NOVA SCOTIA MEDICAL SERVICES INSURANCE

Medical Services Insurance Program Billing Information Session

June 2023

Relationships

Department of Health and Wellness:

- Sets Health Policy

Doctors Nova Scotia:

- Negotiates fees with DHW via the Fee Committee

Medavie Blue Cross:

- Administers the MSI program/policy

Agenda

- Overview of MSI
- Billing Fundamentals
  - Physician's Manual and Bulletins
  - Getting started
  - Important terms
  - Importance of billing correctly
- GP Specific Billing
  - Common billing codes
  - Incentive Programs
- Common Billing Errors
  - Audit and Appeal

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Overview of MSI

- Medavie Blue Cross has administered the MSI program since 1969
- More than 8M claims submitted annually
- Approximately 300k claims are manually assessed/year
  - Claims for OOP and OOC services are also submitted by physicians and patients
- Approximately 80 calls per day
- Bi-weekly payments are made to physicians, optometrists, ancillary providers
- Support DHW and DNS business initiatives i.e., physician tariff and billing education
- https://msi.medavie.bluecross.ca/

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Billing Fundamentals

Important Documents

Physician's Manual:

- Preamble which is the authority for billing rules
- Explanatory Codes
- Definitions
- Schedule of Benefits - Health Service Codes (HSC)

Physician's Bulletins:

- Provides current information for physicians on MSI related matters including new or modified fees, policies and procedures relating to claims for services provided

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Getting Started

Register with MSI

Receive MSI Provider Number and Business Arrangement Numbers

Decide how you want to submit claims – via a software vendor or by hiring a service bureau

Submit claims electronically

Payment issued via direct deposit

All service items claimed to MSI are the sole responsibility of the physician rendering the service with respect to appropriate documentation and claim submission.

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https://msi.medavie.bluecross.ca/physician-registration/

Important Terms

•**Provider Number**: a six-digit number used to identify a physician.

•**Business Arrangement (BA)**: An agreement between a service provider and MSI covering the payment arrangements for health services provided.

•**Medical Service Unit (MSU)**: The value used to obtain the actual monetary value of a service. 2022-2023 value is $2.68. *E.g., 13 units x 2.68 MSU = $34.84*

•**Service Encounter:** Identifies each claim submission. A *Service Encounter Number* is assigned to each service encounter which distinguishes that encounter from others.

•**Facility**: A physical location, e.g., hospital, office etc. All facilities are formally recognized on the MSI register and are assigned a Facility Number used for claim submission.

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Important Terms continued..

- **eLink**: the web application used to download salary payment statements
- **Payment Responsibility:** a mandatory field on a claim that identifies which organization is responsible for payment of the service, i.e., MSI, WCB, etc.
- **Multiples**: used to indicate the number of services performed, the length of time etc.
- **Add-on**: a procedure that is always performed in association with another procedure and never by itself.
- **Premium**: Premium fees are additional amounts paid above normal/customary rates on eligible services.

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Importance of Billing Correctly

- Accountability for the services being billed
- FFS physicians – Billing correctly affects income
- Accurate patient history
- Data collection on services rendered
  - Aids in future decision making
- Reduces the risk of poor audit results
- APP physicians – Contractual commitment of shadow billing.
  - It is important to note that shadow billing for all services provided may actually lead to increased income for APP physicians:
    - Shadow billing in excess of 80% of the contract amount = 5.6% bonus
    - Shadow billing in excess of 100% of the contract amount = $ for $ for anything above contract amount

Timing of Claims Submissions

- 90 days from the date of service to submit claims
- 185 days to resubmit from the date of service
- Services to residents of other provinces must be submitted within 1 year of date of service
- Exceptions can be made to allow submission of claims outside of the 90-day timeframe in **extenuating** circumstances.
  - Acceptable examples include an office fire/flood, prolonged power outages, severe illness, death of a family member etc.
- Adjudication responses should be reviewed regularly to correct claims that have been rejected, reduced or paid at 0. Claims will have an explain code attached advising why the claim was not paid in full.

