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Medical Services Insurance Program
Billing Information Session
NSH BILLING CLERKS
March 2024

Relationships

Department of Health and Wellness:

- Sets Health Policy

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
- Common Billing Codes
- Claim Submission Tips
- Common Billing Errors

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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

Interim Fee Reference Guide

The Interim Fee Reference Guide provides all current interim fees. Interim fees are established in certain circumstances with approval from the Department of Health and Wellness. When a health service code is assigned to an interim fee, it is published in the MSI Physician's Bulletin, and the Interim Fee Reference Guide. If an interim fee is terminated or made permanent, it will be removed from the reference guide and updated in the MSI Physician's Bulletin and/or Physician's Manual as applicable.

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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. 2023-24 value is $2.76. *E.g., 13 units x 2.76 MSU = $35.88*

•**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 incentive/contract 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.
- **Explanatory Code:** A short message attached to a claim which indicates why a service encounter has been refused, reduced, paid at zero or changed in some way

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Importance of Billing Correctly

- Accountability for the services being billed
- Billing correctly affects income
- Accurate patient history
- Data collection on services rendered
  - Aids in future decision making
- Reduces the risk of poor audit results

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Timing of Claims Submissions

*Changes to submission timelines are expected per the 2023-27 Physician Agreement; any updates/changes will be published in a Physician's Bulletin.

- 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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Business Arrangements (BAs)

CMPA BA – For issuing CMPA rebates and/or incentives – no billing occurs on this BA.

FFS BA - For FFS physicians or FFS eligible claims (WCB etc.)

Locum BA – A temporary or long-term BA set up for physician locum payments.

- **LFM Attachment BA** – For the purpose of payment for the patient attachment component for the LFM model. Physicians should not bill any health service codes to this BA.
- **LFM Hourly BA** - For the purpose of payment of funds for LFM hourly contracted hours component of the contract. No shadow billings should be billed to this BA except for the new hourly health service fee codes.
- **LFM FFS 30% BA** - For the purpose of 30% remuneration of submitted health service code claims. Services provided under your LFM will be submitted to this BA.

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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
- Documentation must be signed off by the physician before claims submission
- 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.

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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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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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Common Billing Codes

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
    - ❖ Limited Visit: **03.03 RP=SUBS, LO=OFFC (patients under 65)**
    - ❖ Geriatric Office Visit: **03.03A LO=OFFC (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.

Limited Visits can be billed from a variety of locations. Modifiers vary depending on the location of the visit. E.g., 03.03 LO=HOSP, FN=INPT, DA=DALY or LO=HOME, PT=FTPT

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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 visit services billed must be medically necessary.

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Consultations 03.07/03.08

- 03.07 - Consultation, described as Limited – Examination limited to the relevant body systems and a history relating to the presenting problem. A limited consultation is performed when the nature of the patient's problem does not warrant a comprehensive consultation.

  03.08 - Consultation, described as Comprehensive – In depth evaluation with complete history and physical examination appropriate to the physician's specialty.

- Referred services include all types of consultations and any visits subsequent to the original referral. In the absence of a proper referral, specialty rates may not apply.
- A consultation may not be claimed in the circumstances listed below:
  a) Where ongoing care is provided without an original referral the appropriate non-referred visit is payable.
  b) The patient's regular attending physician cannot claim a consultation and must claim the appropriate visit.
  c) A consult may not be claimed for referrals from other health care professionals; e.g., nurses, podiatrists. However, consults may be claimed for referrals from nurse practitioners, midwives, optometrists and dentists.

- Any consultation requires a written report to the referring provider.

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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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LFM Hourly Billing Codes

- **HDAY1** - Longitudinal Family Medicine (LFM) model hourly fee code for clinical daytime hours worked (both direct and indirect).
- **HEVW1** - Longitudinal Family Medicine (LFM) model hourly fee code for clinical evening/weekend/holiday hours worked.

• The HSC's must be billed under the LFM Hourly Health Card Number 0015800568, DOB April 1, 1969 (Dx Code V689)

Physicians must submit the number of hours in the claimed units of the claim (i.e., 8.5 daytime hours = 8.5 units).

