PHYSICIAN'S BULLETIN
December 14 2020: Vol. LXV, ISSUE 21

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# Notice to Physicians

## INCOME STABILIZATION PROGRAM RECONCILIATION & TRAVEL/EXPOSURE PAYMENTS

The DHW and MSI are currently working on the Income Stabilization Program payment reconciliation and isolation payments. The target payment date for any funding owed to physicians is December 30, 2020. If you participated in the program, you will be receiving a letter regarding your reconciliation.

## TRAVEL/EXPOSURE FUNDING PROGRAM END DATE

Effective December 3, 2020, the travel/exposure funding program has ended. This program provided funding to those approved physicians who were required to self-isolate as a result of travel and/or exposure while at work during the Pandemic.

## VIRTUAL CARE FEE CODE UPDATE

Effective December 31, 2020, the Telephone Management and Telehealth Management for presumptive/confirmed COVID-19 as well as routine/interval care during pandemic (HSC 03.03X) will no longer be available for billing.

**All office based non-procedural services that are normally rendered in a face to face setting will still be permitted to be reported whether they are provided in person, by telephone, via telehealth network, or via a PHIA compliant virtual care platform as outlined in the March 24, 2020 Physicians Bulletin.**

## 2021 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

Please see below, the 2021 cut-off dates for receipt of paper and electronic claims, as well as the 2021 Holiday dates.

## 2020/2021 MASTER AGREEMENT PROGRAM PAYMENT SCHEDULE

Please see below, the anticipated incentive payment timelines for the 2020/2021 fiscal year.

# 2021 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

| PAPER CLAIMS | ELECTRONIC CLAIMS | PAYMENT DATE | SALARY CONTRACT PAY PERIOD |
|---|---|---|---|
| January 4, 2021 | January 7, 2021 | January 13, 2021 | December 25, 2020-January 7, 2021 |
| January 18, 2021 | January 21, 2021 | January 27, 2021 | January 8-21, 2021 |
| February 1, 2021 | February 4, 2021 | February 10, 2021 | January 22-February 4, 2021 |
| **February 12, 2021** | February 18, 2021 | February 24, 2021 | February 5-18, 2021 |
| March 1, 2021 | March 4, 2021 | March 10, 2021 | February 19-March 4, 2021 |
| March 15, 2021 | March 18, 2021 | March 24, 2021 | March 5-18, 2021 |
| **March 26, 2021**** | **March 31, 2021**** | April 7, 2021 | March 19-April 1, 2021 |
| April 12, 2021 | April 15, 2021 | April 21, 2021 | April 2-15, 2021 |
| April 26, 2021 | April 29, 2021 | May 5, 2021 | April 16-29, 2021 |
| May 10, 2021 | May 13, 2021 | May 19, 2021 | April 30-May 13, 2021 |
| **May 21, 2021**** | May 27, 2021 | June 2, 2021 | May 14-27, 2021 |
| June 7, 2021 | June 10, 2021 | June 16, 2021 | May 28-June 10, 2021 |
| June 21, 2021 | June 24, 2021 | June 30, 2021 | June 11-24, 2021 |
| July 5, 2021 | July 8, 2021 | July 14, 2021 | June 25-July 8, 2021 |
| July 19, 2021 | July 22, 2021 | July 28, 2021 | July 9-22, 2021 |
| **July 30, 2021**** | August 5, 2021 | August 11, 2021 | July 23-August 5, 2021 |
| August 16, 2021 | August 19, 2021 | August 25, 2021 | August 6-19, 2021 |
| August 30, 2021 | **September 1, 2021**** | September 8, 2021 | August 20-September 2, 2021 |
| September 13, 2021 | September 16, 2021 | September 22, 2021 | September 3-16, 2021 |
| September 27, 2021 | September 30, 2021 | October 6, 2021 | September 17-30, 2021 |
| **October 8, 2021**** | October 14, 2021 | October 20, 2021 | October 1-14, 2021 |
| October 25, 2021 | October 28, 2021 | November 3, 2021 | October 15-28, 2021 |
| **November 5, 2021**** | November 11, 2021 | November 17, 2021 | October 29-November 11, 2021 |
| November 22, 2021 | November 25, 2021 | December 1, 2021 | November 12-25, 2021 |
| December 6, 2021 | December 9, 2021 | December 15, 2021 | November 26-December 9, 2021 |
| **December 17, 2021**** | **December 22, 2021**** | December 29, 2021 | December 10-23, 2021 |
| January 3, 2022 | January 6, 2022 | January 12, 2022 | December 24-January 6, 2022 |
| | | | |
| **11:00 AM CUT OFF** | **11:59 PM CUT OFF** | | |

**NOTE:**
Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Sessional Payments and Locum Claim Forms. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut-off date to ensure processing for that payment period.

**PLEASE NOTE, THE ** INDICATES A DATE VARIATION**

## 2021 HOLIDAY DATES

| Please make a note in your schedule of the following dates MSI will accept as "Holidays". | |
|---|---|
| NEW YEAR'S DAY | FRIDAY, JANUARY 1, 2021 |
| HERITAGE DAY | MONDAY, FEBRUARY 15, 2021 |
| GOOD FRIDAY | FRIDAY, APRIL 2, 2021 |
| EASTER MONDAY | MONDAY, APRIL 5, 2021 |
| VICTORIA DAY | MONDAY, MAY 24, 2021 |
| CANADA DAY | THURSDAY, JULY 1, 2021 |
| CIVIC HOLIDAY | MONDAY, AUGUST 2, 2021 |
| LABOUR DAY | MONDAY, SEPTEMBER 6, 2021 |
| THANKSGIVING DAY | MONDAY, OCTOBER 11, 2021 |
| REMEMBRANCE DAY | THURSDAY, NOVEMBER 11, 2021 |
| CHRISTMAS DAY | MONDAY, DECEMBER 27, 2021 |
| BOXING DAY | TUESDAY, DECEMBER 28, 2021 |
| NEW YEAR'S DAY | MONDAY, JANUARY 3, 2022 |

# Master Agreement - Program Payment Schedule (2020/21)

| Program | Payment * |
|---|---|
| **EMR (Envelope "A" Payments)**<br>EMR Envelope "A" payments continue monthly to eligible physicians | Monthly |
| **CME (GP & Specialist)**<br>Payment for 2019/20 fiscal year (eligible billings based on 2019 calendar year) | Issued by May 31, 2020 |
| **CDM, CGA (Eligible APP Physicians)**<br>Payment based on eligible shadow billings from April 1, 2020 – June 30, 2020 | Issued by July 31, 2020 |
| **CMPA Premium Reimbursement**<br>Covering April - June 2020 | Issued by August 31, 2020 |
| **Electronic Medical Records (EMR – B&C)**<br>Payments for 2019/20 Fiscal Year | Issued by August 31, 2020 |
| **Family Physician Alternative Payment Plan 5.6% Incentive** | Issued by August 31, 2020 |
| **Surgical Assist Payments**<br>Payment based on eligible billings from April 1, 2019 – March 31, 2020 | Issued by September 30, 2020 |
| **CDM, CGA (Eligible APP Physicians)**<br>Payment based on eligible shadow billings from July 1, 2020 – September 30, 2020 | Issued by October 31, 2020 |
| **Collaborative Practice Incentive Program**<br>Payments for 2019/20 Fiscal Year | Issued by October 31, 2020 |
| **CMPA Premium Reimbursement**<br>Covering July -September 2020 | Issued by December 31, 2020 |
| **Rural Specialist Incentive Program**<br>Measurement period April 1st, 2019 – March 31st, 2020 / Payment for 2020/21 fiscal year | Issued by December 31, 2020 |
| **CDM, CGA (Eligible APP Physicians)**<br>Payment based on eligible shadow billings from October 2020 – December, 2020 | Issued by January 31, 2021 |
| **CMPA Premium Reimbursement**<br>Covering October -December 2020 | Issued by March 31, 2021 |
| **CDM, CGA (Eligible APP Physicians)**<br>Payment based on eligible shadow billings from January 2021 – March, 2021 | Issued by April 30, 2021 |
| **CMPA Premium Reimbursement**<br>Covering January - March 2021 | Issued by May 31, 2021 |

*Please be advised payment dates noted are the anticipated payments for these programs.

PHYSICIAN'S BULLETIN
November 13 2020: Vol. LXV, ISSUE 20

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## MSI News

### IMMUNIZATIONS ADMINISTERED BY OTHER HEALTH CARE PROFESSIONALS

Family physicians are reminded that they may only claim for vaccines they have either personally administered or those administered by nurses under direct supervision and employment of the physician. In the latter circumstance, the physician may only claim for the procedure if the physician is personally on the premises when the nurse administers the vaccine.

Family physicians cannot bill for services provided by nurses that are hired by NSHA as they would not be directly employed by the physician and therefore no service can be billed.

In the past, some family physicians have claimed for influenza vaccines administered by pharmacists, as a reminder, physicians may not claim for any immunizations/vaccines administered by a pharmacist.

## NEW INTERIM FEES

The following Interim Health Service codes are effective November 13, 2020 – May 31, 2022.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VEDT | 66.98E | **Percutaneous Insertion of Tunneled Intraperitoneal Catheter for use in dialysis.**<br><br>**Description**<br>This is a comprehensive code for the percutaneous insertion of a tunneled intraperitoneal catheter, it includes all imaging guidance and injection of contrast as required to complete the procedure.<br><br>**Specialty Restriction:**<br>SP=NEPH<br><br>**Location:**<br>LO=HOSP (QEII only) | 125 MSU |
| VEDT | 66.98F | **Removal of Tunneled Intraperitoneal Catheter (for use in dialysis)**<br><br>**Description**<br>This is a comprehensive code for the removal of tunneled intraperitoneal catheter, it includes all services required to remove the device and close the wound.<br><br>**Specialty Restriction:**<br>SP=NEPH<br><br>**Location:**<br>LO=HOSP (QEII only) | 75 MSU |
| VEDT | 66.98G | **Repositioning of Tunneled Intraperitoneal Catheter for use in dialysis**<br><br>**Description**<br>This is a comprehensive code for the repositioning of a tunneled intraperitoneal catheter, it includes all imaging guidance and injection of contrast as required to complete the procedure.<br><br>**Specialty Restriction:**<br>SP=NEPH<br><br>**Location:**<br>LO=HOSP (QEII only) | 75 MSU |

The following Interim Health Service code is effective November 13, 2020 – May 31, 2022.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VEDT | 15.93D | **Removal or Revision of Intracranial neurostimulator electrodes (SEEG)**<br><br>**Description**<br>This is a comprehensive code for the removal of neurostimulator electrodes such as stereoelectroencephalography (SEEG) electrodes.<br><br>**Specialty Restriction:**<br>SP=NUSG, SP=PEDI<br><br>**Location:**<br>LO=HOSP (QEII & IWK only) | 124 MSU |

BACK TO CONTENTS

## NEW INTERIM FEES (CONTINUED)

As described in the October 15, 2020 Physicians Bulletin, the following interim health service codes are now available for billing effective October 19, 2020:

**51.95A -** Chronic Dialysis, treatment and supervision of care for the patient with end stage kidney disease, in hospital (hemodialysis or peritoneal dialysis) or in central outpatient hemodialysis units (for example; Halifax Victoria General Hospital, Yarmouth Regional Hospital, Cape Breton Regional Hospital) for a 24 hour period

**51.95B -** Chronic Hemodialysis, treatment and supervision of care for the patient with end stage kidney disease, in an urban satellite hemodialysis unit as designated by the Health Authority (for example; Halifax Infirmary, Dartmouth General, and North Sydney hemodialysis units) for a 24 hour period

**51.95C** - Chronic Hemodialysis, treatment and supervision of care, in a rural satellite hemodialysis unit as designated by the Health Authority (for example; Inverness, Straight Richmond, Antigonish, Pictou, Springhill, Liverpool, Berwick) for a 24 hour period.

**51.95D -** Chronic dialysis, treatment and supervision of care, for the patient on home peritoneal dialysis or home hemodialysis for a 24 hour period

## FEE REVISIONS

**Expanded eligibility for high dose influenza**

As announced in the September 24, 2020 Physicians Bulletin, for the 2020/21 flu season the high-dose influenza vaccine may now be claimed for patients equal to or greater than 65 years of age who are also hospitalized and designated alternate level of care awaiting long-term care facility placement. Physicians holding eligible inpatient claims for health service code 13.59L RO=HDIN services performed on or after October 13, 2020 may now submit.

**Infants under 5kg modifier (CO=UN5K) added to ANAE services**

The infants under 5kg modifier has been added to the following health service codes so the proper anesthetic procedure fee may be claimed without a reassessment request:

- 65.01A - Repair of inguinal hernia with hydrocele
- 65.01 - Repair of inguinal hernia, unqualified
- 66.19 - Other laparotomy
- 50.24A - Coarctation of aorta
- 02.76 - Magnetic resonance imaging
- 51.0B - Pulmonary repair - subclavian – Blalock
- 01.09 - Other nonoperative bronchoscopy
- 15.34 - Ventricular shunt to abdominal cavity and organs
- 50.93G - Implantation of subcutaneous venous access system
- 03.39Q - Examination under anaesthesia with intubation
- 49.95 - Right cardiac catheterization

*For additional information on anesthetic service modifiers please see Physician's Manual preamble 3.2.33.

BACK TO CONTENTS

## FEE REVISIONS (CONTINUED)

Premium time modifiers may now be claimed on health service codes 47.25A and 47.25B

| Category | Code | Description | Base Units | Anaes Units |
|---|---|---|---|---|
| MASG | 47.25A | **Aortic Valve and ascending aorta replacement with reimplantation of coronary arteries (Bio-Bentall or Mechanical Bentall repair)**<br><br>**Description**<br>This is a comprehensive code for aortic root replacement with ascending aorta graft and valve conduit including coronary reimplantation.<br><br>**Billing Guidelines**<br>Not reportable with:<br>• 47.25 Other replacement of Aortic valve<br>• 50.34B Excision of thoracic aorta aneurysm<br>• 48.13 Aortocoronary bypass of two coronary vessels<br><br>May report, where clinically indicated, with:<br>• ADON 51.61 Extracorporeal Circulation Auxiliary to open heart surgery<br>• ADON 49.99C Repeat open heart surgery<br><br>**Premium**<br>US=PREM, US=PR50<br><br>**Specialty Restriction:**<br>SP=CASG<br><br>**Location:**<br>LO=HOSP | 1105 MSU | 35+T |
| MASG | 47.25B | **Valve sparing aortic root replacement or remodeling (David or Yacoub) with reimplantation or coronary arteries (VSR)**<br><br>**Description**<br>This is a comprehensive code for valve sparing aortic root replacement with graft, aortic valve suspension or remodeling, and coronary artery reimplantation.<br><br>**Billing Guidelines**<br>Not reportable with:<br>• 47.25 Other replacement of Aortic valve<br>• 50.34B Excision of thoracic aorta aneurysm<br>• 48.13 Aortocoronary bypass of two coronary vessels<br><br>May report, where clinically indicated, with:<br>• ADON 51.61 Extracorporeal Circulation Auxiliary to open heart surgery<br>• ADON 49.99C Repeat open heart surgery<br><br>**Premium**<br>US=PREM, US=PR50<br><br>**Specialty Restriction:**<br>SP=CASG<br><br>**Location:**<br>LO=HOSP | 1105 MSU | 35+T |

*Please refer to Physician's Manual preamble 5.1.81 for designated premium times.

BACK TO CONTENTS

The effective period for interim health service code 03.04I – PSP mental health comprehensive visit to establish the Practice Support Program (PSP) mental health plan, has been extended to April 30, 2021.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.04I | **PSP Mental Health Comprehensive Visit to establish the PSP Mental Health Plan (PSP= Practice Support Program)**<br>This code is for the complete assessment of the patient with a confirmed mental illness meeting the diagnostic criteria in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of sufficient severity and acuity to cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and warrant the development of a Mental Health care plan. This is not intended for patients with self-limited or short lived mental health symptoms. The assessment is to be performed by the PSP trained family physician most responsible for the patient's mental health care. The Mental Health Plan and start and stop times must be documented in the health record.<br>This complete assessment is to include **all** of the following elements and be documented in the health record:<br>• The patient's DSM diagnosis, psychiatric history and current mental state including suicide risk assessment as appropriate<br>• Obtaining collateral history and information from caregivers as required<br>• Performance of a complete medication review to include collateral information from pharmacy and assisted living facility as appropriate<br>• Reviewing and documenting results of relevant validated assessment tools, laboratory, and other test results<br>• Documentation of a clinical plan for the patient's care over the next year. Includes advanced care planning where appropriate<br>• Outline of expected outcomes as a result of the treatment plan<br>• Outline of linkages with other health care providers and community resources who will be involved in the patients care.<br>• Confirmation that the plan has been created jointly and shared with the patient or their medical representative. The plan is to be shared with other care providers as appropriate<br>• A documented care plan must be in place before access to additional counselling hours is provided<br>It is recognized that the required elements may require more than one visit to complete. This health service code may be claimed at the final visit only when all of the information is complete and documented in the health record; other visits may be reported at the usual rate.<br><br>**All** elements must be documented in the health record before reporting this PSP MHP visit service.<br><br>**Billing Guidelines**<br>• Reportable by the patient's PSP trained physician only<br>• Not reportable with any other visit fee for the same physician, same patient, same day<br>• Not reportable for services provided at walk-in clinics<br>• Not to be used for patients living in nursing homes, residential care facilities or hospices<br>• Reportable only once per patient per year<br>• 50 MSU for first 30 minutes, 25 MSU for each additional 15 minutes, up to a maximum of 1 hour (5 multiples)<br>• Start and stop times must be reported in the text field of the claim to MSI, as well as in the clinical record<br><br>**Specialty Restriction**<br>GENP with PSP Training<br><br>**Location**<br>OFFC, HOME | 50 MSU +MU |

BACK TO CONTENTS

## INTERIM FEES MADE PERMANENT

As announced in the October 26, 2020 Physician's Bulletin, the following health service codes are now permanent. Physicians holding their claims for service dates after October 30, 2020 may now submit their billings.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VADT | 13.59P | **Insertion of Buprenorphine Implant (e.g. Probuphine) for the treatment of opioid use disorder**<br>This HSC is for the insertion of the non-biodegradable buprenorphine delivery implant for the treatment of opioid use disorder | 20 MSU |
| VADT | 13.59Q | **Removal of Buprenorphine Implant (e.g. Probuphine)**<br>This HSC is for the removal of the non-biodegradable buprenorphine delivery implant<br><br>For removal and reinsertion of the non-biodegradable buprenorphine delivery implant, report the removal code at 100% and the insertion code at LV50.<br><br>**Billing Guidelines**<br>May not be claimed in addition to OAT1 or OAT2 by any physician for the same patient for 6 months following implantation.<br>If the implant is removed early or there are special circumstances to consider the physician should add text to the OAT management claim explaining the circumstances. | 20 MSU |

As announced in the October 26, 2020 Physician's Bulletin, the following health service code is now permanent. Physicians holding their claims for service dates after October 30, 2020 may now submit their billings.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VEDT | 50.0B | **Endovascular Thrombectomy-Intracranial**<br>Endovascular Thrombectomy for the purpose of revascularization of a thrombotic or embolic occlusion of one or more intracranial vessels. This comprehensive health service code includes:<br>Selective catheterization, diagnostic angiography and all selective angiography required to perform the procedure within the vascular territory.<br><br>SRAS allowed at usual rate (no specialty restriction on surgical assistant)<br><br>**Specialty Restriction**<br>Neuroradiology (DIRD with subspecialty in neuroradiology)<br><br>**Location**<br>HOSP (QEII only) | 300 MSU |

BACK TO CONTENTS

## INTERIM FEES MADE PERMANENT (CONTINUED)

The health service code for Mindfulness Based Cognitive Therapy is now a permanent fee.

| Category | Code | Description | Base Units |
|---|---|---|---|
| PSYC | 08.44A | **Mindfulness-Based Cognitive Therapy (MBCT)**<br>**Group therapy fee per patient per two hour session (minimum 8 to maximum 12 patients per group)**<br><br>**Description**<br>MBCT is defined as a specific psychological intervention incorporating elements of cognitive behavioral therapy and mindfulness. This fee is for each two hour session of the eight week MBCT course provided for a group of 8 to 12 patients with recurrent episodes of depression.<br><br>**Billing Guidelines**<br>• Fee is per patient, per two hour session<br>• Session dates and start/stop times must be documented in the health record of each participant<br>• One series of 8 sessions per patient per 365 days<br>• Additional fees may be charged to the patient for non-billable services such as the provision of course materials and for the services of a privately paid non-MD therapist if applicable.<br>Start and stop time to be documented in the health record; however session outline and activities are standardized to be completed in 2 hours.<br><br>**Specialty Restriction:**<br>SP=GENP with approval from MSI<br>SP=PSYC with approval from MSI<br><br>Physicians eligible to claim this code must submit credentials to MSI directly. Once MSI receives a physician's credentials and grants approval, the physician will be permitted to claim for this fee after the next system update.<br><br>**Location:**<br>LO=OFFC, LO=HOSP, LO=OTHR | 14.3 MSU |

# Billing Matters Billing Reminders, Updates, New Explanatory Codes

## BILLING REMINDERS

Tonometry and Surgical Procedures

Physicians are reminded that tonometry is considered to be an included part of any surgical procedure services claimed, thus a separate claim should not be made for this service.

BACK TO CONTENTS

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| AD087 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS RO=HDIN MAY ONLY BE CLAIMED FROM A LONG TERM CARE/RESIDENTIAL CARE FACILITY OR HOSPITAL INPATIENT FOR PATIENT DESIGNATED ALTERNATE LEVEL OF CARE AWAITING LONG TERM CARE FACILITY PLACEMENT. |
| GN105 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE ALREADY CLAIMED A SURGICAL PROCEDURE ON THIS DAY. TONOMETRY IS CONSIDERED TO BE AN INCLUDED PART OF ANY SURGICAL PROCEDURE. |
| GN106 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE ALREADY CLAIMED FOR TONOMETRY ON THIS DAY FOR THIS PATIENT. TONOMETRY IS CONSIDERED TO BE AN INCLUDED PART OF ANY SURGICAL PROCEDURE. |
| VE028 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A CHRONIC DIALYSIS MANAGEMENT DAILY TREATMENT AND SUPERVISION FEE HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THAT DATE. |
| VE029 | SERVICE ENCOUNTER HAS BEEN REFUSED AS AN OUTPATIENT VISIT OR CONSULT FROM A RELATED SPECIALTY HAS BEEN CLAIMED FOR THIS PATIENT ON THAT DATE. |
| VE030 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE SPECIALTY SUBMITTED MAY ONLY CLAIM THIS SERVICE FROM THE YARMOUTH REGIONAL HOSPITAL. |
| VE031 | SERVICE ENCOUNTER HAS BEEN REFUSED AS ANOTHER CHRONIC DIALYSIS FEE HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THAT DATE. |
| VT172 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A CHRONIC DIALYSIS MANAGEMENT DAILY TREATMENT AND SUPERVISION FEE HAS BEEN CLAIMED FOR THIS PATIENT ON THAT DATE. |
| VT173 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED A DAILY DIALYSIS MANAGEMENT FEE FOR THIS PATIENT ON THIS DATE. IF THIS VISIT IS UNRELATED TO DIALYSIS MANAGEMENT PLEASE SUBMIT A REASSESSMENT REQUEST WITH SUPPORTING INFORMATION. |

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

### UPDATED FILES

Updated files reflecting changes are available for download on Friday November 13th, 2020. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), Modifiers (MODVALS.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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BACK TO CONTENTS

PHYSICIAN'S BULLETIN
November 4 2020: Vol. LXV, ISSUE 19

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# Notice to Physicians

## CHANGE TO BREAST REDUCTION CRITERIA

Effective November 2, 2020, DHW has added the diagnosis of Persistent and Well Documented Gender Dysphoria to the list of criteria for MSI coverage for a breast reduction. Approved GAS applications must be on file and the request for approval must come from the NS physician who will be providing this service.

## LOCUM PHYSICIANS PARTICIPATING IN SUPPLEMENTAL ACTIVITIES

Where locum physicians desire to participate in supplemental activities (e.g. CHIP, PMC), they will be eligible to do so in addition to the locum hours and will be compensated per the supplemental program's funding model. However, a locum physician must fulfill the hours specified for the locum income received on the day before claiming any additional remuneration. Locum hours cannot be 'made up' on a subsequent day.

- Where possible, the supplemental activity should be fulfilled before or after the 'locum' hours.
- Where frequent interruptions are expected throughout any given day (e.g. urgent inpatient response, antenatal services) and there is a considerable likelihood a full day of locum services cannot be achieved, the host/locum physicians should consider the half-day guarantee or FFS remuneration for the care services.
- If a locum physician does not fulfill the service requirement as stated on the host application and/or claim form, the locum physician must advise Medavie for an adjustment to the locum compensation where applicable.

- Please click here for a Primary Maternity Care (PMC) Program QA.
- Please click here for a Community Hospital Inpatient Program (CHIP) QA.

Please see the updated GP Locum Application Form and GP Specialist Locum Claim Form

PHYSICIAN'S BULLETIN
October 26 2020: Vol. LXV, ISSUE 18

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# Notice to Physicians

## INTERIM FEES MADE PERMANENT

Please be advised that the following interim health service codes will be made permanent. However, physicians are asked to hold any claims with service dates October 31, 2020 – November 12, 2020 until the MSI system is updated on November 13, 2020.

**50.0B** – Endovascular Thrombectomy - Intracranial

Details on the above code can be found in the May 14, 2020 Physician's Bulletin.

**13.59P** – Insertion of Buprenorphine Implant (e.g. Probuphine) for the Treatment of Opioid Use Disorder

**13.59Q** – Removal of Buprenorphine Implant (e.g. Probuphine)

Details on the above codes can be found in the April 5, 2019 Physician's Bulletin.

PHYSICIAN'S BULLETIN
October 15 2020: Vol. LXV, ISSUE 17

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# New Interim Fees

## INTERIM HEMODIALYSIS FEES

The following interim fees are effective October 19, 2020. Physicians are advised to hold these claims until the MSI system is updated on November 13, 2020.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VEDT | 51.95A | **Chronic Dialysis – treatment and supervision of care for the patient with end stage kidney disease, in hospital (hemodialysis or peritoneal dialysis) or in central outpatient hemodialysis units (for example; Halifax Victoria General Hospital, Yarmouth Regional Hospital, Cape Breton Regional Hospital) for a 24 hour period.**<br><br>**Description**<br>This comprehensive, daily fee (24 hour period beginning at 12:00am until 11:59pm of the same calendar day) is for the treatment and supervision of care for a patient with end stage kidney disease who is registered in the Renal Program (NSHA, STARS or PHS, as a series visit for dialysis) and requires chronic dialysis (hospital or central outpatient hemodialysis unit). The physician is expected to supervise all aspects of the patients dialysis care and to provide direct, face-to-face clinical assessment of the patient, including a physical examination appropriate to the patient's medical condition, at least once in every 14 day period with additional clinical assessments as required based on concerns related to changes in the patient's medical condition. Each assessment will be documented in the patient's health record.<br><br>Elements of care include:<br><br>A. All management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital in-patients and in-person emergency department visits related to the management of chronic dialysis. It does not include acute dialysis. Acute dialysis is defined as dialysis rendered to a hospital inpatient in an intensive care setting, or to a patient beginning dialysis for the first time in their lifetime through to their 6th treatment at which point the dialysis is defined as chronic. A visit service, consultation or directive care as appropriate, may be claimed for hospital inpatients if the nephrologist is asked by the patient's most responsible physician to render an opinion and furnish advice regarding the patient's ongoing nephrological care during their hospital stay. The most responsible physician requesting the advice may not be another nephrologist.<br><br>B. All outpatient consultations and visits within the scope of practice of nephrology for the assessment and treatment of complications of chronic dialysis and management of end stage kidney disease.<br>Including:<br>a. Review of laboratory and diagnostic test results<br>b. Management of volume status, ideal body weight and blood pressure<br>c. Assessment of dialysis access, such as; central venous catheter, arteriovenous fistula and peritoneal catheter, and management of any complications as required.<br>d. Complete and document the Ambulatory Medication Reconciliation every six months | 12.11 MSU |

C. All related counselling, interviews and family meetings

D. Perform all assessments and consultation requests to refer the chronic dialysis patient to the Multiorgan Transplant Program for determination of kidney transplant eligibility.

E. All related case conferences, such as, but not limited to:
   a. Weekly Morning Program Rounds
   b. Review of laboratory and diagnostic test results with multidisciplinary team

For all patients in all hemodialysis units, the Nephrologist assigned to each unit will provide daily coverage of all dialysis patients to address any dialysis issues by being available to speak with the unit charge nurse or team lead every shift to discuss any problems or concerns with individual patients at any time.

The Nephrologist assigned to each unit will provide additional care and address concerns or problems that arise during the course of a hemodialysis treatment or within the 24 hour period of supervision, such as, but not limited to, changes to dialysis prescription or medications based on laboratory results like serum potassium or INR for patients on oral anticoagulants, when results are received after the treatment.
A standardized review of the patient's overall status on dialysis will be completed and updated every 6 weeks and documented in the patient's health record.

The document will include:
   a. Review and interpretation of laboratory and diagnostic test results
   b. Volume status, ideal body weight, blood pressure and physical examination appropriate to the patient's medical needs.
   c. Assessment of dialysis access, such as; central venous pressure, arteriovenous fistula, peritoneal catheter, and management of any complications as required.

**Billing Guidelines**

- Claimable by the Most Responsible Nephrologist once per patient per 24 hour period beginning at 12:00am (midnight) and ending at 11:59pm.
- May not claim any other chronic dialysis HSCs for the same patient, same 24 hour period.
- May not claim any other outpatient visit HSCs same physician, same patient, same 24 hour period.
- A Nephrologist providing coverage for care of the chronic dialysis patient on behalf of the most responsible nephrologist may not claim any outpatient visit HSC or chronic dialysis HSCs.
- Emergency hospital visits to attend the patient for a condition unrelated to the management of dialysis, its complications and end stage kidney disease may be claimed but must be submitted for manual assessment with supporting information in the text (clinical documentation may be required). Should the patient be admitted to hospital under the care of the nephrologist, who is acting as the most responsible physician, inpatient visits may be claimed.
- First claim may be made on the date of the patient's first chronic dialysis treatment.
- May not be claimed after the treatment terminates by, for example, successful transplantation, loss of resident status, or death.
- When a face-to-face clinical assessment is not documented in the patient's health record in the 14 day period, payment will be recovered from the Most Responsible Physician who claimed for the service the majority of the days in the preceding seven day period at the end of which the examination was to have occurred.

**Specialty Restriction:**
SP=NEPH, SP=INMD acting in the role of the NEPH at the Yarmouth Regional Hospital as designated by NSHA Renal Program Senior Medical Director.

**Location:**
LO=HOSP

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| VEDT | 51.95B | **Chronic Hemodialysis – treatment and supervision of care for the patient with end stage kidney disease, in an urban satellite hemodialysis unit as designated by the Health Authority (for example; Halifax Infirmary, Dartmouth General, and North Sydney hemodialysis units) for a 24 hour period.**<br><br>**Description**<br>This comprehensive, daily fee (24 hour period beginning at 12:00 am until 11:59 pm of the same calendar day) is for the treatment and supervision of care for a patient with end stage kidney disease who is registered in the Renal Program (NSHA, STARS or PHS, as a series visit for dialysis) and requires chronic dialysis in an urban satellite hemodialysis unit as designated by the Health. The physician is expected to supervise all aspects of the patient's dialysis care and to provide direct, face-to-face clinical assessment of the patient, including a physical examination appropriate to the patient's medical condition, at least once in every 42 day period, and via PHIA compliant, synchronous virtual care platform once in every 14 day period, with additional clinical assessments as required based on concerns related to changes in the patient's medical condition. Each assessment will be documented in the patient's health record.<br><br>Elements of care include:<br>A. All management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital in-patients and in-person emergency department visits related to the management of chronic dialysis. It does not include acute dialysis. Acute dialysis is defined as dialysis rendered to a hospital inpatient in an intensive care setting, or to a patient beginning dialysis for the first time in their lifetime through to their 6th treatment at which point the dialysis is defined as chronic. A visit service, consultation or directive care as appropriate, may be claimed for hospital inpatients if the nephrologist is asked by the patient's most responsible physician to render an opinion and furnish advice regarding the patient's ongoing nephrological care during their hospital stay. The most responsible physician requesting the advice may not be another nephrologist.<br><br>B. All outpatient consultations and visits within the scope of practice of nephrology for the assessment and treatment of complications of chronic dialysis and management of end-stage kidney disease.<br>Including:<br>a. Review of laboratory and diagnostic test results<br>b. Management of volume status, ideal body weight and blood pressure<br>c. Assessment of dialysis access, such as; central venous catheter, arteriovenous fistula and peritoneal catheter, and management of any complications as required.<br>d. Complete and document the Ambulatory Medication Reconciliation every six months<br><br>C. All related counselling, interviews and family meetings<br><br>D. Perform all assessments and consultation requests to refer the chronic dialysis patient to the Multiorgan Transplant Program for determination of kidney transplant eligibility.<br><br>E. All related case conferences, such as, but not limited to:<br>a. Weekly Morning Program Rounds<br>b. Review of laboratory and diagnostic test results with multidisciplinary team<br><br>For all patients in all hemodialysis units, the Nephrologist assigned to each unit will provide daily coverage of all dialysis patients to address any dialysis issues by being available to speak with the unit charge nurse or team lead every shift to discuss any problems or concerns with individual patients at any time.<br><br>The Nephrologist assigned to each unit will provide additional care and address concerns or problems that arise during the course of a hemodialysis treatment or within the 24 hour period of supervision, such as, but not limited to, changes to dialysis prescription or medications based on laboratory results like serum potassium or INR for patients on oral anticoagulants, when results are received after the treatment time. | 12.11 MSU |

BACK TO CONTENTS

A standardized review of the patient's overall status on dialysis will be completed and updated every 6 weeks and documented in the patient's health record.

The document will include:

a. Review and interpretation of laboratory and diagnostic test results
b. Volume status, ideal body weight, blood pressure and physical examination appropriate to the patient's medical needs.
c. Assessment of dialysis access, such as; central venous pressure catheter, arteriovenous fistula, peritoneal catheter, and management of any complications as required.

**Billing Guidelines**

- Claimable by the Most Responsible Nephrologist once per patient per 24 hour period beginning at 12:00 am (midnight) and ending at 11:59 pm.
- May not claim any other chronic dialysis HSCs for the same patient, same 24 hour period.
- May not claim any other outpatient visit HSCs same physician, same patient, same 24 hour period.
- A Nephrologist providing coverage for care of the chronic dialysis patient on behalf of the most responsible nephrologist may not claim any outpatient visit HSCs or chronic dialysis HSCs.
- Emergency hospital visits to attend the patient for a condition unrelated to the management of dialysis, its complications and end stage kidney disease may be claimed but must be submitted for manual assessment with supporting information in the text (clinical documentation may be required). Should the patient be admitted to hospital under the care of the nephrologist, who is acting as the most responsible physician, inpatient visits may be claimed.
- First claim may be made on the date of the patient's first chronic dialysis treatment.
- May not be claimed after the treatment terminates by, for example; successful transplantation, loss of resident status, or death.
- When a face-to-face clinical assessment is not documented in the patient's health record in the 14 day period, payment will be recovered from the Most Responsible Physician who claimed for the service for the majority of days in the preceding seven day period at the end of which the examination was to have occurred.

**Specialty Restriction:**
SP=NEPH

**Location:**
LO=HOSP

| Category | Code | Description | Base Units |
|---|---|---|---|
| VEDT | 51.95C | **Chronic Hemodialysis – treatment and supervision of care, in a rural satellite hemodialysis unit as designated by the Health Authority (for example; Inverness, Strait Richmond, Antigonish, Pictou, Springhill, Liverpool, Berwick) for a 24 hour period.**<br><br>**Description**<br>This comprehensive, daily fee (24 hour period beginning at 12:00 am until 11:59 pm of the same calendar day) is for the treatment and supervision of care for a patient with end stage kidney disease who is registered in the Renal Program (NSHA, STARS or PHS, as a series visit for dialysis) and requires hemodialysis in a rural satellite hemodialysis unit as designated by the Health Authority. The physician is expected to supervise all aspects of the patient's dialysis care and to provide direct, face-to-face clinical assessment of the patient, including a physical examination appropriate to the patient's medical condition, at least once in every 90 day period, and via PHIA compliant, synchronous virtual care platform once in every 14 day period, with additional clinical assessments as required based on concerns related to changes in the patient's medical condition. Each assessment will be documented in the patient's health record. | 12.11 MSU |

BACK TO CONTENTS

Elements of care include:

A. All management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital in-patients and in-person emergency department visits related to the management of chronic dialysis. It does not include acute dialysis. Acute dialysis is defined as dialysis rendered to a hospital inpatient in an intensive care setting, or to a patient beginning dialysis for the first time in their lifetime through to their 6th treatment at which point the dialysis is defined as chronic. A visit service, consultation or directive care as appropriate, may be claimed for hospital inpatients if the nephrologist is asked by the patient's most responsible physician to render an opinion and furnish advice regarding the patient's ongoing nephrological care during their hospital stay. The most responsible physician requesting the advice may not be another nephrologist.

B. All outpatient consultations and visits within the scope of practice of nephrology for the assessment and treatment of complications of chronic dialysis and management of end-stage kidney disease.
Including:
    a. Review of laboratory and diagnostic test results
    b. Management of volume status, ideal body weight and blood pressure
    c. Assessment of dialysis access, such as; central venous catheter, arteriovenous fistula and peritoneal catheter, and management of any complications as required.
    d. Complete and document the Ambulatory Medication Reconciliation every six months

C. All related counselling, interviews and family meetings

D. Perform all assessments and consultation requests to refer the chronic dialysis patient to the Multiorgan Transplant Program for determination of kidney transplant eligibility.

E. All related case conferences, such as, but not limited to:
    a. Weekly Morning Program Rounds
    b. Review of laboratory and diagnostic test results with multidisciplinary team

For all patients in all hemodialysis units, the Nephrologist assigned to each unit will provide daily coverage of all dialysis patients to address any dialysis issues by being available to speak with the unit charge nurse or team lead every shift to discuss any problems or concerns with individual patients at any time.

The Nephrologist assigned to each unit will provide additional care and address concerns or problems that arise during the course of a hemodialysis treatment or within the 24 hour period of supervision, such as, but not limited to, changes to dialysis prescription or medications based on laboratory results like serum potassium or INR for patients on oral anticoagulants, when results are received after the treatment time.

A standardized review of the patient's overall status on dialysis will be completed and updated every 6 weeks and documented in the patient's health record.

The document will include:
    a. Review and interpretation of laboratory and diagnostic test results
    b. Volume status, ideal body weight, blood pressure and physical examination appropriate to the patient's medical needs.
    c. Assessment of dialysis access, such as; central venous pressure catheter, arteriovenous fistula, peritoneal catheter, and management of any complications as required.

**Billing Guidelines**

- Claimable by the Most Responsible Nephrologist once per patient per 24 hour period beginning at 12:00 am (midnight) and ending at 11:59 pm.
- May not claim any other chronic dialysis HSCs for the same patient, same 24 hour period.
- May not claim any other outpatient visit HSCs same physician, same patient, same 24 hour period.

BACK TO CONTENTS

- A Nephrologist providing coverage for care of the chronic dialysis patient on behalf of the most responsible nephrologist may not claim any outpatient visit HSCs or chronic dialysis HSCs.
- Emergency hospital visits to attend the patient for a condition unrelated to the management of dialysis, its complications and end stage kidney disease may be claimed but must be submitted for manual assessment with supporting information in the text (clinical documentation may be required). Should the patient be admitted to hospital under the care of the nephrologist, who is acting as the most responsible physician, inpatient visits may be claimed.
- First claim may be made on the date of the patient's first chronic dialysis treatment.
- May not be claimed after the treatment terminates by, for example; successful transplantation, loss of resident status, or death.
- When a face-to-face clinical assessment is not documented in the patient's health record in the 90 day period, payment will be recovered from the Most Responsible Physician who claimed for the service for the majority of days in the preceding seven day period at the end of which the examination was to have occurred.

**Specialty Restriction:**
SP=NEPH, SP=INMD acting in the role of the NEPH at the Yarmouth Regional Hospital as designated by NSHA Renal Program Senior Medical Director.

**Location:**
LO=HOSP

| Category | Code | Description | Base Units |
|---|---|---|---|
| VEDT | 51.95D | **Chronic Dialysis – treatment and supervision of care for the patient on home peritoneal dialysis or home hemodialysis for a 24 hour period.** | 12.11 MSU |

**Description**
This comprehensive, daily fee (24 hour period beginning at 12:00 am until 11:59 pm of the same calendar day) is for the treatment and supervision of care for a patient with end stage kidney disease who is registered in the Renal Program (NSHA, STARS or PHS) and requires home peritoneal dialysis or home hemodialysis. The physician is expected to supervise all aspects of the patient's dialysis care and to provide direct, face-to-face clinical assessment of the patient, including a physical examination appropriate to the patient's medical condition, at least once in every 90 day period with additional clinical assessments as required based on concerns related to changes in the patient's medical condition. Each assessment will be documented in the patient's health record.

Elements of care include:

A. All management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital in-patients and in-person emergency department visits related to the management of chronic dialysis. It does not include acute dialysis. Acute dialysis is defined as dialysis rendered to a hospital inpatient in an intensive care setting, or to a patient beginning dialysis for the first time in their lifetime through to their 6th treatment at which point the dialysis is defined as chronic. A visit service, consultation or directive care as appropriate, may be claimed for hospital inpatients if the nephrologist is asked by the patient's most responsible physician to render an opinion and furnish advice regarding the patient's ongoing nephrological care during their hospital stay. The most responsible physician requesting the advice may not be another nephrologist.

