may bill for this procedure via EC at 130 MSU/hour. **Specialty Restriction** GNSG, PLAS **Location** HOSP	585	8+T

Category	Code	Description	Unit Value	
MAFR	91.35G	**Open Reduction and Internal Fixation (ORIF) Bicondylar Tibial Plateau Fracture:** This is a comprehensive fee for the repair of a bicondylar tibial plateau fracture to include all surgical exposure, fracture reduction, bone grafting, meniscal repair, stabilization of the fracture including all plates and screws, IM nails, and external fixator as required. **Billing Guidelines** Not to be billed with: BOGR 90.06A - Bone graft - tibia ADON 90.09A - Morselized allograft MASG 92.15 - Other arthrotomy MASG 92.89N - Arthroscopic meniscal repair On same patient, same side, same day. **Specialty Restriction** ORTH	250	4+T

Location
HOSP

Regions
Right, left, bilateral

Category	Code	Description	Unit Value
MASG	90.69D	**Removal of Complex Internal Fixation Device(s) (IM nail, locking plate) as sole operative procedure:** This fee code applies to the removal of intermedullary nails and locking plates when performed as the sole operative procedure at that operative site. Not paid in addition to, or part of, another orthopaedic procedure unless the internal fixation device is removed from a separate operative site. Not to be billed when followed by a revision fixation in which case the MAFR code and MASG 90.69B-Removal of internal fixation should be billed. **Billing Guidelines** Not to be billed with: Any other fracture code same patient, same day, same region/site. **Specialty Restriction** ORTH **Location** HOSP **Regions** Right, left, bilateral	110 4+T

Category	Code	Description	Unit Value
VADT	09.03A	**Examination for Retinopathy of Prematurity:** To be billed in addition to the visit fee for the comprehensive ophthalmological examination of both eyes, including all ophthalmic testing, in an infant with an underlying diagnosis of retinopathy of prematurity in the neonatal intensive care setting. **Billing Guidelines** Billable only when the functional centre is the neonatal intensive care unit. Not to be billed with: 09.02 - Comprehensive eye examination 09.04 - Eye exam under anaesthesia. **Specialty Restriction** Paediatric Ophthalmology **Location** HOSP, NICU	15

Category	Code	Description	Unit Value
MASG	71.4C	**Synthetic mid urethral sling for female urinary incontinence, any approach:** This is a comprehensive fee for the surgical treatment of female urinary incontinence by the placement of a synthetic mid urethral sling (for example TVT, TOT) by any approach, including cystoscopy when performed. **Billing Guidelines** Not to be billed with VADT 01.34A - Cystoscopy same patient same day. **Specialty Restriction** UROL, OBGY **Location** HOSP Please note that this code replaces the previous interim code 71.4B (Urethral sling using prosthetic material such as TVT, TOT etc, by any method) effective June 1, 2014.	150 4+T

Category	Code	Description	Unit Value
MASG	71.4D	**Pubo-vaginal sling with autologous fascia for female urinary incontinence, includes cystoscopy as required:** This is a comprehensive fee for the surgical treatment of female urinary incontinence using autologous fascia. This fee includes the harvesting of fascia lata or rectus fascia as required, the placement of the sling using both an abdominal and vaginal approach, and cystoscopy as required. If the skin-to-skin operative time extends beyond 4 hours, then bill IC@ 130 MSU/hr including operative report and record of operation with the claim. Not to be billed for synthetic Mid Urethral Sling (e.g. TVT, TOT). **Billing Guidelines** Not to be billed with VADT 01.34A – Cystoscopy, same patient, same day. Not to be billed for synthetic mid urethral Sling (e.g. TVT, TOT), as described in code above. **Specialty Restriction** UROL, OBGY **Location** HOSP	350 6+T

UPDATE – MSI ELIGIBILITY FOR NS RESIDENTS ON VACATION OUT OF PROVINCE

The Department of Health and Wellness will be extending the length time Nova Scotia residents are eligible for Medical Services Insurance (MSI) while out of the province for vacation. As of August 1, 2014, Nova Scotians are eligible for MSI benefits for an additional month while on vacation outside of the province for a maximum of 7 months in each calendar year. Vacationers are required to inform MSI of their absence by telephoning 902-496-7008 (local) or 1-800-563-8880 (toll-free) or submitting an email to msi@medavie.ca.

In order to allow vacationers an adequate supply of medications while travelling outside the province for more than 100 days, the Nova Scotia Family and Senior's Pharmacare Programs will allow pharmacies to dispense up to three 90 day refills to allow for a 270 day maximum supply of medication for beneficiaries to bring with them as vacation supply.

ELECTIVE OUT OF PROVINCE SERVICES (WITHIN CANADA)

Prior approval is required from the Nova Scotia Department of Health and Wellness before referring a patient out of province for insured health services unavailable in Nova Scotia if the patient wishes to be considered for travel and accommodation assistance. Approval must be sought through the Medical Consultant, MSI. The referral must be from a specialist registered in Nova Scotia, who is actively involved in the eligible resident's care. The referral must include the following:

- A description of the eligible resident's relevant medical history.
- A description of the health services requested as well as an estimation of the expected benefit to the patient.
- A description of any follow-up requirements.
- Information on the available health services in Nova Scotia and an explanation of why these are not sufficient for the resident's needs.
- A written recommendation in support of the out-of-province health services, confirming that this is the specialist's recommendation and that the referral is not being provided solely at the request of the patient.
- Written confirmation of the medical evidence, and the patient's medical requirement for travel with an escort, if required.
- The contact information of the physician who will be treating the patient so a copy of the approval documentation can be forwarded to their office.
- The costs for an escort will not be covered by DHW if there is no medical evidence to support the need for an escort. Evidence of medical need for an escort is not required if the resident is under 19 years of age.
- When the proposed health service is a new or emerging health service, documentation must be included of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.

MSI will review the application and provide a response to the appropriate specialist within 30 days of receiving a complete application.

Upon approval of the application, the Department of Health and Wellness will contact the eligible resident and provide the appropriate application forms for travel and accommodation assistance.

ELECTIVE OUT OF COUNTRY SERVICES

Individuals requiring elective, insured health services that are not available within Canada must be authorized by the DHW prior to making any medical and/or travel arrangement to ensure the service will be insured and in order for the DHW/MSI to negotiate a reasonable and fair compensation with out of country providers prior to the provision of services.

In order for a patient to be referred outside Canada for treatment, prior written approval is required from the Medical Consultant, MSI. The referral must be from a specialist registered in Nova Scotia, who is actively involved in the eligible resident's care. The referral must include the following:

- A description of the eligible resident's relevant medical history.
- A description of the health services requested as well as an estimation of the expected benefit to the patient.
- A description of any follow-up requirements.
- Information on the available health services in Canada and an explanation of why these are not sufficient for the resident's needs.
- A written recommendation in support of the out-of-country health services, confirming that this is the specialist's recommendation and that the referral is not being provided solely at the request of the patient.
- Written confirmation of the medical evidence, and the patient's medical requirement for travel with an escort, if required.
- The contact information of the physician who will be treating the patient so a copy of the approval documentation can be forwarded to their office.
- The costs for an escort will not be covered by DHW if there is no medical evidence to support the need for an escort. Evidence of medical need for an escort is not required if the resident is under 19 years of age.
- When the proposed health service is a new or emerging health service, documentation must be included of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.

MSI will review the application and provide a response to the appropriate specialist within 30 days of receiving a complete application.

Upon approval of the application, the Department of Health and Wellness will contact the eligible resident and provide the appropriate application forms for travel and accommodation assistance.

AUDIT TIME PERIOD

When an onsite billing audit is required, the audit is typically based upon a random sample of services, of a selected service type, drawn from the most recent two-year period. The period may be expanded to cover a longer time period depending upon the nature of any identified billing issues or other information.

There may be instances where services are selected in a non-random manner based on specific criteria related to the identified billing issue.

MMR VACCINE FUNDING

In Nova Scotia the following groups are eligible to receive measles vaccine as part of the publicly funded immunization program:

Infants and Children:

1. Two doses of a measles-containing vaccine MMR(V) are recommended. The first dose should be given on or after the first birthday and the second dose should be given at the 4-6 year old visit but may be given as early as 18 months.

2. For travel to regions where measles is a concern, http://travel.gc.ca/travelling/health-safety/travel-health-notices/measles, MMR may be given as early as six months of age following a risk assessment. Under these circumstances, the routine two dose series must be started on or after the first birthday, for a total of three doses.