• Only one HDAY1 per day per provider
• Only one HEVW1 per day per provider
• Maximum of 24 hours per day across both HSC

The HSC Pays $0 – Physicians are required to submit these claims under their **LFM Hourly BA** for tracking purposes.

For complete billing guidelines – please see the October 27, 2023 Physician's Bulletin.

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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.
  - Keep this in mind for immunizations provided in a hospital location. Enter the corresponding number of multiples on a separate claim for HSC 13.59M (up to a maximum of 4).
  - 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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Allied Health Care Provider to Physician AHCP1

- Available for General Practitioners to provide advice via phone, fax, email or face to face when you have a conversation with an allied health care practitioner regarding a patient with whom you have an established relationship to determine a management decision.

- Intended to compensate for unexpected interruptions to your normal practice routine and includes the time needed to make chart updates after the discussion
  - Not intended for use while providing on-call services

- Can only be used for interactions with providers outside of your practice and must be recorded in the patient's chart

- Full billing guidelines are available in the Interim Fee Reference Guide

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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 per 30 min 15MSU 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 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 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	

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
  - 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
  - Billable for hospital deaths where the physician completes the paperwork necessary to discharge the patient to the morgue

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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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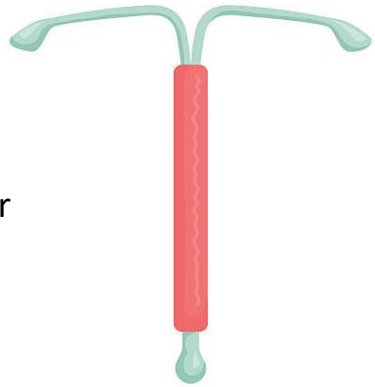
IUD insertion 81.8

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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Additional Billing

Facility On-Call

- Facility On-Call payments are Fee-for-Service electronic claims.
- "After-hours" is defined as weekday (Mon-Thurs) evenings/nights (1700 – 0800), weekends (Fri, Sat, Sun) (24 hours) and holidays (24 hours) beginning at 0800.
- Claims for Facility On-Call should be submitted with the generic health card number 0000002352, date of birth April 1, 1969 and diagnostic code V689. Use the service date that aligns with the beginning time of the shift covered (i.e., weekday coverage claims should be made with the service date that aligns with the 1700 start time)
- Where rotas have organized themselves to share in the call payments for any given shift(s) - Use the 50% modifier (PO=HALF) when billing; both physicians would claim the Facility On-Call fee.
- Use the DA=RGE1 modifier for Weekend/Holiday

Health service codes are established for each rota and physicians are paid per the categories as specified in the Nova Scotia Facility OnCall Program Guidelines. Use the HSC appropriate to your Category and Specialty. E.g.:

F1005 Family Medicine Primary Maternity Care

F2013 Urology

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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 <u>one</u> *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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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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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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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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Claim Submission Tips

Adjudication Responses

Held: Some claims require manual adjudication by the MSI assessment team. When submitted, these claims will show as 'held' and a response will be provided with the outcome once the claim has been manually processed.

Refused/Rejected: When a service encounter is refused/rejected, there is a billing rule preventing the claim from being payable, which would be detailed in the explanatory code. Service encounters that are refused/rejected cannot be adjusted. Any necessary corrections would require a new claim to be submitted.

Delete: In some cases, you may be required to delete a claim prior to submitting a new service encounter. This is typically required when the original claim needs a correction other than the addition of text and has not been outright refused. Not deleting the original would create a duplicate claim making the newly corrected claim unpayable.

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Adjudication Responses

Approved/Paid at $0: A claim 'approved at' or 'paid at' 0 is a term used to indicate that additional information may be required to aid in the assessment of the claim. When a claim is 'paid at zero' there will be an explanatory code attached to indicate why the claim was not paid and provide direction on the information MSI would require to process the claim.

If further information via supporting text or supporting documentation can be provided to process the claim, it can be **readjudicated** (action code R).