B. All outpatient consultations and visits within the scope of practice of nephrology for the assessment and treatment of complications of chronic dialysis and management of end-stage kidney disease.
Including:
   a. Review of laboratory and diagnostic test results
   b. Management of volume status, ideal body weight and blood pressure
   c. Assessment of dialysis access, such as; central venous catheter, arteriovenous fistula and peritoneal catheter, and management of any complications as required.
   d. Complete and document the Ambulatory Medication Reconciliation every six months

BACK TO CONTENTS

C. All related counselling, interviews and family meetings

D. Perform all assessments and consultation requests to refer the chronic dialysis patient to the Multiorgan Transplant Program for determination of kidney transplant eligibility.

E. All related case conferences, such as, but not limited to:
   a. Weekly Morning Program Rounds
   b. Review of laboratory and diagnostic test results with multidisciplinary team

In addition, the nephrologist will be available on a daily basis to address the following:
a. All dialysis related concerns of outpatients that are managed by the home dialysis unit
b. Unexpected or planned drop-in visits by home dialysis patients with concerns related to their dialysis care
c. Concerns of patients who are training for home hemodialysis or peritoneal dialysis

A standardized review of the patient's overall status on dialysis will be completed and updated every 90 days in the patient's health record.

The document will include:
   a. Review and interpretation of laboratory and diagnostic test results
   b. Volume status, ideal body weight, blood pressure and physical examination appropriate to the patient's medical needs.
   c. Assessment of dialysis access, such as; central venous pressure catheter, arteriovenous fistula, peritoneal catheter, and management of any complications as required.

**Billing Guidelines**
- Claimable by the Most Responsible Nephrologist once per patient per 24 hour period beginning at 12:00 am (midnight) and ending at 11:59 pm.
- May not claim any other chronic dialysis HSCs for the same patient, same 24 hour period.
- May not claim any other outpatient visit HSCs same physician, same patient, same 24 hour period.
- A Nephrologist providing coverage for care of the chronic dialysis patient on behalf of the most responsible nephrologist may not claim any outpatient visit HSCs or chronic dialysis HSCs.
- Emergency hospital visits to attend the patient for a condition unrelated to the management of dialysis, its complications and end stage kidney disease may be claimed but must be submitted for manual assessment with supporting information in the text (clinical documentation may be required). ). Should the patient be admitted to hospital under the care of the nephrologist, who is acting as the most responsible physician, inpatient visits may be claimed.
- First claim may be made on the date of the patient's first chronic dialysis treatment.
- May not be claimed after the treatment terminates by, for example; successful transplantation, loss of resident status, or death.
- When a face-to-face clinical assessment is not documented in the patient's health record in the 90 day period, payment will be recovered from the Most Responsible Physician who claimed for the service for the majority of days in the preceding seven day period at the end of which the examination was to have occurred.

**Specialty Restriction:**
SP=NEPH

**Location:**
LO=HOME, LO=OFFC

**Modifiers:**
ME=PERI (peritoneal dialysis), ME=HEMO (hemodialysis)

BACK TO CONTENTS

PHYSICIAN'S BULLETIN
September 24 2020: Vol. LXV, ISSUE 16

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# Notice to Physicians

## NON-FACE-TO-FACE SERVICES DURING PANDEMIC

Physicians are advised that eligible dates of service for non-face-to-face services provided by telephone, via telehealth network or via PHIA compliant virtual care platforms as outlined in the March 27, 2020 bulletin have been extended to December 31, 2020. As a reminder, all services are only eligible to be claimed when rendered by a physician currently physically located in Nova Scotia.

## EXPANDED ELIGIBILITY FOR HIGH-DOSE INFLUENZA VACCINE DURING 2020/21 FLU SEASON

Effective from October 13, 2020 to April 1, 2021 the high-dose influenza vaccine will be available to patients equal to or greater than 65 years of age who are also hospitalized and designated alternate level of care awaiting long-term care facility placement. This eligibility is limited to the 2020/21 influenza season only. Please hold your eligible hospital inpatient claims for HSC 13.59L RO=HDIN until MSI is able to update the billing system. Once updated a communication will be provided via the Physician's Bulletin.

PHYSICIAN'S BULLETIN
August 20 2020: Vol. LXV, ISSUE 15

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## Notice to Physicians

# REMINDER: INCOME STABILITY SHADOW BILLING BA END DATE

The Department of Health and Wellness, Doctors Nova Scotia, IWK and the NSHA worked together to address income stability for fee-for-service (FFS) physicians during COVID-19 through the voluntary Income Stability Program.

Please note that if you have participated in the program, the program formally ended on **July 13, 2020**.

**Q: When should I start to use my existing FFS business arrangement(s) (BA) that I used prior to joining the Income Stability Program?**

Effective **July 14, 2020** claims with services provided from July 14, 2020 must be submitted using your existing FFS BA(s) to receive payment.

**Q: Can MSI make the switch between Income Stability shadow billing arrangement(s) (BA) and my existing FFS business arrangement(s) (BA)?**

**A:** No, your Administrative/Office staff need to revert to your existing FFS BA in your computer software billing system.

**Q: Should the Income Stability Program shadow billing business arrangement(s) (BA) continue to be used?**

**A:** Your shadow billing BA(s) must still be used to submit any outstanding claims associated with services provided from March 13, 2020 to July 13, 2020.

**Q: Claims have been submitted under my Income Stability shadow billing arrangement(s) (BA) with dates of service July 14, 2020 forward. What do I do with these claims?**

**A:** Claims with dates of service July 14, 2020 forward submitted under the Income Stability shadow billing BA(s) must be reversed and resubmitted under the existing FFS BA(s) to receive payment.

PHYSICIAN'S BULLETIN
August 19 2020: Vol. LXV, ISSUE 14

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## Notice to Physicians

# REQUEST FOR PROPOSALS – PHYSICIAN CONSULTANT

The Department of Health and Wellness is seeking the services of a Physician Consultant to provide support and advice on a range of policy issues related to physician services, Pharmacare, Children's Oral Health Program, and other extended health benefit programs.

A Request for Proposals (RFP) is posted in the Government Procurement site at https://procurement.novascotia.ca/tender-details.aspx?id=DOC463104797.

The RFP closes September 11, 2020, 2 PM.

PHYSICIAN'S BULLETIN
July 10 2020: Vol. LXV, ISSUE 13

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## Outdated Policy Reminder

All original claims must be submitted to MSI within 90 days from the date of service. Claims that are outside of the specified time limitations will only be considered if extenuating circumstances can be demonstrated for a late submission and are within a reasonable time frame past the 90 day limit. Request for an extension must be made to MSI in writing and will be approved on a case by case basis. The time frame for submitting the request to MSI for late submission should be within one month following the 90 day limit.

Examples of extenuating circumstances may include physical damage to office such as fire or flood and or a serious technical issue.

Service encounters submitted over the 90-day limitation will be adjudicated to pay "zero" with the following exceptions:
- Reciprocal billing claims (out of province) must be submitted within 12 months of the date(s) of service.
-Resubmission of refused claims or incorrect billings. These claims must be resubmitted to MSI within 185 days of the date of service. Each resubmission must contain an annotation in the text field of the service encounter submission referencing the previous service encounter number.

Circumstances relating to staffing issues/shortages and mislaid, misfiled, or lost claims cannot be accepted by MSI as valid explanations for a late submission.

Claims for registered hospital in-patients must also be submitted within the 90 day time limitation regardless if the patient has been discharged or continues on an in-patient basis. It is incumbent on the physician to obtain the required billing information for these patients and submit claims within the prescribed time limitations. Explanations relating to late discharge summaries, or facilities not consolidating the required information for the physician, cannot be accepted as a valid explanation for a late submission.

Please note: Failure to use a preauthorization code given by MSI and annotate the text field with the previous service encounter number will result in an adjudication paid at "zero".

## UPDATES

### 87.98 Delivery NEC

Effective April 1, 2020 the non-referred GENP fee for HSC 87.98 Delivery NEC has been increased to 263.70 MSU. Physicians who have already submitted their claims at the lower rate may delete and resubmit to be paid at the higher fee. For claims that are now over 90 days, physicians are required to submit with a preauthorization number in the appropriate field.

### Non-Face-to-Face services during Pandemic

Physicians are advised that eligible dates of service for health service code 03.03X and non-face-to-face services provided by telephone, via telehealth network or via PHIA compliant virtual care platforms as outlined in the March 27, 2020 bulletin have been extended to September 30, 2020.

### 01.09D 01.09E EBUS Facility Update

As published in the March 6, 2020 Bulletin, HSC's 01.09D and 01.09E are location restricted to the QEII site. The system has been updated to include the VG as part of the QEII for billing purposes.

### 03.38A Specialty Restriction

With the title/description changes as noted in the May 2020 bulletin, there were also updates to the speciality restriction for 03.38A. This HSC may now be claimed by SP=RSMD in addition to SP=INMD and SP=PEDI.

## BILLING REMINDERS

### Physician Confirmation Letter Reminder

General Practitioners are reminded that to be eligible to use the modifier ME=CARE you must have submitted a Confirmation Letter attesting to your status as a primary care provider providing continuity of care in the context of an ongoing relationship with your patients (see original notification here). Only physicians who have submitted the Confirmation Letter will be eligible to bill with the ME=CARE modifier. Physicians are reminded that eligibility will commence as of the date the letter is received, unless otherwise notified. The letter can be found here and can be sent to: primary_care_investments@medavie.bluecross.ca.

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| VT146 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED THE COMPLEX COMPREHENSIVE ACUTE CARE HOSPITAL DISCHARGE FEE FOR THIS PATIENT ON THE SAME DAY. |

BACK TO CONTENTS

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

### UPDATED FILES

Updated files reflecting changes are available for download on Friday July 10th, 2020. 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/

In partnership with

NOVA SCOTIA

BACK TO CONTENTS

PHYSICIAN'S BULLETIN
June 26 2020: Vol. LXV, ISSUE 12

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# Notice to Physicians

## INCOME STABILITY PROGRAM END DATE

The Department of Health and Wellness, Doctors Nova Scotia, IWK and the NSHA have worked together to address income stability for fee-for-service (FFS) physicians during COVID-19 through the voluntary Income Stability Program.

Please note that if you have participated in the program, the program will formally end on **July 13, 2020**.

**Physician Income Stability Program Completion Q&A**

**Q: What is the last payment date under the Income Stability Program?**
**A:** You will continue to receive regular bi-weekly Income Stability payments on June 30, 2020 and July 15, 2020. The last Income Stability payment will occur on July 29, 2020. The final payment on July 29, 2020 will include payments for the July 10 to July 13, 2020 time period.

**Q: When will the final reconciliation and associated payment under the program be completed?**
**A:** Physicians have 90 days to submit shadow claims associated with services provided during the program's effective period. The reconciliation will be completed after the 90 day submission window has closed. The associated payment date will be communicated at a later date.

**Q: Should the Income Stability Program shadow billing business arrangement(s) (BA) continue to be used?**
**A:** Your shadow billing BA(s) must still be used to submit any outstanding claims associated with services provided from March 13, 2020 to July 13, 2020.

**Q: When can I start to use my existing FFS business arrangement(s) (BA) that I used prior to joining the Income Stability Program?**
**A:** You may start to submit claims using your existing FFS BA(s) effective July 14, 2020 for services provided from July 14, 2020 onward.

**Q: If my shadow billings under the program period exceed my Income Stability payments, how will my top-up be paid?**
**A:** Any required top-up will be paid when the reconciliation process noted above is completed.

# PHYSICIAN'S BULLETIN

May 14 2020: Vol. LXV, ISSUE 11


NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



**AS WE CONTINUE TO WORK THROUGH THE COVID-19 PANDEMIC, PLEASE CLICK HERE FOR AN FAQ ON COVID-19 BILLING. THANK YOU FOR YOUR DEDICATION IN THIS UNPRECEDENTED TIME.**

## ★ Fees New Fees, Updated Fees and Fee Revisions

## NEW FEE

Effective May 14th 2020 the following fee is available for billing:

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.04J | **Comprehensive Diagnostic Evaluation of Suspected Autism Spectrum Disorder**<br><br>**Description**<br>This is a comprehensive health service code for the developmental paediatrician who is present for all components of the diagnostic evaluation and assessment of patients referred with suspected autism disorder performed by a multidisciplinary team at the IWK Health Centre. This service is expected to encompass at least three hours of time with the patient and care providers plus one hour for scoring of assessment tools. This HSC may be reported only when the physician's time has been dedicated to this service encounter and no other concurrent clinical work. Time to generate a report and recommendations is considered to be included in the service. Start and stop times must be recorded in the health record.<br><br>**Billing Guidelines**<br>Reportable no more than once per patient per 12 month period.<br><br>**Specialty Restriction:**<br>Developmental Paediatrics trained in the administration of the Autism Diagnostic Interview<br><br>**Location:**<br>Restricted to IWK Health Centre<br>LO=OFFC, LO=HOSP | 284 MSU |

## UPDATED FEES

Effective March 6, 2020 billing guidelines have been updated to permit a surgical assistant for this service. Physicians who have been holding their SRAS claims since March 6 have 90 days from the date of this bulletin to submit.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VEDT | 50.0B | **Endovascular Thrombectomy-Intracranial**<br><br>**Description**<br>Endovascular Thrombectomy for the purpose of revascularization of a thrombotic or embolic occlusion of one or more intracranial vessels. This comprehensive health service code includes: Selective catheterization, diagnostic angiography and all selective angiography required to perform the procedure within the vascular territory.<br><br>SRAS allowed at usual rate (no specialty restriction on surgical assistant)<br><br>**Specialty Restriction**<br>Neuroradiology (DIRD with subspecialty in neuroradiology)<br><br>**Location**<br>LO=HOSP (QEII only) | 300 MSU |

Effective March 6, 2020 billing guidelines for 13.59O have been updated:

| Category | Code | Description | Base Units |
|---|---|---|---|
| VEDT | 13.59O | **Injection of OnabotulinumtoxinA for the Treatment of Chronic Migraine (Prior Approval)**<br><br>**Description**<br>This is a comprehensive code for the assessment and treatment of adults with a documented history of chronic migraine, defined as having greater than or equal to 15 headache days per month over at least a three month period, and who have not responded to at least three prior pharmacological prophylaxis therapies or for patients who are intolerant of pharmacological prophylaxis.<br>This code includes patient assessment and counselling, preparation of ONA injections, performing all injections using the appropriate protocol, and patient observation prior to discharge.<br>The physician must request prior approval in writing. The request must include:<br>• The patient's clinical history of Chronic Migraine.<br>• Documentation of previous attempts at pharmacological prophylaxis including the names of medication, duration of treatment and results.<br>• If this is a subsequent request for continued treatment, documentation of treatment effect must be included.<br><br>**Billing Guidelines**<br>• Prior approval will be valid for treatment provided to that patient for a period of 24 months.<br>• No more than 11 service encounters for injection of ONA for Chronic Migraine may occur over that 24 month period.<br>• Services to be no more frequent than every 10 weeks.<br>• If treatment continues to be recommended after this time period, prior approval must be requested again.<br><br>Once a request for approval has been made to the MSI Medical Consultant, a response will be issued. If approval is granted you will be advised of a Preauthorization Number. To ensure payment of the service the Preauthorization Number must be entered in the appropriate field on the service encounter.<br><br>**Specialty Restriction**<br>SP=NEUR<br><br>**Location**<br>LO=OFFC | 70 MSU |

BACK TO CONTENTS

## FEE REVISIONS

The following health service codes have title and/or description changes. These changes replace any previously published language effective immediately. These title updates will reflect in the July migration.
Health service codes 03.38A,B,C have expanded specialty restrictions, these will also reflect in the July migration.

| Category | Code | Description | Base Units |
|---|---|---|---|
| ADON | 03.03S | **First Visit After Acute Care In-Patient Hospital Discharge – Complex Care** | 10 MSU |

**Description:**
This is an additional fee for the first office visit of the patient requiring ongoing complex care within 14 days of acute care in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care.

- The physician or their office staff should make every effort to communicate with the patient and/or caregiver within 2 business days of discharge to better facilitate the patient being seen within 14 days.
- Not reportable in the walk-in clinic setting

A complex care patient is defined as:

- A patient with multiple (two or more) chronic conditions as defined below:
  - A condition expected to last one year or more
  - This condition requires ongoing medical management

**Billing Guidelines:**
ADON restricted to:

- 03.03 Office Visit
- 03.03A Geriatric Office Visit
- 03.03E Adults with Developmental Disabilities

- Reportable only if the visit occurs in the primary care physician's office or the patient home within 14 calendar days after hospital discharge (consider discharge date as day zero).
- Hospital length of stay must be greater than or equal to 48 hours.
- Not reportable if the admission to hospital was for the purpose of performing elective surgery (major or minor) or fracture care (major or minor)
- Not reportable if the admission to hospital was for the purpose of obstetrical delivery.
- Not reportable if the admission to hospital was for the purpose of newborn care.
- Not reportable for services rendered in other locations such as Nursing Homes, Residential Care Facilities, or Hospice.
- The physician claiming the service must be the provider most responsible for the patient's ongoing complex care.
- Claimable once per patient per inpatient admission.
- Not reportable for any subsequent discharges within 30 days.
- Not reportable in the same month as other monthly care fees – such as 13.99C
- Maximum of 4 claims per physician per patient per year.

**Specialty Restriction:**
SP=GENP

**Location:**
LO=OFFC, LO=HOME

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| ADON | 03.03P | **First Visit After In-Patient Hospital Discharge – Maternal and Newborn Care**<br><br>**Description:**<br>This is an additional fee for the first maternal/newborn office visit within 14 days of in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care.<br>○ The primary care physician or their office staff should make every effort to communicate with the patient and/or caregiver within 2 business days of discharge to better facilitate the patient being seen within 14 days.<br>○ Not reportable in the walk-in clinic setting<br><br>**Billing Guidelines:**<br>ADON restricted to:<br>○ 03.03 Office Visit<br>○ 03.03 Well Baby Care<br><br>○ Reportable only if the visit occurs in the primary care physician's office or the patient home within 14 calendar days after hospital discharge (consider discharge date as day zero).<br>○ Only reportable if the reason for admission to hospital was for the purpose of obstetrical delivery.<br>○ Physician must be the provider most responsible for the mother and child's ongoing care.<br>○ Claimable once per patient per inpatient admission for obstetrical delivery.<br>○ Not reportable for any subsequent discharges within 30 days.<br>○ Maximum of 1 claim per pregnancy (mother)<br>○ Maximum 1 claim per infant<br><br>**Specialty Restriction:**<br>SP=GENP<br><br>**Location:**<br>LO=OFFC, LO=HOME | 10 MSU |

| Category | Code | Description | Base Units | Anaes Units |
|---|---|---|---|---|
| MASG | 71.7F | **Cystoscopy with Intravesicular Injection(s) of Chemodenervating Agent**<br><br>**Description:**<br>Cystoscopy with intravesicular injection(s) of chemodenervating agent, for example onabotulinumtoxinA, under direct vision. Includes urethroscopy.<br><br>**Billing Guidelines:**<br>Not to be reported with other cystoscopy related HSCs, for example:<br>○ 01.34A, 01.34B, 01.34C, 01.34G<br>Not to be reported with urethroscopy:<br>○ 01.35, 01.35A<br><br>**Specialty Restriction:**<br>SP=UROL, SP=OBGY<br><br>**Location:**<br>LO=HOSP | 90 MSU | 4+T |

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.04F | **Complex Comprehensive Acute Care Hospital Discharge** | 45 MSU |

**Description:**
This complex comprehensive acute care hospital discharge code is intended to be used when services provided on the day of discharge require greater than 30 minutes of the physician's time. This HSC includes all services provided to the patient on the day of discharge from the acute care hospital. These services include the discharge day examination of the patient, the completion of the patient's chart, discharge summary, writing any prescriptions required for the patient, providing discharge instructions to the patient (or caregivers) and arranging for follow-up care for the patient. Every effort is made by the discharge physician to communicate with the community physician who will be most responsible for the patient's care after discharge.

It is recognized that for complex comprehensive discharges, the discharge process may occur over 2 days. For example, the discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge summary, prescriptions and referrals may be completed on one day and the final examination of the patient and discharge order the following day. If this situation arises, the code must be reported on the date of discharge, the cumulative time spent must be greater than 30 minutes, the code may only be claimed once by the MRP and may not be unbundled to accommodate splitting the workload.

- A visit is considered an integral part of this service and is not reportable in addition.
- Documentation of the services provided and time spent must be documented in the health record.

**Billing Guidelines:**
Preamble rules 5.1.30 – 5.1.31 apply. Not reportable if the patient is admitted and discharged on the same day or 24 hour period.

- Reportable by the Most Responsible Physician only. The MRP is defined as the physician in charge of the patient's care for any given day (24 hour period).
- Only once per patient per inpatient hospital admission.
- The physician claiming this health service may not report any other visit service for the same patient, same day. In addition, HSC 03.02A (Hospital Discharge Fee) may not be claimed as the service is included in the Complex Comprehensive Acute Care Hospital Discharge HSC.
- Efforts made to establish communication with the health care provider who will be most responsible for the patient's care after discharge must be documented in the health record.
- Not reportable for hospital deaths.

Do not count time for services provided after the patient physically leaves the hospital.

**Specialty Restriction:**
SP=GENP

**Location:**
LO=HOSP, FN=INPT

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| VEDT | 03.38A | **Bronchial Challenge Testing with methacholine or similar compounds – includes baseline spirometry and all spirometric determinations post administration of agent(s)**<br>RO=INTP<br><br>**Description:**<br>This fee is for the interpretation of the testing and written report. The physician must be present in the pulmonary function laboratory during the time of the testing to be available to deal with adverse events.<br><br>**Billing Guidelines:**<br>Billable once per patient per day.<br>Not to be billed with any additional spirometry same patient same day.<br>○ I1110 Simple Spirometry<br>○ I1140 Flow Volume Loops<br>Billable only when testing is done in the hospital based pulmonary function laboratory.<br><br>**Specialty Restriction:**<br>SP=INMD, SP=PEDI, SP=RSMD<br><br>**Location:**<br>LO=HOSP | 19 MSU |
| VEDT | 03.38B | **Exercise Induced Asthma Assessment, interpretation. Includes interpretation of all serial spirometry, flow/volume loops, bronchodilation responsiveness, and oximetry required to assess the patient.**<br><br>**Description:**<br>This code is used to report the interpretation of all spirometry, including simple spirometry and flow/volume loops, oximetry, and bronchodilation responsiveness, as required to properly assess the response of the patient to exercise.<br><br>**Billing Guidelines:**<br>Only for the interpretation of tests performed in a hospital pulmonary function laboratory (Preamble 5.3.190)<br>Do not report with:<br>○ I1110 Simple Spirometry<br>○ I1140 Flow/Volume Loops<br>○ 03.38C Interpretation of Spirometry Pre and Post Bronchodilator<br><br>**Specialty Restriction:**<br>SP=INMD, SP=PEDI, SP=RSMD<br><br>**Location:**<br>LO=HOSP | 20 MSU |
| VEDT | 03.38C | **Interpretation of Spirometry Pre and Post Bronchodilator**<br><br>**Description:**<br>This code is used to report the interpretation of spirometry, including simple spirometry and flow/volume loops, before and after the administration of a bronchodilator. This includes all testing required to properly assess the response of the patient.<br><br>**Billing Guidelines:**<br>Only for the interpretation of tests performed in a hospital pulmonary function laboratory (Preamble 5.3.190)<br>Do not report with:<br>○ I1110 Simple Spirometry<br>○ I1140 Flow/Volume Loops<br>○ 03.38B Exercise testing for assessment of asthma<br><br>**Specialty Restriction:**<br>SP=INMD, SP=PEDI, SP=RSMD<br><br>**Location:**<br>LO=HOSP | 10 MSU |

BACK TO CONTENTS

| Category | Code | Description | Base Units | Anaes Units |
|---|---|---|---|---|
| MASG | 76.95C | **Inflatable Penile Prosthesis-Insertion of all Components (Pump, Cylinders and Reservoir)** | 230 MSU | 6+T |
| MASG | 76.96C | **Inflatable Penile Prosthesis – Removal of any or all Components (Pump, Cylinders and Reservoir) with or without Reinsertion** | IC | 6+T |

**Description:**
These HSC's are specific to the insertion, and/or removal, with or without re-insertion, of an inflatable penile prosthesis with all its components (pump, cylinders and reservoir) to include any urethral dilation required to insert the device.

**Billing Guidelines:**
Cystoscopy, when required, may be reported in addition to this HSC.
For the removal with or without reinsertion of an inflatable penile prosthesis (any or all components-pump, cylinders and reservoir) IC will be paid at 130 MSU/hr based on surgical start and stop time as documented in the record of operation which must be submitted with the claim.

**Specialty Restriction:**
SP=UROL

**Location:**
LO=HOSP

| Category | Code | Description | Base Units | Anaes Units |
|---|---|---|---|---|
| MASG | 57.59B | **Low Anterior Resection of Rectosigmoid with Low Pelvic Anastomosis (coloproctostomy)**<br>RO=FPHN<br>RO=SPHN | <br>405 MSU<br>300 MSU | 8+T |

**Description:**
Anterior resection of the rectosigmoid including mobilization of the colon, identification of the ureter, dissection of mesocolic vessels, with anastomosis of the bowel including all stapling as required (EEA stapler).
When an ileostomy is required an ADON fee may be used to bill for this portion of the procedure.
To bill as SPHN, the second surgeon must actively participate for 75% of the procedure time. When the second surgeon fee is billed no other assistant fee may be billed.

**Billing Guidelines:**
Not to be billed with:
- 01.24C Sigmoidoscopy
- 58.11 Colostomy
- 58.21 Ileostomy for ulcerative colitis
- 58.39A Ileostomy with tube

Surgical Assistant only billable when RO=SPHN is not billed

**Specialty Restriction:**
RO=FPHN restricted to SP=GNSG
RO=SPHN restricted to SP=GNSG

**Location:**
LO=HOSP

BACK TO CONTENTS

| Category | Code | Description | Base Units | Anaes Units |
|---|---|---|---|---|
| MASG | 57.6D | **Total Proctocolectomy with Ileostomy and Abdominal Perineal Resection**<br>RO=FPHN<br>RO=SPHN | <br>550 MSU<br>400 MSU | 8+T |

**Description:**
This fee is for the complete resection of the entire colon, rectum, and anus with perineal dissection to remove the anal sphincter, and the creation of an ileostomy. Includes mobilization of colon, identification of ureter, dissection of mesocolic vessels, division and suture of bowel, excision of rectum and anus, omental flap for repair as required.
To bill as SPHN, the second surgeon must actively participate for 75% of the procedure time. When the second surgeon fee is billed no other assistant fee may be billed.

**Billing Guidelines:**
Not to be billed with any other fees for resection or suture of bowel or formation of ileostomy on the same patient same day, i.e. HSC's:

- 57.04(A or B) Enterotomy or Colostomy or Multiple Colotomy
- 57.42(A or B) Enterectomy with anastomosis
- 58.52 Closure enterostomy plus resection
- 58.53 Closure of colostomy
- 58.73 Other suture of intestine

Not to be billed with:

- 01.24C Sigmoidoscopy
- 58.21 Ileostomy for ulcerative colitis
- 58.39A Ileostomy with tube
- 66.64(A or B) Omental flap to repair extra-abdominal defect

If reported with Vaginectomy or vaginal reconstruction the operative report and record of operation must be submitted for manual assessment, i.e.HSC's:

- 82.23 Excision of lesion of vagina
- 82.3 (also A, B, C) Obliteration of vagina
- 82.52 Vaginal reconstruction
- 82.62 Repair of fistula of vagina
- 82.69(A or B) Vaginoplasty

Assistant only billable when RO=SPHN is not billed

**Premium:**
No – but if service is provided in premium time for medical necessity, OR report and Time Sheet may be submitted.

**Specialty Restriction:**
RO=FPHN restricted to SP=GNSG
RO=SPHN restricted to SP=GNSG

**Location:**
LO=HOSP

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03R | **Family Physician Telephone Management/Follow Up with Patient**<br><br>**Description:**<br>This health service code may be reported for a 15 minute telephone communication between the family physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face visit by the same physician within the last 9 months and has not been seen within the last 7 days for the same condition. This telephone communication is intended to take the place of an office visit initiated by the patient (or the patient's parent, guardian or proxy as established by written consent) for a new condition or exacerbation of an existing condition, or a follow up visit that would have otherwise been scheduled by either the physician or the patient, when a physical examination is not required. The patient population eligible must be either 65 years and older or be suffering from mental illness or suffering from at least one chronic disease.<br>Chronic disease is defined as:<br>o A condition expected to last one year or more<br>o This condition requires ongoing medical management<br>Mental illness is defined as:<br>o A condition that meets criteria for a DSM diagnosis.<br>The service is not reported if the decision is to see the patient at the next available appointment in the office.<br><br>**Billing Guidelines:**<br>This health service is reportable for a synchronous communication by telephone (or other PHIA compliant synchronous electronic verbal communication) between the family physician and the patient (or the patients parent, guardian or proxy as established by written consent)<br>Telephone management requires synchronous communication between the patient and physician on a clinical level; the HSC is not reportable for administrative tasks.<br>The call must include a discussion of the clinical problem and management decision.<br>The family physician must have seen and examined the patient within the preceding 9 months.<br>The HSC is reportable for a maximum of 4 times per patient per year by the family physician and/or the practice providing ongoing comprehensive care to the patient.<br>The HSC is not reportable by walk-in clinics. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no requirement for an appointment, and episodic care with little or no follow-up. There is no standard patient roster and the patient list is constantly changing.<br>The HSC is not reportable for facility based patients.<br>The HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.<br>The service is not reportable when the purpose of the communication is to:<br>o Arrange a face-to-face appointment<br>o Notify the patient of an appointment<br>o Prescription renewal<br>o Arranging to provide a sick note<br>o Arrange a laboratory, other diagnostic test or procedure<br>o Inform the patient of the results of diagnostic investigations with no change in management plan<br>This service is not reportable for other forms of communication such as:<br>o Written, e-mail or fax communication<br>o Electronic verbal forms of communication that are not PHIA compliant. | 11.5 MSU |

BACK TO CONTENTS

| | | | |
|---|---|---|---|
| | | 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 professional such as:<br>○ Nurse Practitioner<br>○ Resident in training<br>○ Clinical fellow<br>○ Medical student<br>○ Clerical staff<br>The service is not reportable for telephone calls of less than 5 minutes of synchronous medical discussion<br><br>**Documentation Requirements:**<br>○ The date, start and stop times of the conversation must be noted in the medical record<br>○ The medical record must indicate the content of the discussion, the management plan and that the patient (or the patient's parent, guardian or proxy as established by written consent) understands and acknowledges the information provided.<br>○ The start and stop time of the call must be included in the text field of the MSI claim<br><br>**Specialty Restriction:**<br>SP=GENP<br><br>**Location:**<br>LO=OFFC | |
| VIST | 03.03Q | **Specialist Telephone Management/Follow Up with Patient**<br><br>**Description:**<br>This health service code may be reported for a 15 minute telephone communication between the specialist physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face consultation, visit or procedure by the same physician within the last 9 months and has not been seen within the last 7 days. This service is not reported if the outcome of the call is to see the patient at the next available appointment in the office. This communication is intended to take the place of an office follow up visit that would have otherwise been scheduled, when a physical examination of the patient is not required.<br><br>**Billing Guidelines:**<br>This health service is reportable for a synchronous communication by telephone (or other PHIA compliant synchronous electronic verbal communication) between the specialist physician and the patient (or the patient's parent, guardian or proxy as established by written consent)<br>Telephone management requires synchronous communication between the patient and physician on a clinical level; the HSC is not reportable for administrative tasks.<br>The call must include a discussion of the clinical problem and management decision.<br>The specialist physician must have seen and examined the patient within the preceding 9 months.<br>The HSC is reportable for a maximum of 4 times per patient per physician per year.<br>The HSC is not reportable for facility based patients.<br>The HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.<br>The service is not reportable when the purpose of the communication is to:<br>○ Arrange a face-to-face appointment<br>○ Notify the patient of an appointment<br>○ Prescription renewal | 11.5 MSU |

BACK TO CONTENTS

- Arrange a laboratory, other diagnostic test or procedure
- Inform the patient of the results of diagnostic investigations with no change in management plan

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 professional such as:

- Nurse Practitioner
- Resident in training
- Clinical fellow
- Medical student
- Clerical staff

The service is not reportable for telephone calls of less than 5 minutes of synchronous medical discussion.

**Documentation Requirements:**

- The date, start and stop times of the conversation must be noted in the medical record
- The medical record must indicate the content of the discussion, the management plan and that the patient (or the patient's parent, guardian or proxy as established by written consent) understands and acknowledges the information provided.
- A written report must be sent to the referring physician or family physician by the specialist consultant
- The start and stop time of the call must be included in the text field of the MSI claim

**Location:**
LO=OFFC

| Category | Code | Description | Base Units | Anaes Units |
|---|---|---|---|---|
| MISG | 23.99B | **Injection of Chemodenervating Agent into Extraocular Muscles for Strabismus**<br>AG=CH03<br><br>**Description:**<br>Chemodenervating agent (for example, onabotulinumtoxinA) injection of the extraocular muscle(s) for strabismus, unilateral or bilateral, in patients up to three years of age.<br><br>**Specialty Restriction:**<br>Paediatric OPTH<br><br>**Location:**<br>LO=HOSP | 25 MSU | 4+T |

**NOTE:**

**HEALTH SERVICE CODE CPO1 IS UNDER REVIEW AND WILL BE UPDATED IN A FUTURE BULLETIN.**

BACK TO CONTENTS

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| VT170 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.04J HAS ALREADY BEEN APPROVED FOR THIS PATIENT IN THE PREVIOUS 12 MONTHS. |
| VE020 | SERVICE ENCOUNTER HAS BEEN REFUSED AS AN INJECTION OF ONA FOR CHRONIC MIGRAINE HAS ALREADY BEEN APPROVED IN THE PREVIOUS 10 WEEKS. |
| VE021 | SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 11 INJECTIONS OF ONA FOR CHRONIC MIGRAINE MAY BE CLAIMED OVER A 24 MONTH PERIOD. IF TREATMENT CONTINUES TO BE RECOMMENDED AFTER THIS TIME PERIOD, PRIOR APPROVAL MUST BE REQUESTED AGAIN. |

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

### UPDATED FILES

Updated files reflecting changes are available for download on Thursday May 14th, 2020. 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**
https://novascotia.ca/dhw/

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BACK TO CONTENTS

PHYSICIAN'S BULLETIN
May 6, 2020: Vol. LXV, ISSUE 10

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# PHYSICIAN INCOME STABILITY PROGRAM

As published in the April 27th MSI Physicians Bulletin, Physicians have until May 7/20 to submit a completed declaration form if they would like to participate in the Physician Stabilization Program. Due to higher than expected call volumes and email requests, there may be a delay in responding to incoming inquires. If you do not receive a response to your inquiry by May 7, please be assured that you will have the opportunity to submit the declaration form once MSI is in contact with you.

## PHYSICIAN INCOME STABILITY PROGRAM Q&A

**Q: What will be included in MSI's calculation of my 2019 billings?**
**A:** MSI FFS billings will include all of a physician's billings to the MSI program for codes in the MSI tariff of fees for insured medical services, excluding the following billings:

- The unattached patient bonus
- Workers' Compensation
- Inpatient care billings (if the physician is a core team member of an approved Community Hospital Inpatient Program (CHIP) site), and
- Primary Maternity Care (PMC) billings if the physician is a core team member of a PMC.

If a physician has either increased or decreased their regular work hours since 2019, the base income will be adjusted accordingly (e.g., if a physician has gone from full-time to part-time, or vice versa).

**Q: Are chronic disease management codes excluded from the calculation?**
**A**: No, payment for chronic disease management codes are included in the 2019 FFS calculation.

**Q: Where can I obtain information on my 2019 billings so I can decide which option to choose?**
**A:** If physicians need information about their 2019 billing they can contact MSI at 902-496-7011 or toll-free 1-866-553-0585 (option 1/option 1) or email msiproviders@medavie.ca.

**Q: Will extended leaves in 2019 be taken into account when the income for the Physician Stabilization Program is calculated**?
**A**: Physicians will need to request special consideration when submitting the declaration form.

**Q: When will the first payment for this program be?**
**A:** The first biweekly payment under the program will be June 3/20. Physician declaration forms are due back to MSI by May 7, 2020.

## PHYSICIAN INCOME STABILITY PROGRAM Q&A

**Q: Where can I get more information on COVID-19 deployment?**
**A:** The Nova Scotia Health Authority is managing deployment efforts. Physicians seeking more information about deployment can contact physicianrecruit@nshealth.ca.

**Q: I am a family doctor who has been working in a COVID assessment clinic. To date, I have been paid at the GP sessional rate. Is the work I have done so far eligible to be paid at the pandemic sessional rate?**
**A:** Yes, the new pandemic sessional rate of $180.60 now applies to all COVID assessment clinic work.

**Q: Can I continue to bill FFS for my evening and weekend on call work?**
**A**: If a physician enters into the Physician Stabilization Program, these claims are to be shadow billed as they are included in the income within this program, with the exception for PMC and CHIP.

**Q: Can this program be prorated for part-time physicians?**
**A:** Yes, this program can be prorated for part time physicians.

**Q: Are FFS physicians who work at walk-in clinics able to apply for this program?**
**A:** Yes.

**Q: I am a new physician who began practising late in early 2020. Am I eligible to participate?**
**A**: Physicians who started their practice in Nova Scotia after 1 January 2020 will be eligible for a base income of $9,973 bi-weekly, based on a full-time practice, plus any COVID-19 deployment compensation as detailed in the *Program Terms*. That amount will be pro-rated for part time physicians. Please indicate this special circumstance on your physician declaration.

**Q: Can I opt into the program now and opt out later?**
**A**: As per the program terms, a physician may terminate their participation in the program *after July 1, 2020*, by providing written notice to the Minister at least two weeks in advance. The Minister may terminate a physician's participation in the program as described in clause 25 by providing written notice to the physician.

**Q: What are the accountability expectations within this program? Do I have to shadow bill?**
**A:** Physicians are required to shadow bill for all regular office or hospital-based services delivered within their practice while participating in the program. Shadow billings remain subject to billing rules and billing audit provisions.

**Q: I don't want to opt into this program. Can I still participate in COVID-19 deployment?**
**A:** Participation in the income stability program is voluntary. If you choose not to participate you can still be deployed and compensated for COVID-19 work. Please contact the NSHA to organize your COVID-19 deployment work.

## PHYSICIAN INCOME STABILITY PROGRAM Q&A

**Q: Can I refuse deployment?**

**A:** A physician may refuse a deployment request only in one of the following circumstances:

- the work is outside the physician's individual competence or contrary to the physician's license or any restrictions or conditions imposed by the College
- a lack of PPE results in an extraordinary risk to the physician
- the deployment would require the physician to breach public health orders (e.g. a requirement to self-isolate)
- the deployment would require the physician to travel greater than 120 kilometres one-way, and such travel would result in undue hardship to the physician (as determined by the Department).

**Q: If I refuse deployment, am I still eligible to participate in this program?**

**A**: When deploying physicians, the health authority or Minister will make reasonable efforts to accommodate limitations on the Physician's availability for deployment. If a physician refuses a deployment request, the physician must give notice in writing to the health authority and to the Minister outlining the reason for the refusal (and provide any further information or supporting information requested by the health authority and/or Minister) and remain available for other deployment as needed.

**Q: I have an AFP/APP as well as FFS billings for exclusions to my contract. Am I eligible for the stabilization funding for my FFS contract exclusions and my AFP/APP funding will continue?**

**A:** The income stability program will only apply to the FFS portion of your earnings. Physicians will remain eligible to receive other payments that are typically payable in addition to a physician's fee-for-service claims including:

- Master Agreement incentive programs
- Leadership/administrative stipends
- Pathology List B payments
- Facility on-call stipends
- Workers' compensation billings
- Payment under other programs or funding models for which the physician is eligible (including the Primary Maternity Care (PMC) Program
- Community Hospital Inpatient Program (CHIP), payment for Emergency Department or Hospitalist shifts, part-time APP or C/AFP entitlements, etc.)

**Q: Can I access other federal or provincial wage subsidy programs on top of this?**

**A:** This program does not restrict physicians from participating in other provincial or federal COVID stabilization initiative. However, participating physicians' consent to the disclosure of any information concerning financial assistance, support, insurance or indemnity of any kind received by the Physician in connection with the COVID-19 pandemic to the Minister. This could include COVID-19 pandemic related funding from the Government of Canada, the Government of Nova Scotia, the government of any other Canadian province, and any of their Ministers, Departments or related corporations or entities, and any other person or entity. It is recommended that physicians read the guidelines of the other provincial or federal programs carefully to ensure eligibility.

## PHYSICIAN INCOME STABILITY PROGRAM Q&A

**Q: Can I take a vacation or leave of absence if I participate in this program?**
**A:** A physician participating in this program may take a short leave of absence from practice during the pandemic, if approved in writing in advance by the Minister. Otherwise the physician must remain in NS (except as authorized to leave for work required by the health authority or the Department or for those who regularly commute to work in NS from NB). Please direct inquiries to Vimy Glass at Vimy.Glass@novascotia.ca

**Q: If my shadow billings under the program period exceed what I was paid, will I be eligible for a top-up for the difference between what I was paid and the value of my shadow billings?**
**A:** Physicians will shadow bill for all services delivered within their regular practice while participating in the program. If a physician shadow bills for non-deployment work more than their base income (Option 1 or Option 2), then the physician will be paid the difference. This will be paid to the physician following the end of the program.

**Q: When will retroactive payments from March 13 to the implementation date be made?**
**A:** All retroactive payments owing under the program (base income for the period of March 13, 2020 to the first bi-weekly pay period of the program) will be calculated and paid following termination of the program.