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Basics of Billing

The format of a service encounter

03.03 A LO=OFFC SP=GENP

Health Service Code (HSC): A code identifying services or procedures performed by a service provider to a service recipient.

Qualifier: An alpha character appended to some HSCs to subdivide the code and distinguish differences specific to the service.

Modifier: MSI adjudication system uses modifiers to determine the payment amount of a service encounter. They can affect payment by:

- Adding or subtracting an amount from basic fee
- Replacing the basic fee with a different amount
- Indicating role, time, method, age

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Documentation

- Documentation of services that are being claimed to MSI must be completed **before** claims for those services are submitted to MSI

- For MSI purposes, it is required that physicians 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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Preamble 5.1.7, Preamble 5.2.201, https://cpsns.ns.ca/resource/management-of-medical-records/

Uninsured services

- Services such as (but not limited to) removal of cerumen, missed appointments, sick notes or completion of forms are not insured and therefore not billable to MSI.
- If a patient's sole purpose for the appointment is an uninsured service, you may not bill MSI for the visit or procedure.
- NOTE: Each doctor can set their own fees for uninsured services or may choose not to charge. A doctor must inform a patient of any costs **before** providing a service that is not covered by MSI.
- When physicians are providing non-insured services, they are required to advise the patient of any insured alternatives, if any exist.

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Services provided by other health care professionals

If a fee-for-service family physician directly employs a nurse or nurse practitioner, the physician may claim for pap smears and simple injections such as immunizations done by the nurse, provided the physician is on the premises.

This does not apply to other procedures, visits or counselling, nor for services done by nurses who are employed by third parties such as the Nova Scotia Health Authority.

To bill an office visit code for a visit the nurse participates in, you must personally participate in the visit, provide an insurable service and meet preamble requirements. **The chart note must reflect this**.

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Same Day, Same Patient

- A second visit can be claimed for a patient seen in the same day provided the visit is:
  - **For a different condition/diagnosis, or**
  - **For worsening of the condition presented at the first visit**

- Documentation Requirements:
  - **Medical necessity of the second or subsequent services**
  - **Time of the second or subsequent service**
    - **Each occurrence must be at separate and distinct times.**
  - **Must be documented both in the text field on the claim and in the medical chart**

- Submitted as 'Service Occurrence #2' to indicate the second encounter that same day, same patient, same physician.
  - This is a field on the claim submission that must be changed from the standard #1, to #2, etc.

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GP Specific Billing

Visits: Limited Visit 03.03

- **03.03** - Diagnostic Interview and Evaluation, described as Limited - Limited assessment with history of the presenting problem

  - Most commonly billed code for Family Physicians
    - ❖ Office Visit: **03.03 RP=SUBS (patients under 65)**
    - ❖ Geriatric Office Visit: **03.03A (patients 65+)**

- A limited visit may be claimed when:
  - ❖ You see the patient and perform a limited assessment for a new condition
  - ❖ When monitoring or providing treatment of an established condition
  - ❖ It includes a history of the presenting problem and an evaluation of relevant body systems.

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Enhanced office visits ME=CARE

- Family physicians who deliver comprehensive and continuous care to patients with whom they have an ongoing relationship are eligible for an increase to several health service code fees (see full list in section 8 Family Practice section Physicians Manual).

- The enhanced fees are only available to family physicians who attest, via confirmation letter, that they are providing comprehensive and continuous care to patients. To claim the enhanced fee, physicians should use the ME=CARE modifier on applicable claims.

- It does not include episodic care provided to walk-in patients. If your practice offers evening hours or walk-in service, you should bill the enhanced fee whenever you are seeing one of your own patients, or a patient of your practice.