Readjudicate: If a claim has been approved, but not paid, and you need to submit supporting text or documentation, you must readjudicate the claim. This means that you are essentially "re-submitting" the original claim with the addition of text or documents only. This is only possible on claims in an approved status, as rejected or deleted claims are considered null and cannot be readjudicated. Readjudication is also vital when submitting additional information as it acts as a notification to our team that the claim needs to be reviewed again.

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Supporting Text & Submitting Documentation

- Many health service codes, combination of health service codes, or specific claim situations require text or documentation to be submitted along with the claim before a decision can be made on payment.
- When submitting text, ensure it is in the text field that is viewable by MSI and not an internal note as these are not accessible to us
- If submitting documentation with a claim, ensure a text note is also added to the claim indicating what documentation was sent

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Common Explanatory Codes

- **ED104:** *Service encounter accepted at zero as it is outdated*
  - Ask yourself if this is the first time submitting this claim or if is this a correction
    - If the original claim was refused, a new claim with a pre-authorization number will need to be submitted.
    - If the original claim was paid at zero, readjudicate the existing claim with text
- **ED103:** *Service recipient birth date does not match birth date on health card*
  - Double check that the day and month of birth haven't been switched
  - Call MSI to clarify the DOB on the health card, then submit a new claim once corrected
- **NR082:** *Please contact MSI regarding this claim.*
  - Sometimes we don't have the "perfect" message to attach to your claim and the situation would best be described in a quick discussion. Call MSI during business hours and our Assessment Team will be happy to walk you through any steps needed.

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Common Explanatory Codes – cont'd

- **NR072/GN052:** *Service encounter has been disallowed. Submit a reassess (action code R) along with a copy of the operative report/time sheet to aid in the assessment of your service encounter*
  - *Some claims, especially complex surgical services, require supporting documentation to be sent in to be reviewed before the claims can be paid.*
  - *When you see either or both messages, MSI requires those reports to be sent in, typically via fax, where they will then be reviewed by a Medical Consultant.*
  - *Once documentation is sent, the claims should be readjudicated to MSI with a note in the text indicating you have sent in the required documentation.*

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Common Explanatory Codes – cont'd

- **NR020:** *Service encounter has been refused. Resubmit using the appropriate service occurrence number.*
  - Multiple services have been received on the same day at different times. Submit a new claim following the guidelines for second occurrence claims.

- **GN049:** *Service encounter has been disallowed as text provided does not provide sufficient details. If resubmitting, please provide more details to aid in the assessment of your claim.*
  - More details about the service and/or the scenario are needed

- **NR030:** *Service encounter has been disallowed as medical necessity was not indicated*
  - Additional text explaining the medical reason why a service was required, is needed

- **GN046:** *Service encounter has been disallowed as text provided does not include the time of the encounter*

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Common Explanatory Codes – cont'd

- **NR060:** *Service encounter has been refused. Delete the original submission and submit a new encounter based on the information you have provided.*
  - Used when a new claim has been submitted with necessary corrections made, but there is still an approved claim on history that is preventing the new claim from being paid as the second claim is perceived as a duplicate.
- **NR086:** *Request for readjudication has been refused. Delete this submission and submit a new service encounter based on the information you have provided.*
  - Used when text comes in on an approved claim indicating a correction is needed or has been made to the health service code, modifiers or multiples used. These can't be changed via readjudication and so the original claim must be deleted, and a new one submitted.
- **GN047:** *Service encounter has been refused. Submit a reassess (action code R) for the original submission to aid in the assessment of your claim.*
  - Used when a new claim has been submitted instead of a readjudication of the original claim. This is typically used when additional text or documentation was needed.

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Common Billing Errors

- 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 (excl. TPR1)
- 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.

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Take Home Messages

- Know the Preamble
- Read the Bulletins
- Ask questions if in doubt or unsure of appropriate billing
- 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 Assessment and seek clarification:

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

Registration and Enquiry can help with information pertaining to:

- Patient Health Card Eligibility
- Health Card Number Identification
- Birthdates

Telephone: 902-496-7008
Toll Free: 1-800-563-8880
Fax: 902-481-3160
Email: msi@medavie.ca

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

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

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Questions

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