Medical Services Insurance Billing Information Session

Assessment Centre (PACE)

January 2025

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Learning Objectives

At the conclusion of this presentation, participants will be able to:

- Recognize the available resources and how to utilize them to bill accurately
- Acquire a basic level of knowledge surrounding health service codes used to bill for common services provided by General Practitioners
- Gain an awareness of general billing rules
- Deepen their knowledge base, support their own billing and seek support when needed

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Declaration of Conflict

We are presenting today with no conflicts to declare

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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

Overview of MSI

- Medavie Blue Cross has administered the MSI program since 1969
- More than 8M claims submitted annually to MSI
  - Approximately 300k claims are manually processed/assessed per year
- Claims for out of province and out of country services are also submitted by physicians and patients
- Approximately 80 calls per day in Medicare from providers and residents
- Bi-weekly payments are made to physicians, optometrists, ancillary providers
- Support DHW and DNS business initiatives i.e., physician tariff and billing education

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Billing Fundamentals

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Important Documents

Physician's Manual	Preamble – authority for billing 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
Physician's Bulletins	Provides all current interim fees. Interim fees are established in certain circumstances with approval from the DHW. When a health service code is assigned an interim fee, it is published in the MSI Physician's Bulletin and in the Interim Fee Reference Guide. If an interim fee is made permanent or terminated, it will be removed from the IF guide and update in the Physician's Bulletin and/or Physician's Manual as applicable.
Nova Scotia Formulary (Pharmacare)	The Nova Scotia Formulary is updated every month electronically. It can be searched by Drug Name (Brand or Generic) or DIN. The benefit status (plans for which the product is a benefit) is listed by each medication. There is a legend in the front of the Formulary (page iv). It can be found on the DHW website: https://novascotia.ca/dhw/pharmacare/formulary.asp

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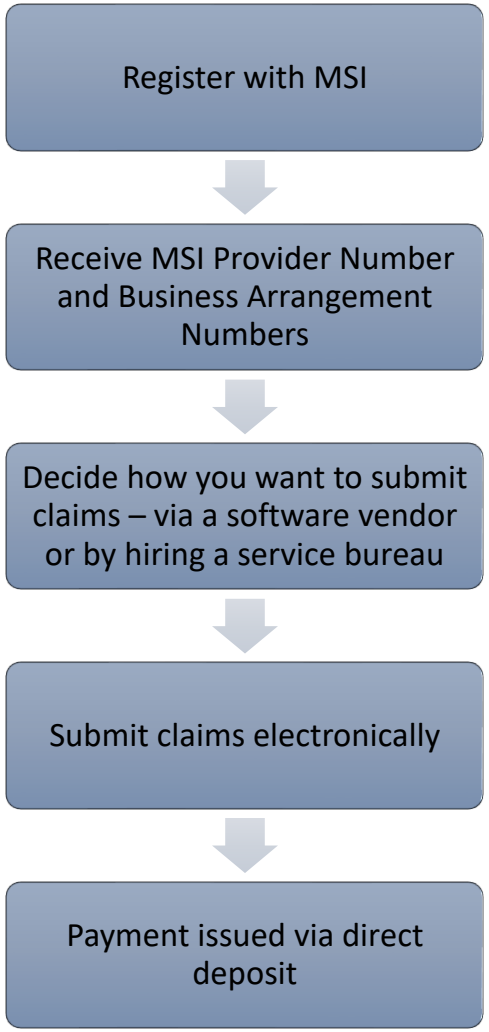
Getting Started

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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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. 2024-25 value is $2.84. *E.g., 13 units x 2.84 MSU = $36.92*

•**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.

•**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.

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Business Arrangements (BAs)

Examples:

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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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.

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

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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

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/

Questions

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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Preamble 1.1.22, Preamble 2.2.0 https://doctorsns.com/sites/default/files/PhysiciansGuideToBillingForNonInsuredServices.pdf

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, Same Physician

- 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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Family Physician Specific Billing

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03.03 Limited Visit

- 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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03.04 Comprehensive Visit

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

- 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.