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Preamble 2.2.225 ME-CARE-FAQ-2021.pdf (bluecross.ca)

Premium TI=GPEW

GP Enhanced Hours Premium – 25% increase in claim value

- Intended to promote enhanced patient access to comprehensive primary care outside of traditional office hours.
- Only available to physicians who have an ongoing clinical relationship with the patient (ME=CARE). The premium is not available for unattached patients.
  - Weekdays M-F from 6 a.m. to 8 a.m. and 5p.m. to 10 p.m.
  - Weekends S-S/Holidays from 9 a.m. to 10 p.m.
- **Can't be used in a walk-in clinic or if you "run late"**

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 .

See full list of GPEW eligible HSC in the Physician's Manual

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Visits: GP Complex Care Visit 03.03B

- May be billed a maximum of 4x per patient per fiscal year by the regular FP and/or the practice i.e., not by walk-in clinics:

- Patient must be under active management for **3 or more** of the following chronic diseases:

Asthma	**Chronic Liver Disease**	**Hypertension**	**Chronic Renal Failure**
COPD **Chronic Obstructive Pulmonary Disease**	**Diabetes**	**Congestive Heart Failure**	**Ischemic Heart Disease**
	Dementia	**Chronic Neurological Disorders**	**Cancer**

- Start and finish times required to be recorded on the clinical record **and** in the text field of the MSI claim

- 15 minutes must be spent in direct patient intervention & visit must address at least 1 chronic disease directly or indirectly

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Visits: Comprehensive Visit 03.04

A comprehensive visit or a subsequent comprehensive visit is an in-depth evaluation of a patient necessitated by the seriousness, complexity, or obscurity of the patient's complaints or medical condition.

Requirements:

- Complete physical exam including:
  - Complete physical exam, appropriate to the physician's specialty and relevant to the presenting complaint
  - Documentation describing the pertinent positive and negative findings of the physical exam.
    - It is not adequate to indicate "physical exam is normal" without indicating what was examined

- **Detailed** patient history including:
  - Relevant history of presenting complaint
  - Relevant past medical and surgical history
  - Medication List, Allergies
  - Family history, Social history
  - Documentation of the above

In situations in which these criteria are not met, it would be appropriate to instead claim a limited visit.

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Visits: 03.04 continued...

Keep in Mind:

- Comprehensive visits when there are no signs, symptoms or family history of disease or disability that would make such an examination medically necessary are not insured.

- Comprehensive visits claimed within 30 days of a previous limited or comprehensive visit will require text indicating what the medical necessity of the comprehensive visit was

- All services billed must be medically necessary. **It is not appropriate to bill MSI for a "meet and greet"** via a claim for a comprehensive visit (or any other service) with a new patient unless a health-related concern/complaint has been addressed at the visit and Preamble requirements are met.

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GP Consultations 03.08

- GPs may only claim a consult if the patient is referred to them and the GP has additional specialized expertise in one of the following areas: **Pain Management, Sports Medicine or Palliative Care.**

- Services considered within the scope of a GP would be considered a transfer of care and a consultation may not be claimed. If the patient is referred for a simple procedure, only the procedure may be claimed.

- Consultations require a formal request, documentation of a complete history and physical, and a report back to the referring practitioner.

Common errors:

- no or minimal physical exam
- billing consult for follow-up examination or transferal of care within the same specialty group

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Immunizations 13.59L

- Physicians may claim for the administration of immunizations covered by the Provincial Immunization Program.

- Most provincial immunizations allow for a tray fee. Tray fees can only be billed when the cost of materials is incurred by the physician/practice.
  - A tray fee can be billed for a maximum of 4 immunizations. Enter the corresponding number of multiples on a separate claim for HSC 13.59M.
  - Claims for Rotavirus (HSC 13.34A) do not allow a tray fee to be billed

- If the sole purpose of the visit is the immunization only, bill only the immunization(s), no office visit can be billed.

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Injections 13.59

Used for simple injections

- **Eg: B12, Depo-Provera**

Classified as 'VEDT' (visit excluded procedure)

- **No visit can be claimed in conjunction.**

No tray fee billable in addition

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Counselling: 08.49A

- Prolonged discussions directed at addressing problems associated with acute adjustment disorder or bereavement.
- May be claimed by family physicians for patients who meet the current DSM dx criteria for a mental health disorder.
- May be claimed in 15 min intervals
  - ❖ At least 80% of the time claimed must be spent in direct patient intervention.