   In general, there is no need to provide early vaccination for infants travelling within Canada. There may be exceptions if there is recent measles activity within the family or closed community to which a visit is planned.

To support the addition of immunization of infants 6-11 months of age, new billing codes have been added as follows:

MSI billing modifier for infants between 6 months and 1 week prior to 12 months of age who are travelling to areas of risk for measles. (There is no change to billing practices for the administration of routine childhood immunizations.)

Immunization	Health Service Code	Modifier	MSUs
Injection for Measles, Mumps and Rubella for travel of infants only to areas of risk.	*13.59L*	*RO=MMRT*	*6.0*
This immunization is only to be claimed for infants between 6 months and 1 week prior to 12 months of age who are travelling to areas of risk. **Text is also required from the physician stating the reasoning for administering the immunization prior to 12 months.**			

Adolescents and Adults:

Adults born in or after 1970 should receive two doses of measles-containing vaccine, unless they have documented immunity (serology) from measles disease, or have documented evidence of receiving two valid doses of measles containing vaccine.

It is generally safe to assume that Canadian residents born **before 1970**, regardless of place of birth, have naturally-acquired immunity against measles, mumps and rubella. However, **international travelers** of this age should receive one dose of measles containing vaccine (**not publically funded**) if they do not have one of the following:

- documented evidence of receiving measles-containing vaccine on or after their first birthday;
- laboratory evidence of immunity (e.g. through blood testing); or
- a history of laboratory confirmed measles disease.

BILLING REMINDERS

3D CT RECONSTRUCTION CODES

Effective August 1, 2014, health service codes 1180, 3180, and 5180 may only be claimed when 3D reconstruction has been carried out. They may not be claimed for 2D reconstruction or multiplanar reconstruction.

SURGICAL ASSISTANT CLAIMS

Preamble 9.5.1 states that a surgical assistant's surgical encounter is 33.8% of the surgical fee. The health service codes claimed for surgical assistant services are expected to align with those submitted by the primary surgeon and all surgical assistant claims should adhere to the preamble guidelines. Physicians are reminded that all claims, including claims for surgical assistant services, are subject to MSI monitoring and audit processes.

UNBUNDLING OF CLAIMS

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

The initiative to assess claims submitted where more than one procedure is claimed for the same patient on the same day is ongoing. Please be advised that as the manual assessment of these claims continues, operative reports may be requested.

DAILY HOSPITAL AND OFFICE VISITS - SECOND OCCURENCE CLAIMS

As per Preamble section 7.2.4, **limited hospital visits are for the daily care of the patient**. This composite fee includes reviewing lab work, discussions with patients and/or their families and instances in which the physician

electively returns to reassess a patient. Additional visits may not be claimed for such activities as they are included in the daily rate.

If a physician is requested by hospital staff to reassess a patient in an emergent situation and the physician responds immediately, an urgent visit may be claimed. **Urgent visits may only be claimed if the physician travels to see the patient**. As per Preamble section 2.31, movement within a hospital or long term care facility or from an office attached to a hospital is not considered travel and therefore does not meet the requirements for an urgent visit.

If more than one visit is provided by the same physician to the same patient on the same day at separate times, **documentation of the necessity for the extra visit(s) must be recorded on the chart**. Time of service occurrence must be provided on second and subsequent visits, per Preamble 7.2.3. When submitting the claim, the service occurrence field is used to indicate the number of separate service encounters with an occurrence number greater than one. Text is required in order for the claim to be paid. This text must indicate the medical necessity of the subsequent visit as well as the time of the occurrence. Any claims submitted with an occurrence number greater than one without text will be paid at zero.

EXPLANATORY CODES

AD049 Service encounter has been refused as the patient's age is not between 6 months and one week prior to 12 months.

AD050 Service encounter has been refused as electronic text is required stating the reasoning for administering the MMRT immunization.

MA061 Service encounter has been disallowed as this claim is incomplete. Please resubmit with text specifying the skin to skin operating time.

MA062 Service encounter has been refused as a cystoscopy has previously been billed for this patient on the same day.

MA063 Service encounter has been refused as cystoscopy is included in the fee for HSC 71.4C which has been previously billed for this patient on this day.

MF006 Service encounter has been refused as you have previously claimed HSC 90.06A, 90.09A, 92.15, or 92.89N for the same patient on the same day.

MF007 Service encounter has been refused as you have previously billed for an ORIF Bicondylar Tibial Plateau Fracture for this patient on this day.

MF008 Service encounter has been refused as you have previously claimed a fracture code for the same site/region on this day.

MJ045 Service encounter has been refused as HSC 01.34A has already been billed for this patient on this day.

VA059 Service encounter has been refused as HSC 71.4D has already been billed on this day which includes cystoscopy.

VA060 Service encounter has been refused as you have previously billed HSC 09.02 or 09.04 for this patient at the same encounter.

VE008 Service encounter has been refused as you have previously billed HSC 09.03A for this patient at the same encounter.

WB031 Service encounter has been refused as the provider indicated is not valid for this service.

UPDATED FILES AVAILABILITY

Updated files reflecting changes are available for download on Friday, July 18th, 2014. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanatory codes (EXPLAIN.DAT), and modifier values (MODVALS.DAT).

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

May 23, 2014 Volume L #3

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http://www.medavie.bluecross.ca/msiprograms

NEW FEES

Note: Physicians holding eligible services must submit their claims from March 1, 2014 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.

Effective March 1, 2014 the following new health service codes are available for billing:

Category	Code	Description	Unit Value
ADON	52.89E	**Sentinel Lymph Node Biopsy for cancer:** This is an "add on" fee to surgical oncologic procedures, payable only for the staging of malignant disease (cancer). It is for the intra-operative identification and sampling of sentinel lymph nodes. The injection of non-radioactive dye is included, when performed. **Billing Guidelines** To be added on to surgical oncologic procedures with the diagnosis of "cancer". May be billed per drainage basin to a maximum of three basins in total **Specialty Restriction** None **Location** HOSP	50

Category	Code	Description	Unit Value	
MASG	28.54A	**Laser Photocoagulation for the treatment of Retinopathy of Prematurity:** This fee is for the treatment of extensive or progressive retinopathy of prematurity in premature infants up to the age of 6 months by laser photocoagulation.	160	6+T

Billing Guidelines
Base fee is for the treatment of one eye.

Specialty Restriction
Paediatric Opthalmology
Retinal Opthalmologist

Location
HOSP

Regions
Right, left, bilateral

Category	Code	Description	Unit Value
MASG	60.24C	**Transanal Endoscopic Microsurgery:** This fee is for the Transanal Endoscopic Microsurgical (TEM) resection of rectal lesion using a transanal operating proctoscope with visualization via the endoscopic camera, with full insufflation and pressure monitoring under general anesthesia. Includes the passage of a sigmoidoscope or proctoscope to ensure luminal patency **Billing Guidelines** 01.24C Rigid sigmoidoscopy not payable same patient same day. **Specialty Restriction** GNSG with colorectal and/or minimally invasive surgery (MIS) fellowship. **Location** HOSP	325 6+T

FAMILY PHYSICIAN CHRONIC DISEASE MANAGEMENT INCENTIVE PROGRAM
Revised April 1, 2014

Please Note: You may now submit any claims since April 1, 2014 for the third chronic disease managed using the new **RP=CON3** *modifier. Physicians holding eligible services must submit their claims from April 1, 2014 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. Claims for the first and second chronic disease managed with a service date from April 1, 2014 to May 22, 2014 will be identified and reconciliation will occur in the Fall of 2014*

The current *Physician Services Master Agreement, Schedule "K" Chronic Disease Management Incentive* is intended to recognize the additional work of General Practitioners, beyond office visits, of providing guidelines-based care to patients with chronic diseases.

The Master Agreement Steering Group (MASG) has recently approved changes to the existing Family Physician Chronic Disease Management (CDM) Incentive Program effective April 1, 2014 including:

- **Addition of chronic obstructive pulmonary disease (COPD) as an eligible chronic disease;**

- **Revisions to program requirements and documentation to incorporate COPD, reflect changes to clinical practice guidelines, and improve clarity; and,**
- **Increases to payment rates.**

The existing program strategy and general guidelines remain unchanged.