PHYSICIAN'S BULLETIN
April 29 2020: Vol. LXV, ISSUE 9

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# Notice to Physicians

## CMPA – CHANGE IN REBATE FREQUENCY

The Department of Health and Wellness (through MSI) will continue to provide reimbursement of all eligible Canadian Medical Protective Association (CMPA) fees directly to physicians. Payments will move from the current semi-annual schedule to a new quarterly payment schedule. The first quarterly payment will be for period January – March 2020 to be issued in spring 2020.

These payments are deposited through an electronic funds transfer. If you do not already have a CMPA Business Arrangement set up to receive these deposits, you may fill out the MSI Provider Business Arrangement Form with a void cheque.

Should you have any questions regarding your CMPA payments, please contact: masteragreement@novascotia.ca

PHYSICIAN'S BULLETIN
April 27 2020: Vol. LXV, ISSUE 8

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## Notice to Physicians

# INCOME STABILITY PROGRAM FOR FEE FOR SERVICE PHYSICANS DURING COVID-19

Recently the Department of Health and Wellness, Doctors Nova Scotia, IWK and the NSHA have worked together to address income stability for fee-for-service (FFS) physicians during COVID-19 and stabilize the supply of physicians to meet the demands of the health-care system during the pandemic. This voluntary income stability program compensates FFS physicians who commit to be available for redeployment as needed during the COVID-19 pandemic.

If you are a FFS physician and choose to participate, you may be deployed to do a variety of tasks in hospitals, assessment centres, long-term care centres or in other locations as needed and as safe and appropriate for your training. Under this program, when you are not deployed you are still required to continue to provide all normal office or hospital-based services (in person or virtually) to the best of your ability within the context of the pandemic.

The physician declaration form offers FFS Physician's two income stability options to choose from and lays out the program terms. Please read the declaration carefully.

If you elect to participate, please complete the declaration form and return it to MSI by May 7, 2020. Only those physicians having signed and returned the declaration form by May 7, 2020 will be eligible for this program unless evidence is provided of extenuating circumstances.

- mail: MSI, PO Box 500, Halifax, NS B3J 2S1
- email: msiproviders@medavie.ca, or
- fax: 902-469-4674

If you have questions or require assistance in competing this form, please contact MSI at 902-496-7011 or toll-free 1-866-553-0585 (option 1/option 1) or email msiproviders@medavie.ca.

Thank you for your leadership in the health care system during COVID-19.

PHYSICIAN'S BULLETIN
April 9 2020: Vol. LXV, ISSUE 7

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# Notice to Physicians

## COVID-19 UPDATE

**Physician Stabilization Program**

The Nova Scotia Department of Health and Wellness and Doctors Nova Scotia are in the process of finalizing details of an income stabilization program for Nova Scotia fee for service physicians.

Physicians wishing to participate in the program will receive a fixed bi-weekly income that will provide a base payment in lieu of their fee for service activities. These physicians will be eligible for additional payment for COVID-19 specific redeployment work.

While the program is optional, it is mandatory that all participating physicians agree to be redeployed as necessary to areas of need during the pandemic.

The program will be retroactive to March 13, 2020 and will end at the conclusion of the pandemic.

Details of this program are being finalized and more information will be made available in the coming days. In the meantime, fee for service physicians should continue to submit claims for their services as they normally would. Once further details are available, there will be adjustments made to payments for services rendered between March 13 and the implementation date.

Staff at MSI and the Nova Scotia Department of Health and Wellness thank Nova Scotia's physicians for their dedication to Nova Scotians during this unprecedented time.

PHYSICIAN'S BULLETIN
April 1 2020: Vol. LXV, ISSUE 6

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## Notice to Physicians

### WCB-SPECIFIC HEALTH SERVICE CODES FOR PHONE, TELEHEALTH, VIRTUAL CARE SERVICES PROVIDED DURING PANDEMIC

WCB Nova Scotia is committed to doing their part to help reduce the spread of COVID-19, and is following the directions of public health officials during these unprecedented times. They are encouraging the use of alternate service delivery methods to promote physical distancing, but also the continued delivery of care to workers.

Effective March 13, 2020 the following WCB-specific health service codes (normally for services rendered in an in-person setting) will be permitted to be billed whether they are provided in person, by telephone, via hospital telehealth network, or via PHIA-compliant virtual care platform:

WCB12 EPS Physician Assessment Service (combined office visit and completion of form 8/10)
WCB28 Comprehensive Visit for Work Related Injury or Illness
WCB31 WCB Interim Fee – Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed

During this time, these services will be paid at the same rate as they would be if delivered in person.

Please submit your claims as you usually would, using your regular practice location. However, for services **not rendered in-person** at that location, include one of the below on the claim to indicate how care was delivered:

- If service was provided over the phone, use: **Pandemic telephone**
- If service was provided over the hospital telehealth network, use: **Pandemic telehealth**
- If service was provided over a virtual care platform, use: **Pandemic virtual care**

As per usual, all encounters must be recorded in the patient's health record. If the health record is not available at the time care is provided, a note should be made and placed in the patient's health record as soon as feasible. This should include your location, if other than the office, and the technology used to deliver care.

All other office-based non-procedural health service codes associated with care being provided to workers during the COVID-19 pandemic (for example, 03.03, 03.03A) are billable as per the direction provided in the MSI Physician's Bulletins of March 18, 24 and 27, 2020.

PHYSICIAN'S BULLETIN
March 27 2020: Vol. LXV, ISSUE 5

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# Notice to Physicians

## COVID-19 UPDATE

As announced in the March 18, 2020 MSI Bulletin, effective March 13, 2020, health service code 03.03X is available for billing on an interim basis for telephone management and telehealth management for presumptive/confirmed Covid-19 diagnosis as well as routine/interval care during the pandemic.

March 18, 2020 Physician's Bulletin

As announced in the March 24, 2020 MSI Bulletin, effective March 13, 2020 on an interim basis all office-based non-procedural services that are normally rendered in a face to face setting will be permitted to be reported whether they are performed in person, by telephone, via telehealth network, or via PHIA compliant virtual care platform.

March 24, 2020 Physician's Bulletin

Both Bulletins state that these services are only reportable when the communication is rendered personally by the physician reporting the service is not reportable if the service is delegated to another professional such as a:

- Nurse Practitioner
- Resident in training
- Clinical Fellow
- Medical Student

Update:
Effective March 13, 2020, the services announced in the March 24 bulletin may be claimed if performed by a resident including a licensed post graduate medical trainee (e.g. PGY-6 or PGY-7) under the direct supervision of a physician. The clinical record must indicate that they were supervised as well as the name of the supervising physician. The supervising physician must be onsite at the time the resident renders the service and additionally must be immediately available to render assistance.

The physician may claim for either the resident's services or his/her own, but not both, if they are performed at the same time.

For clarity, health service code 03.03X can only be claimed when rendered personally by the physician and not when provided by a resident.

Neither health service code 03.03X nor the services announced on March 24 may be claimed when rendered by another health care provider such as a nurse or nurse practitioner.

*All services are only eligible to be claimed when rendered by a physician currently physically located in Nova Scotia.

PHYSICIAN'S BULLETIN
March 24 2020: Vol. LXV, ISSUE 4

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## Notice to Physicians

### IMPORTANT INFORMATION ON NON FACE TO FACE SERVICES PROVIDED DURING PANDEMIC

Last week the new health service code 03.03X was announced to facilitate the provision of synchronous clinical care by physicians to their patients using technology that supports non face to face encounters; Telephone, Telehealth, and PHIA compliant virtual care platforms. This was provided at the same rate as is afforded to physicians who provided comprehensive primary care to their patients (ME=CARE) and is meant to encourage provision of non face to face care wherever possible and appropriate.

**This new health service code will be available to load into your vendor software on Friday, March 27th. Once your vendor software has been updated, you may submit claims for any services rendered since March 13th.**

In view of the extenuating circumstances and recommendations for social distancing, and in order to promote continued delivery of patient care as seamlessly as possible, **effective March 13th, 2020 all office based non-procedural services that are normally rendered in a face to face setting will be permitted to be reported whether they are provided in person, by telephone, via telehealth network, or via a PHIA compliant virtual care platform**. Such services would include limited visits, consultations, psychotherapy, and counselling where appropriate to be delivered in a synchronous non face to face encounter. Long Term Care, Residential Care, and Hospice services normally rendered face to face due to medical necessity could be reported using this format. During this interim measure these services will be paid at the same rate as they would be if delivered face to face.

Please submit your claims for encounters as you usually would, using your normal practice location. For all services not rendered face to face at that location, include the following text on the claim to denote the mode of synchronous care delivery:

- If service was provided via phone call: **Pandemic telephone**
- If service was provided over the telehealth network: **Pandemic telehealth**
- If service was provided over a virtual care platform: **Pandemic virtual care**

If the service is rendered to a patient with suspected or confirmed diagnosis of Covid-19, include diagnostic code **487.8** in the appropriate diagnostic field. For the duration of the pandemic, diagnostic code 487.8 should only be used in confirmed or suspected cases of Covid-19. For other influenza strains please use a separate applicable diagnostic code.

## IMPORTANT INFORMATION ON NON FACE TO FACE SERVICES PROVIDED DURING PANDEMIC *(CONTINUED)*

**Please note:**

We recognize that due to the extenuating circumstances of these difficult times, the ability to perform a comprehensive physical examination using these platforms may be limited, otherwise the usual preamble requirements apply to all services.

- The HSC is not reportable for administrative tasks
- The service is not reportable when the purpose of the communication is to:
  - Arrange a face to face appointment
  - Notify the patient of an appointment
  - Renew prescription
  - Arranging to provide a sick note
  - Arrange a laboratory, other diagnostic test or procedure
  - Inform the patient of the results of diagnostic investigations with no change in management plan

The service is not reportable for other forms of communication such as:

- Written email or fax communication
- Electronic verbal forms of communication that are not PHIA complaint.

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 professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student

The service is not reportable if the decision is to see the patient at the next available appointment in the office or outpatient clinic and is not available for walk-in clinics. The HSC is reportable for Health Authority supported clinics.

All encounters must be recorded in the patient's health record. It is recognized that the health record may not be available at the time of the call, but a note should made and placed in health record as soon as feasible. This should include the location of the provider (if other than office) and the technology used to render the service.

Physicians should offer and book their telephone, telehealth and virtual appointments during the same time periods in the same manner as they would for face to face encounters.

PHYSICIAN'S BULLETIN
March 18 2020: Vol. LXV, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# Notice to Physicians

## COVID-19

Due to the current risk of Coronavirus (COVID-19) effective March 13, 2020 the following new interim service fee code is available for Telephone Management and Telehealth Management for presumptive/confirmed Covid-19 diagnosis as well as routine/interval care during pandemic.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03X | **Telephone Management and Telehealth Management for presumptive/confirmed Covid-19 as well as routine/interval care during pandemic**<br><br>**ME=TELE**<br>**ME=VTCR**<br><br>**Description**<br>Telephone or Telehealth communication between the physician and an established patient or a new patient seeking care during a pandemic (or patient's parent, guardian or proxy as established by written consent). Telephone or Telehealth communication is intended to take the place of an office visit initiated by the patient (or patient's parent, guardian or proxy as established by written consent). Telephone or Telehealth management requires two-way synchronous communication between the patient and physician on a clinical level.<br><br>**Billing Guidelines**<br>• Physicians to bill no more than 2 telephone or telehealth management sessions per patient per day.<br>• Ideally can differentiate between presumptive/confirmed diagnosis of Covid-19 or exacerbation of Covid-19, vs a follow up visit that would have otherwise been scheduled by either the physician or the patient, when a physical examination of the patient is not required. (i.e. Covid-19 related and non Covid-19 related)<br>• The encounter must include a discussion of the clinical problem and a management decision.<br>• The HSC is not reportable for administrative tasks.<br>• The service is not reported if the decision is to see the patient at the next available appointment in the office.<br>• The HSC is not available for walk-in clinics.<br>• The HSC is not reportable for facility-based patients.<br>• The HSC is reportable for Health Authority supported clinics. | 15.28 MSU<br>Increasing to:<br>15.95 MSU<br>Eff. April 1, 2020 |

The service is not reportable when the purpose of the communication is to:

- Arrange a face to face appointment
- Notify the patient of an appointment
- Prescription renewal
- Arranging to provide a sick note
- Arrange a laboratory, other diagnostic test or procedure
- Inform the patient of the results of diagnostic investigations with no change in management plan.

The service is not reportable for other forms of communication such as:

- Written email or fax communication
- Electronic verbal forms of communication that are not PHIA complaint.

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 professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student
- Clerical staff

.

**Documentation Requirements**

- Date, start and stop times of the conversation must be noted in the medical record.
- The medical record must indicate the content of the discussion, the management plan and that the patient (or patient's parent, guardian or proxy as established by written consent) understands and acknowledges the information provided.
- The start and stop time of the call must be included in the text field on the MSI claim
- Use ME=TELE for services provided over the telehealth network; or ME=VTCR if provided over a virtual care platform. For telephone calls, no additional modifier is required.
- If for a presumptive/confirmed diagnosis of Covid-19 submit electronic claim with diagnostic code: 487.8 Influenza with other manifestations.

**Specialty Restriction:**
N/A

**Premium:**
No evening/weekend premium

**Location:**
N/A

*Note: Please hold all eligible service encounters to allow MSI the required time to update the system. Once the system has updated it will be published that the code is available to submit.*

# PHYSICIAN'S BULLETIN

March 6 2020: Vol. LXV, ISSUE 2


NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## MSI News

### MSI UNIT VALUE CHANGES

#### MEDICAL SERVICE UNIT

Effective April 1, 2020, the Medical Service Unit (MSU) value will increase from $2.53 to $2.58.

#### ANAESTHESIA UNIT

Effective April 1, 2020, the Anaesthesia Unit (AU) value will increase from $21.56 to $22.71.

#### PSYCHIATRY FEES

Effective April 1, 2020, the hourly psychiatry rate for General Practitioners will increase to $150.60 while the hourly rate for Specialists increases to $204.20 as per the tariff agreement.

#### SESSIONAL FEES

Effective April 1, 2020 the hourly sessional payment rate for General Practitioners will increase to $154.80 and the hourly rate for Specialists will increase to $180.60 as per the tariff agreement.

#### EMERGENCY DEPARTMENT HOURLY RATES

Effective April 1, 2020 the regional emergency department hourly rate will increase to $232.51. Other levels will increase as per page 45 of the tariff agreement.

### WORKERS COMPENSATION BOARD UNIT VALUE CHANGES

#### WCB MEDICAL SERVICE UNIT

Effective April 1, 2020, the Workers Compensation Board Medical Service Unit (WCB MSU) value will increase from $2.81 to $2.87.

#### WORKERS COMPENSATION BOARD ANAESTHESIA UNIT

Effective April 1, 2020, the Workers Compensation Board Anaesthesia Unit (WCB AU) value will increase from $23.96 to $25.23.

## UPDATED FEES

**Workers' Compensation Board Medical Service Unit 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 2019-20, as well as 2020-21.

Due to the increase in CPI for 2018 and 2019, all of the WCB specific services listed below will have their values increased by 2.2% effective April 1st, 2019 followed by an additional increase of 2.09% effective April 1st, 2020:

| CODE | DESCRIPTION | APRIL 2019 VALUE | APRIL 2020 VALUE |
|---|---|---|---|
| WCB12 | EPS physician assessment Service.<br>Combined office visit and completion of Form 8/10<br>For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15 minute increments to a maximum of 1 additional hour | **Initial visit:**<br>$184.00 + $53.78 per 15 minutes to a maximum 4x<br>(RO=EPS1 and RP=INTL)<br><br>**Subsequent visit:**<br>$184.00<br>(RO=EPS1 and RP=SUBS) | **Initial visit:**<br>$187.87 + $54.93 per 15 minutes to a maximum 4x<br>(RO=EPS1 and RP=INTL)<br><br>**Subsequent visit:**<br>$187.87<br>(RO=EPS1 and RP=SUBS) |
| WCB13 | Chart Summaries / Written Reports.<br>Detailed reports billed in 15-minute intervals<br>- plus multiples, if applicable | GPs……$44.96 per 15 min<br>EPS(RO=EPS1) $53.78 per 15 min<br><br>Specialists……..$60.50 per 15 min | GPs……$45.92 per 15 min<br>EPS(RO=EPS1) $54.93 per 15 min<br><br>Specialists……..$61.79 per 15 min |
| WCB15 | Case Conferencing and Teleconferencing (Treating Physician)<br>Conferencing billed by the Treating Physician<br>- plus multiples, if applicable | GPs……$44.96 per 15 min<br>EPS(RO=EPS1) $53.78 per 15 min<br><br>Specialists……..$60.50 per 15 min | GPs……$45.92 per 15 min<br>EPS(RO=EPS1) $54.93 per 15 min<br><br>Specialists……..$61.79 per 15 min |
| WCB17 | Photocopies of Chart Notes | 10 pgs or less (ME=UP10)……..$26.92<br>11-25 pgs (ME=UP25)……..$53.76<br>26-50 pgs (ME=UP50)….. $107.48<br>Over 50 pgs (ME=OV50)…...$161.21 | 10 pgs or less (ME=UP10)……..$27.49<br>11-25 pgs (ME=UP25)……..$54.93<br>26-50 pgs (ME=UP50)….. $109.75<br>Over 50 pgs (ME=OV50)…...$164.59 |
| WCB20 | Carpal Tunnel Syndrome (CTS) Assessment Report | $68.99 | $70.46 |
| WCB21 | Follow-up visit report | $40.35 | $41.21 |
| WCB22 | Completed Mandatory Generic Exemption Request Form | $13.49 per form | $13.78 per form |
| WCB23 | Completed Non-Opioid Special Authorization Request Form | $13.49 per form | $13.78 per form |
| WCB24 | Completed Opioid Special Authorization Request Form | $45.21 per form | $46.18 per form |
| WCB25 | Completed WCB Substance Abuse Assessment Form | $30.12 | $30.77 |
| WCB26 | Return to Work Report – Physician's Report Form 8/10 | $68.99 | $70.46 |

| CODE | DESCRIPTION | APRIL 2019 VALUE | APRIL 2020 VALUE |
|---|---|---|---|
| WCB27 | Eye Report | $60.50 | $61.79 |
| WCB28 | Comprehensive Visit for Work Related Injury or Illness | $69.41 | $70.89 |
| WCB29 | Initial Request Form For Medical Cannabis | $74.89 | $76.49 |
| WCB30 | Extension Request Form For Medical Cannabis | $44.96 | $45.92 |
| WCB31 | WCB Interim Fee – Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed | $69.41 | $70.89 |

*Note: these increases will be automatically applied to any claims with a date of service on or after March 6, 2020. Claims made with service dates from April 1, 2019 – March 5, 2020 will be identified and a retroactive payment will be sent to physicians once the 90 day window for these services has elapsed.*

## FEE REVISIONS

**INCREASES IN COMPREHENSIVE PRIMARY CARE FEE CODES**

As per the master agreement, the following fees shall have their values increased for family physicians.
(New Value is the value effective April 1, 2020)

| | Old Value | New Value |
|---|---|---|
| **Description** | **MSU** | **MSU** |
| Office Visit (ME=CARE) | 15.28 | 15.95 |
| Geriatric Office Visit (ME=CARE) | 18.90 | 19.73 |
| Office Visit After-Hours (ME=CARE) | 19.10 | 19.94 |
| Geriatric Office Visit After-Hours (ME=CARE) | 23.63 | 24.67 |
| Office Visit – Well Baby Care (ME=CARE) | 15.28 | 15.95 |
| Office Visit Well Baby Care After-Hours (ME=CARE) | 19.10 | 19.94 |
| Office Visit Prenatal Care (ME=CARE) | 15.28 | 15.95 |
| Office Visit Prenatal Care After-Hours (ME=CARE) | 19.10 | 19.94 |
| Office Visit Postnatal Care After-Hours (ME=CARE) | 24.58 | 25.67 |
| Subsq. Inpatient Care Visit (Days 2, 3) | 23.81 | 24.85 |
| Subsq. Inpatient Care Visit – Newborn (Days 2, 3) | 23.81 | 24.85 |
| Subsq. Inpatient Care Visit – Post-Partum (Days 2, 3) | 23.81 | 24.85 |
| Subsq. Inpatient Care Visit (Days 4-7) | 19.67 | 20.53 |
| Subsq. Inpatient Care Visit – Post-Partum (Days 4-7) | 19.67 | 20.53 |
| Subsq. Inpatient Care Visit (Daily to 56 days) | 16.56 | 17.29 |
| Subsq. Inpatient Care Visit (Weekly after Day 56) | 16.56 | 17.29 |

**INCREASES IN PSYCHIATRY FEE CODES**

As per the master agreement, the following fees shall have their values increased for psychiatrists.
(New Value is the value effective April 1, 2020) *Note: these increases are for psychiatrists only*

| | Old Value | New Value |
|---|---|---|
| **Description** | **MSU** | **MSU** |
| Routine Psychiatric Visit (08.5B) | 38.16 | 42.68 |
| Psychotherapy (08.49B) | 38.32 | 43.25 |
| Comprehensive Consultation (03.08) | 82.30 | 94.85 |
| Child Psychiatric Assessment (08.19A) | 42.08 | 48.87 |
| Group Therapy (08.44) | 9.63 | 11.66 |
| Therapeutic/Diagnostic Interview Relating to a child (08.19B) | 38.30 | 43.23 |

BACK TO CONTENTS

## INCREASES IN OBSTETRIC AND GYNECOLOGY FEE CODES

As per the master agreement, the following fees shall have their values increased for obstetrics and gynecology services.
(New Value is the value effective April 1, 2020)

**Gynecology Fee Code Changes**

| HSC | Description | Old Value MSU | New Value MSU |
|---|---|---|---|
| 03.03V | Medical Abortion/Termination of early pregnancy | 47.50 | 62.63 |
| 80.89A | Abortion – Incomplete; examination of the uterus without D&C or anaes. | 25.00 | 32.96 |
| 79.1 | Conization of cervix including colposcopy | 51.00 | 67.24 |
| 87.21 | Dilation and Curettage for termination of pregnancy | 71.00 | 93.61 |
| 81.09 | Other Dilation and Curettage | 42.50 | 56.04 |
| 81.09A | Endocervical Curettage | 10.00 | 13.19 |
| 98.12V | Curettage of warts, including papillomata, keratosis, nevi, moles, pyogenic granulomata, etc., for malignant or recognized pre-malignant condition | 12.00 | 15.82 |
| 81.69A | Endometrial Biopsy | 19.00 | 25.05 |
| 80.4C | Laparoscopic Hysterectomy | 300.00 | 395.55 |
| 80.3 | Total Abdominal Hysterectomy | 240.00 | 316.44 |
| 80.4A | Vaginal Hysterectomy – uterus-total vaginal w/ rectocoele / cystocoele repair | 287.00 | 378.41 |
| 80.4 | Vaginal Hysterectomy (subtotal) | 240.00 | 316.44 |
| 80.2A | Subtotal Abdominal Hysterectomy | 240.00 | 316.44 |
| 80.3A | Uterus – total abdominal w/ rectocoele / cystocoele repair | 287.00 | 378.41 |
| 80.3C | Abdominal hysterectomy with salpingo-oophorectomy including bilateral selective pelvic lymphadenectomies, omental biopsy / selective periaortic | 400.00 | 527.40 |
| 77.19C | Laparoscopic ovarian cystectomy | 150.00 | 197.78 |
| 86.3A | Surgical removal of extrauterine (ectopic) preg. by any means (incl. tubal) | 130.00 | 171.41 |
| 78.1A | Salpingectomy for morbidity, not for sterilization | 130.00 | 171.41 |
| 10.16 | Insertion of vaginal pessary | 23.50 | 30.98 |
| 80.19A | Other excision or destruction of lesion of uterus myomectomy | 160.00 | 210.96 |
| 82.81A | Colposcopy | 8.50 | 11.21 |
| 78.39A | Interruption or removal of fallopian tubes for sterilization purposes | 105.00 | 138.44 |
| 77.51 | Removal of both ovaries and tubes | 195.00 | 257.11 |
| 80.81 | Hysteroscopy | 42.50 | 56.04 |
| 77.19A | Salpingectomy and salpingo-oophorectomy | 130.00 | 171.41 |

**Obstetric Fee Code Changes**

| HSC | Description | Old Value MSU | New Value MSU |
|---|---|---|---|
| 87.98 | Delivery (RF=REFD, SP=OBGY) | 260.00 | 342.81 |
| 87.98 | Delivery (SP=OBGY or SP=GENP; RF=REFD) | 200.00 | 263.70 |
| 86.1 | Cervical Caesarean Section | 260.00 | 342.81 |
| 84.79 | Other Vacuum Extraction | 260.00 | 342.81 |
| 86.1A | Caesarean section with tubal ligation | 280.00 | 369.18 |
| 84.71 | Vacuum extraction with episiotomy | 260.00 | 342.81 |
| 84.0 | Low forceps delivery without episiotomy | 260.00 | 342.81 |
| 84.1 | Low forceps delivery (with episiotomy) | 260.00 | 342.81 |
| 84.8 | Other specified instrumental delivery | 260.00 | 342.81 |
| 84.29 | Other mid forceps delivery | 260.00 | 342.81 |
| 84.21 | Mid forceps delivery (with episiotomy) | 260.00 | 342.81 |
| 84.53 | Total breech extraction | 260.00 | 342.81 |
| 84.51 | Breech extraction, unqualified | 260.00 | 342.81 |
| 84.31 | High forceps delivery with episiotomy | 260.00 | 342.81 |
| 84.39 | Other high forceps delivery | 260.00 | 342.81 |
| 84.52 | Partial breech extraction | 260.00 | 342.81 |
| 84.61 | Partial breech extraction with forceps to aftercoming head | 260.00 | 342.81 |
| 84.62 | Total breech extraction with forceps to aftercoming head | 260.00 | 342.81 |
| 84.9 | Unspecified instrumental delivery | 260.00 | 342.81 |

BACK TO CONTENTS

**INCREASES IN OBSTETRIC AND GYNECOLOGY FEE CODES *(continued)***

As per the master agreement, the following fees shall have their values increased for obstetrics and gynecology services.
(New Value is the value effective April 1, 2020)

**Gynecology and Obstetrics Fee Code Changes**

| HSC | Description | Old Value MSU | New Value MSU |
|---|---|---|---|
| 81.8 | Insertion of intra-uterine contraceptive device | 32.00 | 42.19 |
| 81.01 | Dilation and curettage following delivery or abortion | 57.00 | 75.15 |
| 86.61 | Aspiration curettage following delivery or abortion | 57.00 | 75.15 |

**OB/GYN Consultation Fee Code Changes**

| HSC | Description | Old Value MSU | New Value MSU |
|---|---|---|---|
| 03.08 | Comprehensive Consultation (Prolonged) | 35.10 | 37.60 |
| 03.07 | Limited Consultation | 24.50 | 27.00 |
| 03.07 | Repeat Consultation (Prolonged) | 22.50 | 25.00 |

Effective March 6, 2020 the ADON health service code 99.09A has been revised as follows:

| Category | Code | Description | Base Units | Anesthesia Units |
|---|---|---|---|---|
| ADON | 99.09A | **BMI Surgical Premium**<br><br>**Description:**<br>This premium may be reported by physicians providing surgical services, as described in the billing guidelines, and general or neuraxial anaesthesia for a patient with a body mass index (BMI) greater than or equal to 40.<br><br>**Billing Guidelines:**<br>Billable once per patient per physician in addition to the amount payable for the major procedure(s) where a patient with an elevated BMI undergoes surgery to the neck, hip, or trunk and:<br>a) Has a body mass index (BMI) greater than or equal to 40 and this is recorded in the patient's health record<br>b) The procedure is performed using an open technique through an incision for major neck and hip surgery and an open or laparoscopic technique for the trunk and is performed under general, or neuraxial anaesthesia.<br>c) The principle technique is neither aspiration, core or fine needle biopsy, dilation, endoscopy, cautery, ablation, nor catheterization.<br>d) Not billable for bariatric surgery.<br><br>**Location:**<br>LO=HOSP | 32.9 MSU | 4.6 AU |

BACK TO CONTENTS

## PREAMBLE CHANGE

| Current Definition | New Definition |
|---|---|
| **Morbid Obesity (5.2.38)**<br><br>When providing general, or neuraxial anaesthesia for a patient with a body mass index (BMI) greater than 50, the units will be increased.<br>a) Has a BMI (body mass index) greater than 50 and this is recorded in the patient's health record. | **Morbid Obesity (5.2.38)**<br><br>When providing general, or neuraxial anaesthesia for a patient with a body mass index (BMI) greater than or equal to 40, the units will be increased.<br>a) Has a BMI (body mass index) greater than or equal to 40 and this is recorded in the patient's health record. |
| **Morbid Obesity Add on Fee (5.3.85)**<br><br>a) has a BMI (body mass index) greater than 50 and this is recorded in the patient's health record. | **Morbid Obesity Add on Fee (5.3.85)**<br><br>a) has a BMI (body mass index) greater than or equal to 40 and this is recorded in the patient's health record. |

## NEW FEES

Effective March 6, 2020 the following codes are available for billing:

| Category | Code | Description | Base Units | Anesthesia Units |
|---|---|---|---|---|
| MASG | 52.31A | **Resection of Upper Aerodigestive Tract Malignancy with Lymphadenectomy**<br><br>**Description**<br>This is a comprehensive health service code for the resection of an upper aerodigestive tract (nasal cavity, oral cavity, oropharynx, hypopharynx, larynx, trachea and esophagus) malignancy and lymphadenectomy of at least two contiguous levels (e.g. levels I-III neck dissection, levels II-IV neck dissection). All necessary ablative procedures, resection of multiple soft tissue and bony subsites, resection of cranial or peripheral nerves, and ligation of major vessels are included in this HSC. Nerve monitoring via EMG, placement of NG tube and tracheostomy tube are included. A diagnosis of malignancy must be established preoperatively, by intraoperative frozen section, or on final pathology. Complex reconstruction by pedicled flaps or free tissue transfer may be reported in addition to this HSC. **If the case time exceeds 5 hours based on actual case start time to actual end time (or the time the primary surgeon leaves the case) then report EC @ 160 MSU/hr** with operative note and operating room record.<br><br>**Billing Guidelines**<br>This is a comprehensive fee not to be reported with other resection, ablative or lymphadenectomy codes.<br>May be reported with reconstruction by pedicled flaps or free tissue transfer.<br>Usual rules of multiples apply.<br><br>**Specialty Restriction:**<br>SP=OTOL members of the head and neck subsection within the Dalhousie Division of ORL-HNS*<br><br>**Location:**<br>LO=HOSP – Restricted to QEII site only | 800 MSU | 10 + T |

| Category | Code | Description | Base Units | Anesthesia Units |
|---|---|---|---|---|
| MASG | 38.39C | **Resection of Salivary Gland Malignancy with Lymphadenectomy**<br><br>This is a comprehensive health service code for the resection of a salivary gland (parotid, submandibular, sublingual) malignancy and lymphadenectomy of at least two contiguous levels (e.g. levels I-III neck dissection, levels II-IV neck dissection). All necessary ablative procedures, resection of multiple soft tissue and bony subsites, resection of cranial or peripheral nerves, and ligation of major vessels are included in this HSC. Nerve monitoring via EMG, placement of NG tube and tracheostomy tube are included. A diagnosis of malignancy must be established preoperatively, by intraoperative frozen section, or on final pathology. Complex reconstruction by pedicled flaps or free tissue transfer may be reported in addition to this HSC. **If the case time exceeds 4 hours based on actual case start time to actual end time (or the time the primary surgeon leaves the case) then report EC @ 160 MSU/hr** with operative note and operating room record.<br><br>**Billing Guidelines**<br>This is a comprehensive fee not to be reported with other resection, ablative or lymphadenectomy codes.<br>May be reported with reconstruction by pedicled flaps or free tissue transfer.<br>Usual rules of multiples apply.<br><br>**Specialty Restriction:**<br>SP=OTOL members of the head and neck subsection within the Dalhousie Division of ORL-HNS*<br><br>**Location:**<br>LO=HOSP – Restricted to QEII site only | 640 MSU | 10 + T |

| Category | Code | Description | Base Units |
|---|---|---|---|
| VADT | 01.09D | **Bronchoscopy and Endobronchial Ultrasound (EBUS) with sampling of one or two mediastinal nodal stations and or hilar nodal stations or structures.**<br><br>**Description**<br>This is a comprehensive health service code to include diagnostic bronchoscopy, including imaging guidance where required, and endobronchial ultrasound guided transbronchial sampling of one or two mediastinal and/or hilar nodal stations or structures.<br><br>**Billing Guidelines**<br>Report number of stations or structures in text.<br>For complex cases, such as endobronchial debulking of tumor, report EC with operative report and time to be remunerated at 125 MSU/hr.<br>**Not to be reported** with other bronchoscopy HSCs:<br>01.08A Transbronchial lung biopsy with fiberscope<br>01.09 Other non-operative bronchoscopy<br>01.09A Bronchoscopy with biopsy<br>01.09B Bronchoscopy with foreign body removal<br>**Not to be reported** with mediastinoscopy HSCs:<br>46.82 Mediastinoscopy<br>46.82A Mediastinoscopy with flexible bronchoscopy<br>46.82B Mediastinoscopy with rigid bronchoscopy<br><br>**Specialty Restriction:**<br>SP=RSMD with fellowship in interventional thoracic surgery and CASG (Thoracic surgeons) with EBUS training in their fellowship<br><br>**Location:**<br>LO=HOSP – Restricted to QEII site only | 125 MSU |

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| VADT | 01.09E | **Bronchoscopy and Endobronchial Ultrasound (EBUS) with sampling of three or more nodal stations and or hilar nodal stations or structures.**<br><br>**Description**<br>This is a comprehensive health service code to include diagnostic bronchoscopy, including imaging guidance where required, and endobronchial ultrasound guided transbronchial sampling of three or more mediastinal and/or hilar nodal stations or structures.<br><br>**Billing Guidelines**<br>Report number of stations or structures in text.<br>For complex cases, such as endobronchial debulking of tumor, report EC with operative report and time to be remunerated at 125 MSU/hr.<br>**Not to be reported** with other bronchoscopy HSCs:<br>01.08A Transbronchial lung biopsy with fiberscope<br>01.09 Other non-operative bronchoscopy<br>01.09A Bronchoscopy with biopsy<br>01.09B Bronchoscopy with foreign body removal<br>**Not to be reported** with mediastinoscopy HSCs:<br>46.82 Mediastinoscopy<br>46.82A Mediastinoscopy with flexible bronchoscopy<br>46.82B Mediastinoscopy with rigid bronchoscopy<br><br>**Specialty Restriction:**<br>SP=RSMD with fellowship in interventional thoracic surgery and CASG (Thoracic surgeons) with EBUS training in their fellowship<br><br>**Location:**<br>LO=HOSP – Restricted to QEII site only | 150 MSU |

**Teaching Stipend**

As per the master agreement, effective April 1, 2020 the following codes will be availble for physician preceptors on an alternate payment plan to shadow bill the value of their teaching stipend when assuming responsibility for a Medical Student or a Resident Elective:

| Category | Code | Description | Base Units |
|---|---|---|---|
| DEFT | TESP1 | TEACHING STIPEND FOR MEDICAL STUDENT | 0 |
| DEFT | TESP2 | TEACHING STIPEND FOR RESIDENT ELECTIVE | 0 |

A teaching Stipend may only be claimed once per week per medical student/resident elective you are respnsible for. To shadow bill teaching stipend please use health card number 0000002352 with date of birth April 1, 1969. Diagnostic code V623 should also be included on the claim.

BACK TO CONTENTS

# UPDATES

## Amendment

HSC 87.98A Add On for Detention during Obstetrical Delivery (for attendance beyond three hours) had indicated the maximum number of multiples for 8 hours was 33. This has been corrected as the maximum of 8 hours is 21 multiples.

## Facility On-Call for APP Specialist

Effective October 25, 2019, APP Specialists are eligible to bill Fee-For-Service (FFS) for Facility On-Call. APP Specialists who are eligible and wish to bill FFS for Facility On-Call must have a FFS Business Arrangement (BA) set up by MSI, if there is not an existing FFS BA. The BA form and contact information can be found at: https://msi.medavie.bluecross.ca/update-registration/

It is recognized that there may be claims with dates of service past the 90 day limit for claim submissions. An exception has been made to allow billing of outdated Facility On-Call claims with dates of service between October 25, 2019 to December 31, 2019. All outdated claims from this time period must be submitted no later than March 31, 2020. For information required to submit outdated claims contact: MSI_Assessment@medavie.bluecross.ca

APP Specialists who have submitted shadow claims from October 25, 2019 forward for Facility On-Call may reverse the claims and resubmit as FFS once a BA has been set up by MSI.

## Clinic Sessional

Sessional arrangements are established for clinical services. With the exception of a few unique clinics, submission of claim forms without associated shadow billing will not be paid. If a clinic is cancelled due to inclement weather, closure of a facility, etc., the physician may reschedule that clinic for a later date and claim for those services. When submitting such claims, they should provide a summary on the claim form.

In cases where patients do not present for scheduled clinics and there is no shadow billing for a particular date, the physician should provide a summary of the unbillable services they provided for consideration and approval of payment. Physicians should expect to provide additional information to Medavie upon request where necessary to make an assessment.

## Upcoming Changes

Please note that health service code 50.0B Endovascular Thrombectomy-Intracranial will be revised to permit surgical assist claims. More information will be available in the upcoming May 2020 Physician's Bulletin.

Please note there are upcoming changes to the billing guidelines for health service code 13.59O Injection of OnabotulinumtoxinA for the treatment of Chronic Migraine (prior approval). More information will be available in the upcoming May 2020 Physician's Bulletin.

BACK TO CONTENTS

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| GN104 | SERVICE ENCOUNTER HAS BEEN REFUSED. HEALTH CARD NUMBER IS NOT VALID FOR SERVICE PROVIDED. |
| VA097 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 01.09D OR 01.09E FOR THIS PATIENT AT THE SAME ENCOUNTER. |
| VA098 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 01.08A, 01.09, 01.09A OR B, 46.82, 46.82A OR B FOR THIS PATIENT AT THE SAME ENCOUNTER. |
| VA099 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE NOT INCLUDED TEXT STATING THE NUMBER OF STATIONS OR STRUCTURES. |

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

### UPDATED FILES

Updated files reflecting changes are available for download on Friday March 6th, 2020. 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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BACK TO CONTENTS

PHYSICIAN'S BULLETIN
January 24th 2020: Vol. LXV, ISSUE 1

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## Notice to Physicians

# ALTERNATIVE PAYMENT PLAN (APP) SPECIALISTS BILLING FEE FOR SERIVCE (FFS) WHILE ON-CALL

Effective October 25, 2019, APP Specialists are eligible to bill FFS for services delivered while on-call. APP Specialists who are eligible and wish to bill FFS must have a FFS Business Arrangement (BA) set up by MSI, if there is not an existing FFS BA. The BA form and contact information can be found at: https://msi.medavie.bluecross.ca/update-registration/

It is recognized that there may be claims with dates of service past the 90 day limit for claim submissions. An exception has been made to allow billing of outdated claims for services delivers while on-call with dates of service between October 25, 2019 to December 31, 2019. All outdated claims from this time period must be submitted no later than March 31, 2020. For information required to submit outdated claims contact: MSI_Assessment@medavie.bluecross.ca

APP Specialists who have submitted shadow claims for services delivered while on-call from October 25, 2019 forward may reverse the claims and resubmit as FFS once a BA has been set up by MSI.

PHYSICIAN'S BULLETIN
December 31st 2019: Vol. LXIV, ISSUE 18

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## Notice to Physicians

### UNATTACHED PATIENT BONUS INCENTIVE UPCOMING END DATE

Effective March 1st, 2020, the unattached patient bonus incentive (health service code UPB1) will no longer be available for billing. Physicians who take on patients prior to March 1st and who meet the current criteria are advised to submit their claims within 90 days of the date of service.

*Revised January 3, 2020*

# PHYSICIAN'S BULLETIN

December 13th, 2019: Vol. LXIV, ISSUE 17


NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## MSI News

### MSI UNIT VALUE CHANGES

#### MEDICAL SERVICE UNIT

Effective April 1, 2019, the Medical Service Unit (MSU) value will be increased from $2.48 to $2.53.
*Note: This increase was automatically implemented on any claims made with a date of service on or after November 29, 2019. Claims made with service dates from April 1, 2019 – November 28, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window for these services has elapsed.*

#### ANAESTHESIA UNIT

Effective April 1, 2019, the Anaesthesia Unit (AU) value will be increased from $21.07 to $21.50, followed by an additional increase to $21.56 effective October 25, 2019.
*Note: The current $21.56 value was automatically implemented on any claims made with a service date on or after November 29, 2019. Claims made with service dates from April 1, 2019 – November 28, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window for these services has elapsed*.

#### PSYCHIATRY FEES

Effective April 1, 2019 the hourly Psychiatry rate for General Practitioners has increased to $115.60 while the hourly rate for Specialists increased to $156.74 as per the tariff agreement. An additional increase effective October 25, 2019 has raised the hourly Psychiatry rate for General Practitioners to $137.85 and the hourly rate for Specialists increased to $186.91.
*Note: These rates will automatically take effect on any claims made as of December 13th. Claims made with service dates from April 1, 2019 – December 12, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window for these services has elapsed.*

### WORKERS COMPENSATION BOARD MEDICAL SERVICE UNIT

Effective April 1, 2019, the Workers Compensation Board Medical Service Unit (WCB MSU) value will be increased from $2.76 to $2.81.
*Note: This increase was automatically implemented on any claims made with a date of service on or after December 13, 2019. Claims made with service dates from April 1, 2019 – December 12, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window for these services has elapsed.*

### WORKERS COMPENSATION BOARD ANAESTHESIA UNIT

Effective April 1, 2019, the Workers Compensation Board Anaesthesia Unit (WCB AU) value will be increased from $23.41 to $23.89, followed by an additional increase to $23.96 effective October 25, 2019.
*Note: The current $23.96 value was automatically implemented on any claims made with a service date on or after December 13, 2019. Claims made with service dates from April 1, 2019 – December 12, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window for these services has elapsed.*

### PROVIDER PROFILE CHANGES

This year Provider Profiles will only be sent out by request. If you would like to receive your Provider Profile for 2018/19 please send your request by email to: MSI_Assessment@Medavie.Bluecross.ca
In the email please include: your name, your provider number, and the profile will be mailed to the address on file.