Documentation requirements:

- Presenting problem should be outlined as well as advice given
- Ongoing management/treatment plan
- The recording of symptoms followed by "long discussion" "counselled" etc., is not considered sufficient documentation
  - ❖ <u>Documentation MUST be as specific as possible</u>
- Start and stop times

Note: *Not to be used for prolonged visits for medical problems. Document well what you discussed and therapeutic interventions as well as the start and stop times of the visit.*

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Lifestyle Counselling: 08.49C

- Prolonged discussion where the physician attempts to direct the patient in the proper management of a health-related concern. E.G., lipid or dietary counselling, AIDS advice, smoking cessation.
- This is only billable by the GP providing ongoing primary care to the patient
- May be claimed in 15 min intervals
- At least 80% of the time claimed must be spent in direct patient intervention.
- Document the start and stop times of the visit in the chart as well as the **specifics** of the discussion.

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Psychotherapy 08.49B

Treatment for mental illness, behavioral maladaptation and/or other problems that are assumed to be of an emotional nature in which a physician deliberately establishes a professional relationship with a patient for the purposes of removing, modifying or reducing existing symptoms, of attenuating or reversing disturbed patterns of behaviour and of promoting positive personality growth and development.

- This service, when performed by a GP, is limited to 20 hours per patient or family or group per physician per year.
- Claimed in 15-minute intervals with a minimum of two intervals
  - At least 80% of the time claimed must be spent in direct patient intervention.
- Documentation must include specifics of the discussion as well as the method(s) of psychotherapy used to treat the patient
- Treatment for medical complaints, acute adjustment reactions or bereavement reactions do not qualify as psychotherapy

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Compare & Contrast

Service	Details	Value	What's different?	What's the same?
Counselling (08.49A)	Claimed when patient has an underlying mental health disorder, acute adjustment disorder or bereavement.	**25.4MSU/$68.07 per 30 min 15MSU/$40.20 per 15-minute interval**	Can't claim for: •More than 5 hours/patient, per physician/year •More than 1 hour/patient/day	Must spend at least 80% of the time claimed with the patient. Can't be claimed for children under the age of 4. Must document the details of the discussion and advice given to the patient, not just state "long discussion," "counselled" etc. Start and stop times must be noted in the patient's medical record **and** the text of the MSI claim.
Lifestyle counselling (08.49C)	Claimed when providing advice on lifestyle items such as lipid or dietary counselling, smoking cessation, etc. to patients of your practice.	**15MSU/$40.20 per 15-minute interval**	Can't claim for: •More than 2 hours/patient, per physician/year •More than 30 minutes/patient, per day	
Psychotherapy (08.49B)	Claimed when the physician works to remove, modify or retard symptoms, lessen or reverse patterns of behaviour and promote positive personality growth and development.	**30MSU/$80.40 per 30 min** Claimed in 15 min intervals, a minimum of two intervals must be claimed per visit.	Can't claim for: •More than 20 hours/patient/family/group per physician/year •More than 90 continuous mins/patient/day	

Home Care 03.03 LO=HMHC RO=HMTE

- LO=HMHC = Home Health Care
- RO=HMTE = home care medical chart review, telephone calls, fax or email

- Physicians can claim for medical chart review and telephone call, fax or email advice for patients registered in the home health care program.
- Only services initiated by the care coordinator or health care professionals of Home Care Nova Scotia are eligible for this reimbursement. Physicians and Home Care Nova Scotia representatives are advised to keep a record of telephone calls, faxes or emails.

- Medical chart review and/or telephone calls, fax or email advice for up to three per day per patient, claimed at 11.5 units for each patient each day.