Qualifying Chronic Diseases
Effective April 1, 2014, the qualifying chronic diseases are:

- **Type 1 and Type 2 Diabetes** as evidenced by FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L; and,

- **Ischaemic Heart Disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram.

- **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator FEV_1 < 80% predicted and FEV_1/FVC < 0.70

Required Indicators/Risk factors
Effective April 1, 2014, in order to claim a CDM incentive payment the following indicators/risk factors, as applicable, are required to be addressed as part of the annual cycle of care. The required indicators include all relevant common indicators plus the specific indicators for each disease. For example, if diabetes and COPD are present, the three common indicators for diabetes, IHD and COPD plus the three common indicators for diabetes and IHD plus the specific indicators for diabetes and the specific indicators for COPD would all need to be addressed in order to claim annual incentive payments for the two diseases.

Common Indicators for Diabetes, IHD and COPD

- Smoking cessation – discussed once per year if smoker (document smoker or nonsmoker)
- Immunizations discussed and/or given – once per year
- Exercise/activity – discussed, including possible referrals, once per year

Common Indicators for Diabetes and IHD

- Blood pressure – 2 times per year
- Weight/nutrition counseling – once per year
- Lipids – once per year

PLUS THE FOLLOWING REQUIRED INDICATORS, DEPENDING ON THE APPLICABLE CHRONIC DISEASE:

Indicators for Diabetes only

- HbA1C – ordered 2 times per year
- Renal function – ACR or eGFR ordered once per year
- Foot exam with 10-g monofilament – referred or completed once per year
- Eye exam – discussed and/or referred once per year for routine dilated eye exam

Indicators for IHD only

- Anti-platelet therapy – considered/reviewed once per year
- Beta-blocker – considered/reviewed once per year

- ACEI/ARB – considered/reviewed once per year
- Discuss Nitroglycerin – considered/reviewed once per year
- Consider further cardiac investigations – considered/reviewed once per year

Indicator for COPD only

- **COPD Action Plan required – Develop and then review and complete once per year**

CDM Incentive Payments

Effective April 1, 2014 eligible GPs are paid as follows:

- $100 base incentive payment once per fiscal year for managing an annual cycle of care and addressing the required indicators/risk factors for each patient with one qualifying chronic disease.
- $75 additional payment per fiscal year if the same patient is managed for a second qualifying *c*hronic disease (total payment of $175)
- $50 additional payment per fiscal year if the patient is managed for three qualifying chronic diseases (total payment of $225).

NOTE: Completion of the COPD Action Plan, if applicable, is included in these payments.

The CDM incentive is claimed through a fee code. APP contract physicians are also eligible for the incentive and are paid by cheque twice a year based on their aggregate shadow billings.

CDM Incentive Billing Rules

1. The CDM Incentive fee can be claimed by family physicians only.
2. The base incentive fee may be claimed once per fiscal year (April 1 to March 31) for each patient managed for one qualifying chronic disease condition. An additional incentive amount per patient may be claimed once per fiscal year as part of the fee if the patient has additional qualifying chronic diseases (s) for each qualifying disease.
3. The family physician is expected to act as case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations, including for investigations, follow-up visits and/or referrals.
4. Patients must be seen a minimum of two times per year by a licensed health care provider (includes physicians) in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.
5. Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.
6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year by March 31 of that year.
7. The qualifying chronic diseases eligible for the CDM incentive payment are:
   - **Type 1 and Type 2 Diabetes** defined as: FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L; and/or,
   - **Ischaemic Heart Disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram (includes post-MI <=5 yr); and/or,
   - **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator FEV_1 < 80% predicted and FEV_1/FVC < 0.70.

8. For patients managed for COPD, a COPD Action Plan must be developed and then reviewed and completed annually, with a copy given to the patient and a copy available in the patient's clinical record.

9. The CDM incentive can be claimed once per fiscal year (April 1 to March 31 inclusive) if the following conditions are met:
    - the patient is seen by the family physician in relation to their chronic disease(s) at least once in the fiscal year for which the CDM incentive is being claimed;
    - the patient has had at least one other appointment with the physician or another licensed health care provider in relation to their chronic disease(s) in the previous 12 months; and,
    - the CDM indicators required for the CDM incentive payment have been addressed at the required frequency and documented in the clinical record or optional CDM flow sheet at or before the time of billing.

CDM Flow Sheet

The Family Physician Chronic Disease Management Flow Sheet (attached) is revised effective April 1, 2014. Use of the Flow Sheet continues to be optional.

COPD Action Plan

A required indicator for COPD is the development and annual review and completion of a COPD Action Plan using the program COPD Action Plan template (attached).

BILLING REMINDERS

Exceptional Clinical Circumstances versus Independent Consideration

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. ***An example where EC would apply is when a procedure was performed that does not yet have a fee code.***

Independent Consideration

Independent consideration is applied to certain services that are assigned a health service code but where a wide variation in case to case complexity and time exists and no unit value is listed. Independent consideration services must be accompanied by complete details, including duration of service, adequate to explain and justify the number of units requested. ***An example where IC would apply is HSC 98.11-Debridement of wound or infected tissue ME=COMP.***

The tariff for IC and EC services is agreed to by the Master Agreement Steering Group (MASG) on recommendation from the Fee Schedule Advisory Committee (FSAC) and increased with sessional rate increases as per the Master Agreement. Currently, they are as follows:

- 100 units per hour for surgical and interventional procedures.
- 70 units per hour for specialist, non-surgical, non-interventional services and this rate will increase with the yearly increases for sessional rates as per the Master Agreement.
- 60 units per hour will remain as the rate for any GP non-surgical, non-interventional services until such time as their sessional rate exceeds 60 units per hour.

Payment for surgical services is based upon the skin to skin time.

General Practice Evening and Weekend Office Visit Incentive Program - Reminder

MSI has recently become aware that some physicians are claiming the General Practice Evening and Weekend Office Visit Incentives for services provided at walk in clinics.

By way of reminder, this service may be claimed by eligible fee-for-service general practitioners who open their offices during week day evenings (between 6pm and 10pm) and/or weekends (between 9am to 5pm, Saturday and Sunday). Eligible physicians may claim an incentive for evening and weekend office services provided for their own patients as well as for patients from the stable patient roster of other eligible physicians within the same practice location, providing the patient's record can be assessed and the encounter is recorded.

Services provided in walk-in clinics are not eligible for the evening and weekend office visit incentive funding program and are subject to recovery for inappropriate claims for this incentive. 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.

In situations in which a clinic provides both care to a stable roster of patients and walk-in clinic services, only physicians who maintain a stable roster of patients at that location may claim the incentive and only for individuals who belong to the stable roster of patients.

EXPLANATORY CODES

CC004 Service encounter has been disallowed as HSC 03.05 has previously been claimed. Documentation must be provided if re-assessment is required.

DE016 Service encounter has been refused as the third condition amount has already been approved for this year.

MA061 Service encounter has been refused as the patient is over 6 months old.

MJ044 Service encounter has been refused as HSC 01.24C has previously been billed for this patient on this day.

VA058 Service encounter has been refused as HSC 60.24C has previously been billed for this patient on this day.

VT124 Service encounter has been disallowed as an urgent hospital visit applies only when a physician travels from one location to another. Preamble 7.2.7(a). Resubmit with text stating details of the Physicians travel.

VT125 Service encounter has been refused as this claim does not meet the criteria for an urgent visit, per Preamble 7.2.7 (a),(b),(c).

VT126 Service encounter has been disallowed as an additional visit for an OPD or Emerg patient is only payable if the patient is under observation for more than 4 hours. Preamble 7.2.6 (a). Resubmit with text explaining the necessity of an additional visit.

UPDATED FILES AVAILABILITY

Updated files reflecting changes are available for download on Friday, May 23rd, 2014. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanatory codes (EXPLAIN.DAT), and modifier values (MODVALS.DAT).