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

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TI=GPEW Premium

GP Enhanced Hours Premium – 25% increase in claim value

- Intended to promote enhanced patient access to primary care outside of traditional office hours.
- Available to physicians who have an ongoing clinical relationship with the patient (ME=CARE) and select services for physicians providing care at walk-in clinics.
    - 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.

For services where the Enhanced Hours Premium has been claimed, a record must be maintained and readily available to verify that the patient was seen for an appointment during an eligible time period. The appointment time should be recorded in the patient's record.

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

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03.03B Complex Care Visit

- 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

Questions

03.08 Family Physician Consultation

- 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

13.59L Immunizations

- Physicians may claim for the administration of immunizations covered by the Provincial Immunization Program.
- E.g., 13.59L + (RO=INFL – Flu Shot) (RO=TEDV (PT=RISK) – Tetanus toxoid)

- 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.

13.59 Injections

Classified as ‘VEDT’ (visit excluded procedure)

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

Used for simple injections

- **Such as B12, Depo-Provera**

No tray fee billable in addition

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TPR1 Telephone Prescription Renewal

- Billable by Family Physicians when you receive a request from a patient to communicate a prescription renewal by phone, fax, or email without seeing the patient
- Cannot be used when writing new prescriptions or if you've seen the patient in-person or virtually on the same day
- Documentation on the patient's chart must include the name of the pharmacy, as well as the drug, dose and amount prescribed

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https://msi.medavie.bluecross.ca/interim-fees/

AHCP1 Allied Health Care Provider to Physician

- 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
- 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

https://msi.medavie.bluecross.ca/interim-fees/

08.49A Counselling

- 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
  - ❖ Documentation MUST be as specific as possible
- 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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08.49C Lifestyle Counselling

- 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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08.49B Psychotherapy

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 and Contrast Counselling

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.	**30MSU 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	

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Questions

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Maternity & Well Baby Care

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03.04 RO =ANTL Complete Pregnancy Exam

- 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

03.03 RO=ANTL Routine Pre-Natal Visit

- 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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81.8 Intrauterine Device Insertion

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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03.03 RO=WBCR Well Baby Visit

- 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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US=UNOF, US=UIOH Urgent Fees

- 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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Conclusion

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
- 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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Physician Agreement Incentive Programs

- CME (continuing medical education)
- EMR A
- EMR B & EMR C (rolled into LFM)
- GP Surgical Assist Incentive
- Collaborative Practice Incentive Program (CPIP) (rolled into LFM)
- CMPA Rebate

Physician Agreement | Doctors Nova Scotia (doctorsns.com)

Email: physicianagreement@novascotia.ca

CMPA@medavie.ca

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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
  - physicianagreement@novascotia.ca

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

- Doctors Nova Scotia (DNS)
  - General Inquiries

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Questions

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LFM

LFM

- Physician Information
- Billing Publications
- MSI Monitoring
- Billing Education
- Physician Registration
- LFM
- Resident – CMPA
- Billing FAQs
- Subscribe/Unsubscribe
- Other Links
- Optometry Publications
- Prostheses Programs
- Cancer Patients Programs
- Past Projects

Longitudinal Family Medicine (LFM)

The Longitudinal Family Medicine (LFM) Payment Model is focused on improving patient access, patient attachment, and positioning Nova Scotia to both retain and recruit office-based, longitudinal family medicine. The LFM will be available to all family physicians providing office-based, longitudinal family medicine in Nova Scotia. Physicians can work full-time or part-time within the LFM.

Details related to this payment model are included in Schedule C of the 2023-27 Physician Agreement.

LFM Contract Filling Instructions

LFM Contract | Schedule A – Contracted Activities Template

September 2023 Communication

September 25, 2023 FAQ

LFM Service Encounter Cheat Sheet

Doctors Nova Scotia – LFM: A New Path Forward

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https://msi.medavie.bluecross.ca/longitudinal-family-medicine/

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.

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https://msi.medavie.bluecross.ca/longitudinal-family-medicine/