  Note: each additional group of three can be claimed as new encounter

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Maternity & Well Baby Care

Complete Pregnancy Exam

03.04 RO=ANTL

- Only one prenatal comprehensive visit may be claimed per pregnancy
  - ❖ This restriction is per patient, not provider
- Complete history & physical and gyn exam
- Includes a Pap smear when necessary.
- Includes venipuncture.
- Includes pregnancy related counselling or advice to the patient
- Documenting full details of the history and physical on the standardized Nova Scotia prenatal record form

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Routine Pre-Natal 03.03 RO=ANTL

- No more than 12 limited (routine) prenatal visits may be claimed for one patient's pregnancy regardless of the number of physicians involved.
- All prenatal visits include pregnancy related counselling or advice to the patient or patient's representatives.
  - ❖ Includes a Pap smear when necessary.

- Complicated pregnancies may require more than the limit of 12 prenatal visits. Prenatal care does not include services rendered for major complications related to pregnancy.
  - ❖ If billing for additional visits for major complications of pregnancy such as preeclampsia and other hypertensive disorders, diabetes, etc. include the diagnostic code for the complication on the service encounter.
  - ❖ *Reserve prenatal care billings for uncomplicated/routine visits in pregnancy and use a different office visit code for conditions unrelated to pregnancy

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Postpartum Care 03.03 RO=PTPP

- A limited visit for the routine care of a well mother following obstetrical delivery in the post-partum period
  - Billed in hospital starting on the first calendar day following birth
  - Can be billed for up to 7 calendar days while the mother remains an inpatient

- Normally claimed by one physician only per patient
  - GP's and delivering specialists may claim post-partum visits concurrently.
  - The most responsible physician (GENP or OBGY) would add a modifier to their claim (DA=DA23 or DA=DA47)
    - This allows both physicians to provide care, while also paying a higher fee to the physician who has the most responsibility for the patient.

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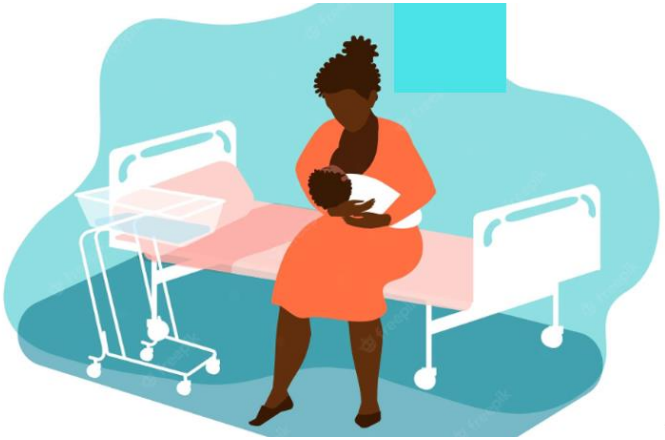
Post Natal Care 03.03 RO=PTNT

A postnatal care visit usually occurs about six weeks following delivery. The service may include a pelvic examination with Pap smear.

It may be billed only once following delivery by one physician.

A diaphragm fitting or insertion of an intrauterine device can be claimed with a post-natal visit



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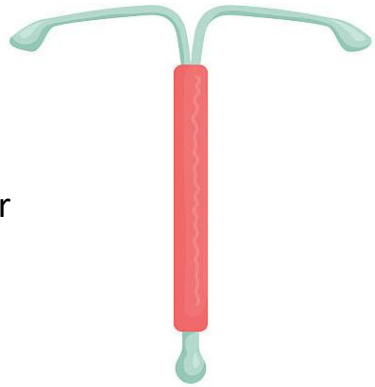
IUD insertion 81.8

Complete Care Code:

Minor surgical procedures that include the visit the same day, and related visits by the same physician for the following 14 days.



- The standard removal of an IUD in office may only be claimed as a visit.
  - ❖ Only surgical IUD removals that require anesthesia can be claimed under the HSC 11.71.

Not to be used for Intradermal Progestin Contraceptive Device:
Insertion: 13.53A
Removal: 13.53C

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Well Baby Visit 03.03 RO=WBCR (CT=RKBR)

- **RO=WBCR** - Well infant/childcare visits are payable as one per month during the first six months; one visit during each three-month period up to one year of age; and one visit at 18 months of age.