Family Physician Chronic Disease Management (CDM) Flow Sheet

Patient Name: _____ Diabetes: Type 1 ☐ Type 2 ☐ IHD ☐ COPD ☐

Date of birth: _____ (dd/mm/yy) Date(s) of Diagnosis: DM _____ (mm/yy) IHD _____ (mm/yy) COPD _____ (mm/yy)

Co morbidities: ☐ HTN ☐ Dyslipidemia ☐ PAD ☐ Renal Disease ☐ A Fib
☐ TIA/Stroke ☐ Mental Health Diagnosis ☐ CHF
Other: _____

Interventions/Investigations: PCI/Stent _____ ☐ Bare metal ☐ Drug-eluting ☐ Spirometry/PFT
CABG _____ Cardiac Cath. _____
Current Medication: _____
_____

REQUIRED COMMON INDICATORS FOR DIABETES, IHD AND COPD		Date / /	Date / /	Date / /	Date / /
ANNUALLY	Smoker ☐ Yes ☐ No If yes, discuss smoking cessation				
ANNUALLY	Immunizations Discussed and/or given				
ANNUALLY	Exercise/Activity				
REQUIRED COMMON INDICATORS FOR DIABETES and IHD		Date / /	Date / /	Date / /	Date / /
2/YR	Blood pressure				
ANNUALLY	Weight/Nutrition Counselling				
ANNUALLY	Lipids Discuss statins LDL-C (mmol/L) TC/HDL-C				
REQUIRED INDICATORS FOR DIABETES ONLY					
2/YR	HbA1C				
ANNUALLY	Renal Function ACR and eGFR				
ANNUALLY	Foot Exam Use 10-g monofilament				
ANNUALLY	Eye Exam Discuss and/or refer				
REQUIRED INDICATORS FOR IHD ONLY					
ANNUALLY	Anti-platelet Therapy Review				
ANNUALLY	Beta-blocker Review				
ANNUALLY	ACEI/ARB Review				
ANNUALLY	Discuss Nitroglycerin				
ANNUALLY	Consider further cardiac investigations				
REQUIRED INDICATORS FOR COPD ONLY					
1/YR	COPD Action Plan Develop. Review and complete annually				
RECOMMENDED ITEMS (Optional for CDM Incentive payment)					

Self Management Referrals: ☐ Diabetes Centre ☐ Cardiac Rehab ☐ Your Way to Wellness ☐ Pulmonary Rehabilitation
Screen for: ☐ Depression/Anxiety ☐ Erectile Dysfunction
Lifestyle: ☐ Alcohol Use ☐ Psychsocial Issues
Economics: ☐ Pharmacare ☐ Third Party Insurance ☐ No Insurance ☐ Financial Issues
End of Life: ☐ Care Discussion

Date CDM Incentive Code Billed: _____

SELECTED CHRONIC DISEASE MANAGEMENT GUIDELINE INDICATORS

Common Indicators: DM, IHD & COPD	Target	Comments
Smoking Cessation	Non-smoker	
Immunizations	Influenza annually. Pneumococcal once, then for DM & IHD repeat at 65 yr.; for COPD repeat every 5-10 years..	
Exercise/Activity	Discuss appropriate exercise/activity and possible referrals	For DM & IHD: 30 mins/day 5x/wk plus resistance exercise 3 x/wk. For COPD: pulmonary rehab program
Common Indicators: DM & IHD	**Target**	**Comments**
Blood Pressure	IHD without DM or CKD: <140/90 DM: <140/80* DM and CKD: <130/80** In children: <95th %ile for age, gender and height	*In DM with no end organ damage ** Where this can be achieved safely without undue burden
Lipids	For IHD or IHD plus DM LDL-C: < 2.0 >50% reduction For DM only LDL-C: < 2.6	Test every 1-3 years OR as clinically indicated
Weight/Waist circumference/ Nutrition counseling	BMI: <25 kg/m^2 or In children: <85th %ile for age Waist circumference: M: <102 cm, F: <88 cm	

Diabetes Indicators	Target	Comments
HbA1C	< 7%	-q 6 mo. In stable DM -q 3 mo. For all others Individualize HbA1C based on age, DM duration & co-morbidity
Renal Function	ACR: <2.0 for males; <2.8 for females eGFR: >60 mL/min	In presence of CKD, at least every 6 months. Referral to nephrologist/internist if eGFR <30 mL/min
Routine foot examination	Annually	Q3-6 mo. In moderate to high risk foot. Assess skin, neuropathy (10 –g monofilament) and perfusion.
Routine dilated eye examination	At diagnosis, then every 1-2 years based on degree of retinopathy.	By optometrist or ophthalmologist

IHD Indicators	Duration	Comments
Beta-blocker	STEMI: Indefinitely Non-STEMI: Indefinitely unless low risk	
ACEI/ARB	Indefinitely unless low risk	ACEI: Titrate to target dose. Consider ARB if contraindication or intolerance to ACEI
Antiplatelet Therapy **ASA** 81 to 325 mg OD **Clopidogrel** 75 mg OD **Ticagrelor** 90 mg BID	**ASA** indefinitely –STEMI, Non-STEMI and Stable Coronary Artery Disease **Clopidogrel: STEMI** - Only if had PCI Minimum 1 mo. post bare metal stent Min. 12 mo. post drug-eluting stent **Clopidogrel: Non-STEMI** No PCI: Low risk - 3 mo; Inc. risk - 12 mo.; Very high risk - >12 mo. PCI: Low risk & bare metal stent - 3 mo.; Increased risk regardless of stent or ≥1 drug-eluting stent - 12 mo.; very high risk regardless of stent or ≥3 drug-eluting stents or complex PCI - >12 mo **Ticagrelor** Prescribed to high risk Acute Coronary Syndrome patients, 12 months of therapy recommended.	**ASA** maximum dose 75-100 mg if on Ticagrelor **Clopidogrel: STEMI** Dependent on type of stent and risk profile **Clopidogrel Non-STEMI** Depends on risk of recurrent event & stent type **Ticagrelor**: Reduce ASA to 75-100 mg. Transient dyspnea can be early side effect. Usually mild and resolves with continued therapy.
Discuss Nitroglycerin		
Consider further cardiac investigations		

COPD Indicators	Target	Comments
COPD Action Plan	Include medications and emergency instructions for patient.	Copy given to patient.

PHARMACOTHERAPY IN COPD

INCREASING DISABILITY AND LUNG FUNCTION IMPAIRMENT

MILD	MODERATE	VERY SEVERE
↓		
SABD prn ↓ Persistent dyspnea	**Infrequent AECOPD (average of <1 per year)** **LAAC *or* LABA + SABA prn** ↓ Persistent dyspnea	**Frequent AECOPD (≥1 per year)** **LAAC + ICS/LABA +SABA prn** ↓ Persistent dyspnea
LAAC + SABA prn or **LABA + SABD prn**	**LAAC + LABA + SABA prn** ↓ Persistent dyspnea **LAAC + ICS/LABA* + SABA prn**	**LAAC + ICS/LABA + SABA prn** ± **Theophylline**

*refers to lower dose ICS/LABA

SABD = Short-acting bronchodilator (e.g. ipatropium or SABA)

LAAC = Long acting anticholinergic (e.g. tiotropium)

LABA = Long acting beta agonist (e.g. salmeterol; formoterol)

SABA = Short-acting beta agonist (e.g. salbutamol; terbutaline)

ICS/LABA = inhaled corticosteroid/LABA (e.g. fluticasone/salmeterol; budesonide/formoteral)

CHRONIC DISEASE MANAGEMENT (CDM) INCENTIVE FEE BILLING RULES

1. The CDM Incentive fee can be claimed by family physicians only.
2. The base incentive fee may be claimed once per fiscal year (April 1 to March 31) for each patient managed for one qualifying chronic disease condition. An additional incentive amount per patient may be claimed once per fiscal year as part of the fee if the patient has additional qualifying chronic disease(s) for each qualifying disease.
3. The family physician is expected to act as case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations, including for investigations, follow-up visits and/or referrals.
4. Patients must be seen a minimum of two times per year by a licensed health care provider (includes physicians) in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.
5. Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.
6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year by March 31 of that year.
7. The qualifying chronic diseases eligible for the CDM incentive payment are:
   - **Type 1 and Type 2 Diabetes** defined as: FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L; and/or,
   - **Ischaemic Heart Disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram (includes post-MI <=5 yr); and/or,
   - **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator FEV_1 < 80% predicted and FEV_1/FVC < 0.70.

8. For patients managed for COPD, a COPD Action Plan must be developed and then reviewed and completed annually, with a copy given to the patient and a copy available in the patient's clinical record.
9. The CDM incentive can be claimed once per fiscal year (April 1 to March 31 inclusive) if the following conditions are met:
   - the patient is seen by the family physician in relation to their chronic disease(s) at least once in the fiscal year for which the CDM incentive is being claimed;
   - the patient has had at least one other appointment with the physician or another licensed health care provider in relation to their chronic disease(s) in the previous 12 months; and,
   - the CDM indicators required for the CDM incentive payment have been addressed at the required frequency (see front of flow sheet) and documented in the clinical record or optional flow sheet at or before the time of billing.