## ★ Fees New Fees and Fee Revisions

## NEW FEES

Effective November 1, 2019 the following code is available for billing:

| Category | Code | Description | Base Units |
|---|---|---|---|
| ADON | 13.34A | **Rotavirus Immunization**<br><br>**Description**<br>Rotavirus vaccine, administered orally.<br>Immunization to occur at 2, 4, and 6 months of age.<br><br>**Billing Guidelines**<br>• Maximum three claims of rotavirus immunization per patient per lifetime.<br>• May only be claimed for patients born on or after November 1, 2019.<br>• May not be claimed for patients greater than 8 months old.<br>• Follows normal provincial immunization billing guidelines with one exception – a tray fee may not be claimed for this immunization. | 6 MSU |

BACK TO CONTENTS

Effective December 13, 2019 the following codes are available for billing:

| Category | Code | Description | Base Units |
|---|---|---|---|
| MASG | 98.99H | **MOHS Micrographic surgery (MMS) for the Removal of a Histologically Confirmed Cutaneous Malignancy – Initial Level and Debulking**<br><br>**Description**<br>This HSC is specific to the Mohs micrographic surgery (MMS) technique for the removal of a histologically confirmed cutaneous malignancy. Reportable only when the preparation of slides is rendered or supervised by the Mohs surgeon claiming the MMS code(s) and all microscopic tissue sections are personally reviewed and interpreted by the Mohs surgeon. If a pathologist reviews the slides and claims for service, the Mohs physician may not report using these codes.<br>Closure of the wound by undermining or advancement flaps is included in this service. When a more complex closure is required, such as rotation flaps, transposition or skin grafting, it may be reported and paid in full (100%) for the first HSC reported followed by the usual rates for multiples.<br>Other lesions addressed by the same surgeon, same day will be paid according to rules of multiples.<br><br>**Billing Guidelines**<br>• Payable once per surgeon per lesion – even if the service extends more than one day.<br>• May not be reported if there is a pathology claim for the same patient same day.<br>• Complex closure may be reported at 100% for the first HSC once per MMS lesion.<br>• If additional closure HSC is reported, the usual rules of multiples apply.<br>• May be reported with:<br>○ 98.51B Local tissue shifts with free skin graft to secondary defect - single<br>○ 98.51C Local tissue shifts – advancements, rotations, transpositions, 'Z' plasty - single<br>○ 98.51D Local tissue shifts– advancements, rotations, transpositions, 'Z' plasty - multiple<br>○ 98.51E Local tissue shifts with free skin graft to secondary defect - multiple<br>○ 98.53A Local tissue shifts, advancements, rotations, transpositions, 'Z' plasty, etc., eyebrow, eyelid, lip, ear, nose – single<br>○ 98.53B Local tissue shifts, advancements, rotations, transpositions, 'Z' plasty, etc., eyebrow, eyelid, lip, ear, nose – two stages<br>• Other non-MMS lesions same patient, same day are subject to the rules of multiples.<br><br>**Specialty Restriction:**<br>SP=DERM<br>SP=PLAS<br>(with proof of Mohs Micrographic surgery fellowship in keeping with the standards of the American College of Mohs Surgery (ACMS) | 155 MSU |
| ADON | 98.99I | **Additional Levels (Comprehensive of all additional levels required for complete excision)**<br><br>**Billing Guidelines**<br>Payable once per surgeon per lesion<br><br>**Specialty Restriction:**<br>SP=DERM<br>SP=PLAS<br>(with proof of Mohs Micrographic surgery fellowship in keeping with the standards of the American College of Mohs Surgery (ACMS) | 135 MSU |

BACK TO CONTENTS

## NEW FEES (CONTINUED)

Effective October 25, 2019 the following code is available for billing:

| Category | Code | Description | Base Units |
|---|---|---|---|
| ADON | 87.98A | **Detention During Obstetrical Delivery (for attendance beyond three hours)**<br>**RO=DETE**<br><br>**Description**<br>Detention time for obstetrical delivery performed by a family physician when the physician is required to be in attendance beyond three hours, notwithstanding clause 5.2.75 *(see below)* of the Physicians Manual (2014). Each 15 minute time increment beyond three hours has a rate of 12.5 MSU to a maximum of 8 hours.<br><br>**Billing Guidelines**<br>May only be claimed as an add-on for HSC 87.98 Delivery NEC.<br>1 multiple = 3 hours with patient<br>2 multiples = 3 hours, 15 minutes<br>3 multiples = 3.5 hours<br>4 multiples = 3.75 hours<br>5 multiples – 4 hours<br>etc. to a maximum of:<br>21 multiples = 8 hours<br><br>**Specialty Restriction**<br>SP=GENP<br><br>{ATTENDANCE AT LABOUR AND DELIVERY*(5.2.75)*<br>This is a service involving constant or periodic attendance on a patient during the period of labour to provide all aspects of care. This includes the initial assessment, and such subsequent assessment as may be indicated, including ongoing monitoring of the patient's condition.<br>Obstetrical delivery covers services rendered during delivery, including medical or surgical inductions by the attending physician, suturing of minor lacerations, hypnosis, detention time during labour, local or regional anesthesia and manual removal of placenta by the attending physician, and all obstetrical manoeuvers that may be required, e.g. use of forceps.} | 12.5 MSU /15 mins |

BACK TO CONTENTS

## PREAMBLE CHANGE

| Current Definition | New Definition |
|---|---|
| **Detention Time *(5.1.75)*** | **Detention Time *(5.1.75)*** |
| Medical Detention occurs when a service provider'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 is not payable when provided in the office. *(5.1.76)*<br>Detention (see section 6 (6.0.23)) commences 30 minutes after the practitioner is first in attendance and may be claimed in 15 minute increments thereafter. When claimed with a Comprehensive or Limited consultation, detention time commences after 1 hour. This may include time spent with the patient travelling from one location to another. However, travel time to transport donor organs from a donor site to the recipient site for transplantation begins at the time the retrieving surgeon accompanied by the donor organs leave the donor site. Where any service is performed during the time spent with the patient, either the service or the detention time, but not both, should be claimed. The circumstances in each case, and the time involved, should be documented with the service encounter. *(5.1.77)*<br><br>The first 30 minutes is the appropriate visit fee. The fee for detention is 12.5 units per 15 minutes. The detention modifier RO=DETE must be indicated on the service encounter. *(5.1.78)*<br>Detention time does not apply to:<br>a) Waiting time for an operating room, x-rays, laboratory results or administrative duties<br>b) Counselling or psychotherapy<br>c) Advice given to the patient or patient's family or representatives<br>d) Waiting time for a patient's arrival for assessment or treatment<br>e) Waiting time for attendance by another medical practitioner or consultant<br>f) Return trip if the physician is not in attendance with the patient<br>g) Time spent in completing or reviewing patient charts<br>h) More than one patient at a time<br>i) Office visits *(5.1.79)*<br><br>Detention time is not payable in conjunction with fees paid for the following on the same day:<br>a) Intensive care or critical care (section 5 (5.1.112 and 5.1.123))<br>b) Diagnostic and therapeutic procedures<br>c) Obstetrical delivery *(5.1.80)* | Medical Detention occurs when a service provider'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 is not payable when provided in the office. (See section 6 (6.0.23)). *(5.1.76)*<br>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.<br>Consultations: When claimed with a Comprehensive or Limited consultation, detention time commences after 1 hour.<br>Obstetrical Delivery: When claimed with an obstetric delivery provided by a general practitioner, detention time commences after 3 hours.<br>This may include time spent with the patient travelling from one location to another. However, travel time to transport donor organs from a donor site to the recipient site for transplantation begins at the time the retrieving surgeon accompanied by the donor organs leave the donor site. Where any service is performed during the time spent with the patient, either the service or the detention time, but not both, should be claimed. The circumstances in each case, and the time involved, should be documented with the service encounter. *(5.1.77)*<br>The fee for detention is 12.5 units per 15 minutes. The detention modifier RO=DETE must be indicated on the service encounter. *(5.1.78)*<br>Detention time does not apply to:<br>a) Waiting time for an operating room, x-rays, laboratory results or administrative duties<br>b) Counselling or psychotherapy<br>c) Advice given to the patient or patient's family or representatives<br>d) Waiting time for a patient's arrival for assessment or treatment<br>e) Waiting time for attendance by another medical practitioner or consultant<br>f) Return trip if the physician is not in attendance with the patient<br>g) Time spent in completing or reviewing patient charts<br>h) More than one patient at a time<br>i) Office visits *(5.1.79)*<br><br>Detention time is not payable in conjunction with fees paid for the following on the same day:<br>a) Intensive care or critical care (section 5 (5.1.112 and 5.1.123))<br>b) Diagnostic and therapeutic procedures<br>c) Obstetrical delivery by specialties other than general practitioner *(5.1.80)* |

BACK TO CONTENTS

## PREAMBLE CHANGE

Upcoming increases to bilateral and multiple surgical procedures:

| Current Definition | New Definition |
|---|---|
| Surgical Services Major or Minor *(5.3.66)*<br>k) Bilateral Procedures<br>i. Unless otherwise specified, bilateral procedures are claimed at an additional 50 percent of the unilateral procedure.<br>ii. When bilateral procedures are performed subsequent to a major procedure through the same incision they should be claimed at 50 percent and 25 percent.<br>iii. When bilateral procedures are performed subsequent to a major procedure through a separate incision, they should be claimed at 65 percent and 32.5 percent.<br>iv. When performed under separate anesthetics at an interval, the full fee will be charged for each procedure. *(5.3.78)*<br>l) Multiple Procedures Same Physician<br>i. When multiple operative procedures are performed through a single incision in the course of an abdominal operation or on any one organ or cavity, the principle procedure will be claimed plus 50 percent for the secondary procedures (secondary incidental procedures, such as appendectomy which are not indicated by pathology, shall not be claimed).<br>ii. A physician who performs multiple operative procedures simultaneously in different areas and through different incisions shall claim for the major procedure plus an additional 65 percent for each of the lesser procedures. Laparoscopic operations are considered to utilize a single incision regardless of the number of incisions.<br>iii. When an appendectomy is claimed with another abdominal surgery, a pathology report must be forwarded to MSI. *(5.3.79)* | Surgical Services Major or Minor *(5.3.66)*<br>k) Bilateral Procedures<br>i. Unless otherwise specified, bilateral procedures are claimed at an additional 70 percent of the unilateral procedure.<br>ii. When bilateral procedures are performed subsequent to a major procedure through the same incision they should be claimed at 70 percent and 35 percent.<br>iii. When bilateral procedures are performed subsequent to a major procedure through a separate incision, they should be claimed at 70 percent and 35 percent.<br>iv. When performed under separate anesthetics at an interval, the full fee will be charged for each procedure. *(5.3.78)*<br>l) Multiple Procedures Same Physician<br>i. When multiple operative procedures are performed through a single incision in the course of an abdominal operation or on any one organ or cavity, the principle procedure will be claimed plus 70 percent for the secondary procedures (secondary incidental procedures, such as appendectomy which are not indicated by pathology, shall not be claimed).<br>ii. A physician who performs multiple operative procedures simultaneously in different areas and through different incisions shall claim for the major procedure plus an additional 70 percent for each of the lesser procedures. Laparoscopic operations are considered to utilize a single incision regardless of the number of incisions.<br>iii. When an appendectomy is claimed with another abdominal surgery, a pathology report must be forwarded to MSI. *(5.3.79)* |

**Note:** This change applies only to MASG and MISG procedures.
It does not apply to Diagnostic and Therapeutic procedures.

*These fee increases will take effect January 1, 2020. At that time, the LV=LV50 and LV=LV65 modifiers previously used to denote multiple procedures will no longer be applicable to major or minor surgical category procedures. These will be replaced with the following new modifiers to facilitate payment at the increased rate:
LV=DIFF – Indicates the surgical procedure done through a separate approach.
LV=SAME – The second or subsequent surgical procedure done through the same approach.

BACK TO CONTENTS

# FEE REVISIONS

**INCREASES IN COMPREHENSIVE PRIMARY CARE FEE CODES**

As per the master agreement, the following fees shall have their values increased for family physicians.
(New Value is the value effective October 25, 2019)

| | Old Value | New Value |
|---|---|---|
| **Description** | **MSU** | **MSU** |
| Office Visit (ME=CARE) | 14.76 | 15.28 |
| Geriatric Office Visit (ME=CARE) | 18.26 | 18.90 |
| Office Visit After-Hours (ME=CARE) | 18.45 | 19.10 |
| Geriatric Office Visit After-Hours (ME=CARE) | 22.83 | 23.63 |
| Office Visit – Well Baby Care (ME=CARE) | 14.76 | 15.28 |
| Office Visit Well Baby Care After-Hours (ME=CARE) | 18.45 | 19.10 |
| Office Visit Prenatal Care (ME=CARE) | 14.76 | 15.28 |
| Office Visit Prenatal Care After-Hours (ME=CARE) | 18.45 | 19.10 |
| Office Visit Postnatal Care After-Hours (ME=CARE) | 23.76 | 24.58 |
| Subsq. Inpatient Care Visit (Days 2, 3) | 23 | 23.81 |
| Subsq. Inpatient Care Visit – Newborn (Days 2, 3) | 23 | 23.81 |
| Subsq. Inpatient Care Visit – Post-Partum (Days 2, 3) | 23 | 23.81 |
| Subsq. Inpatient Care Visit (Days 4-7) | 19 | 19.67 |
| Subsq. Inpatient Care Visit – Post-Partum (Days 4-7) | 19 | 19.67 |
| Subsq. Inpatient Care Visit (Daily to 56 days) | 16 | 16.56 |
| Subsq. Inpatient Care Visit (Weekly after Day 56) | 16 | 16.56 |

*The effective date of these increases is October 25, 2019 however the fees in the system will only display the correct values as of December 13, 2019.
*Claims made for these services from October 25 – December 12, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window has elapsed.*

**INCREASES IN PSYCHIATRY FEE CODES**

As per the master agreement, the following fees shall have their values increased for psychiatrists.
(New Value is the value effective October 25, 2019)
*Note: these increases are for psychiatrists only)*

| | Old Value | New Value |
|---|---|---|
| **Description** | **MSU** | **MSU** |
| Routine Psychiatric Visit (08.5B) | 35.8 | 38.16 |
| Psychotherapy (08.49B) | 35.8 | 38.32 |
| Comprehensive Consultation (03.08) | 75 | 82.30 |
| Child Psychiatric Assessment (08.19A) | 39.32 | 42.08 |
| Group Therapy (08.44) | 9 | 9.63 |
| Therapeutic/Diagnostic Interview Relating to a child (08.19B) | 35.78 | 38.30 |

*The effective date of these increases is October 25, 2019 however the fees in the system will only display the correct values as of December 13, 2019.
*Claims made for these services from October 25 – December 12, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window has elapsed.*

BACK TO CONTENTS

## UPDATES

### Youth Clinic Sessional

*Sessional arrangements are established for clinical services. With the exception of a few unique clinics, submission of claim forms without associated shadow billing will not be paid. If a clinic is cancelled due to inclement weather, closure of a facility, etc., the physician may reschedule that clinic for a later date and claim for those services. When submitting such claims, they should provide a summary on the claim form.*

*In cases where patients do not present for scheduled clinics and there is no shadow billing for a particular date, the physician should provide a summary of the unbillable services they provided for consideration and approval of payment. Physicians should expect to provide additional information to Medavie upon request where necessary to make an assessment.*

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| MJ068 | SERVICE ENCOUNTER HAS BEEN REDUCED TO 70%. WHEN MULTIPLE SURGICAL PROCEDURES ARE PERFORMED AT THE SAME TIME, ONLY ONE IS APPROVED AT 100%. |
| GN103 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THIS SERVICE MAY NOT BE BILLED IF A PATHOLOGIST HAS REVIEWED THE SLIDES AND CLAIMED FOR THE SERVICE. |
| AD086 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST CLAIM THE BASE DELIVERY FEE (HSC 87.98) PRIOR TO CLAIMING DETENTION DURING OBSTETRICAL DELIVERY. |
| AD085 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF ROTAVIRUS IMMUNIZATIONS HAS BEEN REACHED. |
| AD028 | SERVICE ENCOUNTER HAS BEEN REDUCED TO 50%. ONLY ONE IMMUNIZATION AT FULL FEE IS PAYABLE WHEN A VISIT IS CLAIMED |
| BK061 | SERVICE ENCOUNTER HAS BEEN DISALLOWED. PLEASE SUBMIT A COPY OF THE FIRST AND SUBSEQUENT ECHO REPORTS ALONG WITH THE CLINICAL DOCUMENTATION BEFORE REQUESTING REASSESSMENT FOR THIS CLAIM. |

*Note: BK061 was introduced and available for download on October 4, 2019.*

BACK TO CONTENTS

## Claiming for Referred Services

A consultation is a service that results from a formal referral from the patient's physician, nurse practitioner, midwife, optometrist or dentist for an evaluation by a physician qualified to furnish advice. In addition to a formal (i.e. written) referral, a consultation also requires a written report to the referring provider.

A comprehensive consultation (Health Service Code 03.08) is a comprehensive visit. It requires a complete history and physician examination appropriate to the physician's specialty and the working diagnosis. The elements of a comprehensive visit have been outlined in previous MSI Bulletins. (August 2017)

In instances in which a comprehensive assessment is not medically necessary for a referred patient, a limited consultation (Health Service Code 03.07) may be claimed. This is an assessment that is focused on the problem that has led to the referral.

Both comprehensive and limited consultations require a physical examination by the physician.

Here are common questions we receive at MSI with respect to consultation services:

**Q: Another physician in my specialty is retiring. If she sends me a written referral, may I claim for a consultation the first time I see one of her patients?**
A: The situation you describe represents transferral of care. In this situation, where care is transferred either temporarily or permanently from one physician to another, the receiving physician may not claim either a consultation or comprehensive visit.

**Q: I am a family doctor who works in a clinic with several other family doctors. Recently, we were discussing the fact that a specialist in town follows our patients for some chronic conditions. However, if it has been longer than six months since he last saw them, he insists that we send a new referral before he will see them again. This is extra paperwork that I don't need. Does MSI require that a new referral be sent after six months?**
A: MSI has no such requirement. In situations where the specialist wishes to review the patient, the visit should be claimed as a follow-up visit (normally continuing care or directive care) and not as a new consultation.

**Q: I am a specialist. Can I claim a new consultation without a new referral if considerable time has passed since I last saw them?**
A: A valid referral is required each time you claim a new consultation. The referring provider must have assessed the patient and deemed that he/she requires a new opinion from you. If a patient is seen for a new or worsening condition in the absence of a new referral, and a new comprehensive visit is medically necessary and carried out, claim an initial visit with complete examination (HSC 03.04). If there is no new or worsening condition, claim as a limited visit (HSC 03.03).

BACK TO CONTENTS

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

### UPDATED FILES

Updated files reflecting changes are available for download on Friday December 13th, 2019. The files to download are:
Health Service (SERVICES.DAT),
Health Service Description (SERV_DSC.DAT),
Modifiers (MODVALS.DAT) and,
Explanatory Codes (EXPLAIN.DAT).

### CONTACT INFORMATION

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

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(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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BACK TO CONTENTS

# 2020 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

| PAPER CLAIMS | ELECTRONIC CLAIMS | PAYMENT DATE | SALARY CONTRACT PAY PERIOD |
|---|---|---|---|
| **December 19, 2019**** | **December 24, 2019**** | December 31, 2019 | December 13-26, 2019 |
| January 6, 2020 | January 9, 2020 | January 15, 2020 | December 27, 2019-January 9, 2020 |
| January 20, 2020 | January 23, 2019 | January 29, 2020 | January 10-23, 2020 |
| February 3, 2020 | February 6, 2020 | February 12, 2020 | January 24-February 6, 2020 |
| **February 14, 2020**** | February 20, 2020 | February 26, 2020 | February 7-20, 2020 |
| March 2, 2020 | March 5, 2020 | March 11, 2020 | February 21-March 5, 2020 |
| March 16, 2020 | March 19, 2020 | March 25, 2020 | March 6-19, 2020 |
| March 30, 2020 | April 2, 2020 | April 8, 2020 | March 20-April 2, 2020 |
| April 13, 2020 | April 16, 2020 | April 22, 2020 | April 3-16, 2020 |
| April 27, 2020 | April 30, 2020 | May 6, 2020 | April 17-30, 2020 |
| **May 8, 2020**** | **May 13, 2020**** | May 20, 2020 | May 1-14, 2020 |
| May 25, 2020 | May 28, 2020 | June 3, 2020 | May 15-28, 2020 |
| June 8, 2020 | June 11, 2020 | June 17, 2020 | May 29-June 11, 2020 |
| **June 19, 2020**** | **June 24, 2020**** | **June 30, 2020**** | June 12-25, 2020 |
| July 6, 2020 | July 9, 2020 | July 15, 2020 | June 26-July 9, 2020 |
| July 20, 2020 | July 23, 2020 | July 29, 2020 | July 10-23, 2020 |
| **July 31, 2020**** | August 6, 2020 | August 12, 2020 | July 24-August 6, 2020 |
| August 17, 2020 | August 20, 2020 | August 26, 2020 | August 7-20, 2020 |
| **August 28, 2020**** | **September 2, 2020**** | September 9, 2020 | August 21-September 3, 2020 |
| September 14, 2020 | September 17, 2020 | September 23, 2020 | September 4-17, 2020 |
| September 28, 2020 | October 1, 2020 | October 7, 2020 | September 18-October 1, 2020 |
| **October 9, 2020**** | October 15, 2020 | October 21, 2020 | October 2-15, 2020 |
| October 26, 2020 | October 29, 2020 | November 4, 2020 | October 16-29, 2020 |
| **November 6, 2020**** | November 12, 2020 | November 18, 2020 | October 30-November 12, 2020 |
| November 23, 2020 | November 26, 2020 | December 2, 2020 | November 13-26, 2020 |
| December 7, 2020 | December 10, 2020 | December 16, 2020 | November 27-December 10, 2020 |
| **December 17, 2020**** | **December 22, 2020**** | December 30, 2020 | December 11-24, 2020 |
| January 4, 2021 | January 7, 2021 | January 13, 2021 | December 25, 2020-January 7, 2021 |
| **11:00 AM CUT OFF** | **11:59 PM CUT OFF** | | |

**NOTE:**

Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Sessional Payments and Locum Claim Forms. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut-off date to ensure processing for that payment period.

**PLEASE NOTE, THE ** INDICATES A DATE VARIATION**

## 2020 HOLIDAY DATES

| Please make a note in your schedule of the following dates MSI will accept as "Holidays". | |
|---|---|
| NEW YEAR'S DAY | WEDNESDAY, JANUARY 1, 2020 |
| HERITAGE DAY | MONDAY, FEBRUARY 17, 2020 |
| GOOD FRIDAY | FRIDAY, APRIL 10, 2020 |
| EASTER MONDAY | MONDAY, APRIL 13, 2020 |
| VICTORIA DAY | MONDAY, MAY 18, 2020 |
| CANADA DAY | WEDNESDAY, JULY 1, 2020 |
| CIVIC HOLIDAY | MONDAY, AUGUST 3, 2020 |
| LABOUR DAY | MONDAY, SEPTEMBER 7, 2020 |
| THANKSGIVING DAY | MONDAY, OCTOBER 12, 2020 |
| REMEMBRANCE DAY | WEDNESDAY, NOVEMBER 11, 2020 |
| CHRISTMAS DAY | FRIDAY, DECEMBER 25, 2020 |
| BOXING DAY | MONDAY, DECEMBER 28, 2020 |
| NEW YEAR'S DAY | FRIDAY, JANUARY 1, 2021 |

PHYSICIAN'S BULLETIN
August 9th, 2019: Vol. LXIV, ISSUE 16

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## MSI News

### SEEKING PHYSICIAN ASSESSORS

The Nova Scotia Practice Ready Assessment Program (NSPRAP) is a new program funded by the Department of Health and Wellness and developed by multiple stakeholders to assess international medical graduates (IMGs) who have practiced abroad and would like to practice family medicine in underserved communities in Nova Scotia. Those who successfully meet eligibility requirements and pre-screening will need to be placed with experienced family physicians in our communities to determine whether they are in fact practice-ready. The internationally-trained physicians will be placed and assessed in two different communities for 6 weeks each. They are to be exposed to a variety of clinical settings but are not being assessed to provide intrapartum obstetrical care or ER care.

Physician assessors will receive assessor training, be remunerated both for the training and the 6-week assessment period and will be able to claim some Main-Pro credits.

The Assessors' primary duties are to:

- Orient the candidate to the clinical practice including local and regional healthcare services;
- Provide clinical exposures appropriate for the purpose of assessment of candidates (eg. ambulatory/clinic, ER, hospital in-patient and long term-care);
- Assess candidate's clinical skills (should be at the level of a Canadian-trained family medicine resident entering practice);
- Assess candidate's ability to communicate both verbally and in writing;
- Assess their professional demeanor and conduct with patients and colleagues; and
- Complete the required evaluation forms of the candidates' performance and any other documentation required by the program.

Physicians interested in being a physician assessor should contact Gwen MacPherson, Program Coordinator at info@nsprap.ca or Dr. Fiona Bergin, Program Clinical Director at fiona.bergin@dal.ca or 902-473-7188 for more information.

*Candidates will be looking for short-term rentals in the communities in which they will be assessed. If you know of any in your community (whether you wish to be an assessor or not), we would appreciate you providing us with that information to share with them.

## FEE REVISION

The following health service code may now be claimed from a nursing home location:

| Category | Code | Description | Base Units |
|---|---|---|---|
| CONS | 03.09C | **Palliative Care Consultation**<br><br>**Description**<br>The palliative care consultation can only be claimed by designated physicians, general practitioners or specialists, with recognized expertise in palliative care. The service provided must fulfil the normal requirements for a consultation as specified in the preamble. The consultation includes a psychosocial assessment, comprehensive review of pharmacotherapy, appropriate counselling, and consideration of appropriate community resources where indicated.<br><br>**Billing Guidelines**<br>Payable once per patient per physician<br>Maximum 3 hours (8 multiples)<br>Start and stop times must be recorded in the health record and in the text field of the claim when billing multiples.<br><br>**Specialty Restriction**<br>Physicians with recognized expertise in Palliative Care or Certificate of added Competence<br>Physician must forward a letter to MSI indicating their credentials<br><br>**Location**<br>LO=HOSP, LO=OFFC, LO=HOME, LO=NRHM | 62 + MU |

## WCB UPDATES

Submission Requirements

As noted in the June Physician's Bulletin, when submitting claims with a payment responsibility of WCB, one or both of the following are now required:

- Patient's WCB claim number
- Patient's Injury date (month and year)

In some cases, you may provide a service to a patient before a WCB claim exists. In these cases, the month and year of injury should be submitted.

This additional information will be used to verify that the patient was eligible for WCB coverage on the date that the service was provided. Although Medavie will be receiving WCB eligibility updates daily, you may notice a difference in the length of time it takes to process some WCB claims, as this required verification will be completed prior to the claim being paid. Confirming whether your patient is eligible for benefits at the time the claim is submitted for payment will help prevent billing errors and reduce the need for payment reversals.

BACK TO CONTENTS

## WCB UPDATES (CONTINUED)

Return to Work (RTW) Service

Physicians are now able to claim a WCB28 (Comprehensive Visit for Work Related Injury or Illness) or 03.03/03.03A (Limited Visit) depending upon the service provided. If you have been holding any 03.03/03.03A claims since June 27/19, these can now be submitted for payment.

Long Term Benefits (LTB) Service

If your patient has been transitioned to receiving long term benefits, WCB no longer requires the Physician's Report Form 8/10 for follow-up visits. Generally, visits would be no more than monthly for follow-up of the original compensable injury. The health service code to be used for these visits is 03.03 or 03.03A. If WCB28 is submitted, the claim will be refused.

If your patient's condition changes and it is necessary to provide a comprehensive visit, the following interim WCB health service code is now available for billing. Under these circumstances, you may submit a Physician's Report Form 8/10 to WCB outlining the changes in the patient's condition or treatment.

| Category | Code | Description | Value |
|---|---|---|---|
| DEFT | WCB31 | **WCB Interim Fee - Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed.** | $67.90 |

# Billing Matters Billing Reminders, Updates, New Explanatory Codes

## UPDATES

**Addendum – 03.09A**
In the June 14, 2019 Physicians Bulletin HSC 03.09A was incorrectly categorized as a 'VIST' 03.09A is a consult service and is categorized as a 'CONS'.

**2019 Cut off Dates**
Please see the updated 2019 Cut off Dates as changes have been made.

BACK TO CONTENTS

## BILLING REMINDERS

**Multiple Long Bone Fractures**

This is a reminder that the LV=LV85 modifier applies to certain open reduction fractures.
The following is a list of applicable codes:

| HSC | DESCRIPTION |
|---|---|
| 91.30A | Fractured humerus neck without dislocation of head - open reduction |
| 91.30B | Fractured humerus shaft - open reduction |
| 91.30C | Fractured humerus - epicondyle - medial - open reduction |
| 91.30D | Fractured humerus - epicondyle - lateral - open reduction |
| 91.30E | Fractured humerus tuberosity - open reduction |
| 91.30F | Fractured humerus neck with dislocation of head - open reduction |
| 91.30G | Fractured humerus - supra or transcondylar - open reduction |
| 91.31 | Open reduction of fracture with internal fixation, radius and ulna |
| 91.31A | Open reduction - fractured olecranon |
| 91.31B | Open reduction - radius - head or neck |
| 91.31C | Open reduction fractured radius or ulna - shaft |
| 91.31D | Colles' or Smith's fracture - open reduction |
| 91.31E | Monteggia's or Galleazzi's fracture - open reduction |
| 91.31G | Distal comminuted intra-articular fracture of radius (to include distal ulna) due to high energy trauma. To include open reduction, internal/external fixation as required when performed in conjunction with remote donor site bone graft. |
| 91.34A | Fracture femur neck - open reduction with internal fixation |
| 91.34B | Fractured femur - pertrochanteric - open reduction |
| 91.34C | Fractured femur - shaft or transcondylar - open reduction |
| 91.34D | Fracture femur neck - prosthetic replacement |
| 91.35A | Fracture - tibia with or without fibula - shaft - open reduction |
| 91.35B | Fractured tibial plafond, with or without fibula, open reduction and internal fixation - including removal of pre-existing internal or external fixation devices. |
| 91.35C | Fractured tibia with or without fibula - plateau - open reduction |
| 91.35D | Fractured ankle - single malleolus - open reduction |
| 91.35E | Fracture fibula - open reduction |
| 91.35F | Fractured ankle - bi or trimalleolar - open reduction |
| 91.38A | Fractured - clavicle - open reduction |
| 91.95C | External fixation of tibial plafond fracture |
| 91.95D | External fixation of tibial plafond fracture, with open reduction and internal fixation of fibular fracture. |

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| VT165 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.03N CANNOT BE CLAIMED UNLESS THE PROVIDER HAS PREVIOUSLY CLAIMED FOR A MAID SERVICE WITH THE SAME PATIENT. |
| WBHOK | ELIGIBILITY APPROVED BY WCB |
| WBHNM | WCB DID NOT RECEIVE MEDICAL DOCUMENTATION FOR SERVICE DATE BILLED |

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### HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

http://msi.medavie.bluecross.ca/

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

### CONTACT INFORMATION

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BACK TO CONTENTS

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|---|---|---|---|
| **December 19, 2018**** | **December 24, 2018**** | January 2, 2019 | December 14-27, 2018 |
| January 7, 2019 | January 10, 2019 | January 16, 2019 | December 28, 2018-January 10, 2019 |
| January 21, 2019 | January 24, 2019 | January 30, 2019 | January 11-24, 2019 |
| February 4, 2019 | February 7, 2019 | February 13, 2019 | January 25-February 7, 2019 |
| **February 15, 2019**** | February 21, 2019 | February 27, 2019 | February 8-21, 2019 |
| March 4, 2019 | March 7, 2019 | March 13, 2019 | February 22-March 7, 2019 |
| March 18, 2019 | March 21, 2019 | March 27, 2019 | March 8-21, 2019 |
| April 1, 2019 | April 4, 2019 | April 10, 2019 | March 22-April 4, 2019 |
| **April 12, 2019**** | **April 17, 2019**** | April 24, 2019 | April 5-18, 2019 |
| April 29, 2019 | May 2, 2019 | May 8, 2019 | April 19-May 2, 2019 |
| **May 10, 2019**** | **May 15, 2019**** | May 22, 2019 | May 3-16, 2019 |
| May 27, 2019 | May 30, 2019 | June 5, 2019 | May 17-30, 2019 |
| June 10, 2019 | June 13, 2019 | June 19, 2019 | May 31-June 13, 2019 |
| **June 21, 2019**** | **June 26, 2019**** | July 3, 2019 | June 14-27, 2019 |
| July 8, 2019 | July 11, 2019 | July 17, 2019 | June 28-July 11, 2019 |
| July 22, 2019 | July 25, 2019 | July 31, 2019 | July 12-25, 2019 |
| **August 2, 2019**** | August 8, 2019 | August 14, 2019 | July 26-August 8, 2019 |
| August 19, 2019 | August 22, 2019 | August 28, 2019 | August 9-22, 2019 |
| **August 30, 2019**** | September 5, 2019 | September 11, 2019 | August 23-September 5, 2019 |
| September 16, 2019 | September 19, 2019 | September 25, 2019 | September 6-19, 2019 |
| September 30, 2019 | October 3, 2019 | October 9, 2019 | September 20-October 3, 2019 |
| **October 11, 2019**** | October 17, 2019 | October 23, 2019 | October 4-17, 2019 |
| October 28, 2019 | October 31, 2019 | November 6, 2019 | October 18-31, 2019 |
| **November 8, 2019**** | November 14, 2019 | November 20, 2019 | November 1-14, 2019 |
| November 25, 2019 | November 28, 2019 | December 4, 2019 | November 15-28, 2019 |
| December 9, 2019 | December 12, 2019 | December 18, 2019 | November 29-December 12, 2019 |
| **December 19, 2019**** | **December 24, 2019**** | December 31, 2019 | December 13-26, 2019 |
| January 6, 2020 | January 9, 2020 | January 15, 2020 | December 27, 2019-January 9, 2020 |
| **11:00 AM CUT OFF** | **11:59 PM CUT OFF** | | |

**NOTE:**

Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Sessional Payments and Locum Claim Forms. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut-off date to ensure processing for that payment period.

**PLEASE NOTE, THE ** INDICATES A DATE VARIATION**

## HOLIDAY DATES

| Please make a note in your schedule of the following dates MSI will accept as "Holidays". | |
|---|---|
| NEW YEAR'S DAY | TUESDAY, JANUARY 1, 2019 |
| HERITAGE DAY | MONDAY, FEBRUARY 18, 2019 |
| GOOD FRIDAY | FRIDAY, APRIL 19, 2019 |
| EASTER MONDAY | MONDAY, APRIL 22, 2019 |
| VICTORIA DAY | MONDAY, MAY 20, 2019 |
| CANADA DAY | MONDAY, JULY 1, 2019 |
| CIVIC HOLIDAY | MONDAY, AUGUST 5, 2019 |
| LABOUR DAY | MONDAY, SEPTEMBER 2, 2019 |
| THANKSGIVING DAY | MONDAY, OCTOBER 14, 2019 |
| REMEMBRANCE DAY | MONDAY, NOVEMBER 11, 2019 |
| CHRISTMAS DAY | WEDNESDAY, DECEMBER 25, 2019 |
| BOXING DAY | THURSDAY, DECEMBER 26, 2019 |
| NEW YEAR'S DAY | WEDNESDAY, JANUARY 1, 2020 |

PHYSICIAN'S BULLETIN
June 28, 2019: Vol. LXIV, ISSUE 14

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# MSI News

## CHANGE TO BREAST AUGMENTATION COVERAGE

Starting July 1, 2019, the province will cover breast augmentation surgery for transgender women in Nova Scotia. Breast augmentation is being added to the list of publicly funded gender affirming surgeries. Eligibility is determined based on the criteria outlined in the revised application form. Assessment and referral by a physician and pre-approval by MSI are required.

Please view the DHW website for more information on gender affirming surgeries:
https://novascotia.ca/dhw/gender-affirming-surgery/

PHYSICIAN'S BULLETIN
June 17, 2019: Vol. LXIV, ISSUE 13

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## PATIENT ENROLMENT INCENTIVE UPDATE – EXTENSION

The Department of Health and Wellness (DHW) has decided to provide an additional extension to the deadline for finalizing your patient panel. Your patient panel will be accessible via the link provided until midnight on **July 2, 2019**. Your patient panel will need to be updated and finalized by July 2 as the DHW has indicated there will be no further extensions. We recommend that you finalize your panel early to avoid any unexpected system issues which may occur closer to the deadline.

As noted in previous Physician's Bulletins, an incentive will only be paid to those physicians who completed the verification process and finalized their panel. The payment date associated with the incentive has changed given that the time to complete your panel is being extended to July 2. Your payment will be deposited into the same bank account that you have provided for other incentive and CMPA payments as per the Master Agreement on August 14, 2019.

If you have any questions while you are completing your patient panel, please do not hesitate to contact us. The following sections of the Patient Panel Verification Instructions have been updated based on questions/feedback received:

- Accessing Your Panel
- Resetting a Forgotten Password

Please click here to view the updated instructions.

We can be reached at 902-496-7011 / toll-free 1-866-553-0585 Mon – Fri, 8am – 5pm or at msi_assessment@medavie.bluecross.ca

PHYSICIAN'S BULLETIN
June 14th, 2019: Vol. LXIV, ISSUE 12

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## MSI News

### WCB CLAIMS PROCESSING – UPCOMING CHANGES

As noted in previous Physician's Bulletins, additional information will be required when submitting claims to Medavie for WCB payment, effective June 27, 2019.

Submission requirements

From June 27, 2019 onward, you will need to include one or both of the following when submitting claims with a payment responsibility of WCB:

- Patient's WCB claim number
- Patient's injury date (month and year)

In some cases, you may provide a service to a patient before a WCB claim exists. In these cases, the month and year of injury should be submitted.

This additional information will be used to verify that the patient was eligible for WCB coverage on the date that the service was provided. Although Medavie will be receiving WCB eligibility updates daily, you may notice a difference in the length of time it takes to process some WCB claims, as this required verification will be completed prior to the claim being paid. Confirming whether your patient is eligible for benefits at the time the claim is submitted for payment will help prevent billing errors and reduce the need for payment reversals.

Your billing vendor has made changes to their software to enable you to provide this additional information. Please contact your vendor directly if you have any questions regarding the rollout of their software changes. If you do not provide the WCB claim number and/or injury date, your claim will be refused.

## ★MSI News Continued

Return to Work (RTW) Service

As you know, WCB believes strongly that work is a healthy part of recovery. As a health care provider, you play a vital role in formulating a plan for successful return-to-work of your patient, and you understand the importance of helping your patient stay active and connected to their workplace. WCB encourages you to follow your patient as frequently as needed to ensure a successful return-to-work.

The health service code to be used when claiming for these visits is WCB28 (Comprehensive Visit for Work Related Injury or Illness). The typical visit frequency is biweekly. If health service code 03.03 or 03.03A (limited visit) is submitted, the claim will be refused.

The associated reporting to WCB is to occur within 5 days of each visit using the report Form 8/10. Health service code WCB26 is to be used for billing purposes.

Long Term Benefits (LTB) Service

If your patient has been transitioned to receiving long term benefits, WCB no longer requires Form 8/10 for follow-up visits. Generally, visits would be no more than monthly for follow-up of the original compensable injury. The health service code to be used for these visits is 03.03 or 03.03A. If WCB28 is submitted, the claim will be refused.

If your patient's condition changes, you can submit a Form 8/10 to WCB. WCB26 is to be used for billing purposes.

Ongoing updates will be provided via the MSI Physician's Bulletin. Relevant information will also be posted on the MSI Website, https://msi.medavie.bluecross.ca. If you have any questions, please email msi_assessment@medavie.bluecross.ca or call 902-496-7011/toll-free 1-866-553-0585.

