PHYSICIAN'S BULLETIN

September 19, 2022 Vol. LXVII, 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Outdated Policy Reminder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".

FEE UPDATES

Physicians are advised that Health Service Codes 51.95A, 51.95B, 51.95C and 51.95D are now permanent.

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 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 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	12.11 MSU

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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 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 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	12.11 MSU

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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.
- 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

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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. 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	12.11 MSU

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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.

- 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

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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.** **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 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	12.11 MSU

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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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FEE UPDATES (CONTINUED)

Effective October 1, 2022, DGH and QEII are eligible an extra hospitalist ROTA per day.

Health Service Code	Description
F1006	Facility on Call Category 1 – Hospitalist

*Must meet the established Nova Scotia Facility On-Call Program Guidelines.

HIGHLIGHTED FEES

Physicians are reminded of interim health service codes 03.09K and 03.09L:

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 (or other synchronous electronic verbal communication) regarding the assessment and management of 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 physician may also receive requests 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 followed by a management decision and a written report from the specialist to the referring physician.
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 for a new patient or an established patient with a new condition or 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 findings as reported by the referring physician.
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 03.09K 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 03.09L may be reported when the telephone call for an urgent consultation occurs on the same day as the patient visit that generated the consultation.

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The HSC is not reportable when the purpose of the communication is to:
- Arrange a 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 their call group within the previous 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 physician and specialist in the same institution or practice location.

Documentation Requirements:
- The referring physician must document that they have communicated the reason for the consultation and relevant patient information to the specialist
- Both the specialist consultant and referring physician must document the patient name, identifying data, date and start and stop time of the call in their respective 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 physician, the opinion of the consultant physician and the plan for future management must be documented.
- A written report must be sent to the referring physician by the specialist consultant.
- The referring physicians 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 of the MSI claim.

Location:
LO=OFFC

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Major Surgery (MASG) Location

Physicians are reminded to ensure selecting the appropriate facility when billing MASG services.

Virtual Encounters

When the AP=PHON and AP=VIRC modifiers were announced in the May 27, 2022 Physician's Bulletin it had indicated that the service is not reportable if delegated to another professional such as Nurse Practitioner, Resident in training, Clinical fellow or Medical student. However, the modifiers may be claimed when the service is 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.

AP=PHON and AP=VIRC apply to visit, consultation, counselling and psychiatric care non-procedural services and physicians are reminded to select the appropriate health service codes when claiming for virtual services.

Health Service Code Description Updates

The following health service codes have had their descriptions updated:
R1220 – Pelvis
69.29D – Cystoscopy with resection of bladder neck
72.1C – Endoscopy – resection of bladder neck – transurethral prostatectomy
75.61 – Vasectomy procedure, unqualified
05.29A – Fertility investigation – sperm count and morphology
03.26C – Comprehensive pelvic examination with speculum
71.4C – Synthetic mid urethral sling for urinary incontinence, any approach
71.4D – Pubo-vaginal sling with autologous fascia for urinary incontinence, includes cystoscopy as required
97.79B – Masculinization of the chest wall
97.44A – Feminization of the chest wall

NEW AND UPDATED EXPLANATORY CODES

Code	Description
GN122	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THIS SERVICE IS NOT REPORTABLE IF THE CONSULTATION RESULTS IN A FACE TO FACE SERVICE WITHIN THE NEXT 14 DAYS OR THE NEXT AVAILABLE APPOINTMENT.
GN123	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM OF 2 HOSPITALIST ROTAS HAVE ALREADY BEEN CLAIMED FROM THIS FACILITY ON THIS DATE.

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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 September 16, 2022. 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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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

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