COPD ACTION PLAN

(Review annually with your doctor)

Patient Name: _____ Date: _____

HCN: _____ Date of Birth: _____

You have been diagnosed with Chronic Obstructive Pulmonary Disease (COPD). As someone with COPD, you are either in your stable, everyday state or having a flare up. This Plan will help you to quickly recognize and treat flare ups to manage your COPD and improve your health.

COPD (*Chronic Obstructive Pulmonary Disease*) can be stable or you could have a flare-up:

When you are stable:

1. Breathing with your usual shortness of breath
2. Able to do your usual daily activities
3. Mucous is easy to cough up

How to tell if you are having a flare-up

A flare up may occur after you get a cold, get run down or are exposed to air pollution, pollen or very hot or cold weather. There are 3 things that define a flare-up:

1. Increased shortness of breath from your usual level
2. Increased amount of sputum from your usual level
3. Sputum changes from its usual colour to yellow, green or rust colour

Some people may feel a change in mood, fatigue or low energy prior to a flare-up.

If any 2 or all of these symptoms persist for 48 or more hours do the following:

- □ Take your rescue inhaler 2-4 puffs as needed (up to 4-6 times per day) for shortness of breath.
- □ Take your prescribed antibiotic for a COPD flare-up (see over).
- □ Take your prescribed prednisone for a COPD flare-up (see over).
- □ Contact your doctor if you feel worse or do not feel better after 48 hours of treatment.
- □ Call 811 if you have questions
- □ Other _____

IF YOU ARE EXTREMELY BREATHLESS, ANXIOUS, FEARFUL, DROWSY, CONFUSED OR HAVING CHEST PAIN, CALL 911 FOR AN AMBULANCE TO TAKE YOU TO THE EMERGENCY ROOM.

Physician Signature_____

Patient/Caregiver Signature_____

COPD MAINTENANCE MEDICATION RECORD

Patient Name: _____ Date: _____

HCN: _____ Date of Birth: _____

Patients: Take the following maintenance medications **everyday** to help maintain control of your COPD symptoms.

Physicians: Please fill in prescribed maintenance medications.

Medication Prescribed	How Much to Take	When To Take

COPD FLARE-UP MEDICATION RECORD

Patients: Please fill in date when you start and finish your flare-up medications.

Physicians: Please fill in prescribed flare-up (antibiotics & prednisone) medications.

Medication Prescribed	Start Date / Finish	Start Date / Finish	Start Date / Finish

Make sure you take your prescribed medications until finished.

Please review this plan with your doctor at least annually.

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

March 28, 2014 Volume L #2

Inside this issue

CONTACT US:

MSI_Assessment@medavie.bluecross.ca

On-line documentation available at :

http://www.medavie.bluecross.ca/msiprograms

MEDICAL SERVICE UNIT/ANAESTHESIA UNIT CHANGE

Effective April 1, 2014, the Medical Service Unit (MSU) value will be increased from $2.37 to $2.42 and the Anaesthesia Unit (AU) value will be increased from $20.15 to $20.55.

WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC

Effective April 1, 2014 the Workers' Compensation Board MSU Value will increase from $2.63 to $2.69 and the Workers' Compensation Board Anaesthetic Unit Value will increase from $22.39 to $22.83.

PSYCHIATRY FEES

Effective April 1, 2014 the hourly Psychiatry rate for General Practitioners will increase to $110.55 while the hourly rate for Specialists increases to $149.90 as per the tariff agreement.

SESSIONAL PAYMENTS

Effective April 1, 2014 the hourly Sessional rate for General Practitioners will increase to $145.20 while the hourly rate for Specialists increases to $169.40 as per the tariff agreement.

FEE REVISIONS

The following health service codes have been terminated effective March 27, 2014:

Category	Code	Description
MASG	65.51C	Recurrent hernia – by laparoscopy
MASG	65.59C	Recurrent hernia – by laparoscopy

These fees have been replaced by HSC 65.51E – Recurrent ventral or incisional hernia repair, by laparoscopy, reducible or strangulated, with mesh, with or without enterolysis. Please refer to the January 31, 2014 MSI Physicians' Bulletin for more details on this service.

CATARACT FEE REMINDER

As announced previously in the March 28, 2013 MSI Physicians' Bulletin, the following reduction in cataract fees are effective April 1, 2014:

	Cataract surgical fee reduction		Cataract anaesthesia fee reduction	
Code	Current MSU	April 1st, 2014	Current AU	April 1st, 2014
27.72	285	270	5+T	4+T
27.72B	309	293	5+T	4+T
27.49A	218.5	207	5+T	4+T
27.49B	218.5	207	5+T	4+T
27.59A	218.5	207	5+T	4+T
27.59B	218.5	207	5+T	4+T

FAMILY PHYSICIAN CHRONIC DISEASE MANAGEMENT INCENTIVE PROGRAM
Revised April 1, 2014

The current *Physician Services Master Agreement, Schedule "K" Chronic Disease Management Incentive* is intended to recognize the additional work of General Practitioners, beyond office visits, of providing guidelines-based care to patients with chronic diseases.

The Master Agreement Steering Group (MASG) has recently approved changes to the existing Family Physician Chronic Disease Management (CDM) Incentive Program effective April 1, 2014 including:

- **Addition of chronic obstructive pulmonary disease (COPD) as an eligible chronic disease;**
- **Revisions to program requirements and documentation to incorporate COPD, reflect changes to clinical practice guidelines, and improve clarity; and,**
- **Increases to payment rates.**

The existing program strategy and general guidelines remain unchanged.

Qualifying Chronic Diseases
Effective April 1, 2014, the qualifying chronic diseases are:

- **Type 1 and Type 2 Diabetes** as evidenced by FPG ^{3}7.0 mmol/L ***or*** Casual PG ^{3}11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ^{3}11.1 mmol/L; and,
- **Ischaemic Heart Disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram.
- **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator FEV_1 < 80% predicted and FEV_1/FVC < 0.70

Required Indicators/Risk factors

Effective April 1, 2014, in order to claim a CDM incentive payment the following indicators/risk factors, as applicable, are required to be addressed as part of the annual cycle of care. The required indicators include all relevant common indicators plus the specific indicators for each disease. For example, if diabetes and COPD are present, the three common indicators for diabetes, IHD and COPD plus the three common indicators for diabetes and IHD plus the specific indicators for diabetes and the specific indicators for COPD would all need to be addressed in order to claim annual incentive payments for the two diseases.

Common Indicators for Diabetes, IHD and COPD

- Smoking cessation – discussed once per year if smoker (document smoker or nonsmoker)
- Immunizations discussed and/or given – once per year
- Exercise/activity – discussed, including possible referrals, once per year

Common Indicators for Diabetes and IHD

- Blood pressure – 2 times per year
- Weight/nutrition counseling – once per year
- Lipids – once per year

PLUS THE FOLLOWING REQUIRED INDICATORS, DEPENDING ON THE APPLICABLE CHRONIC DISEASE:

Indicators for Diabetes only

- HbA1C – ordered 2 times per year
- Renal function – ACR or eGFR ordered once per year
- Foot exam with 10-g monofilament – referred or completed once per year
- Eye exam – discussed and/or referred once per year for routine dilated eye exam

Indicators for IHD only

- Anti-platelet therapy – considered/reviewed once per year
- Beta-blocker – considered/reviewed once per year
- ACEI/ARB – considered/reviewed once per year
- Discuss Nitroglycerin – considered/reviewed once per year
- Consider further cardiac investigations – considered/reviewed once per year

Indicator for COPD only

- **COPD Action Plan required – Develop and then review and complete once per year**

CDM Incentive Payments

Effective April 1, 2014 eligible GPs are paid as follows:

- $100 base incentive payment once per fiscal year for managing an annual cycle of care and addressing the required indicators/risk factors for each patient with one qualifying chronic disease.
- $75 additional payment per fiscal year if the same patient is managed for a second qualifying chronic disease (total payment of $175)

- $50 additional payment per fiscal year if the patient is managed for three qualifying chronic diseases (total payment of $225).

NOTE: Completion of the COPD Action Plan, if applicable, is included in these payments.