- It is recommended that the Rourke Baby Record be used to guide each visit and be documented in the health record. In order to provide optimal protection, age recommendations from the Nova Scotia Provincial Immunization Schedule must be followed.

- **RO=WBCR CT=RKBR** - The comprehensive well infant/child visit, the Rourke Baby Record (RBR) must be used to guide the visit, completed in full, reviewed and signed by the physician and documented in the health record. Age-appropriate preventative care and education to the parent(s)/caregiver according to the RBR must be delivered and documented in the RBR and recorded in the health record.
- 2 visits between 0 and <6 months, 1 between 6 months and <12 months, 1 visit between 12 months and <18 months, and 1 visit between 18 months and <24 months

- All other well infant/child visits to be claimed at the regular, applicable well baby care rate. Maximum of 9 WBCR total, 5 of which can be RKBR

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Nursing Home & Hospital-Based Care

Long Term Care Facilities

- LTC visits must be specifically requested by patient, family or nursing home staff
- Must be documented with a progress note
- Visits made at the convenience of the physician must be claimed using the 0800-1700 M-F rate
- If claiming other than the 0800-1700 M-F fee, document when you were called and why

TI=AMNN (0801-1200)
TI=NNEV (1201-1700)
TI=EVNT (1701-2000)

TI=ETMD (2001-2359)
TI=MDNT (0000-0800)
DA=RGE1 (Sat., Sun & Stat Holidays)
DA=RGE2 (Sundays & Stat Holidays)

- If the visit is requested in one time period and conducted in another, the lesser fee must be claimed
- Documentation for patients at LTC facilities is still the responsibility of the physician

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Medication Review ENH1

- Medication Review **(ENH1)**

  - For reviewing, completing, dating and signing pharmacy-generated Medication Administration Recording System (MARS) drug review sheet for the patient

  - May be claimed a maximum of 2 times per fiscal year per resident.

  - The completed MARS form must be readily available within the patient record (in the nursing home)

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Hospital Inpatient Visits

- 03.03 RP=SUBS DA=DA23 – A subsequent limited visit provided to patients admitted to hospital where the family doctor is the most responsible physician
  - Can also be billed for patients recently discharged from ICU
  - First day out of ICU should be considered equivalent to Day 2
- 03.03 RP=SUBS DA=DA47 – A subsequent limited visit provided to patients admitted to hospital where the family doctor is the most responsible physician
  - Can also be billed for days 4-7 out of ICU
- After 7 days of admission (or if the physician is not the MRP) a regular limited visit may be claimed when the physician provides daily care to the patient. Includes reviewing lab work and discussions with the patient and/or family.
  - 03.03 RP=SUBS DA=DALY - Daily hospital visits up to 56 days
  - 03.03 RP=SUBS DA=WKLY - After 56 days admission, up to a maximum of 5 visits/week

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Discharge Fee 03.02A

- Can be claimed when a patient is admitted for non-surgical hospitalization and is billable by the physician who performs the activities involved in discharging a hospital inpatient.
  - Activities include:
    - Completing the patient's chart and writing the discharge summary
    - Providing necessary prescriptions
    - Providing discharge instructions and arranging for follow-up care
  - Can be billed in addition to a hospital visit if one was provided on the same day

- Billable for hospital deaths where the physician completes the paperwork necessary to discharge the patient to the morgue
  - If the physician is also present to perform the pronunciation of death, a limited visit can also be billed.
  - Solely signing the death certificate does not warrant billing the discharge fee or a visit

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Premium Fees US=PREM US=PR50

*Additional amounts paid above normal or customary rates on eligible services provided on an **emergency basis** during designated times. An emergency basis is defined as services that must be performed without delay because of the medical condition of the patient.*

Premium Fees may only be claimed on specific services - for General Practitioners these would most often include:

