PHYSICIAN'S BULLETIN

March 15, 2024: Vol. LXIX, ISSUE 2

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MSI News

Public Health – Measles Vaccination

The publicly funded immunization program eligibility for measles containing vaccines is now updated due to the risk of importation of a case of measles case into Nova Scotia associated with travel.

Please see full eligibility for measles containing vaccines on pages 9 and 10 of the Publicly Funded Vaccine/Immunoglobulin Eligibility Policy.

The eligibility now includes the following:

- Infants 6 months to less than 12 months of age travelling to regions where measles is endemic or there is community-based transmission during an outbreak are eligible for 1 dose of measles, mumps, rubella (MMR) vaccine.
  - Infants 6 months to less than 12 months of age who received 1 dose of MMR vaccine for travel still require the routine childhood 2 dose schedule.
- Adults born before 1970 without measles immunity travelling to regions where measles is endemic or there is community-based transmission during an outbreak are eligible for 1 dose of measles-containing vaccine.
- Adults born in 1970 or later without measles immunity are eligible for 2 doses of measles-containing vaccine as part of the routine adult schedule.

For MMR vaccine given for travel purposes:
(Infants 6 months to less than 12 months and adults born before 1970)
13.59L RO=MMRT, PT=RISK Measles, Mumps, Rubella vaccine for travel to areas at risk for measles: text required to indicate travel/risk
Physicians will need to hold their MMRT claims for patients born prior to 1970 until the May 24, 2024 system update. A Bulletin will be published when physicians can submit these claims.

For MMRV vaccine given in the routine childhood schedule:
13.59L RO=MMRV Measles, Mumps, Rubella and Varicella vaccine

For routine MMR vaccine given in the routine adult schedule:
13.59L RO=MMAR Measles, Mumps, Rubella vaccine

MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT
Effective April 1, 2024, the Medical Service Unit (MSU) value increased from $2.76 to $2.84

ANAESTHESIA UNIT
Effective April 1, 2024, the Anaesthesia Unit (AU) increased from $26.06 to $26.84

PSYCHIATRY

Effective April 1, 2024, the hourly psychiatry rate for General Practitioners increased to $170.59 while the hourly rate for Specialists increased to $226.85 per the tariff agreement.

NEW FEES

Effective March 15, 2024 the following codes are available for billing:

Category	Code	Description	Base Units	Anae Units
MISG	97.6F	Minor Fat Grafting to breast post mastectomy or lumpectomy for malignant or premalignant conditions to breast – to include harvesting and grafting of autologous fat ≤100ml	100 MSU	4+T
MISG	97.6G	Major Fat Grafting to breast post mastectomy or lumpectomy for malignant or premalignant conditions to breast – to include harvesting and grafting of autologous fat >100ml	150 MSU	4+T
		Description: This is a comprehensive fee for lipoaspiration from the autologous donor site(s), preparation of the grafting material by the physician, and lipoinjection to clinically significant deformities of the breast post-surgery for malignant or premalignant conditions of the breast. Based on total volume of the injectate not on the number of injection sites in the recipient area. Not intended for liposuction which is an uninsured service. **Billing Guidelines:** Maximum of 3 procedures per patient per lifetime **Regions Required:** RG=RIGT, RG-LEFT, RG=BOTH **Specialty Restriction:** SP=PLAS **Location:** LO=HOSP		

Effective March 15, 2024 the following code is available for billing:

Category	Code	Description	Base Units
ADON	02.25C	Unilateral Diagnostic Digital Breast Tomosynthesis - Not to be used for screening	5 MSU
ADON	02.25D	Bilateral Diagnostic Digital Breast Tomosynthesis - Not to be used for screening	10 MSU

Description:
When digital breast tomosynthesis is performed and interpreted by the radiologist in addition to diagnostic mammography, digital breast tomosynthesis may be claimed as an add on to R485 is unilateral. If the imaging is bilateral, bilateral DBT may be claimed as add on to R490.