The CDM incentive is claimed through a fee code. APP contract physicians are also eligible for the incentive and are paid by cheque twice a year based on their aggregate shadow billings.

CDM Incentive Billing Rules

1. The CDM Incentive fee can be claimed by family physicians only.

2. The base incentive fee may be claimed once per fiscal year (April 1 to March 31) for each patient managed for one qualifying chronic disease condition. An additional incentive amount per patient may be claimed once per fiscal year as part of the fee if the patient has additional qualifying chronic diseases (s) for each qualifying disease.

3. The family physician is expected to act as case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations, including for investigations, follow-up visits and/or referrals.

4. Patients must be seen a minimum of two times per year by a licensed health care provider (includes physicians) in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.

5. Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.

6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year by March 31 of that year.

7. The qualifying chronic diseases eligible for the CDM incentive payment are:

   - **Type 1 and Type 2 Diabetes** defined as: FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L; and/or,

   - **Ischaemic Heart Disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram (includes post-MI <=5 yr); and/or,

   - **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator FEV_1 < 80% predicted and FEV_1/FVC < 0.70.

8. For patients managed for COPD, a COPD Action Plan must be developed and then reviewed and completed annually, with a copy given to the patient and a copy available in the patient's clinical record.

9. The CDM incentive can be claimed once per fiscal year (April 1 to March 31 inclusive) if the following conditions are met:

   - the patient is seen by the family physician in relation to their chronic disease(s) at least once in the fiscal year for which the CDM incentive is being claimed;

- the patient has had at least one other appointment with the physician or another licensed health care provider in relation to their chronic disease(s) in the previous 12 months; and,
- the CDM indicators required for the CDM incentive payment have been addressed at the required frequency and documented in the clinical record or optional CDM flow sheet at or before the time of billing.

CDM Flow Sheet

The Family Physician Chronic Disease Management Flow Sheet (attached) is revised effective April 1, 2014. Use of the Flow Sheet continues to be optional.

COPD Action Plan

A required indicator for COPD is the development and annual review and completion of a COPD Action Plan using the program COPD Action Plan template (attached).

Please Note: The system update for this revision is scheduled for May 23rd, 2014. At present time, please submit claims for managing up to two chronic diseases in the usual manner. Please hold all claims for the new 3rd chronic disease management incentive amount. A new modifier will be added during the May 23rd, 2014 migration to account for this additional incentive. Once the update is complete, effective claims with a service date from April 1, 2014 to May 22, 2014 will be identified and reconciliation will occur in the Fall of 2014.

BILLING REMINDERS

Critical Care Codes-Heath Service Code 03.05

As per Preamble section 7.9, Critical Care codes may be claimed for patients admitted to areas of the hospital that have been designated as Intensive Care Units by the Department of Health and Wellness by physicians who have been assigned to cover the ICU by the hospital because of their training or expertise.

It has come to MSI's attention that physicians other than those designated to cover the ICU are attempting to claim critical care codes. Critical care codes may be claimed only once per 24 hours by only one physician who is designated to cover the ICU that day. Non-designated physicians may not claim these codes.

While two (or more) physicians may share coverage of the ICU over a 24 hour period, Preamble rules do not permit both physicians to claim either the same ICU code or additional visits per patient (critical care or otherwise).

Supervision of Anticoagulant Therapy by Telephone, Fax or E-Mail- Health Service Code 13.99C

As per Preamble section 7.7.2, this health service code may be claimed once per month if the patient's treatment is managed by telephone, fax or e-mail. It may not be claimed within one month of hospitalization. As there will be months when a physician does not provide the monitoring necessary to claim this code, such as months during which the patient does not have an INR drawn or when they are hospitalized, physicians are discouraged from setting up automatic monthly billing systems for this health service code.

EXPLANATORY CODES

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

MJ043 Service encounter has been disallowed as the provider number is not valid for this service.

MA058 Service encounter has been refused as you have previously billed HSC 82.42.

MA059 Service encounter has been refused as you have previously billed HSC 83.61.

AD048 Service encounter has been refused as you have previously billed HSC 66.3E or 66.3F.

MA060 Service encounter has been refused as you have previously billed HSC 66.82A.

UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, March 28th, 2014. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanatory codes (EXPLAIN.DAT).

Family Physician Chronic Disease Management (CDM) Flow Sheet

Patient Name: _____ Diabetes: Type 1 ☐ Type 2 ☐ IHD ☐ COPD ☐

Date of birth: _____ (dd/mm/yy) Date(s) of Diagnosis: DM _____ (mm/yy) IHD _____ (mm/yy) COPD _____ (mm/yy)

Co morbidities: ☐ HTN ☐ Dyslipidemia ☐ PAD ☐ Renal Disease ☐ A Fib
☐ TIA/Stroke ☐ Mental Health Diagnosis ☐ CHF
Other: _____

Interventions/Investigations: PCI/Stent _____ ☐ Bare metal ☐ Drug-eluting ☐ Spirometry/PFT
CABG _____ Cardiac Cath. _____
Current Medication: _____
_____

REQUIRED COMMON INDICATORS FOR DIABETES, IHD AND COPD		Date / /	Date / /	Date / /	Date / /
ANNUALLY	Smoker ☐ Yes ☐ No If yes, discuss smoking cessation				
ANNUALLY	Immunizations Discussed and/or given				
ANNUALLY	Exercise/Activity				
REQUIRED COMMON INDICATORS FOR DIABETES and IHD		Date / /	Date / /	Date / /	Date / /
2/YR	Blood pressure				
ANNUALLY	Weight/Nutrition Counselling				
ANNUALLY	Lipids Discuss statins LDL-C (mmol/L) TC/HDL-C				
REQUIRED INDICATORS FOR DIABETES ONLY					
2/YR	HbA1C				
ANNUALLY	Renal Function ACR and eGFR				
ANNUALLY	Foot Exam Use 10-g monofilament				
ANNUALLY	Eye Exam Discuss and/or refer				
REQUIRED INDICATORS FOR IHD ONLY					
ANNUALLY	Anti-platelet Therapy Review				
ANNUALLY	Beta-blocker Review				
ANNUALLY	ACEI/ARB Review				
ANNUALLY	Discuss Nitroglycerin				
ANNUALLY	Consider further cardiac investigations				
REQUIRED INDICATORS FOR COPD ONLY					
1/YR	COPD Action Plan Develop. Review and complete annually				
RECOMMENDED ITEMS (Optional for CDM Incentive payment)					

Self Management Referrals: ☐ Diabetes Centre ☐ Cardiac Rehab ☐ Your Way to Wellness ☐ Pulmonary Rehabilitation
Screen for: ☐ Depression/Anxiety ☐ Erectile Dysfunction
Lifestyle: ☐ Alcohol Use ☐ Psychsocial Issues
Economics: ☐ Pharmacare ☐ Third Party Insurance ☐ No Insurance ☐ Financial Issues
End of Life: ☐ Care Discussion

Date CDM Incentive Code Billed: _____

SELECTED CHRONIC DISEASE MANAGEMENT GUIDELINE INDICATORS

Common Indicators: DM, IHD & COPD	Target	Comments
Smoking Cessation	Non-smoker	
Immunizations	Influenza annually. Pneumococcal once, then for DM & IHD repeat at 65 yr.; for COPD repeat every 5-10 years..	
Exercise/Activity	Discuss appropriate exercise/activity and possible referrals	For DM & IHD: 30 mins/day 5x/wk plus resistance exercise 3 x/wk. For COPD: pulmonary rehab program
Common Indicators: DM & IHD	**Target**	**Comments**
Blood Pressure	IHD without DM or CKD: <140/90 DM: <140/80* DM and CKD: <130/80** In children: <95th %ile for age, gender and height	*In DM with no end organ damage ** Where this can be achieved safely without undue burden
Lipids	For IHD or IHD plus DM LDL-C: < 2.0 >50% reduction For DM only LDL-C: < 2.6	Test every 1-3 years OR as clinically indicated
Weight/Waist circumference/ Nutrition counseling	BMI: <25 kg/m^2 or In children: <85th %ile for age Waist circumference: M: <102 cm, F: <88 cm	