- Obstetrical Deliveries
- Newborn Resuscitation

Common errors:

- billing premiums for all services during premium hours
- billing at times not eligible for premium or 50% rather than 35%

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)

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Case Management Conference Fee 03.03D

- A time-based code that may be claimed for formal, scheduled, multi-disciplinary health team meetings
  - Meeting must be called by an employee of the DHA/IWK or a Director of Nursing/Director of Care at a Long-Term Care Facility to address a specific health concern for a specific patient
  - For ad hoc situations, e.g.: team conference regarding a patient in a nursing home with disruptive behaviour
  - Clinical record must include start and finish times and a list of all physician participants
  - Cannot be used for regularly scheduled rounds e.g., grand rounds, tumour rounds, teaching rounds, recurring regularly scheduled meetings, etc., or for family meetings

- Claims submission requires the start and stop time in the text as well as the clinical record. The appropriate number of multiples is required as well.
  - Minimum 15 minutes
  - 80% of a 15-minute time interval must be spent at the conference to bill that time interval

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Urgent visits

- An urgent visit is such that a physician must respond **immediately** with regard to the patient's condition.
  - ❖ Attendance due to personal choice or availability does not warrant billing an urgent visit

- The physician **must travel** from one location to another
  - ❖ This travel must be documented in the clinical record and in the text field of the claim
    - ❖ e.g.: Traveled from office to hospital, 5km

Modifiers:

- **US=UNOF unscheduled** = urgent visit not interrupting normal office hours
- **US=UIOH unscheduled** = urgent visit interrupting normal office hours

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Detention Time RO=DETE

- Medical detention occurs when a practitioner'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 may only be claimed for emergency care and/or treatment provided outside of the office. **Detention time is not payable when provided in the office.**

- **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.
- **Obstetrical Delivery**: When detention is claimed with an obstetric delivery provided by a general practitioner, detention time commences after 3 hours.
  - ADON 87.98A

- <u>Detention time does not apply to:</u>
  - Waiting time
  - Counselling or psychotherapy
  - Advice given to the patient or their representatives
  - Return trip if the physician is not in attendance
  - Completing/reviewing charts
  - More than one patient at a time
  - Office visits

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Questions

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Incentive Programs

Master Agreement Incentive Programs

- Chronic Disease Management (CDM1)
- Comprehensive Geriatric Assessment (CGA1)
- CME (continuing medical education)
- EMR A
- EMR B & EMR C
- GP Surgical Assist Incentive
- Family Physician 5.6% APP
- Collaborative Practice Incentive Program (CPIP)
- CMPA Rebate

https://doctorsns.com/contract-and-support/master-agreement/programs-funding

Email: MasterAgreement@novascotia.ca
CMPA@medavie.ca

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Chronic Disease Management CDM1

- The 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 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.

The qualifying chronic diseases eligible for the CDM incentive payment are:

- **Type 1 and Type 2 Diabetes**
- **Ischaemic Heart Disease (IHD)**
- **Chronic Obstructive Pulmonary Disease (COPD)**

- 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. (use modifiers to identify 2nd and 3rd qualifying disease)
  - **CDM1 RP=CON2 CDM1 RP=CON3**

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CDM1 continued...

In order to claim the CDM1:

- the patient must be 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.

- indicators/risk factors are required to be addressed as part of the annual cycle of care for diabetes and/or IHD. The required indicators include all relevant common indicators plus the specific indicators for each disease.

  Indicators can be found in Physicians Manual 5.1.199

*The CDM1 **must** be submitted on or before March 31st of that fiscal year.

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Clinical Geriatric Assessment CGA1

- LTC Clinical Geriatric Assessment **(CGA1)** is a form that should be kept near the front of every nursing home chart and will serve as the lead clinical document that will travel with the patient when a transfer occurs. The CGA is normally completed through a collaborative team process involving the family physician and other licensed long-term care healthcare providers.

- The physician is directly responsible for completing the diagnostic section, medication section, and provides the final overall opinion of the frailty level of the resident.