Billing Guidelines:
May be claimed as an add on to diagnostic breast imaging studies only,
not for screening breast imaging
ADON to R485 Diagnostic Mammography Unilateral (5 MSU)
ADON to R490 Diagnostic Mammography Bilateral (10 MSU)

Regions Required:
RG=RIGT, RG-LEFT, RG=BOTH

Specialty Restriction:
SP=DIRD

Location:
LO=HOSP

Effective March 15, 2024 the following code is available for billing:

Category	Code	Description	Base Units	Anae Units
MASG	72.1E	Laser Anatomic Endoscopic Enucleation of prostate >60 grams with morcellation (HoLEP, ThuLEP not for photoselective vaporization or green light laser)	406 MSU	7+T

Description:
This comprehensive fee is for the complete anatomic enucleation of large prostates (>60 grams) using laser (Holmium, Thulium) with morcellation and removal of tissue. This fee includes all endoscopic and imaging procedures required to accomplish the prostatectomy including, but not limited to, cystoscopy, urethroscopy, and retrograde pyelography. This fee includes removal of tissue, control of hemorrhage, meatotomy, vasectomy, urethrotomy, urethral dilation/calibration, as required. May not be claimed with any other prostatectomy health service codes.

Billing Guidelines:
This comprehensive fee may not be claimed with:

- MAAS 72.1A Endoscopy – revision of transurethral resection of prostate
- MASG 72.1B Endoscopy – transurethral electro-resection
- MASG 72.1C Endoscopy – resection of bladder neck – transurethral prostatectomy
- MASG 72.1D Endoscopy – transurethral electro-resection of the prostate by laser

Specialty Restriction:
SP=UROL

Location:
LO=HOSP

INTERIM FEE UPDATE

Effective March 15, 2024, Health Service Codes 03.09L 03.09K have been adjusted to allow for multiples if the discussion exceeds 24 minutes. Please see updates below:

Category	Code	Description	Base Units
CONS	03.09K	Specialist Telephone Advice – Consultant Physician – providing advice	25 MSU **+ MU**
CONS	03.09L	Specialist Telephone Advice – Referring Physician – requesting advice	13 MSU **+ MU**

Description

This health service code may be reported for two-way telephone (or other synchronous electronic verbal communication) or face to face conversations regarding the assessment and management of the patient but without the consulting physician seeing the patient.

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

This health service code may also be reported for asynchronous communication regarding the assessment and management of a patient, but only when utilizing a health authority-approved platform and consistent with all other billing requirements. **Multiples may not be claimed for asynchronous services.**

The referring physician may be a nurse practitioner, midwife, optometrist, family physician or other specialist seeking an opinion from the consulting physician due to the complexity and severity of the case.

The referring physician or provider must document:

1. The patient demographic information
2. The date and time of the communication with the consultant
3. The clinical concern
4. The advice received from the consultant – including the name of the consultant

The referring physician or provider must provide an electronic or written copy of this documentation within 7 days of the service to the consultant physician.

The consultant physician must review the documentation from the referring physician or provider within 14 days of the service. If clarification or corrections are indicated in the documentation, the consulting physician must provide a written addendum to provide this clarification and return it to the referring physician or provider within 21 days of the service. Both physicians/providers are responsible for retaining medical records pertaining to this service.

The services are not reportable when the purpose of the communication is to:

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

The service is 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

Category	Code	Description	Base Units
		This service is not reportable for telephone calls or face to face conversations of less than 5 minutes of two-way medical discussion. **If the discussion exceeds 24 minutes, multiple units may be claimed in 15-minute increments up to a total of maximum time of 60 minutes for the entire encounter. Where MU are claimed, start and stop times must be recorded in the patient's health record and in the text of the claim. Multiples may not be claimed for asynchronous services.** **Documentation Requirements** • The referring physician or provider must document that he/she/they have communicated the reason for the consultation and relevant patient information to the consultant physician • Both the consultant physician and the referring health care provider must document the patient's name, identifying data, date and encounter time in their respective charts or EMRs. • The names of the referring health care provider and the consultant physician must be documented by both the referring health care provider and the consultant physician. • The diagnosis, reason for referral, elements of the history and physical as relayed by the referring health care provider, the opinion of the consultant physician and the plan for future management must be documented by the referring health care provider and the specialist consultant. The consulting physician may use a copy of the documentation from the referring health care provider to support this HSC claim, but it must be reviewed and 'signed off' by the consulting physician. • A written report must be sent to the referring health care provider by the specialist consultant. The specialist consultant may satisfy this requirement by returning a copy of the documentation from the referring provider as long as it was reviewed and 'signed off' by the consultant physician. • The referring health care provider's billing number must be noted on the claim from the consultant. This is not required for the referring health care provider's claim. **Billing Guidelines** The consultant physician service is not reportable in addition to any other service for the same patient by the same physician on the same day. The referring health care provider service may be reported when the communication with the consultant occurs on the same day as the patient visit or other service. **Multiples:** **03.09K 17.5 MSU per 15 minutes** **03.09L 13 MSU per 15 minutes** **Specialty Restriction:** SP=GENP, SP=PSYC, SP=INMD, SP=PEDI, SP=OBGY **Location:** LO=OFFC	