## ★ Fees New Fees and Fee Revisions

### NEW FEES

The following new WCB codes are available for billing:
Request forms submitted since June 1st may now be claimed using these codes.

| Category | Code | Description | Base Units |
|---|---|---|---|
| DEFT | WCB29 | **Initial Request Form for Medical Cannabis**<br><br>**Description**<br>Completed Initial Request Form for Medical Cannabis<br><br>**Billing Guidelines**<br>No multiple submissions permitted for the same patient on the same day<br><br>**Notes:**<br>Incomplete forms may be subject to fee reversal | $73.25 |

BACK TO CONTENTS

## NEW FEES (CONTINUED)

| Category | Code | Description | Base Units |
|---|---|---|---|
| DEFT | WCB30 | **Extension Request Form for Medical Cannabis**<br><br>**Description**<br>Completed Extension Request Form for Medical Cannabis<br><br>**Billing Guidelines**<br>No multiple submissions permitted for the same patient on the same day<br><br>**Notes:**<br>Incomplete forms may be subject to fee reversal | $43.95 |

Effective June 14, 2019 the following codes are available for billing:

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03W | **Medical Geneticist Virtual Care Follow Up Visit – Per 15 Minutes**<br>**ME=VTCR**<br><br>**Description**<br>This is a time based health service code for follow up visits by the geneticist post genetics consultation using a PHIA compliant, synchronous, virtual care platform. Report virtual face to face care with geneticist only, 80% of the documented clinical encounter time must be virtual face to face with the geneticist. Start and stop times must be documented in the health record and submitted in text with the claim.<br><br>**Billing Guidelines**<br>• 80% of the documented clinical encounter time must be virtual face to face with the geneticist<br>• A total of four 15 minute time periods may be reported for any one encounter. Should the patient-physician encounter take longer than 60 minutes, report EC with a note explaining the clinical circumstances.<br>• Start and stop times must be documented in the health record and submitted in text with the claim.<br>• Service must be delivered via a PHIA compliant, synchronous, virtual care platform.<br><br>**Specialty Restriction**<br>SP=HUGE, SP=MEGE<br><br>**Location**<br>LO=OFFC, LO=HOSP<br><br>**Notes:**<br>Total of 60 minutes per encounter | 16.3 MSU |

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| VEDT | 03.39T | **Clinical Interpretation of complex genetics tests (e.g. microarray analysis, next generation sequencing, and exome sequencing) by geneticist – findings must be recorded in health record and recommendations made in writing to the referring physician. Per 15 Minutes**<br>**RO=INTP**<br><br>**Description**<br>This is a time based code to enable clinical reporting of the time spent by the geneticist who interprets complex abnormal genetic test results and relays that information in writing to the referring physician. Start and stop times must be recorded in the health record. No other HSC's reportable during that time period for that physician.<br><br>**Billing Guidelines**<br>Start and stop times must be recorded in the health record.<br>No other HSC to be reported by the physician in the same time period.<br><br>**Specialty Restriction**<br>SP=HUGE, SP=MEGE<br><br>**Location**<br>LO=OFFC, LO=HOSP | 15 MSU |

| Category | Code | Description | Base Units |
|---|---|---|---|
| VEDT | RGN1 | **Review by Geneticist of Patient encounter with Genetics Counsellor**<br><br>**Description**<br>This health service code is for the review by the geneticist of the patient encounter performed solely by the genetics counsellor. This service includes the review of any pertinent investigations and results. The letter back to the referring physician must be reviewed and co-signed by the geneticist and must indicate that the patient was seen by the genetics counsellor.<br>Not payable if the patient has been seen by geneticist within 30 days.<br><br>**Billing Guidelines**<br>The encounter must be documented in the health record and indicate that the patient was seen by the genetics counsellor alone but the clinical information and letter to the referring physician were reviewed by the geneticist.<br><br>**Specialty Restriction**<br>SP=HUGE, SP=MEGE<br><br>**Location**<br>LO=OFFC, LO=HOSP | 30 MSU |

BACK TO CONTENTS

# FEE REVISIONS

Effective June 14, 2019 the description for 03.09A has been updated:

| Category | Code | Description | Base Units |
|---|---|---|---|
| CONS | 03.09A | **Complex Genetic Counselling Consultation** | 125 MSU |

**Description**

1. This code may only be used by a physician who is:
   a) Certified in Medical Genetics by the RCPSC or;
   b) Certified in Clinical Genetics by the Canadian College of Medical Genetics and/or;
   c) Registered by the College of Physicians and Surgeons of Nova Scotia as a specialist in Medical Genetics or Human Genetics.
2. This is a specific and detailed activity, which includes interviewing of appropriate family members, and collection and assessment of adequate clinical and genetic data to characterize the problem, establish a likely diagnosis (or differential diagnosis), construct a family pedigree and assess (both qualitatively and quantitatively) the risks to the persons seeking advice. It includes imparting this information and the various options for dealing with the problem to the individuals and appropriate family members in such a way that they can make informed decisions about the genetic problem. It may, in addition or alternatively, include the establishment or verification of a plan for further investigative and/or therapeutic management.
3. This type of consultation is to be distinguished from a routine genetics consult. It requires one or both of the following:
   a) Detailed, intensive review of patient data (including medical records and diagnostic studies), ***or***
   b) Detailed and lengthy review of appropriate medical literature because of the complexity and/or rarity of the problem.
4. Because of the complexity involved in such a service it is expected that more than one hour is required for the completion of this consultation.
5. As is the case for all consultations, a request for consultation must be initiated by a referring physician, and a written report with the opinion and recommendations of the consultant must be sent to the referring physician. A written summary or report may be also sent to the patient or family. This fee code may be claimed only once per patient.
6. A prolonged Complex Genetic Counselling Consultation may be reported if the encounter exceeds 90 minutes. No other fee codes may be reported for the same patient for that time period; two additional 15 minute multiples may be reported for a total of 120 minutes. If reporting a prolonged consultation service, start and stop times must be documented in the health record and in the text field of the MSI claim. MU=16.3 MSU/15 min

**Note:**

May be provided via PHIA compliant, synchronous, virtual care platform
ME=VTCR

**Specialty Restriction**

SP=HUGE, SP=MEGE

Effective June 14, 2019 the virtual care modifier (ME=VTCR) is available for use on the follow-up visit services (03.03 office visit and 03.03A geriatric office visit) by providers designated as Virtual Care Health Care Providers.

Effective June 14, 2019, any extra patient (PT=EXPT) visits performed in a hospital or nursing home location will also require the correct time of day modifier TI=AMNN (8:01am – 12pm) TI=NNEV (12:01pm – 5pm) on the claim.

BACK TO CONTENTS

## FEE ADJUSTMENTS

Select time based HSC have the following fee adjustments:

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | Select time based codes | 03.03C Palliative Care Support<br><br>**Specialty Restriction**<br>N/A | 30 MSU per 30 minutes |
| VIST<br><br>PSYC | Select time based codes | 03.03D Case Management Conference Fee<br><br>08.41 Hypnotherapy<br>08.44 Group Therapy<br>08.45 Family Therapy<br>08.49A Counselling<br>08.49B Psychotherapy<br>08.49C Lifestyle Counselling<br><br>**Specialty Restriction**<br>SP=GENP | 15 MSU per 15 minutes<br><br>30 MSU per 30 minutes<br>7.6 MSU per 30 minutes<br>30 MSU per 30 minutes<br>15 MSU per 15 minutes<br>30 MSU per 30 minutes<br>15 MSU per 15 minutes |

# Billing Matters Billing Reminders, Updates, New Explanatory Codes

## BILLING REMINDERS

**Ultrasounds and 02.84A**

Physicians are reminded HSC 02.84A for Obstetrical Doppler is a stand-alone procedure, thus no ultrasound should be claimed during the same encounter. If an ultrasound does occur, the appropriate ultrasound fee should be claimed along with HSC 02.84B – Obstetrical Doppler in conjunction with ultrasound.

**Tonsillectomy 40.2A**

Physicians are reminded that HSC 40.2A is only to be claimed for surgical tonsillectomy and/or adenoidectomy at a hospital location.

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| AD084 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 02.84A WHICH IS A STAND ALONE PROCEDURE HAS ALREADY BEEN CLAIMED DURING THE SAME ENCOUNTER |
| GN012 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 02.84A WHICH IS A STAND ALONE PROCEDURE HAS ALREADY BEEN CLAIMED DURING THE SAME ENCOUNTER. IF AN ULTRASOUND HAS OCCURRED THE APPROPRIATE ULTRASOUND FEE SHOULD BE CLAIMED ALONG WITH ADD ON HSC 02.84B – OBSTETRICAL DOPPLER IN CONJUNCTION WITH ULTASOUND |

BACK TO CONTENTS

| Code | Description |
|---|---|
| VA096 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 02.84A IS A STAND ALONE PROCEDURE AND MAY NOT BE CLAIMED WITH ANY OTHER ULTRASOUNDS DURING THE SAME ENCOUNTER |
| VE025 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU PREVIOUSLY CLAIMED A VISIT WITH THIS PATIENT IN THE LAST 30 DAYS |
| VE026 | SERVICE ENCOUNTER HAS BEEN REFUSED AS NO OTHER FEES ARE PAYABLE DURING THE SAME TIME PERIOD AS HSC 03.39T |
| VE027 | SERVICE ENCOUNTER HAS BEEN REFUSED AS NO OTHER FEES ARE PAYABLE DURING THE SAME TIME PERIOD AS HSC 03.09A |
| WB036 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE INITIAL OR EXTENSION FOR MEDICAL CANNABIS FORM HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY |
| WB037 | SERVICE ENCOUNTER HAS BEEN REFUSED AS AN INITIAL OR EXTENSION REQUEST FOR MEDICAL CANNABIS WAS PREVIOUSLY CLAIMED IN THE PAST SEVEN WEEKS |
| VT169 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU ARE NOT AUTHORIZED TO PROVIDE THIS SERVICE OVER A VIRTUAL CARE PLATFORM |

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

### UPDATED FILES

Updated files reflecting changes are available for download on Friday June 14th, 2019. The files to download are health service (SERVICES.DAT), health service description (SERV_DSC.DAT), and, explanatory codes (EXPLAIN.DAT).

### HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

http://msi.medavie.bluecross.ca/

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

### 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

In partnership with

NOVA SCOTIA

BACK TO CONTENTS

# MEDICAL CONSULTANT JOB POSTING

**Job Title:** Medical Consultant
**Department:** Medicare Programs
**Competition:** 5131
**Internal/External:** Internal/External
**Employment Type:** External Consultant – Part Time (21.75 hours per week)
**Location(s):** Dartmouth
**Salary:** Competitive Compensation
**Reports to:** Team Leader
**Closing Date:** July 5, 2019

**Role Summary:**

We are currently accepting applications for a part time external Medical Consultant. The successful candidate will work onsite with the Medicare Programs team in our Dartmouth office and will be responsible for providing professional medical guidance in support of the MSI assessment and audit functions. In this role, the successful candidate will be responsible for providing a professional link between physicians, government and patients.

**As an External Medical Consultant, your key responsibilities will include:**

- Providing direction and guidance to the Claims Assessment team regarding claims adjudication and payment.
- Reviewing requests for pre-authorization of in-province physician services; out-of-province/country physician services or hospitalization and retroactive payment of out-of-province/country physician services or hospitalization claims.
- Ensuring all administrative processes are followed for out-of-province/country referrals for addiction and mental health services.
- Providing or assisting in the first level of appeals for citizen/provider complaints regarding issues of medical insurability, medical necessity and treatment not normally insured as well as provider appeals regarding claims payment.
- Conduct fee for service and shadow billing audits in collaboration with the Medicare Auditors.
- Support the evaluation of select alternative funding contracts; includes interviews with providers, associations and other parties.
- Assist in the development of the annual audit plan, procedures to enhance pre and post payment monitoring operations, and the development of risk analysis strategies to utilize departmental resources efficiently.
- Providing assistance to the Department of Health and Wellness Medical Consultant to support medical policy, medical tariff development and activities related to claims assessment
- Participate on various Department of Health and Wellness and professional committees as required.
- Resolve issues and maintain productive, professional relationships with medical provider community and Department of Health and Wellness; inform providers through bulletin articles of changing audit policies, administrative procedures and billing issues.
- Responding to enquiries from patients, physicians, Doctors NS, Nova Scotia College of Physicians and Surgeons, Medical Directors and the Department of Health and Wellness with respect to individual patient claims and the insurability of specific services for an individual according to Department of Health and Wellness policy.

## MEDICAL CONSULTANT JOB POSTING (CONTINUED)

**As the ideal candidate, you possess the following qualifications:**

Education: University degree with a Doctorate in Medicine.

Work Experience: 10 to 15 years' experience as a physician in a range of practice settings. Surgical and administrative experience would be an asset.

Other Qualifications: Strong interpersonal skills and the ability to resolve conflicts and deal with stressful situations.

Computer Skills: General computer knowledge.

Communication Skills: Excellent written and verbal communication skills are fundamental to the position.

**You also demonstrate the following core competencies:**

Knowledge: Uses knowledge and industry best practices to provide guidance and/or advice to leaders and coworkers on key issues in own area of expertise. Demonstrates a specialized knowledge of all processes, policies and precedents to do the job and solve day to day issues independently.

Analytical Thinking: Uses knowledge and experience to solve a variety of routine and complex technical problems. Identifies the cause of problems and implements the most appropriate solution.

Communication: Able to communicate complex information effectively through both oral and written means. Demonstrates the full range of effective verbal communication skills in a variety of settings such as formal meetings, presentations, and any one on one situation.

Customer Orientation: Independently processes many unusual and demanding customer requests. Maintains library/database/network of all customer information and materials to meet both routine and complex customer needs.

Execution and Organization Skills: Exceptional organizational and time-management skills. Able to prioritize work within in a changing work environment under the pressure of deadlines.

Team Work: Provides professional advice and direction to team members and leads work processes and proactively searches for ways to improve team effectiveness and performance.

If you are interested in working with a team of professionals in a challenging role and you possess the necessary qualifications, please follow the instructions for applying online via the Medavie Blue Cross Corporate website by clicking on the link below.

**Apply Now**

We would like to thank all candidates for expressing interest. Please note only those selected for interviews will be contacted.

**Medavie Blue Cross is an equal opportunity employer.**

BACK TO CONTENTS

PHYSICIAN'S BULLETIN
June 11, 2019: Vol. LXIV, ISSUE 11

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## PATIENT ENROLMENT INCENTIVE UPDATE

This is a reminder that your patient panel will be accessible via the link provided until midnight on **June 21, 2019**. Your patient panel will need to be updated and finalized during this time period as there will be no further extensions/exceptions beyond the June extension. We recommend that you finalize your panel early to avoid any unexpected system issues which may occur closer to the deadline.

As noted in previous Physician's Bulletins, an incentive will only be paid to those physicians who completed the verification process and finalized their panel. The payment date associated with the incentive had changed given that the time to complete your panel was extended to June 21. Your payment will be deposited into the same bank account you have provided for other incentives and CMPA payments as per the Master Agreement on August 14, 2019.

If you have any questions while you are completing your patient panel, please do not hesitate to contact us. The following sections of the Patient Panel Verification Instructions have been updated based upon questions/feedback received:

- Accessing Your Panel
- Resetting a Forgotten Password

Please click here to view the updated instructions.

We can be reached at msi_assessment@medavie.ca or 902-496-7011/toll-free 1-866-553-0585 Mon – Fri, 8am – 5pm.

PHYSICIAN'S BULLETIN
June 5, 2019: Vol. LXIV, ISSUE 10

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## PATIENT ENROLMENT INCENTIVE UPDATE

We would like to remind you that your patient panel will be available via the link provided until midnight on **June 21, 2019**. Your patient panel will need to be updated and finalized during this time period as there will be no further extensions/exceptions beyond the June extension. As noted in previous Physician's Bulletins, an incentive will only be paid to those physicians who completed the verification process and finalized their panel.

The following sections of the Patient Panel Verification Instructions have been updated based upon questions/feedback received:

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PHYSICIAN'S BULLETIN
May 29, 2019: Vol. LXIV, ISSUE 9

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## WCB CLAIMS PROCESSING – UPCOMING CHANGES

As noted in the Physician's Bulletin dated March 27, 2019, the implementation date for including the WCB claim number and/or the worker's injury date (month and year) when submitting claims to Medavie for WCB payment is, June 27, 2019.

Accredited billing vendors have been contacted regarding this implementation date. Please contact your vendor directly if you have any questions regarding the rollout of their software changes.

Ongoing updates will be provided via the MSI Physician's Bulletin. Relevant information will also be posted on the MSI website, https://msi.medavie.bluecross.ca. If you have any questions, please email msi_assessment@medavie.bluecross.ca or call 902-496-7011/toll-free 1-866-553-0585.

PHYSICIAN'S BULLETIN
May 7, 2019: Vol. LXIV, ISSUE 8

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## PATIENT ENROLMENT INCENTIVE UPDATE

The Department of Health and Wellness has decided to extend the deadline for finalizing your patient panel. Your patient panel will be available via the link provided until midnight on **June 21, 2019**. Your patient panel will need to be updated and finalized during this time period as there will be no further extensions/exceptions beyond the June extension. As noted in the Physician's Bulletin of April 5, an incentive will only be paid to those physicians who completed the verification process and finalized their panel.

Please click here to view the updated instructions based on questions/feedback received.

If you have any questions while you are completing your patient panel, please do not hesitate to contact us. We can be reached at msi_assessment@medavie.ca or Mon – Fri, 8am – 5pm, 902-496-7011/toll-free 1-866-553-0585.

PHYSICIAN'S BULLETIN
May 6, 2019: Vol. LXIV, ISSUE 7

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## PATIENT ENROLMENT INCENTIVE REMINDER

A patient panel package was mailed to eligible physicians on April 15, 2019. The package was sent to family physicians who attested that they are providing comprehensive and continuous care to their patients by signing and returning the Physician Confirmation Letter provided by MSI, prior to February 1, 2019.

We would like to remind you that your patient panel will be accessible via the link provided until May 23, 2019. Your patient panel will need to be updated and finalized during this time period. As noted in the Physician's Bulletin of April 5, an incentive will only be paid to those physicians who completed the verification process and finalized their panel.

The following sections of the Patient Panel Verification Instructions have been updated based upon questions/feedback received:

- Accessing Your Panel
- Resetting a Forgotten Password

Please click here to view the updated instructions.

If you have any questions while you are completing your patient panel, please do not hesitate to contact us. We can be reached at msi_assessment@medavie.ca or Mon – Fri, 8am – 5pm, 902-496-7011/toll-free 1-866-553-0585.

PHYSICIAN'S BULLETIN
April 26, 2019: Vol. LXIV, ISSUE 6

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## PATIENT ENROLMENT INCENTIVE REMINDER

A patient panel package was mailed to eligible physicians on April 15, 2019. The package was sent to family physicians who attested that they are providing comprehensive and continuous care to their patients by signing and returning the Physician Confirmation Letter provided by MSI, prior to February 1, 2019.

We would like to remind you that your patient panel will be accessible via the link provided until May 23, 2019. Your patient panel will need to be updated and finalized during this time period. As noted in the Physician's Bulletin of April 5, an incentive will only be paid to those physicians who completed the verification process and finalized their panel.

The following sections of the Patient Panel Verification Instructions have been updated based upon questions/feedback received over the last week:

- Accessing Your Panel
- Resetting a Forgotten Password

Please click here to view the updated instructions.

If you have any questions while you are completing your patient panel, please do not hesitate to contact us. We can be reached at msi_assessment@medavie.ca or Mon – Fri, 8am – 5pm, 902-496-7011/toll-free 1-866-553-0585.

# PHYSICIAN'S BULLETIN

April 5, 2019: Vol. LXIV, ISSUE 5


NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## MSI News

### UNIT VALUES AND PAYMENT RATES

**MEDICAL SERVICE UNIT / ANAESTHESIA UNIT VALUE**
Effective April 1, 2019 the Medical Service Unit (MSU) value is $2.48 and the Anaesthesia Unit (AU) Value is $21.07.

**WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC UNIT VALUE**
Effective April 1, 2019 the Workers' Compensation Board MSU Value is $2.76 and the Workers' Compensation Board Anaesthetic Unit Value is $23.41.

**PSYCHIATRY FEES**
Effective April 1, 2019 the hourly Psychiatry rate for General Practitioners is $113.33 and the hourly rate for Specialists is $153.67 as per the tariff agreement.

**SESSIONAL PAYMENTS**
Effective April 1, 2019 the hourly Sessional payment rate for General Practitioners is $148.80 and the hourly rate for Specialists is $173.60 as per the tariff agreement.

### CHANGE TO BREAST REDUCTION CRITERIA

Effective immediately DHW has removed the criteria that patients have a BMI of 27 or less to qualify for MSI coverage for a breast reduction. All other requirements remain unchanged.

### REISSUING REQUEST FOR PROPOSALS – MEDICAL CONSULTANT

The Department of Health and Wellness is reissuing the Request for Proposals (RFP) for part time services of a Medical Consultant to provide support and advice on a range of policy issues related to Physician Services, Pharmacare, Children's Oral Health Program, and other extended health benefit programs. It is anticipated that the RFP will be posted on the Government Procurement site the week of April 8, 2019 and will be posted for a period of 15 days. Please watch for it on the Government Procurement site at https://novascotia.ca/tenders/default.aspx

BACK TO CONTENTS

## PATIENT PANEL ENROLLMENT INCENTIVE

In March 2018 the Premier announced a number of new investments in Primary Care. This announcement included a one-time flat enrollment fee of $7.50 per current patient to enable family physicians to identify a panel of patients for whom they are providing comprehensive and continuing care.

As noted in the Physician's Bulletins posted on December 11, 2018 and January 14, 2019 the patient enrollment incentive is available to those family physicians who attest that they are providing comprehensive and continuous care to their patients by signing and returning the Physician Confirmation Letter provided by MSI, prior to February 1, 2019. Participation in the patient panel verification initiative is on a voluntary basis.

An initial patient panel has been created for each eligible physician based upon claims submitted to MSI over the past 3 years. A package containing instructions on how to access your panel online and verify your patients will be mailed to you on April 15, 2019. Your patient panel will be accessible via the link provided until May 23, 2019. Your patient panel will need to be updated and finalized during this time period. An incentive will only be paid to those physicians who completed the verification process and finalized their panel. Your incentive will be based upon the number of patients that appear on your final approved and validated panel. The payment will be issued on July 17, 2019. Additional details will be provided in the package.

If you have any questions regarding this upcoming verification process, please do not hesitate to contact us. We can be reached at msi_assessment@medavie.bluecross.ca or 902-496-7011/toll-free 1-866-553-0585.

# ★ Fees New Fees and Highlighted Fees

## UPDATED FEES

Effective April 6, 2019 Health Service Code 02.02B has been updated to include patients starting hydroxychloroquine or chloroquine treatment.

| Category | Code | Description | Base Units |
|---|---|---|---|
| **VADT** | **02.02B** | **Optic Nerve Imaging**<br>Optic Nerve Imaging by any means (e.g. OCT, HRT) for patients with a diagnosis of glaucoma, wet AMD, retinal vein occlusion, diabetic macular edema, *and patients starting hydroxychloroquine or chloroquine treatment.*<br>This fee is for the interpretation of scanning computerized ophthalmic diagnostic imaging, with interpretation and written report, unilateral or bilateral, of the optic nerve and/or retina regardless of the technology used to perform the imaging. Not to be used for glaucoma screening.<br><br>**Billing Guidelines**<br>• Glaucoma Diagnosis – once per patient per year.<br>• Diabetic macular edema, retinal vein occlusion or wet age related macular degeneration having been treated once in the past year with intravitreal anti-VEGF drugs – up to 6 times per patient per year.<br>• *One baseline OCT for patients starting treatment with hydroxychloroquine or* | **8 MSU** |

| Category | Code | Description | Base Units |
|---|---|---|---|
| | | *chloroquine*<br>• *After five years of hydroxychloroquine or chloroquine treatment, one OCT per year will be considered medically necessary.*<br>• *For patients on hydroxychloroquine or chloroquine who have suspicious visual fields, clinical findings on examination of the retina, or are at high risk (dosing in excess of 5mg/kilo per day), OCT will be considered medically necessary up to twice a year.*<br><br>**Eligible Diagnostic Codes**<br>• 362.52 – Exudative Senile Macular Degeneration<br>• 362.01 – Background Diabetic Retinopathy<br>• 362.35 – Central Retinal Vein Occlusion<br>• 362.36 – Venous Tributary Occlusion<br>• 379.27 – Vitreomacular Adhesion<br>• 365.9 – Unspecified Glaucoma<br>• *362.10 – Background Retinopathy Unspecified (this is to be used for patients on hydroxychloroquine/chloroquine as there is no specific ICD9 code- see note below)*<br><br>**Location**<br>OFFC, HOSP<br><br>**Note**<br>Claims submitted with 362.10 ICD9 diagnostic code will require text stating the type of medication and any additional risk factors. These claims will be manually assessed. | |

**Effective April 6, 2019 the modifier (US=UNOF) has been removed from (PT=EXPT) claims**.
By definition an urgent visit requires the physician to travel from one location to another in order to visit the patient, as outlined in Preamble 5.1.52. While an urgent visit is appropriate for the first patient seen at a facility, it does not apply to the second or subsequent patients seen at the same location as the physician is already physically in the facility and thus no travel occurred.

**13.59L RO=HPV9 PT=RISK Age Restriction**
High-Risk patients will only be eligible for this vaccination up to and including 45 years of age.

## ★ Fees New Fees and Highlighted Fees

## NEW FEES

Effective April 6, 2019 the following health service code will be available for billing:

| Category | Code | Description | Base Units |
|---|---|---|---|
| **VEDT** | **13.59O** | **Injection of onabotulinumtoxinA for the treatment of Chronic Migraine (Prior Approval)**<br>This is a comprehensive code for the assessment and treatment of adults with a documented history of chronic migraine, defined as having greater than or equal to 15 headache days per month over at least a three month period, and who have not responded to at least three prior pharmacological prophylaxis therapies or for patients who are intolerant of pharmacological prophylaxis. | **70 MSU** |

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| | | This code includes patient assessment and counselling, preparation of ONA injections, performing all injections using the appropriate protocol, and patient observation prior to discharge.<br>The physician must request prior approval in writing. The request must include:<br>• The patient's clinical history of Chronic Migraine<br>• Documentation of previous attempts at pharmacological prophylaxis including the names of medication, duration of treatment and results.<br>• If this is a subsequent request for continued treatment, documentation of treatment effect must be included.<br><br>**Billing Guidelines**<br>• Prior approval will be valid for treatment provided to that patient for a period of 24 months<br>• No more than 8 service encounters for injection of ONA for Chronic Migraine may occur over that 24 month period<br>• Services to be no more frequent than every 3 months<br>• If treatment continues to be recommended after this time period, prior approval must be requested again<br><br>Once a request for approval has been made to the MSI Medical Consultant, a response will be issued. If approval is granted you will be advised of a Preauthorization Number. To ensure payment of the service the Preauthorization Number must be entered in the appropriate field on the service encounter.<br><br>**Specialty Restriction**<br>NEUR<br><br>**Location**<br>OFFC | |

Effective April 6, 2019 the following health service codes will be available for billing:

| Category | Code | Description | Base Units |
|---|---|---|---|
| **VEDT** | **13.99F** | **Assessment and management of patient with Acute Stroke: From activation of Acute Stroke Protocol through completion of thrombolytic therapy (e.g. t-PA)**<br>This HSC is specific for the assessment and management of a patient experiencing symptoms of acute stroke and for whom the Acute Stroke Protocol has been activated. The service includes ongoing evaluation, clinical monitoring, diagnostic evaluation, review of diagnostic imaging and completion of thrombolytic therapy (e.g. t-A)<br><br>**Billing Guidelines**<br>• Reportable by one physician per patient per day<br>• Must complete thrombolytic therapy in order to report this HSC<br>• If patient does not receive thrombolytic therapy, only the pertinent visit code is reportable<br><br>**Location**<br>HOSP (Provincial Stroke Centers only) | **130 MSU** |
| **VEDT** | **13.99G** | **Assessment and management of patient with Acute Stroke: From activation of Acute Stroke Protocol through receiving endovascular thrombectomy (EVT) with or without administration of thrombolytic therapy** | **170 MSU** |

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| | | This HSC is specific for the assessment and management of a patient experiencing symptoms of acute stroke and for whom the Acute Stroke Protocol has been activated. The service includes ongoing evaluation, clinical monitoring, diagnostic evaluation, review of diagnostic imaging, with or without thrombolytic therapy, and supervision of patient receiving EVT.<br><br>**Billing Guidelines**<br>• Reportable by one physician per patient per day<br>• Patient must undergo EVT in order to report this HSC<br><br>**Specialty Restriction**<br>NEUR<br><br>**Location**<br>HOSP (Halifax Infirmary only) | |

## NEW INTERIM FEES

Effective April 6, 2019 the following interim health service codes will be available for billing:

| Category | Code | Description | Base Units |
|---|---|---|---|
| **VADT** | **13.59P** | **Insertion of Buprenorphine Implant (e.g. Probuphine) for the treatment of opioid use disorder**<br>This HSC is for the insertion of the non-biodegradable buprenorphine delivery implant for the treatment of opioid use disorder | **20 MSU** |
| **VADT** | **13.59Q** | **Removal of Buprenorphine Implant (e.g. Probuphine)**<br>This HSC is for the removal of the non-biodegradable buprenorphine delivery implant<br><br>For removal and reinsertion of the non-biodegradable buprenorphine delivery implant, report the removal code at 100% and the insertion code at LV50.<br><br>**Billing Guidelines**<br>May not be claimed in addition to OAT1 or OAT2 by any physician for the same patient for 6 months following implantation.<br>If the implant is removed early or there are special circumstances to consider the physician should add text to the OAT management claim explaining the circumstances. | **20 MSU** |

Effective April 6, 2019 the following interim health service code will be available for billing:

| Category | Code | Description | Base Units |
|---|---|---|---|
| **VEDT** | **50.0B** | **Endovascular Thrombectomy-Intracranial**<br>Endovascular Thrombectomy for the purpose of revascularization of a thrombotic or embolic occlusion of one or more intracranial vessels. This comprehensive health service code includes: Selective catheterization, diagnostic angiography and all selective angiography required to perform the procedure within the vascular territory.<br><br>**Specialty Restriction**<br>Neuroradiology (DIRD with subspecialty in neuroradiology)<br><br>**Location**<br>HOSP (QEII only) | **300 MSU** |

BACK TO CONTENTS

Effective April 6, 2019 the following interim health service code will be available for billing:

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.04I | **PSP Mental Health Comprehensive Visit to establish the PSP Mental Health Plan (PSP= Practice Support Program)**<br>This code is for the complete assessment of the patient with a confirmed mental illness meeting the diagnostic criteria in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of sufficient severity and acuity to cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and warrant the development of a Mental Health care plan. This is not intended for patients with self-limited or short lived mental health symptoms. The assessment is to be performed by the PSP trained family physician most responsible for the patient's mental health care. The Mental Health Plan and start and stop times must be documented in the health record.<br>This complete assessment is to include **all** of the following elements and be documented in the health record:<br>• The patient's DSM diagnosis, psychiatric history and current mental state including suicide risk assessment as appropriate<br>• Obtaining collateral history and information from caregivers as required<br>• Performance of a complete medication review to include collateral information from pharmacy and assisted living facility as appropriate<br>• Reviewing and documenting results of relevant validated assessment tools, laboratory, and other test results<br>• Documentation of a clinical plan for the patient's care over the next year. Includes advanced care planning where appropriate<br>• Outline of expected outcomes as a result of the treatment plan<br>• Outline of linkages with other health care providers and community resources who will be involved in the patients care.<br>• Confirmation that the plan has been created jointly and shared with the patient or their medical representative. The plan is to be shared with other care providers as appropriate<br>• A documented care plan must be in place before access to additional counselling hours is provided<br>It is recognized that the required elements may require more than one visit to complete. This health service code may be claimed at the final visit only when all of the information is complete and documented in the health record; other visits may be reported at the usual rate.<br><br>**All** elements must be documented in the health record before reporting this PSP MHP visit service.<br><br>**Billing Guidelines**<br>• Reportable by the patient's PSP trained physician only<br>• Not reportable with any other visit fee for the same physician, same patient, same day<br>• Not reportable for services provided at walk-in clinics<br>• Not to be used for patients living in nursing homes, residential care facilities or hospices<br>• Reportable only once per patient per year<br>• 50 MSU for first 30 minutes, 25 MSU for each additional 15 minutes, up to a maximum of 1 hour (5 multiples)<br>• Start and stop times must be reported in the text field of the claim to MSI, as well as in the clinical record<br><br>**Specialty Restriction**<br>GENP with PSP Training<br><br>**Location**<br>OFFC, HOME | **50 MSU +MU** |

## PREAMBLE CHANGES

Counselling- Preamble 5.2.151

| Current Definition | New Definition |
|---|---|
| The following services and restrictions apply to general practitioners only. *(5.2.152)*<br>Counselling is a prolonged discussion directed at addressing problems associated with acute adjustment reactions or bereavement reactions. *(5.2.153)*<br>Counselling may be claimed in 15 minute intervals. At least 80 percent of the time claimed must be spent in direct patient intervention. *(5.2.154)*<br>Restrictions:<br>Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, counselling may not be claimed for the following:<br>– More than five hours per patient per physician per year.<br>– More than one hour per patient per day.<br>– A patient younger than four years old.<br>– More than one general practitioner providing counselling to a particular patient. *(5.2.155)* | The following services and restrictions apply to general practitioners only. *(5.2.152)*<br>Counselling is a prolonged discussion directed at addressing issues pertaining to the patient's underlying mental illness, acute adjustment disorder or bereavement. Counselling may be claimed by family physicians for patients who meet the current DSM (Diagnosis and Statistical Manual of Mental Disorders) diagnostic criteria for the diagnosis of a mental health disorder *(5.2.153)*<br>Counselling may be claimed in 15 minute intervals. At least 80 percent of the time claimed must be spent in direct patient intervention. *(5.2.154)*<br>Restrictions:<br>Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, counselling may not be claimed for the following:<br>– More than five hours per patient per physician per year.<br>– More than one hour per patient per day.<br>– A patient younger than four years old.<br>– More than one general practitioner providing counselling to a particular patient.<br>– Physicians who have completed training in the Practice Support Program Adult Mental Health Module may have access to an additional 4 hours of counselling per patient per year. The physician's name must be in the Nova Scotia Health Authority database confirming completion of training. *(5.2.155)*[1] |
| PSYC<br>08.49A Counselling.....12.7 per 15 min<br>TI=GPEW.....15.88 per 15 min | PSYC<br>08.49A Counselling.....25.4 per 30 min.<br>(12.7 units per 15 min. thereafter)<br>TI=GPEW.....15.88 per 15 min. |

*[1] PSP Physicians who are billing above the 5 hour maximum per patient per year GP restriction must indicate in the text field of the claim that they are a PSP qualified physician. These physicians must be in the NSHA database to confirm completion of training.*

## BILLING REMINDERS

**Meet and Greet**

Preamble rules stipulate that all services billed to MSI must be medically necessary i.e. there must be a specific health related concern/ complaint that has led the patient to seek medical attention. It is not appropriate to bill MSI for a "meet and greet" encounter with a new patient unless a health related concern/complaint has been addressed during the encounter and the Preamble requirements for medically necessary visits have been satisfied.

BACK TO CONTENTS

## Unattached Patient Bonus Incentive (UPB1)

Physicians are reminded that this incentive may only be claimed for individuals they have agreed to take on as regular patients. The incentive may be claimed at the time of the first visit to the physician's office. The fee cannot be claimed in other circumstances such as placing the patient on a waiting list for the practice, when the patient is not being accepted into the practice, or is being directed to another physician for care.

The current guidelines for UPB1 were effective April 1, 2018

| Category | Code | Description | Value |
|---|---|---|---|
| **DEFT** | **UPB1** | **Unattached Patient Bonus**<br>This incentive is available for eligible general practitioners who take on a patient who does not have a family physician and meets the criteria indicated below<br><br>**Billing Guidelines**<br>• The GP has to have had at least one visit service with the patient prior to claiming the UPB1 fee. The UPB1 fee is billable in addition to the associated visit fee.<br>• A GP can only claim UPB1 once per patient per lifetime. A physician cannot claim the unattached patient bonus more than once for the same patient.<br>• An unattached patient is described as: patients taken from the 811 list, referred from an emergency department, patients who do not have a family physician, newborns and patients whose family physician is about to retire or relocate and does not have a new family physician to assume their practice.<br>• The GP keeps the Unattached Patient in his/her practice and maintains an open chart for the patient for a minimum of one year.<br>• The UPB1 cannot be claimed for walk-in clinics, for patients who already appear on a physician's patient list (physician validated), for patients who were taken off the 811 list before the establishment of this fee enhancement, or for new physicians who are building their practices until that point when their patient panel reaches 1350.<br>• New Physicians must be practicing in the community for a minimum of two years, or have reached a patient panel of 1350 prior to claiming the UPB1.<br>• Locum physicians are not eligible for this incentive.<br><br>**Documentation**<br>The GP must confirm and document at the initial visit with the Unattached Patient that the patient is unattached (i.e., does not already have a regular family physician). Information about the encounter that resulted in the GP taking the Unattached Patient into his/her practice must also be recorded in the patient's record. This can be a patient from the 811 list, referral from the hospital emergency department, for enrolling patients who do not have a physician or are unattached at time of enrolment, for enrolling patients for whom un-attachment is imminent because their family practitioner is retiring/relocating and no new family physician is taking over the practice, an inpatient hospital report or other documentation. (Other documentation may include a note by the physician, documenting their discussion with the patient, confirming the prior hospital encounter.)<br><br>**Specialty Restriction**<br>GENP<br><br>**Location**<br>All Locations | **$150.00**<br>(one time per patient) |

## BILLING REMINDERS (CONTINUED)

**Consultations with unknown medical necessity**

As outlined in Preamble 2.2.9, MSI will pay for a visit or consultation to determine if a treatment method is insured. This applies in circumstances in which the proposed procedure is sometimes, but not always insured. If the proposed procedure or treatment method is always uninsured, a visit or consultation may not be claimed.

**Health Service Code 13.59N (Intravenous Infusion of Local Anaesthetic/Adrenergic Drugs for Chronic Pain Management)**

The protocol required in order to claim Health Service Code 13.59N was originally outlined in the submission to the Fee Committee. In the performance of this procedure, patients are to be monitored with both an electrocardiogram and a pulse oximeter. An intravenous line is established and an infusion pump is used to deliver the drug. The physician must be in attendance or readily available to intervene to ensure that side effects do not occur and to make the necessary adjustments in the dosage of the medication. The patient also must be monitored for 10-15 minutes after the infusion is completed and then transferred to a 'post-recovery area' where they are continued to be monitored for a further 30 minutes before being discharged.

**Imaging Studies Ordered by Chiropractors**

Radiologists are reminded that they may only claim for imaging studies requested by physicians and nurse practitioners. They may not claim for studies requested by other health care providers, including chiropractors.

## NEW EXPLANATORY CODES

| Code | Description |
|---|---|
| AD083 | SERVICE ENCOUNTER HAS BEEN REFUSED BASED ON THE AGE OF THE RECIPIENT |
| DE035 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS OAT1 AND OAT2 MAY NOT BE CLAIMED IN THE 6 MONTHS FOLLOWING AN INSERTION OF BUPRENORPHINE IMPLANT FOR THE TREATMENT OF OPIOID USE DISORDER |
| MA076 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU ARE NOT PERMITTED TO CLAIM THIS FEE |
| VA094 | SERVCE ENCOUNTER HAS BEEN REFUSED AS ELECTRONIC TEXT IS REQUIRED ON THE CLAIM STATING TYPE OF MEDICATION AND ANY ADDITIONAL RISK FACTORS |
| VA095 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF OCT FEES PER YEAR FOR THIS DIAGNOSIS HAVE PREVIOUSLY BEEN CLAIMED IN THE PAST YEAR |
| VE020 | SERVICE ENCOUNTER HAS BEEN REFUSED AS AN INJECTION OF ONA FOR CHRONIC MIGRAINE HAS ALREADY BEEN APPROVED IN THE PREVIOUS 3 MONTHS |
| VE021 | SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 8 INJECTIONS OF ONA FOR CHRONIC MIGRAINE MAY BE CLAIMED OVER A 24 MONTH PERIOD. IF TREATMENT CONTINUES TO BE RECOMMENDED AFTER THIS TIME PERIOD, PRIOR APPROVAL MUST BE REQUESTED AGAIN |
| VE022 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR ASSESSMENT AND MANAGEMENT OF A PATIENT WITH ACUTE STROKE WAS PREVIOUSLY MADE FOR THIS PATIENT ON THIS DAY |
| VE023 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS FACILITY IS NOT AUTHORIZED TO CLAIM THE ACUTE STROKE PROTOCOL FEE |
| VE024 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE MAY ONLY BE CLAIMED FROM THE QEII |

| Code | Description |
|---|---|
| VT166 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS TEXT INDICATING THE STOP AND START TIMES FOR THIS SERVICE IS REQUIRED |
| VT167 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.04I IS NOT REPORTABLE WITH ANY OTHER VISIT FEES ON THE SAME DAY |
| VT168 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.04I MAY ONLY BE REPORTED ONCE PER PATIENT PER YEAR |

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

### UPDATED FILES

Updated files reflecting changes are available for download on Saturday April 6, 2019. The files to download are health service (SERVICES.DAT), health service description (SERV_DSC.DAT) and, explanatory codes (EXPLAIN.DAT).

### HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

http://msi.medavie.bluecross.ca/

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

### 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

In partnership with

NOVA SCOTIA

BACK TO CONTENTS

PHYSICIAN'S BULLETIN
March 27, 2019: Vol. LXIV, ISSUE 4

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## WCB CLAIMS PROCESSING – UPCOMING CHANGES

The target implementation date, for including the WCB claim number and/or the worker's injury date (month and year) when submitting claims to Medavie for WCB payment, is no longer April 18, 2019 as specified in the Physician's Bulletin dated January 21, 2019. The revised target date is June 27, 2019.

Accredited billing vendors have been contacted regarding the revised date. Please contact your vendor directly if you have any questions regarding the rollout of their software changes.

Ongoing updates will be provided via the MSI Physician's Bulletin. Relevant information will also be posted on the MSI website, https://msi.medavie.bluecross.ca. If you have any questions, please email msi_assessment@medavie.bluecross.ca or call 902-496-7011/toll-free 1-866-553-0585.

PHYSICIAN'S BULLETIN
March 1, 2019: Vol. LXIV, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## REQUEST FOR PROPOSALS – MEDICAL CONSULTANT

The Department of Health and Wellness is seeking the part time services of a Medical Consultant to provide support and advice on a range of policy issues related to physician services, Pharmacare, Children's Oral Health Program, and other extended health benefit programs.