- The CGA requires one direct service encounter with the resident by the physician on the date of the final completion and signing of the CGA form. **This service encounter is included in the CGA fee.** The CGA evaluation process may involve additional service encounters (visits) which would be paid separately from the CGA per the Preamble requirements. The dates of all physician service encounters associated with the completion of the CGA must be tracked on the CGA form.

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Common Billing Errors - GPs

- No/lack of documentation (other than recording diagnosis)
  - Documentation does not provide specifics of the visit/discussion/management plan etc.
  - Documentation missing sign-off or sign-off completed by a person other than the physician
- Lack of start and finish times for timed-based services
- Billing for prescriptions without an assessment of the patient
- Billing for the work of other practitioners
- Billing a visit when only a procedure or injection was carried out
- Billing for uninsured services:
  - Third party requests, uninsured warts, services of other providers, alternative therapies.
- Billing "meet and greets"

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Audits and Appeals

The audit process is in place to ensure accountability, enhance physician education with respect to billing processes and promote optimal claim submission practices.

- The audit process is part of the 2019 Physician Services Master Agreement as negotiated by DHW and DNS.
- All parties agree that it is the physician's responsibility to ensure claims are appropriate and consistent with the Physician's Manual.
- Opportunity for discussion and education with respect to audit results.

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Pre-Payment Assessment

- **If your pre-payment assessment claims have been rejected or adjusted by MSI (MSI Result GN080) you have the right to appeal.**

❖ To dispute an MSI Result, the physician must within ten (10) days after receipt of the MSI Result, contact MSI in writing to initiate the 'Request for Pre-Payment Assessment (PPA) Review'.

❖ If Pre-Payment Assessment results in adjustment or rejection of a claim due to rules that are in the billing system, it cannot be disputed by an individual physician.

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Post-Payment Audit and Schedule E

If you are selected for an audit:

- You will receive a letter in the mail from MSI Audit Personnel to set up a date and time for record collection.
- Audit team will take a random sample of 105 records associated with the codes under review to determine if the documentation supports the health service code submitted to MSI

Audit results will be sent to the respective physician.

- If the audit reveals incorrect billing or any concerns, the physician can request an audit review

Schedule E of the Master Agreement

- Appeal process to resolve issues relating to interpretation of fee codes listed in the MSI Physician's Manual and MSI Physicians' Bulletins.

Each phase of the appeal process has strict timelines

- Missing a deadline forfeits the right to appeal.
- Where the physician disagrees with the Audit Result, the physician has twenty (20) days of receipt of the findings to contact MSI in writing to initiate the 'Notice of Audit Review'
- Upon review of all additional information/documentation provided to MSI by the physician, MSI will issue a 'Notice of Determination'
- If the physician disagrees with the Notice of Determination, the physician may, by notice in writing, within twenty (20) days from the date they receive the Notice of Determination, submit an objection in writing to MSI (the "Notice of Dispute")
- A Facilitated Resolution may proceed, agreement may only be reached with consensus between the DHW Medical Consultant and the physician

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Take Home Messages

- Know the Preamble
- Read the Bulletins
- Ask questions if in doubt or unsure of appropriate billing
- Know what your billing clerk is submitting for each service
- Review your adjudication responses regularly
- Documentation, documentation, documentation
- Physicians are responsible for their billing

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Contacts

- Medical Services Insurance (MSI)

Should you have any questions or uncertainty regarding billings, please contact MSI and seek clarification.

  - 902-496-7011
  - Toll-free: 1-866-553-0585
  - Fax: 902-490-2275
  - msi_assessment@medavie.bluecross.ca

- Department of Health and Wellness (DHW)
  - 902-424-5818
  - MasterAgreement@novascotia.ca

- College of Physicians and Surgeons NS (CPSNS)
  - 902-422-5823
  - Info@cpsns.ns.ca

- Doctors Nova Scotia (DNS)
  - Jessica Moore, Compensation Manager, Master Agreement and Fee Schedule
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    (902) 481-4922
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Questions

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