Diabetes Indicators	Target	Comments
HbA1C	< 7%	-q 6 mo. In stable DM -q 3 mo. For all others Individualize HbA1C based on age, DM duration & co-morbidity
Renal Function	ACR: <2.0 for males; <2.8 for females eGFR: >60 mL/min	In presence of CKD, at least every 6 months. Referral to nephrologist/internist if eGFR <30 mL/min
Routine foot examination	Annually	Q3-6 mo. In moderate to high risk foot. Assess skin, neuropathy (10 –g monofilament) and perfusion.
Routine dilated eye examination	At diagnosis, then every 1-2 years based on degree of retinopathy.	By optometrist or ophthalmologist

IHD Indicators	Duration	Comments
Beta-blocker	STEMI: Indefinitely Non-STEMI: Indefinitely unless low risk	
ACEI/ARB	Indefinitely unless low risk	ACEI: Titrate to target dose. Consider ARB if contraindication or intolerance to ACEI
Antiplatelet Therapy **ASA** 81 to 325 mg OD **Clopidogrel** 75 mg OD **Ticagrelor** 90 mg BID	**ASA** indefinitely –STEMI, Non-STEMI and Stable Coronary Artery Disease **Clopidogrel: STEMI** - Only if had PCI Minimum 1 mo. post bare metal stent Min. 12 mo. post drug-eluting stent **Clopidogrel: Non-STEMI** No PCI: Low risk - 3 mo; Inc. risk - 12 mo.; Very high risk - >12 mo. PCI: Low risk & bare metal stent - 3 mo.; Increased risk regardless of stent or ≥1 drug-eluting stent - 12 mo.; very high risk regardless of stent or ≥3 drug-eluting stents or complex PCI - >12 mo **Ticagrelor** Prescribed to high risk Acute Coronary Syndrome patients, 12 months of therapy recommended.	**ASA** maximum dose 75-100 mg if on Ticagrelor **Clopidogrel: STEMI** Dependent on type of stent and risk profile **Clopidogrel Non-STEMI** Depends on risk of recurrent event & stent type **Ticagrelor**: Reduce ASA to 75-100 mg. Transient dyspnea can be early side effect. Usually mild and resolves with continued therapy.
Discuss Nitroglycerin		
Consider further cardiac investigations		

COPD Indicators	Target	Comments
COPD Action Plan	Include medications and emergency instructions for patient.	Copy given to patient.

PHARMACOTHERAPY IN COPD

INCREASING DISABILITY AND LUNG FUNCTION IMPAIRMENT

MILD	MODERATE	VERY SEVERE
↓		
SABD prn ↓ Persistent dyspnea	**Infrequent AECOPD (average of <1 per year)** **LAAC *or* LABA + SABA prn** ↓ Persistent dyspnea	**Frequent AECOPD (≥1 per year)** **LAAC + ICS/LABA +SABA prn** ↓ Persistent dyspnea
LAAC + SABA prn or **LABA + SABD prn**	**LAAC + LABA + SABA prn** ↓ Persistent dyspnea **LAAC + ICS/LABA* + SABA prn**	**LAAC + ICS/LABA + SABA prn** ± **Theophylline**

*refers to lower dose ICS/LABA

SABD = Short-acting bronchodilator (e.g. ipatropium or SABA)

LAAC = Long acting anticholinergic (e.g. tiotropium)

LABA = Long acting beta agonist (e.g. salmeterol; formoterol)

SABA = Short-acting beta agonist (e.g. salbutamol; terbutaline)

ICS/LABA = inhaled corticosteroid/LABA (e.g. fluticasone/salmeterol; budesonide/formoteral)

CHRONIC DISEASE MANAGEMENT (CDM) INCENTIVE FEE BILLING RULES

1. The CDM Incentive fee can be claimed by family physicians only.
2. The base incentive fee may be claimed once per fiscal year (April 1 to March 31) for each patient managed for one qualifying chronic disease condition. An additional incentive amount per patient may be claimed once per fiscal year as part of the fee if the patient has additional qualifying chronic disease(s) for each qualifying disease.
3. The family physician is expected to act as case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations, including for investigations, follow-up visits and/or referrals.
4. Patients must be seen a minimum of two times per year by a licensed health care provider (includes physicians) in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.
5. Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.
6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year by March 31 of that year.
7. The qualifying chronic diseases eligible for the CDM incentive payment are:
   - **Type 1 and Type 2 Diabetes** defined as: FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L; and/or,
   - **Ischaemic Heart Disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram (includes post-MI <=5 yr); and/or,
   - **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator FEV_1 < 80% predicted and FEV_1/FVC < 0.70.

8. For patients managed for COPD, a COPD Action Plan must be developed and then reviewed and completed annually, with a copy given to the patient and a copy available in the patient's clinical record.
9. The CDM incentive can be claimed once per fiscal year (April 1 to March 31 inclusive) if the following conditions are met:
   - the patient is seen by the family physician in relation to their chronic disease(s) at least once in the fiscal year for which the CDM incentive is being claimed;
   - the patient has had at least one other appointment with the physician or another licensed health care provider in relation to their chronic disease(s) in the previous 12 months; and,
   - the CDM indicators required for the CDM incentive payment have been addressed at the required frequency (see front of flow sheet) and documented in the clinical record or optional flow sheet at or before the time of billing.

COPD ACTION PLAN

(Review annually with your doctor)

Patient Name: _____ Date: _____

HCN: _____ Date of Birth: _____

You have been diagnosed with Chronic Obstructive Pulmonary Disease (COPD). As someone with COPD, you are either in your stable, everyday state or having a flare up. This Plan will help you to quickly recognize and treat flare ups to manage your COPD and improve your health.

COPD (*Chronic Obstructive Pulmonary Disease*) can be stable or you could have a flare-up:

When you are stable:

1. Breathing with your usual shortness of breath
2. Able to do your usual daily activities
3. Mucous is easy to cough up

How to tell if you are having a flare-up

A flare up may occur after you get a cold, get run down or are exposed to air pollution, pollen or very hot or cold weather. There are 3 things that define a flare-up:

1. Increased shortness of breath from your usual level
2. Increased amount of sputum from your usual level
3. Sputum changes from its usual colour to yellow, green or rust colour

Some people may feel a change in mood, fatigue or low energy prior to a flare-up.

If any 2 or all of these symptoms persist for 48 or more hours do the following:

- □ Take your rescue inhaler 2-4 puffs as needed (up to 4-6 times per day) for shortness of breath.
- □ Take your prescribed antibiotic for a COPD flare-up (see over).
- □ Take your prescribed prednisone for a COPD flare-up (see over).
- □ Contact your doctor if you feel worse or do not feel better after 48 hours of treatment.
- □ Call 811 if you have questions
- □ Other _____

IF YOU ARE EXTREMELY BREATHLESS, ANXIOUS, FEARFUL, DROWSY, CONFUSED OR HAVING CHEST PAIN, CALL 911 FOR AN AMBULANCE TO TAKE YOU TO THE EMERGENCY ROOM.

Physician Signature_____

Patient/Caregiver Signature_____

COPD MAINTENANCE MEDICATION RECORD

Patient Name: _____ Date: _____

HCN: _____ Date of Birth: _____

Patients: Take the following maintenance medications **everyday** to help maintain control of your COPD symptoms.

Physicians: Please fill in prescribed maintenance medications.

Medication Prescribed	How Much to Take	When To Take

COPD FLARE-UP MEDICATION RECORD

Patients: Please fill in date when you start and finish your flare-up medications.

Physicians: Please fill in prescribed flare-up (antibiotics & prednisone) medications.

Medication Prescribed	Start Date / Finish	Start Date / Finish	Start Date / Finish

Make sure you take your prescribed medications until finished.

Please review this plan with your doctor at least annually.

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

January 31, 2014 Volume L #1

Inside this issue

CONTACT US:

MSI_Assessment@medavie.bluecross.ca

On-line documentation available at :

http://www.medavie.bluecross.ca/msiprograms

Electronic Bulletin now available

Please note, that effective January 1, 2014, the MSI Physicians' Bulletin is only available on the MSI website at http://www.medavie.bluecross.ca/msiprograms. To be automatically notified of upcoming bulletins, follow the "Subscribe" link located on the home page. Bulletins can be easily saved and printed directly from the new MSI website

Subscribing to electronic access to physicians' bulletins is not only important, but strongly encouraged as it is the responsibility of all physicians to be aware of changes, updates, new billing codes and practices communicated in the bulletins. If for some reason you are unable to access the website please contact MSI at 496-7011 or 1-866-553-0585.

NEW FEES

Note: Physicians holding eligible services must submit their claims from January 1, 2014 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.