A Request for Proposals (RFP) is posted in the Government Procurement site at:
https://novascotia.ca/tenders/tenders/tender-details.aspx?id=Doc208398473.
The RFP closes March 11, 2019, 2 PM.

# PHYSICIAN'S BULLETIN

February 8th, 2019: Vol. LXIV, ISSUE 3


NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## MSI News

### CHANGES TO NOVA SCOTIA HEALTH CARDS

Beginning February 11th 2019, Nova Scotia Residents will have the option to remove their sex designation from the front of their health card. A resident's sex designation will still be contained on the health card's magnetic stripe and in the MSI Registration files. A resident's sex designation is still required as part of the claims submission process. If you have any questions concerning the change or require assistance, please contact the MSI Resident Services Department at 902-496-7008 or 1-800-563-8880.

### MSI DOCUMENTATION REMINDER

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribed, and start and stop times for time based codes.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptation's, or emotional problems, the physician "deliberately established a professional relationship with the patient for the purposes of removing, modifying or alleviating existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional wellbeing of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy," etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service on that date, then the service is not paid for or a lesser benefit is given. **When the clinical record does not support the service claimed, there will be a recovery to MSI at the time of audit.** Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

BACK TO CONTENTS

## HIGHLIGHTED FEES

The Master Agreement Management Group increased newborn and post-partum inpatient fees, applicable to all relevant providers. The following adjustments complete that increase, first published for family physicians in the November 30th 2018 bulletin. This increase for post-partum and newborn inpatient fees is interim, pending Fee Committee review of inpatient fees for all specialties: Effective February 8th, 2019 the adjusted MSU values apply to the following health service codes.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03 | **Subsequent Care – Newborn Healthy Infant (LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS, SP=PEDI)**<br>**Days 2, 3 (DA=DA23)**<br>**Days 4-5 (DA=DA45)**<br><br>**Description**<br>These adjusted MSU values apply to the following health service codes:<br>03.03 LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS, SP=PEDI – Subsequent Care – Newborn Healthy Infant<br>When the visit is provided to patients admitted to hospital where the pediatrician is the most responsible physician.<br><br>**Billing Guidelines**<br>May only be claimed once per patient per day by the most responsible physician (MRP)<br><br>**Specialty Restriction**<br>SP=PEDI<br><br>**Location**<br>LO=HOSP, FN=INPT<br><br>**Notes:**<br>First day out of ICU should be considered equivalent to day 2 and subsequent inpatient days as 3,4,5 for the purpose of reporting these increased code values. | <br>23 MSU<br>19 MSU |

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03 | **Post-Partum Visit (LO=HOSP, FN=INPT, RO=PTPP, SP=OBGY)**<br>**Days 2, 3 (DA=DA23)**<br>**Days 4-7 (DA=DA47)**<br><br>**Description**<br>These adjusted MSU values apply to the following health service codes:<br>03.03 LO=HOSP, FN=INPT, RO=PTPP, SP=OBGY – Post-Partum Visit<br>When the visit is provided to post-partum patients admitted to hospital where the obstetrician or gynecologist is the most responsible physician.<br><br>**Billing Guidelines**<br>May only be claimed once per patient per day by the most responsible physician (MRP).<br><br>**Specialty Restriction**<br>SP=OBGY<br><br>**Location**<br>LO=HOSP, FN=INPT<br><br>**Notes:**<br>First day out of ICU should be considered equivalent to day 2 and subsequent inpatient days as 3,4,5,6,7 for the purpose of reporting these increased code values. | <br>23 MSU<br>19 MSU |

BACK TO CONTENTS

# FEE REVISIONS

As announced in the November 30, 2018 bulletin, HSC **78.39A – Interruption or removal of fallopian tubes for purposes of sterilization: abdominal, vaginal, laparoscopic-not hysteroscopic (unilateral or bilateral**) will now accept a Surgical Assistant modifier.
Effective February 8th, 2019, offices may now bill their Surgical Assist claims for services provided since November 30th, 2018.

Effective February 8th, 2019, HSC **03.03J, 03.03K, 03.03L** have been updated:

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03J | **Initial Opioid Use Disorder Assessment for Initiation of Opioid Agonist Treatment (OAT) Community Primary Care Setting Only (30 minutes)** | 50MSU + MU |

**Description**
This is a time based fee for the complete assessment of the patient entering into opioid agonist treatment (OAT) for the first time as prescribed by their primary care provider. The required elements of this service are outlined below and must be documented in the patient's health record. Required elements include:

i. A complete substance use history including illicit, prescription and OTC medications with a risk of abuse and a DSM diagnosis for each problematic drug;
ii. A complete addiction treatment history;
iii. Past medical and surgical history;
iv. Family history;
v. Psychosocial history, including living situation, source of income and education;
vi. Review of systems;
vii. A focused physical examination;
viii. Review of treatment options;
ix. Formulation of a treatment plan;
x. Communication with the patient and/or family to obtain information for the assessment as well as with support staff working in the treatment environment;
xi. Communication with previous care providers, including family doctors, pharmacists, Mental Health and Addictions staff, etc. as necessary.
xii. Obtain a patient profile for the previous 12 months through the Nova Scotia Prescription Monitoring Program (NSPMP) or Drug Information System (DIS)
xiii. Obtain a urine drug screen;
xiv. The health care provider should request blood work serology (screening for HIV, and Hepatitis A, B, and C) if not done recently by a previous provider.
xv. Consider obtaining an ECG if indicated.

- Start and stop times are to be documented in the health record.
- It is recognized that the required elements may be gathered over several visits with the patient. This fee is for the initial visit only

**Billing Guidelines**

- Billable only by the health care provider who is most responsible for the patient's ongoing OAT in the community primary care setting.
- Not reportable for care provided in an Opioid Use Disorder Treatment Program
- Multiples of 15 minutes may be billed in addition to the base fee code to a maximum of 60 minutes in total.
- 80% of the time must be spent in face to face contact with the patient and/or family.
- If time less than 25 minutes, bill as regular visit.
- Once per health care provider per patient.

**Specialty Restriction**
SP=GENP

**Premium**
TI=GPEW

**Location**
LO=OFFC

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03K | **Initial Opioid Use Disorder Assessment for Opioid Agonist Treatment (OAT) – Transfer from Opioid Use Disorder Treatment Program to community Primary Care Provider** | 50MSU |

**Description**

This is a fixed fee for the complete assessment of the patient being transferred from an established Opioid Use Disorder Treatment Program to the primary health care provider who will be most responsible for that patient's ongoing OAT. The required elements of this service are outlined below and must be documented in the patient's health record. Required elements include:

i. A complete substance use history including illicit, prescription and OTC medications with a risk of abuse and a DSM diagnosis for each problematic drug;
ii. A complete addiction treatment history;
iii. Past medical and surgical history;
iv. Family history;
v. Psychosocial history, including living situation, source of income and education;
vi. Review of systems;
vii. A focused physical examination;
viii. Review of treatment options;
ix. Formulation of a treatment plan;
x. Communication with the patient and/or family to obtain information for the assessment as well as for support staff working in the treatment environment;
xi. Communication with previous care providers, including family doctors, pharmacists, Mental Health and Addictions staff, etc. as necessary;
xii. Obtain a patient profile for the previous 12 months through the Nova Scotia Prescription Monitoring Program (NSPMP) or Drug Information System (DIS);
xiii. Obtain a urine drug screen;
xiv. The physician should request blood work serology (screening for HIV, and Hepatitis A, B and C) if not done recently by a previous provider;
xv. Consider obtaining an ECG if indicated.

It is recognized that the required elements may be gathered over several visits with the patient. This fee is for the initial visit only.

**Billing Guidelines**

- Reportable only by the health care provider who is most responsible for the patient's ongoing OAT in the community primary care setting
- Once per patient per health care provider
- Applies only to patients transferred from a recognized Opioid Use Disorder Treatment Program
- Not reportable by health care providers who have previously seen the patient in a recognized Opioid Use Disorder Treatment Program

**Specialty Restriction**
SP=GENP

**Premium**
TI=GPEW

**Location**
LO=OFFC

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03L | **Permanent Transfer of a patient on active Opioid Agonist Treatment (OAT) for opioid use disorder-Full acceptance of responsibility for ongoing care –Initial visit with accepting health care provider** | 50MSU |

**Description**

This is a fixed fee available to the primary care provider accepting full and ongoing responsibility for OAT for the patient's substance use disorder from the community health care provider currently providing care, due to a patient's relocation or desire for permanent change in health care provider. The required elements of this service are outlined below and must be documented in the patient's health record. Required elements include:

- A complete substance use history including illicit, prescription and OTC medications with a risk of abuse and a DSM diagnosis for each problematic drug;
- A complete addiction treatment history;
- Past medical and surgical history;
- Family history;
- Psychosocial history, including living situation, source of income and education;

BACK TO CONTENTS

- Review of systems;
- A focused physical examination;
- Review of treatment options;
- Formulation of a treatment plan;
- Communication with the patient and/or family to obtain information for the assessment as well as for support staff working in the treatment environment;
- Communication with previous care providers, including family doctors, pharmacists, Mental Health and Addictions staff, etc. as necessary;
- Obtain a patient profile for the previous 12 months through the Nova Scotia Prescription Monitoring Program (NSPMP) or Drug Information System (DIS);
- Obtain a urine drug screen;
- The physician should request blood work serology (screening for HIV, and Hepatitis A, B and C) if not done recently by a previous provider;
- Consider obtaining an ECG if indicated.

It is recognized that the required elements may be gathered over several visits with the patient. This fee is for the initial visit only. Regular visit fees may be billed for subsequent visits.

**Billing Guidelines**

- Reportable only by the health care provider who is most responsible for the patient's ongoing OAT
- Once per patient per health care provider
- Reportable only by the accepting health care provider
- Not reportable for health care providers within the same group practice
- Not reportable by health care providers who have previously seen the patient in a recognized Opioid Use Disorder Treatment Program

**Specialty Restriction**
SP=GENP

**Premium**
TI=GPEW

**Location**
LO=OFFC

## NEW FEES

Effective February 8th, 2019, HSC **MMM1 and MMM2** have been terminated and replaced with **OAT1 and OAT2**:

| Category | Code | Description | Base Units |
|---|---|---|---|
| DEFT | OAT1 | **Opioid Agonist Treatment (OAT) Monthly Management Fee for the Comprehensive Primary Care Provider Only**<br>**ME=CARE** | 60MSU |

**Description**
This fee may be billed once per month by the comprehensive primary care provider, outside of the Opioid Use Disorder Treatment Program, who is most responsible for providing opioid agonist treatment (OAT) as defined by current DSM-criteria. The patient will be seen by the health care provider for a face to face visit or counselling session at least once per month (not including visits for urine drug screening alone). The following items are considered to be included in this service:

- All medication reviews and OAT dosage adjustments as required;
- Communicating on a regular timely basis with the pharmacy responsible for administering the patient's opioid agonist dose for the provision of safe and effective OAT: managing missed doses, checking on daily presentation at the pharmacy, helping coordinate prescriptions going to multiple pharmacies if there are Sunday or holiday closures or if a patient is travelling;
- Providing and/or coordinating care for the patient's concurrent physical and mental health conditions;
- Counselling the patient on issues related to their opioid use disorder;
- Connecting the patient to appropriate community resources;
- Providing case management and coordination of care functions, and facilitating connection with other addiction care providers;
- Arranging **random** point of care (POC) urine drug screening (UDS) appropriate to the patient's phase of treatment; To include generation of **random** UDS encounters, collection of urine, interpretation of results, documentation of the process of **randomization** and results of the screen in the health care record, and provision of feedback to the patient based on the results.
- A visit may not be claimed if the sole purpose of the patient's office encounter is to provide a urine sample.

BACK TO CONTENTS

- An annual discussion of treatment options with rationale for continued OAT must be documented in the health record.

**Billing Guidelines**

- Only one claim per patient per month
- Billable only by the comprehensive primary care provider working outside of the Opioid Use Disorder Treatment Program who is most actively supervising/ responsible for the patient's use of OAT (ME=CARE)
- If there is no evidence to support randomization of the POC UDS then the fee will not be paid
- Not reportable for care provided in an Opioid Use Disorder Treatment Program.
- Payment stops when the patient stops OAT
- Will not be paid unless at least 1 face to face visit or counselling session has been reported for the same patient by the same health care provider in the previous 30 day period.

**Specialty Restriction**
RO=GENP

**Location**
LO=OFFC

| Category | Code | Description | Base Units |
|---|---|---|---|
| DEFT | OAT2 | **Opioid Agonist Treatment (OAT) Monthly Management Fee for provision of OAT only – patient referred by another health care provider with written progress updates supplied to the primary care provider at least quarterly.** | 45MSU |

**Description**
This fee may be billed once per month by the health care provider, outside of the Opioid Use Disorder Treatment Program, who is most responsible for providing opioid agonist treatment (OAT) as defined by current DSM-criteria. The patient will be seen by the health care provider for a face to face visit or counselling session at least once per month (not including visits for urine drug screening alone). The following items are considered to be included in this service:

- All medication reviews and OAT dosage adjustments as required;
- Communicating on a regular timely basis with the pharmacy responsible for administering the patient's opioid agonist dose for the provision of safe and effective OAT: managing missed doses, checking on daily presentation at the pharmacy, helping coordinate prescriptions going to multiple pharmacies if there are Sunday or holiday closures or if a patient is travelling;
- Providing and/or coordinating care for the patient's concurrent physical and mental health conditions;
- Counselling the patient on issues related to their opioid use disorder;
- Connecting the patient to appropriate community resources;
- Providing case management and coordination of care functions, and facilitating connection with other addiction care providers;
- Arranging **random** point of care (POC) urine drug screening (UDS) appropriate to the patient's phase of treatment; To include generation of **random** UDS encounters, collection of urine, interpretation of results, documentation of the process of **randomization** and results of the screen in the health care record, and provision of feedback to the patient based on the results.
- A visit may not be claimed if the sole purpose of the patient's office encounter is to provide a urine sample.
- An annual discussion of treatment options with rationale for continued OAT must be documented in the health record.
- Written progress updates will be supplied to the patient's comprehensive primary care provider at least quarterly and documented in the health record.

**Billing Guidelines**

- Only one claim per patient per month
- Billable only by the comprehensive primary care provider working outside of the Opioid Use Disorder Treatment Program who is most actively supervising/ responsible for the patient's use of OAT
- If there is no evidence to support randomization of the POC UDS then the fee will not be paid
- Not reportable for care provided in an Opioid Use Disorder Treatment Program.
- Payment stops when the patient stops OAT
- Will not be paid unless at least 1 face to face visit or counselling session has been reported for the same patient by the same health care provider in the previous 30 day period.

**Specialty Restriction**
N/A

**Location**
LO=OFFC

BACK TO CONTENTS

Effective February 8th, 2019, HSC OFI1 is available for billing:

| Category | Code | Description | Base Units |
|---|---|---|---|
| ADON | OFI1 | **Incentive for use of Official Interpreter services when caring for a patient of limited English proficiency (LEP)** | 5MSU |

**Description**
This incentive is available to health care professionals who utilize the services of an official interpreter, as designated by the NSHA or IWK, when providing care to a patient of Limited English Proficiency (LEP). LEP refers to individuals who do not speak English as their primary language and have a limited ability to read, speak, write or understand English. This definition includes individuals who are deaf or hearing impaired and communicate using American Sign Language. Contact with the interpreter may be in person or via real time PHIA compliant technology. The interpreter's official identification must be documented in the patient's health record.

**Billing Guidelines**
This incentive may be added on to the appropriate visit code when the services of an official interpreter are required to facilitate a clinical encounter with a patient of Limited English Proficiency (LEP).
Available only for face to face or real time PHIA compliant technology encounters.

**Documentation Requirements**
The official identification number of the interpreter must be documented in the health record.

**Specialty Restriction**
N/A

**Location**
N/A

# PREAMBLE CHANGES

## GP EVENING AND WEEKEND INCENTIVE (5.1.188)

| Current Definition | New Definition |
|---|---|
| **GP EVENING AND WEEKEND INCENTIVE *(5.1.188)*** | **GP ENHANCED HOURS PREMIUM** |
| This incentive program is intended to promote enhanced evening and weekend access to primary care services provided in the offices of fee-for-service family physicians who have an established practice and provide comprehensive and on-going care for their patients. *(5.1.189)*<br>Billing Guidelines:<br>• The eligible time periods for claiming the evening and weekend office visit incentive are 6 – 10p.m. during weekday evenings and 9 a.m. – 5 p.m. on weekends (Saturday and Sunday).<br>• Physicians should offer and book appointments during these time periods in the same manner as they would for other (weekday) office hours.<br>• Evening and weekend services eligible for incentive funding are office visit services provided in a community-based family practice in which the physician maintains a comprehensive patient chart to record all patient encounters, provides all necessary follow-up care for each encounter and takes responsibility for initiation and follow-up on all related referrals.<br>• Eligible physicians may claim an incentive for evening and weekend office services provided for their own patients as well as for patients from the stable patient roster of other eligible<br>physicians within the same practice location, providing the patient's record can be accessed and the encounter is recorded.<br>• Services provided in walk-in clinics are not eligible for the evening and weekend office visit incentive funding program. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no | This premium in intended to promote enhanced patient access to comprehensive primary care outside of traditional office hours. This premium will be available only to physicians who have an ongoing clinical relationship with the patient and are practicing comprehensive and continuous primary care. Physicians working in a group or collaborative care setting may report this premium when providing care during the premium hours for patients of the practice if they have access to the patient's medical record. This premium is not available for unattached patients. This premium is not available for patients being seen in a walk in clinic where the care provided is episodic in nature.<br>Billing Guidelines:<br>• The eligible time periods are from 6a.m. to 8a.m. weekday mornings and 5p.m. to 10p.m. on weeknights where weekdays are defined as Monday through Friday. On Saturday, Sunday and Holidays (as defined by the MSI Physicians Bulletin) the eligible time period is from 9a.m. to 10p.m.<br>• Physicians providing comprehensive and continuous primary care to patients (eligible for modifier ME=CARE only – see Physicians Bulletin May 17, 2018) should offer and book appointments during these time periods.<br>• Services eligible for the Enhanced Hours Premium are office visit services provided by a practitioner providing comprehensive and continuous primary care and who maintains a comprehensive patient chart to record all patient encounters, provides all necessary follow-up care for each encounter and takes responsibility for the initiation of, and the follow-up on, all related referrals.<br>• Eligible physicians may claim the premium for office services provided for their own patients as well as for patients from the registered patient panel of other eligible physicians within the same group practice, provided that the patient's health record can be accessed and the encounter is recorded.<br>• Services provided in walk-in clinics are not eligible for the Enhanced Hours Premium. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no requirement for an appointment, and |

BACK TO CONTENTS

| Current Definition | New Definition |
|---|---|
| requirement for an appointment, and episodic care with little or no follow-up. There is no standard patient roster and the patient list is constantly changing.*(5.1.190)* | episodic care with little or no follow-up. Walk in clinics have no standard patient panel and the patient list is constantly changing. |
| The following office services are eligible for the 25% evening and weekend incentive providing all other eligibility criteria are met. Only one incentive can be claimed per patient encounter regardless of the number of services provided during the encounter. Claims for eligible services should be submitted with the modifier TI =GPEW. *(5.1.191)*<br>NOTE: For services where the evening and weekend incentive has been claimed, a record must be maintained and readily available to verify that the patient was booked for an appointment during an incentive-eligible time period. The appointment time should be recorded in the patient's record or office appointment books retained. *(5.1.192)*<br>APP contract physicians can shadow bill the GP Evening and Weekend Office Visit Incentive (GPEW) *(5.1.193)*<br>The evening and weekend office visit incentive should not be claimed in circumstances where the patient is booked for an appointment time that is not eligible for the incentive and then the physician "runs late". *(5.1.194)* | Refer to the MSI Physician's Bulletins for services eligible for the 25% Enhanced Hours Premium.<br>Only one incentive can be claimed per patient encounter regardless of the number of services provided during the encounter.<br>Claims for eligible services should be submitted with the modifier TI=GPEW<br><br>NOTE: 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.<br>APP contract physicians may shadow bill the GP Enhanced Hours Premium.<br>The Enhanced Hours Premium should not be claimed in circumstances where the patient is booked for an appointment time that is not eligible for the premium and then the physician "runs late". |

| Time Period | Time | Payment Rate |
|---|---|---|
| Monday to Friday | 6:00a.m – 8:00a.m | TI=GPEW (25% premium) |
| Monday to Friday | 5:00p.m – 10:00p.m | TI=GPEW (25% premium) |
| Saturday and Sunday | 9:00a.m – 10:00p.m | TI=GPEW (25% premium) |
| Recognized Holidays | 9:00a.m – 10:00p.m | TI=GPEW (25% premium) |

# Billing Matters Billing Reminders, Updates, New Explanatory Codes

## BILLING REMINDERS

**Routine Prenatal Care 5.2.72**
Physicians are reminded that any prenatal visit, limited or comprehensive, includes a Pap smear when medically indicated. However, a Pap smear is not required in order to bill a prenatal visit.

**Hypnotherapy 5.2.145**
Physicians practicing hypnotherapy must have at least 20 hours of training in clinical hypnotherapy and be an active member in good standing of a recognized Canadian Clinical Hypnosis society.

**2019 Cut Off Dates**
Please be advised there have been some adjustments made to the 2019 cut off dates. See attachment.

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| VA093 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS IT IS INCLUDED IN THE REMUNERATION OF ANOTHER SERVICE RECENTLY BILLED FOR THIS PATIENT. |

BACK TO CONTENTS

| Code | Description |
|---|---|
| AD082 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE INTERPRETER INCENTIVE MAY ONLY BE CLAIMED AFTER A VISIT OR CONSULT DURING THE SAME SERVICE OCCURRENCE. |
| DE034 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THERE HAVE BEEN NO SERVICES CLAIMED BY YOU FOR THIS PATIENT IN THE PREVIOUS 30 DAYS. |
| GN100 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST SUBMIT YOUR SIGNED PHYSICIAN CONFIRMATION LETTER IN ORDER TO BILL THE ENHANCED FEES FOR OFFICE AND GERIATRIC VISITS. |
| GN101 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE IS NOT BILLABLE FROM A HOSPICE FACILITY. |

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

### UPDATED FILES

Updated files reflecting changes are available for download on Friday February 8th, 2019. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT), modifiers (MODVALS.DAT) and, explanatory codes (EXPLAIN.DAT).

### HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

http://msi.medavie.bluecross.ca/

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

### 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

In partnership with

NOVA SCOTIA

BACK TO CONTENTS

# 2019 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

| PAPER CLAIMS | ELECTRONIC CLAIMS | PAYMENT DATE | SALARY CONTRACT PAY PERIOD |
|---|---|---|---|
| **December 19, 2018**** | **December 24, 2018**** | January 2, 2019 | December 14-27, 2018 |
| January 7, 2019 | January 10, 2019 | January 16, 2019 | December 28, 2018-January 10, 2019 |
| January 21, 2019 | January 24, 2019 | January 30, 2019 | January 11-24, 2019 |
| February 4, 2019 | February 7, 2019 | February 13, 2019 | January 25-February 7, 2019 |
| **February 15, 2019**** | February 21, 2019 | February 27, 2019 | February 8-21, 2019 |
| March 4, 2019 | March 7, 2019 | March 13, 2019 | February 22-March 7, 2019 |
| March 18, 2019 | March 21, 2019 | March 27, 2019 | March 8-21, 2019 |
| April 1, 2019 | April 4, 2019 | April 10, 2019 | March 22-April 4, 2019 |
| **April 12, 2019**** | **April 17, 2019**** | April 24, 2019 | April 5-18, 2019 |
| April 29, 2019 | May 2, 2019 | May 8, 2019 | April 19-May 2, 2019 |
| **May 10, 2019**** | **May 15, 2019**** | May 22, 2019 | May 3-16, 2019 |
| May 27, 2019 | May 30, 2019 | June 5, 2019 | May 17-30, 2019 |
| June 10, 2019 | June 13, 2019 | June 19, 2019 | May 31-June 13, 2019 |
| **June 21, 2019**** | **June 26, 2019**** | July 3, 2019 | June 14-27, 2019 |
| July 8, 2019 | July 11, 2019 | July 17, 2019 | June 28-July 11, 2019 |
| July 22, 2019 | July 25, 2019 | July 31, 2019 | July 12-25, 2019 |
| **August 2, 2019**** | August 8, 2019 | August 14, 2019 | July 26-August 8, 2019 |
| August 19, 2019 | August 22, 2019 | August 28, 2019 | August 9-22, 2019 |
| **August 30, 2019**** | September 5, 2019 | September 11, 2019 | August 23-September 5, 2019 |
| September 16, 2019 | September 19, 2019 | September 25, 2019 | September 6-19, 2019 |
| September 30, 2019 | October 3, 2019 | October 9, 2019 | September 20-October 3, 2019 |
| **October 11, 2019**** | October 17, 2019 | October 23, 2019 | October 4-17, 2019 |
| October 28, 2019 | October 31, 2019 | November 6, 2019 | October 18-31, 2019 |
| **November 8, 2019**** | November 14, 2019 | November 20, 2019 | November 1-14, 2019 |
| November 25, 2019 | November 28, 2019 | December 4, 2019 | November 15-28, 2019 |
| December 9, 2019 | December 12, 2019 | December 18, 2019 | November 29-December 12, 2019 |
| **December 19, 2019**** | **December 22, 2019**** | December 31, 2019 | December 13-26, 2019 |
| January 6, 2020 | January 9, 2020 | January 15, 2020 | December 27, 2019-January 9, 2020 |
| **11:00 AM CUT OFF** | **11:59 PM CUT OFF** | | |

**NOTE:**

Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Sessional Payments and Locum Claim Forms. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut off date to ensure processing for that payment period.

**PLEASE NOTE, THE ** INDICATES A DATE VARIATION**

| Please make a note in your schedule of the following dates MSI will accept as "Holidays". | |
|---|---|
| NEW YEAR'S DAY | TUESDAY, JANUARY 1, 2019 |
| HERITAGE DAY | MONDAY, FEBRUARY 18, 2019 |
| GOOD FRIDAY | FRIDAY, APRIL 19, 2019 |
| EASTER MONDAY | MONDAY, APRIL 22, 2019 |
| VICTORIA DAY | MONDAY, MAY 20, 2019 |
| CANADA DAY | MONDAY, JULY 1, 2019 |
| CIVIC HOLIDAY | MONDAY, AUGUST 5, 2019 |
| LABOUR DAY | MONDAY, SEPTEMBER 2, 2019 |
| THANKSGIVING DAY | MONDAY, OCTOBER 14, 2019 |
| REMEMBRANCE DAY | MONDAY, NOVEMBER 11, 2019 |
| CHRISTMAS DAY | WEDNESDAY, DECEMBER 25, 2019 |
| BOXING DAY | THURSDAY, DECEMBER 26, 2019 |
| NEW YEAR'S DAY | WEDNESDAY, JANUARY 1, 2020 |

PHYSICIAN'S BULLETIN
January 21, 2019: Vol. LXIV, ISSUE 2

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## WCB CLAIMS PROCESSING – UPCOMING CHANGES

As part of an overall modernization initiative, WCB Nova Scotia (WCB) is introducing improvements to how physicians' claims are processed for the care of work-related injuries and occupational disease, and how they communicate with physicians.

The target implementation date is April 18, 2019. At that time, you will need to include the WCB claim number and/or the worker's injury date (month and year) when submitting claims to Medavie for WCB payment.

Physicians should be already capturing this information as part of a patient visit as this information is currently required on the WCB Physician Report 8/10. Confirming whether the worker is eligible for benefits at the time the claim is submitted for payment will help prevent billing errors and the need for payment reversals.

Accredited billing vendors have been contacted regarding these new requirements. As a result, vendors have been updating their software to enable the submission of this additional information. Please contact your vendor directly, if you have any questions regarding the rollout of their software changes.

WCB is committed to improving communications with physicians as timely information is important to help you provide the best care to your patients. Therefore, beginning in spring 2019, WCB will notify you when there are eligibility changes related to a worker under your care. You will receive updates when coverage has been approved, denied, or closed, and if a worker moves into receiving long-term benefits from a return-to-work plan. This will further assist in preventing billing errors.

Ongoing updates including more details regarding claims submission will be provided via the MSI Physician's Bulletin. Relevant information will also be posted on the MSI website, https://msi.medavie.bluecross.ca. If you have any questions, please email msi_assessment@medavie.ca or call 902-496-7011/toll-free 1-866-553-0585.

PHYSICIAN'S BULLETIN
January 11, 2019: Vol. LXIV, ISSUE 1

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## PHYSICIAN CONFIRMATION LETTER REMINDER

Family physicians who are responsible for the comprehensive and continuous care of their patients are requested to forward a signed Physician Confirmation Letter to MSI by January 31, 2019. The enhanced fees for office and geriatric visits are only available to family physicians who attest that they are providing comprehensive and continuous care. As well, only those physicians having signed and returned the letter by January 31 will be eligible for the upcoming patient enrollment incentive. Additional information regarding this incentive will be sent to you in February, 2019.

If you have not already submitted your signed Physician Confirmation Letter, you can find the letter here. The signed letter can be emailed to: primary_care_investments@medavie.bluecross.ca

# PHYSICIAN'S BULLETIN

December 14th, 2018: Vol. LXIII, ISSUE 21


NOVA SCOTIA MEDICAL SERVICES INSURANCE

## PHYSICIAN CONFIRMATION LETTER REMINDER

Family physicians who are responsible for the comprehensive and continuous care of their patients are requested to forward a signed Physician Confirmation Letter to MSI by January 31, 2019. The enhanced fees for office and geriatric visits are only available to family physicians who attest that they are providing comprehensive and continuous care. As well, only those physicians having signed and returned the letter by January 31 will be eligible for the upcoming patient enrollment incentive. Additional information regarding this incentive will be sent to you in February, 2019.

You can find the Physician Confirmation Letter here. The signed letter can be emailed to: primary_care_investments@medavie.bluecross.ca

## TI=GPEW

Fee Committee has made changes to the GP Evening Weekend (GPEW) modifier that will make it necessary to have a Physician Confirmation Letter on file for eligibility to claim the GPEW. Additional information regarding this change will be published upon implementation in February, 2019.

## MSI ELINK UPGRADE REMINDER

MSIeLink, the internet gateway to Medavie for a range of network services related to medicare claims processing, is being upgraded. Accredited vendors have been notified of this upgrade. Effective December 15, 2018, all vendor software must be using a new MSIeLink client which has been distributed to accredited vendors. If your vendor does not make the required changes, you will not be able to submit claims as of December 15, 2018. If you have any questions regarding how your software will be impacted, we recommend that you contact your vendor.

PHYSICIAN'S BULLETIN
November 30th, 2018: Vol. LXIII, ISSUE 20

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## MSI News

# PRESCRIBING MEDICATION

**AN ARTICLE BY DR. RHONDA CHURCH**

It's a weekday afternoon. It's flu season. You have a waiting room full of patients and your assistant and two of the other physicians in your clinic are out sick. You're running almost an hour behind and have been fielding calls from the local nursing home about a number of ill residents there. You missed your son's last few basketball games because of work issues and you promised him you'd get to the one later today.

As you are attempting to sort out a complex, confused, and slightly hard of hearing elderly man who is short of breath, there is a knock at the exam room door.

"Call from the pharmacy on line 2. Question about a prescription you wrote this morning."

Sound familiar?

In addition to managing payments to physicians, Medavie Blue Cross also administers payments to pharmacists under the provincial Pharmacare Program. Recently, I met with members of our Pharmacare team who told me that one of the most frustrating aspects of a community pharmacist's job is having to call a physician for clarification on a busy day.

A great pharmacist is like a living, breathing CPS, with a tremendous depth of knowledge about medications we prescribe. Like physicians, they run small businesses, often employ staff and have practice standards in place to ensure safe and effective care of the people they serve. If they fill a prescription that contains incomplete information, there is a risk that they will fill the script in a way other than the physician intended. Not only can this lead to increased risk to the patient, filling such prescriptions can have significant financial implications for these small businesses as third party payers may not honour their fees.

## MSI News continued

Here are the suggestions they had to reduce the number of calls:

- Include the patient's full name i.e. Walter White rather than Mr. White
- Include the name of the medication or product being prescribed rather than using nonspecific terms such as "ostomy supplies x 1 year"
- Include the dosage of the medication prescribed as well as the total number to dispense i.e. furosemide 20 mg once daily (90 tabs) rather than "furosemide as before" For individuals whose conditions are stable, three months' supply is generally the most cost effective option but if finances are tight, or the medication is new, a shorter duration may be appropriate.
- Include the size of the bottle or tube for liquids, ointments, etc. The pharmacist will only be able to fill this without clarifying it with you if the product comes in just one size.
- Include specific refill instructions i.e. "3 refills" rather than "as necessary" or "release with methadone."
- Sign the prescription.

A few extra seconds when prescribing can make a difference in the flow of you and your pharmacist's day and get you out the door and onto the bleachers.

## ★ Fees New Fees and Highlighted Fees

### HIGHLIGHTED FEES

Effective November 30th, 2018 the adjusted MSU values apply to the following health service codes:

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03 | **Post-Partum Visit (LO=HOSP, FN=INPT, RO=PTPP)** | |
| | | **Days 2, 3 (DA=DA23)** | 23 MSU |
| | | **Days 4-7 (DA=DA47)** | 19 MSU |
| | | **Subsequent Care – Newborn Healthy Infant (LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS)** | |
| | | **Days 2, 3 and (DA=DA23)** | 23 MSU |
| | | **Days 4-5 (DA=DA45)** | 19 MSU |
| | | **Description**<br>These adjusted MSU values apply to the following health service codes:<br>03.03 LO=HOSP, FN=INPT, RO=PTPP – Post-Partum Visit<br>03.03 LO=HOSP, FN=INPT, RO-NBCR, RP=SUBS – Subsequent Care, Newborn Healthy Infant.<br>When the visit is provided to patients admitted to hospital where the family doctor is the most responsible physician.<br><br>**Billing Guidelines**<br>May only be claimed once per patient per day by the most responsible physician (MRP).<br><br>**Specialty Restriction**<br>SP=GENP<br><br>**Location**<br>LO=HOSP, FN=INPT | |

As per the October 18th, 2017 bulletin, if a home visit occurs for a patient that is not considered homebound, then the visit is considered to be rendered at the home for convenience and may be claimed at the normal office rate. To facilitate this use, the new modifier ME=CONV (visit of convenience) has been added to the 03.03 home visit fee (effective November 30th, 2018), and will now pay at the correct normal office rate.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03 | **ME=CONV, PT=FTPT, LO=HOME**<br>**AG=OV65, ME=CONV, PT=FTPT, LO=HOME**<br><br>**Description**<br>This modifier is to be used when a visit outside of the office occurs for the convenience of either the patient or general practitioner.<br><br>**Billing Guidelines**<br>The modifier should be added to 03.03 home visit services for the first patient and the visit is for convenience.<br>The modifier should also be added for 03.03 home visits for the first patient if they are 65 years of age or older and the visit is for convenience.<br>If a home visit for convenience is claimed, the physician may not claim for mileage (HSC HOVM1).<br><br>**Specialty Restriction**<br>SP=GENP<br><br>**Location**<br>LO=HOME | 13 MSU<br>16.5 MSU |

## NEW FEES

Effective November 30th, 2018 the following health service codes will be available for billing:

| Category | Code | Description | Base Units | Anaes Units |
|---|---|---|---|---|
| MAAS IC | 66.99B | **Cytoreductive Surgery with or without perioperative intraperitoneal chemotherapy (Sugarbaker Procedure)**<br><br>This is a comprehensive fee based on the "skin to skin" operative time required to perform cytoreductive surgery with or without intraperitoneal chemotherapy (Sugarbaker). This procedure may include, but is not limited to, peritonectomy and multivisceral resections and may be followed by the infusion of intraperitoneal chemotherapy.<br><br>**Billing Guidelines**<br>• Surgical start and stop times must be reported in text with the claim and be verifiable by the record of operation in the patient's health record.<br>• No other health service codes may be reported by the same physician, same patient, same service encounter, same day.<br><br>**Specialty Restriction**<br>SP=GNSG<br><br>**Location**<br>LO=HOSP | 175MSU/Hour | 12+T |

| Category | Code | Description | Base Units | Anaes Units |
|---|---|---|---|---|
| MASG | 47.25A | **Aortic valve and ascending aorta replacement with reimplantation of coronary arteries (Bio-Bentall or Mechanical Bentall repair)**<br><br>This is a comprehensive code for aortic root replacement with ascending aorta graft and valve conduit including coronary reimplantation.<br><br>**Billing Guidelines**<br>• Not reportable with:<br>- 47.25 Other replacement of Aortic valve<br>- 50.34B Excision of thoracic aorta aneurysm<br>- 48.13 Aortocoronary bypass of two coronary vessels<br><br>• May report, where clinically indicated, with:<br>- ADON 51.61 Extracorporeal Circulation auxiliary to open heart surgery<br>- ADON 49.99C Repeat open heart surgery<br><br>**Specialty Restriction**<br>SP=CASG<br><br>**Location**<br>LO=HOSP | 1105MSU | 35+T |

| Category | Code | Description | Base Units | Anaes Units |
|---|---|---|---|---|
| MASG | 47.25B | **Valve sparing aortic root replacement or remodeling (David or Yacoub) with reimplantation of coronary arteries (VSR)**<br><br>This is a comprehensive code for valve sparing aortic root replacement with graft, aortic valve suspension or remodeling, and coronary artery reimplantation.<br>**Billing Guidelines**<br>• Not reportable with:<br>- 47.25 Other replacement of Aortic valve<br>- 50.34B Excision of thoracic aorta aneurysm<br>- 48.13 Aortocoronary bypass of two coronary vessels<br><br>• May report, where clinically indicated, with:<br>- ADON 51.61 Extracorporeal Circulation auxiliary to open heart surgery<br>- ADON 49.99C Repeat open heart surgery<br><br>**Specialty Restriction**<br>SP=CASG<br><br>**Location**<br>LO=HOSP | 1105 MSU | 35+T |

# FEE REVISIONS

During the Province's March 2018 announcement of its $39.6 million investment in Primary Care simplification of the existing telephone health service codes was promised. The work of simplifying the documentation and billing guidelines has now finished and the following are the result of that work. Click here to go to the billing reminder in the September, 2018 bulletin

| Category | Code | Description | Base Units |
|---|---|---|---|
| CONS | 03.09K | **Specialist Telephone Advice – Consultant Physician – providing advice** | 25 MSU |
| | 03.09L | **Specialist Telephone Advice – Referring Physician – requesting advice** | 11.5 MSU |

**Description**

This health service code may be reported for a two-way telephone (or other synchronous electronic verbal communication) regarding the assessment and management of the patient but without the consulting physician seeing the patient. The referring physician may be a family physician or other specialist seeking an expert opinion from the consulting physician due to the complexity and severity of the case and with the intent of continuing to provide the patient's care closer to home. The consultant specialist may also receive requests for advice from a nurse practitioner.

The referring physician (or NP) must communicate to the specialist the reason for the consultation and relevant patient information through verbal, written or electronic communication, either before or within four business days after the telephone call. The referring physician must document that this information was supplied to the specialist. There must be a two-way verbal communication discussing the clinical situation followed by a management decision and a written report from the specialist to the referring provider.

The formal consultation report must be available in the patient's medical record, both the referring physician (or NP) and the specialist must maintain copies of this document, both medical records must include the date and time of the service and any contemporaneous notes, in addition to the written documents.

The service is reportable by the specialist for a new patient or an established patient with a new condition or an exacerbation of an existing condition.

**Billing Guidelines**

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

If subsequent phone calls are necessary within 14 days to complete the consultation they are considered included in the HSC for the telephone consultation.

The Consultant Physician HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.

The Referring Physician HSC may be reported when the telephone call for an urgent consultation occurs on the same day as the patient visit that generated the consultation.

The HSC is 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 not reportable for other forms of communication such as:

- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another health professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student

The service is not reportable by the consulting physician if the patient has had a face to face visit with the consultant or any member of his/her call group within the previous 14 days for the same condition or if the telephone consultation results in a face to face service within the next 14 days or the next available appointment of the consultant.
The service is not reportable for telephone calls of less than 5 minutes of two way medical discussion. The service is not reportable for calls between a referring provider and specialist in the same institution or practice location.

**Documentation Requirements**

- The referring physician must document that s/he has communicated the reason for the consultation and relevant patient information to the specialist
- Both the specialist consultant and the referring provider must document the patient name, identifying data, date and start and stop time of the call in their respective charts or EMRs.
- The names of the referring physician (or NP) and the consultant physician must be documented by both physicians.
- The diagnosis, reason for referral, elements of the history and physical as relayed by the referring provider, the opinion of the consultant physician and the plan for future management must be documented.
- A written report must be sent to the referring provider by the specialist consultant.
- The referring physician's billing number must be noted on the electronic claim.
- Both physicians must submit the start and stop time of the call in the text field on the MSI service report.

**Specialty Restriction**
N/A

**Location**
LO=OFFC

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03Q | **Specialist Telephone Management/Follow Up with Patient**<br><br>**Description**<br>This health service code may be reported for a 15 minute telephone communication between the specialist physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face consultation, visit or procedure by the same physician within the last 9 months and has not been seen within the last 7 days. This service is not reported if the outcome of the call is to see the patient at the next available appointment in the office. This communication is intended to take the place of an office follow up visit that would have otherwise been scheduled, when a physical examination of the patient is not required. | 11.5 MSU |

**Billing Guidelines**
This health service is reportable for a telephone (or synchronous electronic verbal communication) between the specialist physician and the patient, or the patient (or the patient's parent, guardian or proxy as established by written consent).
Telephone management requires communication between the patient and physician on a clinical level; the HSC is not reportable for administrative tasks.
The call must include a discussion of the clinical problem and a management decision.
The specialist physician must have seen and examined the patient within the preceding 9 months.
The HSC is reportable a maximum of 4 times per patient per physician per year.
The HSC is not reportable for facility based patients.
The HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.