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WORKERS COMPENSATION BOARD UNIT VALUE CHANGES/INCREASES

WCB MEDICAL SERVICE UNIT

Effective April 1, 2024, the Workers Compensation Board Medical Service Unit (WCB MSU) value will increase to $3.16.

WORKERS COMPENSATION BOARD ANAESTHESIA UNIT

Effective April 1, 2024, the Workers Compensation Board Anesthesia Unit (WCB AU) value will increase to $29.83.

Workers' Compensation Board Fee Code Update

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been calculated for the listed WCB specific fees for fiscal year 2024-25.
The WCB specific services listed below will have their values increased effective April 1, 2024:

CODE	DESCRIPTION	APRIL 2024 VALUE
WCB12	EPS physician assessment Service. Combined office visit and completion of Form 8/10 For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15-minute increments to a maximum of 1 additional hour	**Initial visit:** $220.54 + $64.53 per 15 minutes to a maximum 4x (RO=EPS1 and RP=INTL) **Subsequent visit:** $220.54 (RO=EPS1 and RP=SUBS)
WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable	GPs……………….$54 per 15 min EPS (RO=EPS1)..$64.53 per 15 min Specialists……….$72.62 per 15 min
WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable	GPs……………….$54.00 per 15 min EPS (RO=EPS1)..$64.53 per 15 min Specialists……….$72.62 per 15 min
WCB17	Photocopies of Chart Notes	10 pgs or less (ME=UP10)……..$32.33 11-25 pgs (ME=UP25)…………$64.53 26-50 pgs (ME=UP50)…………$128.90 Over 50 pgs (ME=OV50)……….$193.20
WCB20	Carpal Tunnel Syndrome (CTS) Assessment Report	$82.73
WCB21	Follow-up visit report	$48.44
WCB22	Completed Mandatory Generic Exemption Request Form	$16.24 per form
WCB23	Completed Non-Opioid Special Authorization Request Form	$16.24 per form
WCB24	Completed Opioid Special Authorization Request Form	$54.29 per form
WCB25	Completed WCB Substance Abuse Assessment Form	$36.21
WCB26	Return to Work Report – Physician's Report Form 8/10	$82.73
WCB27	Eye Report	$72.62
WCB28	Comprehensive Visit for Work Related Injury or Illness	$83.27
WCB29	Initial Request Form For Medical Cannabis	$89.84
WCB30	Extension Request Form For Medical Cannabis	$54.00
WCB31	WCB Interim Fee – Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed	$83.27

PROLONGED VISIT UPDATE

Please review the updated description and requirements below:

Category	Code	Description	Base Units
VIST	03.03	**Prolonged Office Visit for ME=CARE** ME=CARE, RP=SUBS	17 MSU +MU
VIST	03.03A	**Prolonged Geriatric Office Visit for ME=CARE** ME=CARE	20.99 MSU +MU

An 03.03/03.03A is defined as a limited visit. A limited visit or an initial limited visit may be claimed when the physician provides a limited assessment for diagnosis and treatment of a patient's condition. It includes a history of the presenting problem and an evaluation of relevant body systems.

Description

A prolonged visit service is paid to family physicians who are delivering face-to-face ('in person') comprehensive and continuous care to patients whom they have an ongoing relationship.
Prolonged office visits are paid in 15-minute time blocks or portion thereof, 80% of the time must be spent in direct physician to patient contact. Prolonged office visits are not to be confused with active treatment associated with detention.

A statement of the rationale for the length of the appointment, noting it was a face-to-face ('in person') encounter, documentation of the clinical encounter as outlined in the CPSNS Professional Standards and Guidelines Regarding Charting, and the start and stop time of the face-to-face encounter are documentation elements that support the claim for this fee code.