Effective January 1, 2014 the following new health service codes are available for billing:

Category	Code	Description	Unit Value
MASG	57.6C	**Laparoscopic Total Colectomy** Laparoscopic resection of colon with the creation of an ileorectal anastomosis or end ileostomy. Includes mobilization of entire colon, identification of both ureters, dissection of mesocolic vessels, division of colon, delivery of colon through the extraction site, with intra- or extra-corporeal anastomosis of bowel or creation of an end ileostomy, and closure of the extraction site.	500 8+T

Billing Guidelines:
Not to be billed with any other fees for resection of bowel or formation of colostomy or ileostomy on the same patient same day.

Specialty Restriction:
GNSG

Location:
HOSP

Category	Code	Description	Unit Value
MASG	60.4B	**Laparoscopic Assisted Abdominoperineal Resection**	630 8+T

Laparoscopic resection of distal sigmoid colon, rectum, and anus with creation of end sigmoid colostomy and perineal dissection to remove the appropriate segment of bowel along with the anal sphincter. Includes mobilization of colon, identification of ureter, dissection of mesocolic vessels, division of colon, total mesorectal excision of rectum and delivery of sigmoid colon, rectum, and anus through perineal incision.

Billing Guidelines:
Not to be billed with any other fees for resection of bowel or formation of colostomy or ileostomy on the same patient same day.

Specialty Restriction:
GNSG with a fellowship in colorectal surgery and/or fellowship in minimally invasive surgery.

Location:
HOSP

Category	Code	Description	Unit Value
MASG	65.51D	**Initial ventral or incisional hernia repair by laparoscopy, reducible or strangulated, with mesh, with or without enterolysis**	220 6+T

This fee is for the initial repair of a ventral or incisional hernia using a laparoscopic approach. This fee includes the use of mesh or prosthesis and any lysis of adhesions required to perform the procedure.

Billing Guidelines:
1. May not be billed with:
   66.4A Intestinal Obstruction - without resection
   66.3 Excision or destruction of lesion or tissue or peritoneum
2. May be billed with:
   57.42B Enterectomy with anastomosis if required providing this is documented in the operative report.

3. If the surgical time (skin to skin) exceeds 3 hours for this procedure, it shall be paid EC at a rate of 110 MSU per hour.

Specialty Restriction:
GNSG

Location:
HOSP

Category	Code	Description	Unit Value
MASG	65.51E	**Recurrent ventral or incisional hernia repair, by laparoscopy, reducible or strangulated, with mesh, with or without enterolysis**	325 6+T

This fee is for the repair of a recurrent ventral or incisional hernia using a laparoscopic approach. This fee includes the use of mesh or prosthesis and any lysis of adhesions required to perform the procedure. Previous attempt at surgical repair of ventral/incisional hernia must be documented on the health record.

Billing Guidelines:
1. May not be billed with:
   66.4A Intestinal Obstruction - without resection
   66.3 Excision or destruction of lesion or tissue or peritoneum
2. May be billed with:
   57.42B Enterectomy with anastomosis if required providing this is documented in the operative report.
3. If the surgical time (skin to skin) exceeds 3.5 hours for this procedure, it shall be paid EC at a rate of 130 MSU per hour.

Specialty Restriction:
GNSG

Location:
HOSP

Category	Code	Description	Unit Value
MASG	97.6E	**Post Mastectomy Breast Reconstruction with tissue expander or implant, immediate or delayed.**	140 4+T

This is a comprehensive fee for breast reconstruction, post mastectomy (immediate or delayed), with a tissue expander or implant to include any or all pectoralis major muscle elevation, serratus anterior muscle transposition, and any tissue shifts required to close the mastectomy wound.

Billing Guidelines:
Comprehensive fee, not to be billed with :
MASG 97.95 - Insertion of breast tissue expander(s) (regions required)

MASG 97.43 - Unilateral augmentation mammoplasty by implant or graft
MASG 97.44- Bilateral augmentation mammoplasty
Local tissue shifts

On the same patient, same side, same day.

Specialty Restriction:
PLAS

Location:
HOSP

Region:
Right, Left, Bilateral

FEE REVISIONS

Effective November 1, 2013, health service code **60.55** – Hartmann Resection has been revised and updated with the following information:

Category	Code	Description	Unit Value
MASG	60.55	**Hartmann Resection**	325 8+T

This is a comprehensive fee for a Hartmann resection (partial sigmoid colectomy, formation of end colostomy, and closure of the distal segment).

Billing Guidelines:
Not to be billed with:
MASG 58.11 Colostomy unqualified
MASG 57.59 Other partial excision of large intestine

Specialty Restriction:
GNSG and VASG

Location:
HOSP

NOTE: The MSI system has now been updated. Claims for this code with a service date from November 1, 2013 to January 30, 2014 will be identified and a reconciliation will occur in the spring of 2014. The reconciliation will be calculated after the 90 day waiting period for submission of claims.

HEALTH SERVICE CODE CLARIFICATION

Geriatrician's Initial Comprehensive Geriatric Consultation to Include CGA (Comprehensive Geriatric Assessment) HSC VIST 03.04D - Please refer to the September 13, 2013 MSI Physicians Bulletin for complete details on this new health service code.

Billing Guidelines:
Time based fee requiring a minimum of 90 minutes. At least 80% of time must be spent in direct patient contact. No other fee codes may be billed for that patient in the same time period.

Please note:
Time spent with family/care givers to obtain pertinent information that cannot be obtained from the patient will constitute time spent in direct contact with the patient for the purposes of billing this code.

BILLING REMINDERS

Second Surgical Assistants

A surgical assistant is defined as a physician who assists the operating surgeon throughout a substantial portion of the operation. As per Preamble section 9.5.1 (d), when a second assistant is necessary, his or her claim is 50% of the stated service encounter for the first assistant with a minimum of 10.5 units. The need for a second assistant is to be supported by a letter from the surgeon explaining necessity. Please direct the supporting letter from the surgeon explaining the necessity to the MSI Medical Consultant for approval. When approval has been granted the physician may then submit the claim for adjudication.

Claims for second surgical assistants are to be submitted using exceptional circumstances (HSC EC). The text should indicate the health service code (HSC) of the procedure performed, the duration of the service, as well as indicating there is an approval letter on file for this second surgical assist claim.

Paediatric Care of Over-age Patients Age 16 up to and Including 18 Years of Age

As per section 8.4.5 of the preamble, visits, excluding paediatric consultations, outside hospital for over-age patients are not to be paid at paediatric rates except for:

(i) Behavioural management.
(ii) Follow-up visits in a paediatrician's office for approved over-age patients with complex multi-system medical problems. **Application must be made in writing to the MSI Medical Consultant and prior approval obtained for each patient.**

Please note: Application for approval must clearly state the diagnosis and provide sufficient clinical information to support complex multi-system medical problems.

Family Physician Chronic Disease Management Incentive (CDM1)

This program is intended to recognize the additional work of General Practitioners, beyond office visits, of providing guidelines-based care to patients with chronic diseases. Providing all eligibility requirements are met, the CDM incentive can be billed once per patient per Fiscal year. Please refer to the July 3, 2009 MSI Physicians' Bulletin for details on eligibility requirements.

In order to receive payment for services provided in Fiscal 2013/14, all claims must be submitted to MSI by March 31, 2014.

EXPLANATORY CODES

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

GN063 Multiple SRAS have claimed for this patient on same day. If second surgical assist for same surgery claim EC. If claiming as surgical assist on a different surgery (same patient/same day) resubmit with text indicating subsequent surgery

MA050 Service encounter has been refused as you have previously billed HSC 58.11 or 57.59.

MA051 Service encounter has been refused as you have previously billed HSC 60.55.

MA052 Service encounter has been refused as you have previously billed HSC 66.4A or 66.3.

MA053 Service encounter has been refused as you have previously billed HSC 65.51D or 65.51E.

MA054 Service encounter has been refused as you have previously billed HSC 97.95, 97.43, 97.44.

MA055 Service encounter has been refused as you have previously billed HSC 97.6E.

MA056 Service encounter has been refused as you have previously billed for a resection of bowel or formation of colostomy or ileostomy.

MA057 Service encounter has been refused as you have previously billed for a laparoscopic total colectomy or laparoscopic assisted Abdominoperineal.

VA056 Service encounter has been refused as the diagnostic code provided is not valid for this service.

UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, January 31, 2014. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanatory codes (EXPLAIN.DAT).