The service is not reportable when the purpose of the communication is to:

- Arrange a face to face appointment
- Notify the patient of an appointment
- Prescription renewal
- Arrange a laboratory, other diagnostic test or procedure
- Inform the patient of the results of diagnostic investigations with no change in management plan.

The service is not reportable for other forms of communication such as:

- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student
- Clerical staff

The service is not reportable for telephone calls of less than 5 minutes of two way medical discussion.

**Documentation Requirements**

- The date, start and stop times of the conversation must be noted in the medical record.
- The medical record must indicate the content of the discussion, the management plan and that the patient (or the patient's parent, guardian or proxy as established by written content) understands and acknowledges the information provided.
- A written report must be sent to the referring physician or family physician by the specialist consultant
- The start and stop time of the call must be included in the text field on the MSI service report

**Specialty Restriction**
N/A

**Location**
LO=OFFC

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03R | **Family Physician Telephone Management/Follow Up with Patient** | 11.5MSU |

## Description

This health service code may be reported for a 15 minute telephone communication between the family physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a lace to face visit by the same physician within the last 9 months and has not been seen within the last 7 days for the same condition. This telephone communication is intended to take the place of an office visit initiated by the patient (or the patient's parent, guardian or proxy as established by written consent) for a new condition or an exacerbation of an existing condition, or a follow up visit that would have otherwise been scheduled by either the physician or the patient, when a physical examination of the patient is not required.
The patient population eligible must be either 65 years and older or be suffering from mental illness or suffering from at least one chronic disease.

Mental Illness is defined as;

- A condition that meets criteria for a DSM diagnosis

The service is not reported if the decision is to see the patient at the next available appointment in the office.

**Billing Guidelines**

This health service is reportable for a telephone (or synchronous electronic verbal communication) between the family physician and the patient (or the patient's parent, guardian or proxy as established by written consent).
Telephone management requires communication between the patient and physician on a clinical level; the HSC is not reportable for administrative tasks.
The call must include a discussion of the clinical problem and a management decision.
The family physician must have seen and examined the patient within the preceding 9 months.
The HSC is reportable a maximum of 4 times per patient per physician per year by the family physician and/or the practice providing ongoing comprehensive care to the patient.
The HSC is not reportable by walk in clinics. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no requirement for an appointment, and episodic care with little or no follow-up. There is no standard patient roster and the patient list is constantly changing.
The HSC is not reportable for facility based patients.
The HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.
The service is not reportable when the purpose of the communication is to:

- Arrange a face to face appointment
- Notify the patient of an appointment
- Prescription renewal
- Arranging to provide a sick note
- Arrange a laboratory, other diagnostic test or procedure
- Inform the patient of the results of diagnostic investigations with no change in management plan.

This service is not reportable for other forms of communication such as:

- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

The service is not 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 professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student
- Clerical staff

The service is not reportable for telephone calls of less than 5 minutes of two way medical discussion.

**Documentation Requirements**

- The date, start and stop times of the conversation must be noted in the medical record.
- The medical record must indicate the content of the discussion, the management plan and that the patient (or the patient's parent, guardian or proxy as established by written content) understands and acknowledges the information provided.
- The start and stop time of the call must be included in the text field on the MSI service report

**Specialty Restriction**
N/A

**Location**
LO=OFFC

## UPCOMING FEE REVISION

Physicians are advised that health service **code 78.39A – Interruption or removal of fallopian tubes for purposes of sterilization: abdominal, vaginal, laparoscopic-not hysteroscopic (unilateral or bilateral)** – will be revised to permit surgical assist claims as of November 30th, 2018. Any physicians providing surgical assistance should hold their claims for this procedure until MSI can update the billing system in early 2019.

# Billing Matters Billing Reminders, Updates, New Explanatory Codes

## BILLING REMINDERS

**Facility Numbers**
Physicians are reminded to ensure that when submitting claims they are using the correct facility number.

**Pacemaker battery/leads replacement**
Physicians are reminded that the health service codes for pacemaker battery change and leads replacement/adjustment include any necessary programming. It is not appropriate to make a separate claim for pacemaker programming.

**After Hours Visits**
When a physician is called urgently to a hospital, nursing home or the patient's home after hours, responds immediately because of the patient's condition, and travels to see the patient, the service may be claimed using an urgent modifier (US=UIOH and US=UNOF). As a reminder, use of an urgent modifier requires that the physician travel to see the patient and movement within a hospital or nursing home is not considered travel. Therefore, if additional patients are seen during the same trip, the visit must be claimed as an extra patient without an urgent modifier.

**Confirmation Letter Notice**
A reminder that to be eligible to use the modifier ME= CARE you must have submitted a Confirmation Letter attesting to your status as a primary care provider providing continuity care in the context of an ongoing relationship with your patients (see original notification here). Only physicians who have submitted said Confirmation Letter will have claims with the ME=CARE modifier processed. If you have not submitted the Confirmation Letter your claim should be submitted as an otherwise unmodified visit.

Click here to be taken to the updated FAQ on the Primary Care Investments.

BACK TO CONTENTS

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| MJ065 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR PROGRAMMING TO A PACEMAKER WHICH IS PART OF THIS SERVICE HAS ALREADY BEEN CLAIMED ON THIS DAY. |
| NR089 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS PROCEDURE SHOULD ONLY BE BILLED FROM A HOSPITAL LOCATION. IF A VALID REASON EXISTS FOR BILLING THIS PROCEDURE FROM A LOCATION OTHER THAN HOSPITAL PLEASE RESUBMIT WITH SUPPORTING DOCUMENTATION. |
| VA092 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR EITHER BATTERY OR LEADS REPLACEMENT/ADJUSTMENT HAS ALREADY BEEN CLAIMED ON THIS DAY WHICH INCLUDES ANY NECESSARY PROGRAMMING. |
| MJ066 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR HEALTH SERVICE CODE 47.25, 48.13 OR 50.34B AT THE SAME ENCOUNTER. |
| MJ067 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR HEALTH SERVICE CODE 47.25A OR B AT THE SAME ENCOUNTER. |
| AD081 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC HOVM1 CANNOT BE CLAIMED ON HOME VISITS THAT OCCUR FOR PATIENT OR PHYSICIAN CONVENIENCE. |
| WBHUJ | FILE IS BEING ADJUDICATED FOR WORKERS COMPENSATION WITH A PROVINCE OTHER THAN NS. |
| WBHSD | SERVICE DATE NOT WITHIN WCB COVERAGE PERIOD. |
| WBHNC | INDIVIDUAL HAS NO WCB COVERAGE |
| WBHLT | HSC INVALID FOR WCB LTB CLAIM |
| WBHRT | HSC INVALID FOR WCB RTW CLAIM |

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

## UPDATED FILES

Updated files reflecting changes are available for download on Friday November 30th, 2018. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT), modifiers (MODVALS.DAT) and, explanatory codes (EXPLAIN.DAT).

## HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

http://msi.medavie.bluecross.ca/

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

## 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

In partnership with

PHYSICIAN'S BULLETIN
September 21st, 2018: Vol. LXIII, ISSUE 18

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## MSI News

### MSI ELINK PASSWORDS WILL EXPIRE OCTOBER 15TH 2018

Submitters will need to reset their current password prior to October 15, 2018, if they haven't already done so. If a submitter's password is not reset, the password will expire on October 15 and the submitter will not be able to submit claims.

If you have more than one individual in your office that uses the same Submitter ID to submit claims, please remember to provide the new password to them.

Vendors have been notified of these changes. In some cases, a vendor may make the required changes on your behalf. If you haven't heard from your vendor regarding this implementation, please contact your vendor for further direction.

Click here to go to the change instructions Q&A.

### Physicians Moving out of Province

Physicians are reminded that it is important to call MSI and update their mailing and e-mail address for future correspondence when they move.

BACK TO CONTENTS

# Billing Matters Billing Reminders, Updates, New Explanatory Codes

## BILLING REMINDERS

**Tympanometry Only – 09.41H**

Physicians are reminded that it is not appropriate to submit a claim for HSC 09.41H if another code was claimed during the same encounter that includes tympanometry.

**Non-Face to face Health Service Codes**

In the spring of 2017, four new health service codes were implemented for select services provided by physicians without face to face contact with patients. Since the time of implementation, MSI has been gathering information on the use of these health service codes through the service verification letter process. A number of concerns have been identified. The following are among the known incorrect applications of the Non-Face-to-Face Health Service Codes:

- Using these health service codes when the call to the patient is not made by the physician. As a reminder, these HSCs may only be claimed when the physician personally makes the call, and not when the call is made by office staff, nurse, nurse practitioner, or a medical trainee such as a medical student or resident;
- Claiming for a call when its purpose is to arrange or notify the patient of an appointment;
- Claiming for a call when its purpose is to arrange for a lab or other diagnostic test or a procedure;
- Claiming for a call when its purpose is to provide a sick note;
- Claiming for a call when its purpose is solely to notify a patient of test results; and
- Claiming for a call when its purpose is solely to renew a prescription.

These are all purposes which are identified as not reportable for this service in the existing Billing Guidelines.

Physicians are asked to carefully review the requirements for claiming these health service codes. A full description of the requirements can be found in the July 27th, 2018 bulletin by clicking here. Please note that the Non-Face-to-Face Health Service Codes have been approved for further changes. Please watch the November bulletin for the final wording.

**Unattached Patients – UPB1**

The unattached patient bonus is an incentive for family physicians who take on unattached patients and agree to become those patients' primary care provider. It is not available to physicians practicing in a walk-in setting. This fee should only be billed if all criteria are being met. Click here to be taken to the May 17th, 2018 bulletin where the billing guidelines are outlined.

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| VA090 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PREVIOUSLY BILLED HSC 09.41E, F OR G INCLUDES TYMPANOMETRY. |
| VA091 | SERVICE ENCOUNTER HAS BEEN REFUSED. HSC 09.41E, F, OR G CANNOT BE BILLED AT THE SAME ENCOUNTER AS HSC 09.41H AS THEY INCLUDE TYMPANOMETRY. |

BACK TO CONTENTS

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## HELPFUL LINKS

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**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

## CONTACT INFORMATION

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Phone: 902-496-7011
Toll-Free: 1-866-553-0585
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**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

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In partnership with

PHYSICIAN'S BULLETIN
September 13th, 2018: Vol. LXIII, ISSUE 17

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# MSI ELINK PASSWORD CHANGE

**Passwords Will Expire October 15**

Submitters will need to reset their current password prior to October 15, 2018, if they haven't already done so. If a submitter's password is not reset, the password will expire on October 15 and the submitter will not be able to submit claims.

If you have more than one individual in your office that uses the same Submitter ID to submit claims, please remember to provide the new password to them.

Vendors have been notified of these changes. In some cases, a vendor may make the required changes on your behalf. If you haven't heard from your vendor regarding this implementation, please contact your vendor for further direction.

## MSI ELINK PASSWORD CHANGE INSTRUCTIONS Q & A

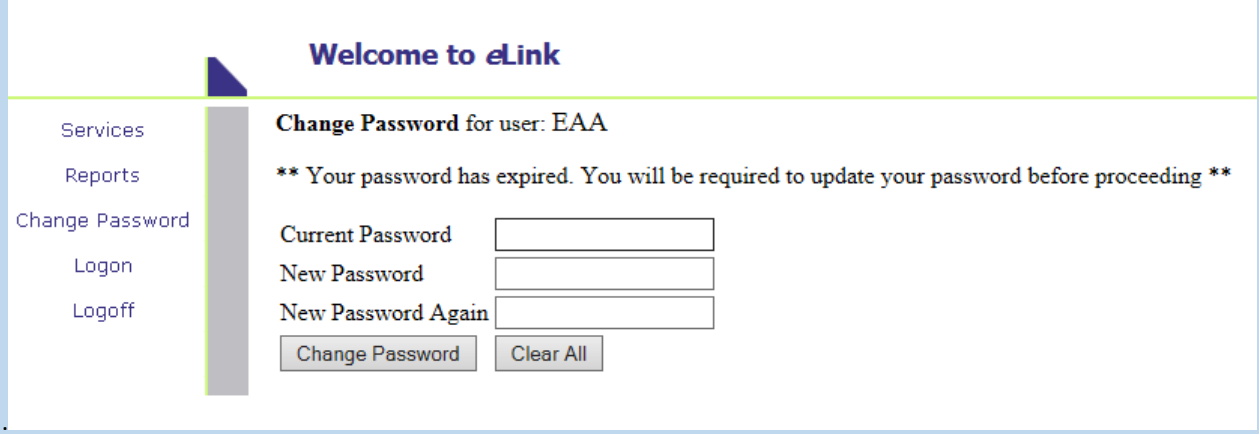
Effective July 15th, 2018, the current process of submitting a password change request via your claims submission software using the change password (/cp) service is no longer available. The current process has been replaced with a password change user interface.

**How will I change my current password to a complex password to enable claims submission?**

Please take the following steps, to change your current password to a new complex password:

1. Use your preferred browser to navigate to https://www.MSIeLink.ca.
2. Login using your Submitter ID (3 letters) as the User ID and your current password.
3. Select "Change Password" from the menu on the left side of the screen.
4. Using your current password, create a new password. The new password requirements are:
    - New password is not to match the current password.
    - Minimum password length is 14 and maximum length is 20.
    - Must contain at least 1 lowercase character, at least 1 uppercase character, at least 1 number, and at least 1 of the following special characters ! @ # $ * . , ? - = _
5. Cannot start with a special character.
6. Save the new password by selecting the **Change Password** button.

Note: The new password will not have an expiry date and can be changed whenever you choose, but you need to know your current password to change it to a new complex password.




**If I am a new submitter, what will be my assigned password?**

A temporary password will be assigned as, 'submitter id' || pass. For example, if your Submitter ID is 'zzz', the password will be 'zzzpass' (all lowercase). The password will only permit access to the MSIeLink website's change password functionality. Claims cannot be submitted using this password. This temporary password will have to be reset to a complex password before it can be used for this purpose. The steps described above will need to be followed to create a complex password that will allow for claims submission and file pick up.

**If I forget my current password, what steps do I take to obtain a new password?**

If you do not remember your current password, please do the following:

1. Contact Medavie's Provider Coordinators during regular business hours to have your password reset. They can be reached via email (msiproviders@medavie.ca) or phone (902-496-7011/toll-free 1-866-553-0585). Your password will be reset to the temporary password, 'submitter id' || pass, which will allow you to access the MSIeLink website.
2. Follow the process described above to create a new complex password that will allow for claim submission and file pick up.

# PHYSICIAN'S BULLETIN

July 27th, 2018: Vol. LXIV, ISSUE 17


NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## ★ Fees New Fees, Fee Revisions, and Highlighted Fees

### NEW FEES

Effective in the coming months, the following changes will be made to the Provincial Immunization Schedule:

| HSC | Modifier | Description |
|---|---|---|
| 13.59L | RO=HPV9 | Human Papillomavirus<br>- Requires PT=RISK when third dose is given<br>- Requires text when claiming PT=RISK<br>- **Available September 1st, 2018** |
| | RO=HDIN | High-dose-Influenza – Inactivated<br>- Patient to be equal to or greater than 65 years of age.<br>- Location Restricted to Long-Term Care Facility (i.e. Nursing Home or Residential Care Facility) only<br>- **Available October 1st, 2018** |

Please note as of August 1st, 2018 RO=TDAP (Tetanus Toxoid, Diphtheria, Acellular Pertussis) is available to female patients with each pregnancy. Physicians are reminded to bill as EC with explanatory text if the patient was previously incompletely immunized or pregnant.

# FEE REVISIONS

Effective July 27th, 2018 the following billing guidelines changed to allow more than one physician to claim per patient (see underlined below). Physicians are asked that if they bill this health service code and receive explanation code AD068, they should rebill the claim as an EC for it to be manually processed. MSI will make the following billing changes in the near future.

*Revised March 31, 2020 – See May 2020 Bulletin for updated information*

| Category | Code | Description |
|---|---|---|
| **ADON** | 03.03P | **First Visit after In-Patient Hospital Discharge – Maternal and Newborn Care**<br>This is an additional fee for the first maternal/newborn office visit within 14 days of in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care.<br>• The primary care physician or their office staff should make every effort to communicate with the patient and/or caregiver within 2 business days of discharge to better facilitate the patient being seen within 14 days of discharge.<br>• Not reportable in the walk-in clinic setting.<br><br>**Billing Guidelines**<br>ADON Restricted to:<br>03.03 Office visit<br>03.03 Well Baby Care<br>• Reportable only if the visit occurs in the primary care physician's office or the patient's home within 14 calendar days after hospital discharge (consider discharge date as Day zero).<br>• Only reportable if the reason for admission to hospital was for the purpose of obstetrical delivery.<br>• Physician must be the provider most responsible for the mother and child's ongoing care.<br>• Claimable once per physician per patient per inpatient admission for obstetrical delivery.<br>• Not reportable for any subsequent discharges within 30 days.<br>• Maximum of 1 claim per pregnancy (mother)<br>• Maximum 1 claim per infant<br><br>**Specialty Restriction**<br>SP=GENP<br><br>**Location**<br>LO=OFFC, HOME |

Effective July 27th, 2018 the following billing guidelines for 03.03R have changed from requiring two or more chronic diseases, to at least one chronic disease. Please see the underlined change below.

*Revised March 31, 2020 – See May 2020 Bulletin for updated information*

| Category | Code | Description | Base Units |
|---|---|---|---|
| **VIST** | 03.03R | **Family Physician Telephone Management/Follow Up with Patient**<br><br>This health service code may be reported for a 15 minute telephone communication between the family physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face visit by the same physician within the last 9 months and has not been seen within the last 7 days for the same condition. This telephone communication is intended to take the place of an office visit initiated by the patient (or the patient's parent, guardian or proxy as established by written consent) for a new condition or an exacerbation of an existing condition, or a follow up visit that would have otherwise been scheduled by either the physician or the patient, when a physical examination of the patient is not required.<br>The patient population eligible must be either 65 years and older or be suffering from mental illness or suffering from at least one chronic disease.<br><br>Mental illness is defined as<br>• A condition that meets criteria for a DSM diagnosis<br><br>The service is not reported if the decision is to see the patient at the next available appointment in the office. | 11.5 MSU |

**Billing Guidelines**

- This health service is reportable for a telephone (or synchronous electronic verbal communication) between the family physician and the patient (or the patient's parent, guardian or proxy as established by written consent).
- Telephone management requires communication between the patient and physician on a clinical level; the HSC is not reportable for administrative tasks.
- The call must include a discussion of the clinical problem and a management decision.
- The family physician must have seen and examined the patient within the preceding 9 months.
- The HSC is reportable a maximum of 4 times per patient per physician per year by the family physician and/or the practice providing ongoing comprehensive care to the patient. The HSC is not reportable by walk in clinics. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no requirement for an appointment, and episodic care with little or no follow-up. There is no standard patient roster and the patient list is constantly changing.
- The HSC is not reportable for facility based patients.
- The HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.
- The service is not reportable when the purpose of the communication is to:
    - Arrange a face to face appointment
    - Notify the patient of an appointment
    - Prescription renewal
    - Arranging to provide a sick note
    - Arrange a laboratory, other diagnostic test or procedure
    - Inform the patient of the results of diagnostic investigations with no change in management plan
- The service is not reportable for other forms of communication such as:
    - Written, e-mail or fax communication
    - Electronic verbal forms of communication that are not PHIA compliant
- The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another professional such as:
    - Nurse practitioner
    - Resident in training
    - Clinical fellow
    - Medical student
    - Clerical staff

The service is not reportable for telephone calls of less than 5 minutes of medical discussion.

**Documentation requirements**

- The date, start and stop times of the conversation must be noted in the medical record.
- The medical record must indicate the content of the discussion, the management plan and that the patient (or the patient's parent, guardian or proxy as established by written consent) understands and acknowledges the information provided.
- For patient initiated appointment requests that result in a telephone management service on the same day, the following text should be entered in the MSI text field:
    - Same day access
- The start and stop time of the call must be included in the text field on the MSI service report.
- There must be text on the MSI service report to indicate whether or not this service replaced a face to face service.

**Location**

LO=OFFC

BACK TO CONTENTS

Effective July 27th, 2018 the below billing guidelines have been updated. Please note: work is continuing with the Nova Scotia Health Authority and the Fee Committee to review travel time compensation. Details to follow in a future MSI Physicians bulletin.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03M | **Medical assistance in dying – First physician assessor (first 15 minutes)**<br>30 MSU for first 15 minutes, 15 MSU for each additional 15 minutes up to a maximum of 4 hours<br>Service may be provided via PHIA compliant, synchronous, virtual care platform.<br>Modifier ME=VTCR is available for this service<br><br>**Description**<br>This fee is to compensate the first physician assessor for time spent providing MAiD services outlined in the College of Physicians and Surgeons of Nova Scotia Professional Standard Regarding Medical Assistance in Dying. It includes, but is not limited to, the time spent engaging the patient in a discussion of their diagnosis, prognosis, and treatment options, discussing the availability of palliative care for terminally ill patients, assessment of patient for MAiD criteria and arrangement for a second physician to assess the patient.<br><br>**Billing Guidelines**<br>Start and stop times must be recorded in the patient's medical record and on the MSI claim. Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family as required. Total duration of all components may be claimed. If the physician is a specialist and the patient has been formally referred the physician may bill the appropriate specialist prolonged consult fee with the same time documentation requirements as noted above. MAiD must be noted in the text on the MSI claim.<br><br>**Premium**<br>TI=MDNT for the hours of 0000-0800<br>TI=EVWH for evenings after 1800, weekends, and holidays<br><br>**Location**<br>OFFC, HOSP, HOME, CCNT, NRHM | 30 MSU<br>+MU |

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03O | **Medical assistance in dying – Second physician assessor (first 15 minutes)**<br>30 MSU for first 15 minutes, 15 MSU for each additional 15 minutes up to a maximum of 4 hours<br><br>Service may be provided via PHIA compliant, synchronous, virtual care platform.<br>Modifier ME=VTCR is available for this service<br><br>**Description**<br>This fee is to compensate the second physician assessor for time spent providing MAiD services outlined in the College of Physicians and Surgeons of Nova Scotia Professional Standard Regarding Medical Assistance in Dying. It includes, but is not limited to; the time spent conducting the subsequent assessment of the patient for MAiD criteria.<br><br>**Billing Guidelines**<br>Start and stop times must be recorded in the patient's medical record and on the MSI claim. Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family as required. Total Duration of all components may be claimed.<br><br>**Premium**<br>TI=MDNT for the hours of 0000-0800<br>TI=EVWH for evenings after 1800, weekends, and holidays<br><br>**Location**<br>OFFC, HOSP, HOME, CCNT, NRHM | 30 MSU<br>+MU |

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03N | **Medical assistance in dying – Prescribing physician**<br>**RO=FPHN**<br>(30 MSU for the first 15 minutes, 15 MSU for each additional 15 minutes up to a maximum of 4 hours)<br>**RO=SPHN**<br><br>**Description**<br>This fee is to compensate the prescribing physician for time spent providing MAiD services outlined in the College of Physicians and Surgeons of Nova Scotia Professional Standard Regarding Medical Assistance in Dying. It includes, but is not limited to, procuring the medication and administration at the patient's request. This physician must also be either the first physician or second physician assessor.<br><br>**Billing Guidelines**<br>Start and stop times must be recorded in the patient's medical record and on the MSI claim. Non face to face components include all documentation required by the pharmacist and the administration process. Total duration of all components may be claimed. FPHN must have previously claimed for a MAiD service with the same patient. When a second physician assists at the time of administering the medication, RO=SPHN may be claimed. This fee is not intended to compensate a second physician for administrative duties or procurement/return of medications as these activities are considered to be the responsibility of FPHN.<br><br>**Premium**<br>TI=MDNT for the hours of 0000-0800<br>TI=EVWH for evenings after 1800, weekends, and holidays<br><br>**Specialty Restriction**<br>None | 30 MSU<br>+MU<br><br>56 MSU |

# Billing Matters Billing Reminders, Updates, New Explanatory Codes

## BILLING REMINDERS

**Claiming for a General Anesthetic for Dental Surgery**

If a general anesthetic is deemed medically necessary when providing a dental service, the anesthetic fee is payable whether the dental surgery is an insured or uninsured service. The anesthetist must indicate the medical necessity in the text segment of the service encounter. Examples of conditions where a general anesthetic might be medically necessary include, for example, an individual with a developmental delay or significant mental health issues.

**Chronic Disease Management Incentive Program**

Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year. The claim **must** be submitted to MSI no later than March 31st of that year in order to receive payment for that fiscal year.

**Outdated Policy**

All original claims must be submitted to MSI within 90 days from the date of service. Claims that are outside of the specified time limitations will only be considered if extenuating circumstances can be demonstrated for a late submission and are within a reasonable time frame past the 90 day limit. Request for an extension must be made to MSI in writing and will be approved on a case by case basis.

The time frame for submitting the request to MSI for late submission should be within one month following the 90 day limit. Examples of extenuating circumstances may include physical damage to office such as fire or flood and or a serious technical issue.

Service encounters submitted over the 90-day limitation will be adjudicated to pay "zero" with the following exceptions

- Reciprocal billing claims (out of province) must be submitted within 12 months of the date(s) of service.

BACK TO CONTENTS

- Resubmission of refused claims or incorrect billings. These claims must be resubmitted to MSI within 185 days of the date of service. Each resubmission must contain an annotation in the text field of the service encounter submission referencing the previous service encounter number.

Circumstances relating to staffing issues/shortages and mislaid, misfiled, or lost claims cannot be accepted by MSI as valid explanations for a late submission.
Claims for registered hospital in-patients must also be submitted within the 90 day time limitation regardless if the patient has been discharged or continues on an in-patient basis. It is incumbent on the physician to obtain the required billing information for these patients and submit claims within the prescribed time limitations. Explanations relating to late discharge summaries, or facilities not consolidating the required information for the physician, cannot be accepted as a valid explanation for a late submission.
Please note: Failure to use a preauthorization code given by MSI and annotate the text field with the previous service encounter number will result in an adjudication paid at "zero".

**Unbundling of claims**
Preamble rules prohibit unbundling procedural codes into constituent parts and claiming for them separately as well as claiming for the means used to access the procedural or surgical site. Please note that payment rules are inserted into the MSI system periodically to allow MSI to confirm adherence to Preamble rules. In some circumstances, physicians may be requested to provide a copy of the clinical record in order to substantiate the claim for payment.
As per the Preamble:

- Procedural codes and their associated tariff are intended to remunerate the physician for all parts of the procedure that would normally be considered the defined technique for that procedure. It is not appropriate to deconstruct (unbundle) the procedure into constituent parts and bill MSI for these codes in addition to the procedural codes. (5.3.68).

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| AD077 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A THIRD INJECTION FOR RO=HPV9 REQUIRES PT=RISK. PLEASE RESUBMIT WITH THE APPROPRIATE MODIFIERS. |
| AD078 | SERVICE ENCOUNTER HAS BEEN REFUSED AS PATIENT IS NOT 65 YEARS OF AGE OR OLDER. |
| AD079 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS RO=HDIN MAY ONLY BE CLAIMED FROM A LONG TERM CARE/RESIDENTIAL CARE FACILITY. |
| AD080 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF HPV9 INJECTIONS HAS BEEN REACHED. |
| VA089 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS HSC 50.99A REQUIRES TEXT INDICATING THE INTRAVENOUS WAS PERFORMED BY THE PHYSICIAN. |
| VA045 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS HSC 69.94 REQUIRES TEXT INDICATING WHY THE CATHETER INSERTION WAS PERFORMED BY THE PHYSICIAN. |
| VT164 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS MEDICAL ASSISTANCE IN DYING CLAIMS REQUIRE START AND STOP TIMES. |
| VT165 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.03N CANNOT BE CLAIMED UNLESS THE PROVIDER HAS PREVIOUSLY CLAIMED HSC 03.03M OR 03.03O FOR THIS PATIENT. |

BACK TO CONTENTS

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

## UPDATED FILES

Updated files reflecting changes are available for download on Friday July 27th, 2018. The files to download are health service (SERVICES.DAT), modifier values (MODVALS.DAT), health service description (SERV_DESC.DAT), diagnostic codes (DIAG_CD.DAT) and, explanatory codes (EXPLAIN.DAT).

## HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

http://msi.medavie.bluecross.ca/

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

## CONTACT INFORMATION

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

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BACK TO CONTENTS

PHYSICIAN'S BULLETIN
June 15th, 2018: Vol. LXII, ISSUE 15

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# MSI News

## PRIMARY CARE INVESTMENTS UPDATE – COMPREHENSIVE AND CONTINUOUS CARE

In March 2018 the Department of Health and Wellness announced increased investment in services provided by family physicians that practice full scope family medicine and are responsible for the comprehensive and continuous care of their patients. This investment has necessitated that new fees be implemented. In follow up to the May 17th 2018 bulletin, the following fees are also included in that primary care investment (details below). The health service codes will be available as of June 15th, 2018. Once the health service codes become available we ask physicians to bill as usual. Any claims eligible for the enhanced fee value that were submitted between April 1st and June15th will later be identified, and a retroactive payment will be provided to physicians.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03 | **Office Visit (Well Baby Care) – Comprehensive and Continuous Care**<br>ME=CARE, RO=WBCR, (RF=REFD)<br>ME=CARE, RO=WBCR, TI=GPEW, (RF=REFD) | <br>14.76 MSU<br>18.45 MSU |
| | | **Office Visit (Prenatal) – Comprehensive and Continuous Care**<br>ME=CARE, RO=ANTL, RP=SUBS (RF=REFD)<br>ME=CARE, RO=ANTL, TI=GPEW, RP=SUBS (RF=REFD) | <br>14.76 MSU<br>18.45 MSU |
| | | **Extra Patient to: Urgent Care Codes – Comprehensive and Continuous Care**<br>ME=CARE, PT=EXPT, US=UNOF (RF=REFD) | <br>11.9 MSU |

**Billing Guidelines**
By "full scope family medicine" it is meant that the physician has an ongoing relationship as a primary care provider to their patients and ensures their patients' continuity of care. These enhanced fees are not intended for episodic care provided to walk-in patients. The submission of a Physician Confirmation Letter is required to successfully use these enhanced fees.

**Specialty Restriction**
GENP

**Location**
OFFICE

PHYSICIAN'S BULLETIN
May 17, 2018: Vol. LXI, ISSUE 14

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## MSI News

# PRIMARY CARE INVESTMENTS

The investments represent a significant increase to the fees for services commonly provided by family physicians. With the input of Doctors Nova Scotia, the investments are structured with the intent that Nova Scotians will see an increase in physicians who are able to establish new relationships with patients who currently either do not have or are seeking a new family doctor. Highlights of the investment package include:

### COMPREHENSIVE AND CONTINUOUS CARE

Effective April 1st, 2018 there is an increase of 13.5% to the fee paid for health service code 03.03 (office visit and geriatric office visit) for family physicians who are delivering comprehensive and continuous care to patients with whom they have an ongoing relationship. It does not include episodic care provided to walk-in patients. The enhanced fees are only available to family physicians who attest, via confirmation letter, that they are providing comprehensive and continuous care to patients. The MSI system will not be updated until May 17th. To claim the new enhanced fees, physicians should begin to use the new ME=CARE modifier on applicable claims submitted on May 17th or after, even if the service date was prior to May 17th. A confirmation letter must be filled out and returned directly to MSI no later than May 25th, 2018. Any claims eligible for the enhanced fee value that were submitted between April 1st and May 25th will later be identified, and a retroactive payment will be provided to physicians. Letters received after May 25th, 2018 will still be processed and eligibility will commence as of that date, no retroactive payments will be made for letters received after May 25th, 2018. All physicians who intend to use, or have been using, the enhanced fees, are required to submit the letter in order to continue to be eligible to bill these enhanced fees. The letter can be found here and must be sent to: primary_care_investments@medavie.bluecross.ca.

### ENROLMENT FEE

Effective April 1st 2018, a one-time flat enrolment fee of $7.50 per current patient to enable family physicians to identify panels of patients for whom they are providing comprehensive and continuing care. However, it will take some time to define the enrolment process and for the initial/preliminary patient panel lists to be developed and distributed to family physicians for verification. Once these lists are received you will have the opportunity to add and/or remove names from the list based on your own charts. The $7.50 per patient will apply to the final approved and validated roster. More details on this fee, including the process will be shared in the coming weeks.

BACK TO CONTENTS

## UNATTACHED PATIENTS

Effective April 1st 2018, the rules for the $150 unattached patient bonus have been expanded. The fee will be available to APP, FFS, and eligible AFP family physicians for taking on patients from the 811 Find a Family Practice list as well as other patients who were previously unattached at the time they enrolled or who may become unattached, such as patients referred from the Emergency Department and patients from a practice where the physician is retiring or relocating and who no longer have a family physician. The criteria for the existing UPB1 will be broadened and the process for claiming the fee simplified. The fee should be billed at the time of your initial visit. You are required to keep the patient in your practice and to maintain an open chart for at least a year, but you should still bill the incentive at the time of the initial visit. (Note that this is a change from the instructions first communicated, which suggested that you should hold your billing until the unattached patient has been in your practice for a year.)

## ALTERNATIVE PAYMENT PLAN (APP) CONTRACTS

Family practitioners compensated through APP contracts will have the opportunity to increase their compensation by 5.6%. It applies to APPs regardless of the full or part-time nature of the arrangement, based on volume of shadow billing. APP physicians who shadow bill a minimum 80% of their contract's payment will receive the 5.6% bonus.

Click here for FAQs regarding the Primary Care Investments.

## TECHNOLOGY STIPEND - VIRTUAL CARE PILOT (MyHealthNS)

A working group, chaired by Dr. Stewart Cameron and with Doctors Nova Scotia representation, is working on the MyHealthNS Virtual Care Pilot criteria where physicians can receive up to $12,000 a year. This pilot will look at the benefits and impacts of using the secure e-messaging function and telephone to improve access to primary health care. When information is available, it will be added to the Physician's Bulletin. Meanwhile, to schedule a demo of MyHealthNS you can reach DHW at 902-424-3951 or email MyHealthNS@novascotia.ca.

## ELECTRONIC MEDICAL RECORD (EMR) INCENTIVE TRUST AND SUPPORT

The DHW Migration Project Office will trigger payment of all incentives after the migration has been completed and all eligibility criteria have been met. Payments will be processed through MSI on a quarterly basis.

The following incentives and supports are available:

- **A one-time migration incentive of $2,300** will be paid to each physician in recognition for time spent by them and their staff to ensure migration of their patient records in accordance with provincial migration project standards, including testing and validating migrated data.

- ***A one-time incentive payment to expedite the required migration from Nightingale On Demand*** (NOD). Eligible physicians currently on Nightingale on Demand may also receive up to a maximum of $3,000 (one-time payment) to compensate them for migrating their patient records from Nightingale On Demand to a Certified EMR. Incentive amounts will be determined as follows:

    - Physicians who, between December 1, 2017 and October 31, 2018, secure a migration date with the vendor and DHW and submit their Consent to Grant Access Form to DHW, shall receive the maximum amount of the NOD Migration Incentive ($3,000). (Note that the migration date may be after October 31st, 2018, but it must be ***secured*** by October 31st, 2018)
    - Physicians who, between November 1, 2018 and March 31, 2019, secure a migration date with the vendor and DHW and submit their Consent to Grant Access Form to DHW, shall receive 75% of the maximum NOD Incentive (actual $2,250). (Note that the migration date may be after March 31, 2019, but it must be ***secured*** by March 31, 2019.)
    - Physicians who, between April 1, 2019 and October 31, 2019, secure a migration date with the vendor and DHW and submit their Consent to Grant Access Form to DHW, shall receive 50% of the maximum NOD Incentive (actual $1,500) (Note that the migration date may be after October 31, 2019, but it must be ***secured*** by October 31, 2019.)
    - Once a migration date is secured, it is expected that the physician will complete the migration as scheduled. If the scheduled migration date is changed by the DHW Migration Project Office, this will not negatively affect the amount of the incentive to be paid to the physician. If the scheduled migration date is changed by the physician, the new migration secured date will be used to determine eligibility for incentive payments.

- To qualify for compensation under the EMR Migration Incentive Program physicians are required to meet specific migration eligibility criteria and must have migrated from a provincial EMR to a Certified EMR between December 1, 2017 and December 31, 2019.

### ELECTRONIC MEDICAL RECORD (*EMR) SUBSIDY*

To encourage ongoing EMR use, *existing* provincial EMR users (i.e. Practimax, Accuro and Med Access), who are receiving eResults from provincial information systems, will receive an EMR subsidy of $200 per month. The EMR Subsidy payment will be processed by DHW and paid through MSI on a quarterly basis. No action is required by physicians.

- Nightingale On Demand physicians will qualify for the subsidy in the month after they have completed their migration to a Certified EMR.
- For Accuro, Practimax and Med Access EMR users who meet the eligibility criteria (see FAQ), the subsidy is effective April 1, 2018.
- The end date for the EMR Subsidy is December 31, 2019 or earlier if a new Physician Master Agreement has been ratified.

Click here for the complete DHW EMR Communication and FAQ.

## Fees New Fees, Fee Revisions, and Highlighted Fees

## NEW FEES

Effective May 17th, 2018, the following health service code will be available for billing:

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03V | **Medical Abortion/Termination of early Pregnancy**<br><br>This comprehensive fee includes the assessment of the patient requesting termination of an early (first trimester) pregnancy, counselling, ordering and interpretation of laboratory tests and diagnostic imaging as required, prescription of the medication and telephone follow up. Administration/prescription of cytotoxic medication(s) and Rh immune globulin (where required) is included as are all verbal or electronic communications with the patient to relay results of follow up blood work and address questions or concerns.<br>**Billing Guidelines**<br>• May not be reported with any other consultation or visit service same patient same day.<br>• Follow up visits are not included in the comprehensive HSC.<br>**Premium**<br>GPEW<br>**Location**<br>OFFICE | 47.5 MSU |

Effective April 1, 2018 the following health service premium is available for billing. Physicians holding claims from April 1st - May 16th have 90 days from the date of the bulletin to submit; please refer to this bulletin in electronic text for any claims submitted over 90 days from their date of service.

| Category | Code | Description | Base Units | Anaes Units |
|---|---|---|---|---|
| ADON | AHSP1 | **After Hours Service Premium (extended service hours)**<br><br>This premium applies in circumstances where elective procedures are moved to an eligible premium time period due to factors beyond the control of the physician.<br>The 35% after hours service premium is intended to compensate the physician for the disruption of their personal time while providing extended hours of service in addition to the scheduled workday.<br>Eligible time periods are defined as:<br>• Weekday evenings: Mon-Friday 17:00-23:59<br>• After midnight: Tuesday-Saturday 00:00-07:59<br>• Weekend day time: Saturday 08:00-16:59<br>• Weekend night time and Sunday all day: Saturday to Monday 17:00-07:59<br>• Official recognized holidays: 08:00-23:59<br>**Billing Guidelines**<br>• May only be reported for scheduled electively booked interventional procedures that have been moved to a premium eligible time period due to factors beyond the control of the physician.<br>• The premium does not apply to elective procedures that have been intentionally booked during premium hours ex: elective cases booked to start before 0800 hours, scheduled weekend joint replacement OR lists etc.<br>**Specialty Restriction**<br>Surgical specialties, endoscopies and interventional radiology<br>**Location**<br>LO=HOSP<br>**Note**<br>Only one claim for AHSP1 is required for all applicable services billed during the same occurrence. While not a billing requirement, physicians may reference in text the service encounter number(s) or health service code(s) the premium should apply to, as this may expedite processing and reduce wait times. | 35% premium | 35% |

Effective April 1st 2018 the following enhanced office visit fees for GPs is available for billing:

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03 | **Office Visit – comprehensive and continuous care**<br>A) ME=CARE, RP=SUBS (RF=REFD)<br>B) ME=CARE, TI=GPEW, RP=SUBS (RF=REFD) | 14.76 MSU<br>18.45 MSU |
| VIST | 03.03A | **Geriatric Office Visit (for patients aged 65+)**<br>A) ME=CARE, RP=SUBS (RF=REFD)<br>B) ME=CARE, TI=GPEW, RP=SUBS (RF=REFD)<br><br>The creation of these new enhanced fees will better remunerate full scope family medicine physicians for services provided, while also allowing physicians who provide episodic care to continue billing the current fees for normal and geriatric office visits.<br><br>**Billing Guidelines**<br>By "full scope family medicine" it is meant that the physician has an ongoing relationship as a primary care provider to their patients and ensures their patients' continuity of care. The enhanced fee is not intended for episodic care provided to walk-in patients. The submission of a Physician Confirmation Letter is required to successfully use this enhanced fee.<br>**Specialty Restriction**<br>GENP<br>**Location**<br>OFFICE | 18.26 MSU<br>22.83 MSU |

# FEE REVISIONS

Effective April 1st, 2018 the billing guidelines associated with the following health service codes have been updated:

| Category | Code | Description | Base Units |
|---|---|---|---|
| DEFT | UPB1 | **Unattached Patient Bonus**<br><br>On April 1st, 2018 the Department of Health and Wellness implemented revisions to the criteria for claiming HSC UPB1 — the unattached patient bonus fee.<br>**Billing Guideline Updates**<br>• The UPB1 service will be claimable from an office, nursing home, acute home care, or home location. Previously the service was limited to office claims.<br>• The GP has to have had at least one visit service with the patient prior to claiming the UPB1 fee. This visit can occur at the same encounter in which UPB1 is claimed.<br>• A GP can only claim UPB1 once per patient per lifetime. A physician cannot claim the unattached patient bonus more than once for the same patient.<br>• The UPB1 cannot be claimed for walk-in clinics, for patients who already appear on a physician's patient list (physician validated), for patients who were taken off the 811 list before the establishment of this fee enhancement (i.e. retroactive payment before April 1st, 2018), or for new physicians who are building their practices until that point when their patient panel reaches 1350.<br><br>**Documentation**<br>The GP must confirm and document at the initial visit with the Unattached Patient that the patient is unattached (i.e., does not already have a regular family physician). Information about the encounter that resulted in the GP taking the Unattached Patient into his/her practice must also be recorded in the patient's record. This can be a patient from the 811 list, referral from the hospital emergency department, for enrolling patients who do not have a physician or are unattached at time of enrolment, for enrolling patients for whom un-attachment is imminent because their family practitioner is retiring/relocating and no new family physician is taking over the practice, an inpatient hospital report or other documentation. (Other documentation may include a note by the physician, documenting their discussion with the patient, confirming the prior hospital encounter.)<br><br>**Specialty Restriction**<br>GENP<br><br>**Location**<br>All locations | $150.00 (one time per patient) |

*Revised march 31, 2020 – see May 2020 bulletin for updated information*

| Category | Code | Description | Base Units |
|---|---|---|---|
| **ADON** | 03.03S | **First Visit After Acute Care In-Patient Hospital Discharge – Complex Care**<br><br>This is an additional fee for the first office visit of the patient requiring ongoing complex care within 14 days of acute care in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care.<br>• The physician or their office staff should make every effort to | 10 MSU |

communicate with the patient and/or caregiver within 2 business days of discharge to better facilitate the patient being seen within 14 days.
- Not reportable in the walk-in clinic setting.