Billing Guidelines

- Only physicians eligible to bill the ME=CARE modifier may bill for prolonged office visits.
- Each office visit can be billed up to a maximum of 60 minutes (68MSU) per day. This would include a base fee plus up to 3 additional multiples of 15 minutes each.
- Start and stop times are required for any visit billed with multiples greater than 1.
- The start and stop times must be documented in the health record and on the text field of the claim.
- Multiples are not applicable for virtual care.

Documentation

Documentation of the following provides a clear indication that a prolonged visit has taken place:

- The visit occurred face-to-face ('in person')
- Rationale for the length of the appointment time. *For example: 'due to xx health concern, xx required in depth evaluation involving xx which resulted in prolonged appointment time'.*
- Patients' current health status and concerns
- Relevant history of the presenting complaint(s)
- Assessment relevant to the presenting complaint(s)
- Physical assessment relevant to the presenting complaint (if required)
- Diagnostic Impression
- Advice given to the patient (or documented substitute decision maker)
- Management and follow-up plan
- Start and Stop times of the time spent with the patient.

Multiples:

03.03 – 17 MSU per 15 minutes to a maximum of 4 multiples (60 minutes) per day
03.03A – 20.99 MSU per 15 minutes to a maximum of 4 multiples (60 minutes) per day

Premium Eligible:

TI=GPEW

Specialty Restriction:

SP=GENP

Location:

LO=OFFC

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PROLONGED VISIT REMINDERS

- Multiples are not eligible for virtual care for prolonged visits. I.E., the prolonged visit must occur in person and may not be claimed when provided over the phone or via virtual care platform.
- Time spent on provision of uninsured services, such as, but not limited to: sick slips, completion of third party forms, removal of ear wax, cannot be counted as time for multiples for a prolonged visit.
- If the purpose of the visit is to provide a procedure or injection, only the procedure or injection may be claimed. The procedural/injection fee encompasses all aspects of the procedure including advice to the patient concerning the procedure.
- A visit or prolonged visit may only be claimed in conjunction with a pap smear when the visit is for a non-gynecologic diagnosis. Time spent on the pap smear cannot be counted towards multiples for the prolonged visit.

ME=CARE FOR LOCUM PHYSICIANS

Physicians are advised that if they are hosting a long-term locum that will be billing the ME=CARE modifier for the comprehensive and continuous care of their patients during the locum, please advise the Physician Services team so that your patients can be manually adjusted for the attachment algorithm: LFMfunding@novascotia.ca

PHYSICIAN CONTACT

Physicians are reminded of the importance of keeping their contact information (email address, telephone, and mailing address) current with MSI. To update your contact information, you may reach out to MSIProviders@medavie.ca or 902-496-7011 (toll-free 1-877-910-4674).

PHYSICIAN'S MANUAL

Applicable updates in the Physician's Bulletin's will be reflected in the Physician's Manual within 3 weeks; however, it may be necessary to refer to Physician's Bulletins for additional detailed information and any billing clarifications or reminders.

INTERIM FEE REFERENCE GUIDE

Physicians are reminded of the Interim Fee Reference Guide (PDF) available on the MSI website, which provides a comprehensive list of all current interim fees.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
MJ092	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 92.89N CANNOT BE CLAIMED WITH HSC 91.35A OR 31.35C AT THE SAME ENCOUNTER
MF009	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS HEALTH SERVICE CODE CANNOT BE CLAIMED WITH HSC 92.89N AT THE SAME ENCOUNTER
MJ093	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED HSC 72.1A, 72.1B, 72.1C OR 72.1D AT THE SAME ENCOUNTER
MJ094	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED HSC 72.1E AT THE SAME ENCOUNTER
MI008	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM OF 3 PROCEDURES PER PATIENT PER LIFETIME HAS BEEN REACHED
DE048	SERVICE HAS BEEN DISALLOWED AS YOU HAVE CLAIMED A VISIT ON THE SAME DAY/ PLEASE RESUBMIT WITH EXPLANATORY TEXT
AD095	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST CLAIM THE DIAGNOSTIC MAMMOGRAPHY FEE PRIOR TO CLAIMING DIGITAL BREAST TOMOSYNTHESIS. THIS SERVICE MAY NOT BE CLAIMED INDEPENDENTLY

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

UPDATED FILES

Updated files reflecting changes are available for download on March 15, 2024. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

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

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

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