A complex care patient is defined as:
- A patient with multiple (two or more) chronic

**Billing Guidelines**

ADON Restricted to:
03.03 Office visit
03.03A Geriatric Office Visit (for patients age 65+)
03.03E Adults with Developmental Disabilities

- Reportable only if the visit occurs in the primary care physician's office or the patient's home within 14 calendar days after hospital discharge (consider discharge date as Day zero).
- Hospital length of stay must be greater than or equal to 48 hours.
- Not reportable if the admission to hospital was for the purpose of performing elective surgery (major or minor) or fracture care (major or minor).
- Not reportable if the admission to hospital was for the purpose of obstetrical delivery.
- Not reportable if the admission to hospital was for the purpose of newborn care.
- Not reportable for services rendered in other locations such as Nursing Homes, Residential Care Facilities, or Hospice.
- The physician claiming the service must be the provider most responsible for the patient's ongoing complex care.
- Claimable once per patient per inpatient admission.
- Not reportable for any subsequent discharges within 30 days.
- Not reportable in the same month as other monthly care fees - such as 13.99C
- Maximum of 4 claims per physician per patient per year.

**Specialty Restriction**
GENP
**Location**
LO=OFFC, HOME

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***Revised march 31, 2020 – see May 2020 bulletin for updated information***

| Category | Code | Description | Base Units |
|---|---|---|---|
| **ADON** | 03.03P | **First Visit after In-Patient Hospital Discharge – Maternal and Newborn Care**<br>This is an additional fee for the first maternal/newborn office visit within 14 days of in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care.<br><br>• The primary care physician or their office staff should make every effort to communicatewith the patient and/or caregiver within 2 business days of discharge to better facilitate the patient being seen within 14 days of discharge.<br>• Not reportable in the walk-in clinic setting.<br><br>**Billing Guidelines**<br><br>ADON Restricted to:<br><br>03.03 Office visit<br>03.03 Well Baby Care<br>• Reportable only if the visit occurs in the primary care physician's office or the patient's home within 14 calendar days after hospital discharge (consider discharge date as Day zero).<br>• Only reportable if the reason for admission to hospital was for the purpose of obstetrical delivery. | 10 MSU |

- Physician must be the provider most responsible for the mother and child's ongoing care.
- Claimable once per patient per inpatient admission for obstetrical delivery.
- Not reportable for any subsequent discharges within 30 days.
- Maximum of 1 claim per pregnancy (mother)
- Maximum 1 claim per infant

**Specialty Restriction**
SP=GENP

**Location**
LO=OFFC, HOME

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Please note the removal of the requirement for a written referral to be sent to the specialist and available in the patient's medical record only applies to the following health service codes:

| Category | Code | Description | Base Units |
|---|---|---|---|
| **VIST** | 03.09K | **Specialist Telephone Advice – Consultant Physician – Providing Advice** | 25 MSU |
| **VIST** | 03.09L | **Specialist Telephone Advice – Referring Physician – Requesting Advice** | 11.5 MSU |

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

The referring physician may be a family physician or other specialist seeking an expert opinion from the consulting physician due to the complexity and severity of the case and with the intent of continuing to provide the patient's care closer to home. The consultant specialist may also receive requests for advice from a nurse practitioner.
The referring physician (or NP) must communicate to the specialist the reason for the consultation and relevant patient information through verbal, written or electronic communication, either before or within four business days after the telephone call. The referring physician must document that this information was supplied to the specialist. There must be by a two-way verbal communication discussing the clinical situation followed by a management decision and a written report from the specialist to the referring provider.
The formal consultation report must be available in the patient's medical record; both the referring physician (or NP) and the specialist must maintain copies of this document. Both medical records must include the date and time of the service and any contemporaneous notes, in addition to the written documents.
The service is reportable by the specialist for a new patient or an established patient with a new condition or an exacerbation of an existing condition.

**Billing Guidelines**

The HSC includes a review of the relevant patient's history, relevant family history and relevant history of present complaint, and a review of any laboratory data, PACS images, medical records or other data as needed to provide advice.
The health service includes a discussion of the relevant physical findings as reported by the referring provider.
If subsequent phone calls are necessary within 14 days to complete the consultation they are considered included in the HSC for the telephone consultation.
The Consultant Physician HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.
The Referring Physician HSC may be reported when the telephone call for an urgent consultation occurs on the same day as the patient visit that generated the consultation.

The HSC is 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 not reportable for other forms of communication such as:

- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another health professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student

The service is not reportable by the consulting physician if the patient has had a face to face visit with the consultant or any member of his/her call group within the previous 14 days for the same condition or if the telephone consultation results in a face to face service within the next 14 days or the next available appointment of the consultant.
The service is not reportable for telephone calls of less than 5 minutes of two way medical discussion.

The service is not reportable for calls between a referring provider and specialist in the same institution or practice location.

**Documentation requirements**

- The referring physician must document that s/he has communicated the reason for the consultation and relevant patient information to the specialist
- Both the specialist consultant and the referring provider must document the patient name, identifying data and date and start and stop time of the call in their respective charts or EMRs.
- The names of the referring physician (or NP) and the consultant physician must be documented by both physicians.
- The diagnosis, reason for referral, elements of the history and physical as relayed by the referring provider, the opinion of the consultant physician and the plan for future management must be documented.
- A written report must be sent to the referring provider by the specialist consultant.
- The referring physician's billing number must be noted on the electronic claim.
- Both physicians must submit the start and stop time of the call in the text field on the claim.
- There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service.

**Location**
LO=OFFC

| Category | Code | Description | Base Units |
|---|---|---|---|
| **VIST** | 03.03Q | **Specialist Telephone Management/Follow Up with Patient**<br><br>This health service code may be reported for a 15 minute telephone communication between the specialist physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face consultation, visit or procedure by the same physician within the lasts months and has not been seen within the last 7 days. This service is not reported if the outcome of the call is to see the patient at the next available appointment in the office. This communication is intended to take the place of an office follow up visit, that would have otherwise been scheduled, when a physical examination of the patient is not required.<br><br>**Billing Guidelines**<br>• This health service is reportable for a telephone (or synchronous electronic verbal communication) between the specialist physician and the patient, or the patient (or the patient's parent, guardian or proxy as established by written consent).<br>• Telephone management requires communication between the patient and physician on a clinical level; the HSC is not reportable for administrative tasks.<br>• The call must include a discussion of the clinical problem and a management decision.<br>• The specialist physician must have seen and examined the patient within the preceding 9 months.<br>• The HSC is reportable a maximum of 4 times per patient per physician per year.<br>• The HSC is not reportable for facility based patients.<br>• The HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.<br><br>The service is not reportable for other forms of communication such as:<br>• Written, e-mail or fax communication<br>• Electronic verbal forms of communication that are not PHIA compliant<br><br>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 professional such as:<br>• Nurse Practitioner<br>• Resident in training<br>• Clinical fellow<br>• Medical student<br>• Clerical staff<br><br>The service is not reportable for telephone calls of less than 5 minutes of medical discussion.<br>**Documentation requirements**<br>• The date, start and stop times of the conversation must be noted in the medical record.<br>• The medical record must indicate the content of the discussion, the management plan and that the patient (or the patient's parent, guardian or proxy as established by written consent) understands and acknowledges the information provided.<br>• A written report must be sent to the referring physician or family physician by the specialist consultant.<br>• The start and stop time of the call must be included in the text field on the MSI service report.<br>• There must be text on the MSI service report to indicate whether or not this service replaced a face to face service.<br><br>**Location**<br>LO=OFFC | 11.5 MSU |

| Category | Code | Description | Base Units |
|---|---|---|---|
| **VIST** | 03.03R | **Family Physician Telephone Management/Follow Up with Patient**<br><br>This health service code may be reported for a 15 minute telephone communication between the family physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face visit by the same physician within the last 9 months and has not been seen within the last 7 days for the same condition. This telephone communication is intended to take the place of an office visit initiated by the patient (or the patient's parent, guardian or proxy as established by written consent) for a new condition or an exacerbation of an existing condition, or a follow up visit that would have otherwise been scheduled by either the physician or the patient, when a physical examination of the patient is not required.<br>The patient population eligible must be either 65 years and older or be suffering from mental illness or multiple (two or more) chronic diseases.<br><br>Mental illness is defined as<br>• A condition that meets criteria for a DSM diagnosis<br><br>The service is not reported if the decision is to see the patient at the next available appointment in the office.<br>**Billing Guidelines**<br>• This health service is reportable for a telephone (or synchronous electronic verbal communication) between the family physician and the patient (or the patient's parent, guardian or proxy as established by written consent).<br>• Telephone management requires communication between the patient and physician on a clinical level; the HSC is not reportable for administrative tasks.<br>• The call must include a discussion of the clinical problem and a management decision.<br>• The family physician must have seen and examined the patient within the preceding 9 months.<br>• The HSC is reportable a maximum of 4 times per patient per physician per year by the family physician and/or the practice providing ongoing comprehensive care to the patient. The HSC is not reportable by walk in clinics. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no requirement for an appointment, and episodic care with little or no follow-up. There is no standard patient roster and the patient list is constantly changing.<br>• The HSC is not reportable for facility based patients.<br>• The HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.<br>• The service is not reportable when the purpose of the communication is to:<br>- Arrange a face to face appointment<br>- Notify the patient of an appointment<br>- Prescription renewal<br>- Arranging to provide a sick note<br>- Arrange a laboratory, other diagnostic test or procedure<br>- Inform the patient of the results of diagnostic investigations with no change in management plan<br>• The service is not reportable for other forms of communication such as:<br>- Written, e-mail or fax communication<br>- Electronic verbal forms of communication that are not PHIA compliant<br>• 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 professional such as:<br>- Nurse practitioner<br>- Resident in training<br>- Clinical fellow<br>- Medical student<br>- Clerical staff | 11.5 MSU |

The service is not reportable for telephone calls of less than 5 minutes of medical discussion.

**Documentation requirements**

- The date, start and stop times of the conversation must be noted in the medical record.
- The medical record must indicate the content of the discussion, the management plan and that the patient (or the patient's parent, guardian or proxy as established by written consent) understands and acknowledges the information provided.
- For patient initiated appointment requests that result in a telephone management service on the same day, the following text should be entered in the MSI text field:
  - Same day access
- The start and stop time of the call must be included in the text field on the MSI service report.
- There must be text on the MSI service report to indicate whether or not this service replaced a face to face service.

**Location**

LO=OFFC

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# Billing Matters Billing Reminders, Updates, New Explanatory Codes

## BILLING REMINDERS

### Travel for HSC HOVM1

Physicians are reminded that they cannot bill for travel from personal home location to patient home, only for travel from office to patient home (unless the physician has an at-home office registered with MSI).

## UPDATES

### Methadone Exemption

Effective May 2018 the federal government will permit health care practitioners to prescribe and administer methadone without requiring an exemption from federal law. Due to this policy change, physicians no longer need to provide proof of a valid Health Canada exemption to prescribe methadone in order to claim the following fees through MSI:

- **03.03J** – Initial Opioid Use Disorder Assessment in a community setting for initiation of Methadone Treatment
- **03.03K** – Initial Opioid Use Disorder Assessment for Methadone Treatment – Transfer from Methadone Maintenance Treatment Clinic to community physician
- **03.03L** – Permanent Transfer of patient on active Methadone Treatment for substance use disorder – Full acceptance of responsibility for ongoing care – Initial visit with accepting physician
- **MMM1** – Methadone Treatment Monthly Management fee: Intensive
- **MMM2** – Methadone Monthly Management Fee: Maintenance

BACK TO CONTENTS

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| DE032 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED THE UNATTACHED PATIENT BONUS PAYMENT FOR THIS PATIENT. |
| DE033 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THERE HAVE BEEN NO VISIT SERVICES CLAIMED BY YOU FOR THIS PATIENT IN THE PREVIOUS 365 DAYS. |
| VT162 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.03V MAY NOT BE BILLED IN ADDITION TO OTHER SERVICES FOR THIS PATIENT ON THE SAME DAY. |
| VT163 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A CONSULT MAY NOT BE BILLED IN ADDITION TO 03.03V FOR THIS PATIENT ON THE SAME DAY. |

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

### UPDATED FILES

Updated files reflecting changes are available for download on Thursday May 17, 2018. The files to download are health service (SERVICES.DAT), modifier values (MODVALS.DAT), health service description (SERV_DESC.DAT) and, explanatory codes (EXPLAIN.DAT).

### HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

http://msi.medavie.bluecross.ca/

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

### 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

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NOVA SCOTIA

PHYSICIAN'S BULLETIN
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NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## MSI News

### MSI UNIT VALUE CHANGES

**MEDICAL SERVICE UNIT/ANAESTHESIA UNIT CHANGE**

Effective April 1, 2018, the Medical Service Unit (MSU) value will be increased from $2.44 to $2.48 and the Anaesthesia Unit (AU) value will be increased from $20.76 to $21.07.

**PSYCHIATRY FEES**

Effective April 1, 2018 the hourly Psychiatry rate for General Practitioners will increase to $113.33 while the hourly rate for Specialists increases to $153.67 as per the tariff agreement.

**SESSIONAL PAYMENTS**

Effective April 1, 2018 the hourly Sessional rate for General Practitioners will increase to $148.80 while the hourly rate for Specialists increases to $173.60 as per the tariff agreement.

**WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC**

Effective April 1, 2018 the Workers' Compensation Board MSU Value will increase from $2.71 to $2.76 and the Workers' Compensation Board Anaesthetic Unit Value will increase from $23.07 to $23.41.

BACK TO CONTENTS

## NEW FEES

Effective April 1, 2018 the following health service premium will be available for billing. Physicians are asked to hold these premiums until notified that they may be submitted for payment.

| Category | Code | Description | Base Units | Anaes Units |
|---|---|---|---|---|
| ADON | | **After Hours Service Premium (extended service hours)**<br><br>This premium applies in circumstances where elective procedures are moved to an eligible premium time period due to factors beyond the control of the physician.<br><br>The 35% after hours service premium is intended to compensate the physician for the disruption of their personal time while providing extended hours of service in addition to the scheduled workday.<br><br>Eligible time periods are defined as:<br>a. Weekday evenings: Mon-Friday 17:00-23:59<br>b. After midnight: Tuesday-Saturday 00:00-07:59<br>c. Weekend day time: Saturday 08:00-16:59<br>d. Weekend night time and Sunday all day: Saturday to Monday 17:00-07:59<br>e. Official recognized holidays: 08:00-23:59<br><br>**Billing Guidelines**<br><br>May only be reported for scheduled electively booked interventional procedures that have been moved to a premium eligible time period due to factors beyond the control of the physician.<br><br>The premium does not apply to elective procedures that have been intentionally booked during premium hours ex: elective cases booked to start before 0800 hours, scheduled weekend joint replacement OR lists etc.<br><br>**Specialty Restriction**<br>Surgical specialties, endoscopies and interventional radiology<br>**Location**<br>HOSP | 35% premium | 35% |

Effective March 23, 2018 the following health service codes will be available for billing:

| Category | Code | Description | Base Units | Anaes Units |
|---|---|---|---|---|
| MASG | 76.95B | **Insertion of semi-rigid or malleable penile prosthesis** | 140 MSU | 5+T |
| MASG | 76.96B | **Removal with or without reinsertion of semi-rigid or malleable penile prosthesis**<br><br>These HSCs are specific to the insertion, and/or removal, with or without re-insertion of a malleable or semi-rigid penile prosthesis to include any urethral dilation required to insert the device.<br><br>**Billing Guidelines**<br><br>Cystoscopy, when required, may be reported in addition to these HSCs.<br>For the removal with or without reinsertion of semi-rigid or malleable penile prosthesis, IC will be paid at 125 MSU/hr based on surgical start and stop time as documented in the record of operation which must be submitted with the claim.<br><br>**Specialty Restriction**<br>UROL<br>**Location**<br>HOSP | IC @125MSU/hr | 5+T |

*Revised March 31, 2020 – See May 2020 Bulletin for updated information*

| Category | Code | Description | Base Units | Anaes Units |
|---|---|---|---|---|
| MASG | 76.95C | **Inflatable penile prosthesis-insertion of all components (pump, cylinders and reservoir)** | 230 MSU | 6+T |
| MASG | 76.96C | Inflatable penile prosthesis-removal of any or all components (pump, cylinders and reservoir), with or without reinsertion<br><br>These HCSs are specific to the insertion, and/or removal, with or without reinsertion of an inflatable penile prosthesis with all its components (pump, cylinders and reservoir) to include any urethral dilation required to insert the device.<br><br>**Billing Guidelines**<br>Cystoscopy, when required, may be reported in addition to this HSC.<br>For the removal with or without reinsertion of an inflatable penile prosthesis (any or all components-pump, cylinders and reservoir), IC will be paid at 130 MSU/hr based on surgical start and stop time as documented in the record of operation which must be submitted with the claim.<br><br>**Specialty Restriction**<br>UROL<br>**Location**<br>HOSP | IC @130MSU/hr | 6+T |

# UPDATED FEES

**Workers' Compensation Board Medical Service Unit 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 2018-19.

Due to the increase in CPI for 2017, all of the WCB specific services listed below will have their values increased by 1.65% effective April 1st, 2018:

| CODE | DESCRIPTION | NEW VALUE |
|---|---|---|
| WCB12 | EPS physician assessment Service.<br>Combined office visit and completion of Form 8/10<br><br>For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15 minute increments to a maximum of 1 additional hour | **Initial visit:**<br>$180.03 + $51.61 per 15 minutes to a maximum 4x<br>(RO=EPS1 and RP=INTL)<br><br>**Subsequent visit:**<br>$180.03<br>(RO=EPS1 and RP=SUBS) |
| WCB13 | Chart Summaries / Written Reports.<br>Detailed reports billed in 15-minute intervals<br>- plus multiples, if applicable | GPs…….$43.97 per 15 min<br>EPS(RO=EPS1) $52.61 per 15 min<br>Specialists……..$59.17 per 15 min |
| WCB15 | Case Conferencing and Teleconferencing (Treating Physician)<br>Conferencing billed by the Treating Physician<br>- plus multiples, if applicable | GPs…….$43.97 per 15 min<br>EPS(RO=EPS1)$52.61 per 15 min<br>Specialists……..$59.17 per 15 min |
| WCB17 | Photocopies of Chart Notes | 10 pgs or less (ME=UP10)……..$26.33<br>11-25 pgs (ME=UP25)……..$52.61<br>26-50 pgs<br>(ME=UP50)….. $105.16<br>Over 50 pgs (ME=OV50)……$157.71 |
| WCB20 | Carpal Tunnel Syndrome (CTS) Assessment Report | $67.48 |
| WCB21 | Follow-up visit report | $39.47 |
| WCB22 | Completed Mandatory Generic Exemption Request Form | $13.19 per form |
| WCB23 | Completed Non-Opioid Special Authorization Request Form | $13.19 per form |
| WCB24 | Completed Opioid Special Authorization Request Form | $44.22 per form |
| WCB25 | Completed WCB Substance Abuse Assessment Form | $29.45 |
| WCB26 | Return to Work Report – Physician's Report Form 8/10 | $67.48 |
| WCB27 | Eye Report | $59.17 |
| WCB28 | Comprehensive Visit for Work Related Injury or Illness | $67.90 |

# BILLING REMINDERS

**Text required on claims for removal of progestin contraceptive device (HSC 13.53C)**

Physicians are reminded to include explanatory text on claims for removal of progestin contraceptive device. This health service code is for the removal of intradermal devices. Removal of intrauterine devices are to be claimed using visit codes.

**Correct Location Code When Submitting Claim to MSI**

Physicians are reminded to use the correct location and facility code when submitting claims to MSI. The location code to be used is the physical location of where the service was provided.

**Elective Out of Province Services (within Canada)**

Prior approval is required from the Nova Scotia Department of Health and Wellness before referring a patient out of province for insured health services unavailable in Nova Scotia if the patient wishes to be considered for travel and accommodation assistance. Approval must be sought through the Medical Consultant, MSI. The referral must be from a specialist registered in Nova Scotia, who is actively involved in the eligible resident's care. The referral must include the following:

- A description of the eligible resident's relevant medical history.
- A description of the health services requested as well as an estimation of the expected benefit to the patient.
- Confirmation that the health service(s) are provided in a publicly funded facility and are covered by the medical insurer in the proposed province
- Written confirmation of the medical evidence supporting the requested health service.
- When the proposed health service is a new or emerging health service, documentation must be included of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.
- Information on the available health services in Nova Scotia and an explanation of why these are not sufficient for the resident's needs.
- The contact information of the physician who will be treating the patient so a copy of the approval documentation can be forwarded to their office.
- A description of any follow-up requirements.
- A written recommendation in support of the out-of-province health services, confirming that this is the specialist's recommendation and that the referral is not being provided solely at the request of the patient.
- Written confirmation of, the patient's medical requirement for travel with an escort, if required.
- The costs for an escort will not be covered by DHW if there is no medical evidence to support the need for an escort. Evidence of medical need for an escort is not required if the resident is under 19 years of age.

MSI will review the application and provide a response to the appropriate specialist within 30 days of receiving a complete application.

Upon approval of the application, the Department of Health and Wellness will contact the eligible resident and provide the appropriate application forms for travel and accommodation assistance.

**Elective out of Country Services**

Individuals requiring elective, insured health services that are not available within Canada must be authorized by the DHW prior to making any medical and/or travel arrangement to ensure the service will be insured and in order for the DHW/MSI to negotiate a reasonable and fair compensation with out of country providers prior to the provision of services.

In order for a patient to be referred outside Canada for treatment, prior written approval is required from the Medical Consultant, MSI. The referral must be from a specialist registered in Nova Scotia, who is actively involved in the eligible resident's care. The referral must include the following:

- A description of the eligible resident's relevant medical history.
- A description of the health services requested as well as an estimation of the expected benefit to the patient.
- The contact information of the physician who will be treating the patient so a copy of the approval documentation can be forwarded to their office.

- Written confirmation of the medical evidence supporting the requested health service.
- When the proposed health service is a new or emerging health service, documentation must be included of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.
- Information on the available health services in Canada and an explanation of why these are not sufficient for the resident's needs.
- A description of any follow-up requirements.
- A written recommendation in support of the out-of-country health services, confirming that this is the specialist's recommendation and that the referral is not being provided solely at the request of the patient.
- Written confirmation of the patient's medical requirement for travel with an escort, if required.
- The costs for an escort will not be covered by DHW if there is no medical evidence to support the need for an escort. Evidence of medical need for an escort is not required if the resident is under 19 years of age.

MSI will review the application and provide a response to the appropriate specialist within 30 days of receiving a complete application.

Upon approval of the application, the Department of Health and Wellness will contact the eligible resident and provide the appropriate application forms for travel and accommodation assistance.

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| MJ064 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR URETHRAL DILATION AT THE SAME ENCOUNTER. THIS SERVICE INCLUDES ANY URETHRAL DILATION REQUIRED TO INSERT THE DEVICE. |
| MN016 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR AN INSERTION OR REMOVAL WITH OR WITHOUT REINSERTION OF A PENILE PROSTHESIS AT THE SAME ENCOUNTER WHICH INCLUDES ANY URETHRAL DILATION REQUIRED TO INSERT THE DEVICE. |
| NR088 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR URETHRAL DILATION AT THE SAME ENCOUNTER. THIS SERVICE INCLUDES ANY URETHRAL DILATION REQUIRED TO INSERT THE DEVICE. |
| VA087 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR AN INSERTION OR REMOVAL WITH OR WITHOUT REINSERTION OF A PENILE PROSTHESIS AT THE SAME ENCOUNTER WHICH INCLUDES ANY URETHRAL DILATION REQUIRED TO INSERT THE DEVICE. |
| VA088 | SERVICE ENCOUNTER HAS BEEN DISALLOWED. PLEASE RESUBMIT, INDICATING IN THE TEXT FIELD THIS CLAIM IS FOR THE REMOVAL OF AN INTRADERMAL DEVICE. |

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

## UPDATED FILES

Updated files reflecting changes are available for download on Friday March 23, 2018. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT) and, explanatory codes (EXPLAIN.DAT).

## HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

http://msi.medavie.bluecross.ca/

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

## CONTACT INFORMATION

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Fax: 902-490-2275
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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

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# PHYSICIAN'S BULLETIN

February 9, 2018: Vol. LIX, ISSUE 12

NOVA SCOTIA MEDICAL SERVICES INSURANCE


## CONTENTS



## MSI News

### MSI DOCUMENTATION REMINDER

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribed, and start and stop times for time based codes.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptations, or emotional problems, the physician "deliberately established a professional relationship with the patient for the purposes of removing, modifying or alleviating existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional well being of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy," etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service on that date, then the service is not paid for or a lesser benefit is given. **When the clinical record does not support the service claimed, there will be a recovery to MSI at the time of audit.** Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

## NEW FEES

Effective February 9, 2018 the following health service code will be available for billing:

*Revised March 31, 2020 – See May 2020 Bulletin for updated information*

| Category | Code | Description | Base Units | Anaes Units |
|---|---|---|---|---|
| MASG | 71.7F | **Cystoscopy with intravesicular injection(s) of chemodenervating agent**<br><br>**Billing Guidelines**<br><br>Not to be reported with other cystoscopy related HSCs. For example, do not report with HSC 01.34A, 01.34B, 01.34C, 01.34G<br><br>**Specialty Restriction**<br>UROL, OBGY<br>**Location**<br>HOSP | 90 MSU | 4+T |

## NEW INTERIM FEES (2015-2019 MASTER AGREEMENT)

Effective February 9, 2018 the following interim health service codes will be available for billing:

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | | **Inpatient Trauma Service Leader Level I Trauma Centre** | |
| | 03.04G | 1. Inpatient Trauma Service Admission and Assessment Day 1 | 100 MSU(+MU) |
| | 03.04H | 2. Inpatient Trauma Service Tertiary survey Day 2 | 62 MSU(+MU) |
| | 03.03T | 3. Inpatient Trauma Service subsequent daily visit Day 3 | 23 MSU |
| | 03.03U | 4. Inpatient subsequent daily visit Day 4-7 | 19 MSU |
| | | The Inpatient Trauma Service Leader HSC's are intended for the care and co-ordination of care for the patient on the inpatient trauma service in a level I trauma centre.<br>Day 1 and Day 2 HSC's are time based codes intended for the first hour of care and coordination of care.<br>The care is to include:<br>Complete history and physical examination<br>Documentation of all injuries in the health record<br>Review of all formal radiological reports and laboratory tests results<br>Ongoing and active daily medical and surgical management<br>Co-ordination of care between specialty services | |

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|

**Billing Guidelines**

1. Patient must have met the criteria for Trauma Team activation as set by Trauma Nova Scotia and been referred to the Trauma Service by the Trauma Team Leader in the ER.
2. Reportable only while an inpatient on the Trauma Service. Not reportable if the patient is admitted to ICU.
3. For Day 1 Admission and Assessment and Day 2 Tertiary Survey, **start and stop times** must be recorded in the health record.
4. Day 2 Tertiary Survey is only reportable by the same physician providing the admission assessment (same provider number) and is not reportable if Day 1 Admission and Assessment HSC has not been reported.
5. Reportable in addition to operative procedures by the same physician and/or physician of the same specialty (exempt from Preamble 5.3.52 and 5.3.55) if the visit is independent of the operative procedure performed.
6. Reportable by only one physician per patient.

**Premium**

Inpatient Trauma Service Admission and Assessment Day 1 is premium eligible.
Day 2 and subsequent daily visits are not premium eligible.

**Specialty restriction**

Inpatient Trauma Service physician members as designated by Trauma Nova Scotia.

**Multiples**

1. Inpatient Trauma Service Admission and Assessment Day 1 Per 15 minutes, maximum of 5 multiples (2 hours total time)
2. Inpatient Trauma Service Tertiary survey Day 2 Per 15 minutes, maximum of three multiples (90 minutes total time)

**Location**

HOSP

**Preamble Reference:**

SURGICAL SERVICES MAJOR (5.3.50)
Surgical procedures are described as major if they have a value in excess of 50 units: (5.3.51)
The procedure fee is intended to cover the operation and customary preoperative, operative and postoperative care by the surgeon or a designated covering physician. (5.3.52)

a) A consultation at any time prior to surgery may be claimed, even if the surgery is on the same day. A visit other than a consultation is not payable the same day as a major surgical procedure.(5.3.53)
b) Preoperative care includes:
   i. Comprehensive visit (the admission history and physical exam)
   ii. Hospital visits for up to two calendar days immediately prior to and including the day of surgery
   iii. Hospital visits in a preoperative period that extends beyond two days should be claimed using the appropriate visit codes (5.3.54)
c) Postoperative care includes care during the postoperative hospital stay up to 14 days. (5.3.55)
d) Urgent visits or emergency hospital visits (See Section 5 (5.1.52)) to attend the patient for an unrelated condition are not included in the surgical benefit and may be claimed accordingly. (5.3.56)
e) Hospital visits may be claimed starting on the 15th postoperative day for visits if the postoperative in hospital stay exceeds 14 consecutive calendar days. For the purpose of calculation, the day of the last operative procedure is considered day zero. Weekly routine visit maximums beyond 56 days apply starting from the date of admission. (5.3.57)
f) When a patient is readmitted to hospital during the first 14 days of the post-surgical period because of postoperative complications which do not require a surgical procedure, the surgeon or other physician attending this readmitted patient should claim hospital visits as for a new admission. (5.3.58)

BACK TO CONTENTS

Note: There will be no reduction in the surgical payment when a service related to the surgery is claimed by another physician in the postoperative period. (5.3.59)

## BILLING REMINDERS

**Visit and Programming to a Pacemaker (HSC 49.83B and 49.83C)**

Physicians are reminded that the visit and programming to a pacemaker health service codes include a visit in their description. It is inappropriate to make a separate claim for a visit or consult service at the same encounter.

**MRI Guided Placement of MRI Compatible Clip (HSC 97.99A)**

Physicians are reminded that health service code 97.99A MRI guided placement of MRI compatible clip to locate a breast abnormality, includes any related biopsy. It is inappropriate to report an additional breast biopsy code during the same encounter.

**Visits to Pronounce Death**

If a physician attends a patient to pronounce death, a limited visit may be claimed. However, this service may not be claimed using an urgent modifier. If another healthcare provider, such as a nurse, pronounces the patient, the physician may not claim a visit. It is not appropriate to claim a visit for filling out the death certificate or for telephone calls related to the death.

**Insertion and Removal of Intradermal Progestin Contraceptive Device (HSC 13.53A and 13.53C)**

Physicians are reminded that these HSCs are for the insertion or removal of intradermal progestin contraceptive devices only. They may not be used for insertion or removal of intrauterine progestin contraceptive devices.

**Duplicate Services**

Physicians are reminded that it is inappropriate for two physicians to claim the same service for the same patient on the same day.

**Arthroscopic Debridement (HSC 92.89M)**

Physicians are reminded that an arthroscopic debridement is tricompartmental, and thus should only be claimed for services on the knee.

**Arthroscopy**

Physicians are reminded that composite arthroscopy fees include the procedure and arthroscopy. As well, when other or multiple surgical procedures are performed through the arthroscope, only the major fee applies.

**Pathology Interpretation**

Physicians are reminded that pathology interpretation billing and service date must be the date the patient was seen in hospital and had specimens removed. The date the report was completed is not the correct service date. The only exception would be for consults or second opinion, which should be claimed for the date of service of the consult.

## CLARIFICATION

**Other incision with drainage of skin and subcutaneous tissue (HSC 98.03)**

The October 18, 2017 bulletin reported that other incision with drainage of skin and subcutaneous tissue (AN = LOCL) (HSC 98.03), fell under category MISG. The correct category is VADT for this health service code.

BACK TO CONTENTS

## MSI HEALTH CARD RENEWAL

**Revised Health card renewal form**

Please be advised there is an updated version of the MSI Nova Scotia health card renewal form. This form should be used when a Nova Scotia resident's health card has expired. If the card has been expired for more than one year instruct the resident to contact our office to confirm eligibility.

This form cannot be used for new residents moving to Nova Scotia, to make changes to a residents file such as name, date of birth or gender changes and cannot be used to request duplicate or replacement cards if lost or stolen. This form cannot be used to renew cards for international students or foreign workers.

Helpful tips to ensure completeness of the renewal form and timely processing:

- Resident must sign the form to confirm they are ordinarily present in NS and to authorize the release of information for payment and audit purposes, this is mandatory to issue a health card
- Organ and/or tissue donation is optional and should only be signed if they wish to be a donor and should include their donor choice.
- A parent or guardian must sign for children under the age of 16

This form can also be found online at https://novascotia.ca/DHW/msi/docs/MSI-Health-Card-Renewal-Form.pdf. To ensure consistency with the renewal process, beginning **April 1, 2018** no other version of the renewal form will be accepted for processing.

For questions please contact the MSI Registration & Enquiry department at 902-496-7008 or toll free at 1-800-563-8880.

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| MJ062 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED HSC 07.08A, B OR C AT THE SAME ENCOUNTER. |
| VA084 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED A MAJOR SURGERY PROCEDURE AT THE SAME ENCOUNTER. |
| VA085 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 97.99A AT THE SAME ENCOUNTER. |
| VA086 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A VISIT OR CONSULT HAS ALREADY BEEN CLAIMED AT THE SAME ENCOUNTER. HSC 49.83B AND 49.83C INCLUDE THE ACCOMPANYING VISIT IN THE HEALTH SERVICE DESCRIPTION. |
| VE019 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 66.89A AT THE SAME ENCOUNTER. |
| VT155 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR HSC 49.83B OR 49.83C HAS ALREADY BEEN CLAIMED AT THE SAME ENCOUNTER AND INCLUDES THE ACCOMPANYING VISIT IN THE HEALTH SERVICE DESCRIPTION. |
| MJ063 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED A CYSTOSCOPY RELATED SERVICE AT THE SAME ENCOUNTER. |

BACK TO CONTENTS

| Code | Description |
|---|---|
| NR087 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 71.7F AT THE SAME ENCOUNTER. |
| VT156 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS START AND STOP TIMES FOR THIS SERVICE MUST BE INCLUDED IN TEXT. |
| VT157 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THERE IS NO CLAIM FOR 03.04G ADMISSION AND ASSESSMENT DAY 1 ON HISTORY BY THIS PROVIDER. |
| VT158 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE INPATIENT TRAUMA SERVICE TERTIARY SURVEY DAY 2 SHOULD ONLY BE BILLED BY THE PHYSICIAN THAT BILLS THE INITIAL DAY ONE ADMISSION AND ASSESSMENT. |
| VT159 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS INPATIENT TRAUMA SERVICE HAS ALREADY BEEN CLAIMED FOR THIS HOSPITAL ADMISSSION. |
| VT160 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.03U HAS ALREADY BEEN CLAIMED FOR THIS DAY. |
| VT161 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE HAS ALREADY BEEN CLAIMED FOR DAYS 4 THROUGH 7. |

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**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

### CONTACT INFORMATION

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

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BACK TO CONTENTS

# PHYSICIAN'S BULLETIN

November 17, 2017: Vol. LVIII, ISSUE 11


NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## ★ Fees New Fees and Highlighted Fees

## NEW FEES

Effective November 17, 2017 the following health service code will be available for billing:

| Category | Code | Description | Base Units |
|---|---|---|---|
| MAAS | 50.77C | **Portal Vein Embolisation**<br><br>Vascular embolization or occlusion of the portal vein (s), inclusive of percutaneous portal vein catheterization and all radiological supervision and interpretation, intra-procedural road mapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction.<br><br>**Billing Guidelines**<br><br>• Each case to be evaluated based on active physician skin to skin time defined as the time of first incision for placement of percutaneous catheter until the completion of embolization and removal of the venous catheter by the physician.<br>• Time must be documented in the patient's health record.<br>• Procedural time sheets to be submitted with claim.<br><br>**Specialty Restriction**<br>Interventional Radiology Fellowship with additional training in PVE<br>**Location**<br>HOSP | IC 140 MSU/hr |

BACK TO CONTENTS

The following codes were made effective November 1, 2017. Physicians were previously advised to hold these claims until November 17, 2017; codes are now available for billing.

Health Service Codes with fee value adjustments; physicians are asked to continue billing these codes, and a retroactive payment will be provided at a later date for claims billed between November 1, 2017 and November 17, 2017.

| Category | Code | Description | Base Units |
|---|---|---|---|
| DEFT | CPO1 | **Care Plan Oversight (CPO) Nursing Home, Residential Care Facility, or Hospice** | |
| | | A) | 15 MSU |
| | | B) | 30 MSU |
| | | Supervision of care for a nursing home, residential care facility, or hospicepatient<br><br>**Billing Guidelines**<br><br>• Do not report with other telephone service or non face to face codes such as:<br>o 13.99C Supervision of long-term anticoagulant therapy - in the same calendar month.<br>o ENH1 Long Term Care Medication Review - in the same calendar year.<br><br>**Specialty Restriction**<br>GENP<br><br>**Location**<br>LO=NRHM, Residential Care Facility, or Hospice | |

*Revised March 31, 2020 – See April 2020 Bulletin for updated information*

**NOTE:**
**HEALTH SERVICE CODE CPO1 IS UNDER REVIEW AND WILL BE UPDATED IN A FUTURE BULLETIN.**

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03 | **Subsequent Daily Hospital Visit (LO=HOSP, FN=INPT, DA= DA23 or DA=DA47)**<br><br>A) Days 2, 3, and first day out of ICU (DA=DA23)<br><br>B) Days 4 – 7 (DA=DA47)<br><br>These adjusted MSU values apply to health service code 03.03 LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, a subsequent limited visit provided to patients admitted to hospital where a family doctor is the most responsible physician.<br><br>**Billing Guidelines**<br><br>• May only be claimed once per patient per day by the most responsible physician (MRP).<br><br>First day out of ICU should be considered equivalent to day 2 and subsequent inpatient days as 3,4,5,6,7 for the purpose of reporting these increased code values.<br><br>**Specialty Restriction**<br>GENP<br>**Location**<br>LO=HOSP, FN=INPT | <br><br>23 MSU<br><br>19 MSU |

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.04F | **Complex Comprehensive Acute Care Hospital Discharge** | 45 MSU |

The comprehensive hospital discharge code is intended to be used whenservices provided on the day of discharge require greater than 30 minutes of the physician'stime. This HSC includes all services provided to the patient on the day of discharge from theacute care hospital. Every effort is to be made by the dischargephysician to communicate with the community physician who will be most responsible for the patient's care after discharge.
It is recognized that for complex comprehensive discharges, the discharge process may occur over 2 days. For example the discussion of the hospital stay, instructions for continuing careto all relevant caregivers, and preparation of discharge summary, prescriptions and referrals may be completed on one day and the final examination of the patient and dischargeorder the following day.
If this situation arises, the code must be reported on the date of discharge, the cumulative time spent must be greater than 30 minutes, the code may only be reported once by the MRP and may not be unbundled to accommodate splitting the workload

- A visit is considered an integral part of this service and is not reportable in addition.
- Documentation of the services provided and time spent must be documented in the health record.

**Billing Guidelines**

Preamble Rules 5.1.30 - 5.1.31 apply. Not reportable if the patient is admitted and discharged on the same day or 24 hour period.

- Reportable by the Most Responsible Physician only. The Most Responsible Physician (MRP) is defined as the physician in charge of the patient's care for any given day (24 hour period).
- May only be claimed once per patient per inpatient hospital admission.
- The physician claiming this health service may not report any other visit service for the same patient, same day. In addition, HSC 03.02A (Hospital Discharge Free) A may not be claimed as the service is included in the Complex Comprehensive Acute Care Hospital Discharge Health Service Code.
- Efforts made to establish communication with the health care provider who will be most responsible for the patient's care after discharge must be documented in the health record.
- Not reportable for hospital deaths.

Do not count time for services performed after the patient physically leaves the hospital.

**Specialty Restriction**
GENP

**Location**
LO=HOSP, FN=INPT

*Revised March 31, 2020 – See April 2020 Bulletin for updated information*

| Category | Code | Description | Base Units |
|---|---|---|---|
| ADON | 03.03S | **First Visit After Acute Care In-Patient Hospital Discharge – Complex Care** | 10 MSU |

This is an additional fee for the first office visit of the patient requiring ongoing complex care within 14 days of acute care in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care.

- The physician or their office staff must make every effort to communicate (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
- Not reportable in the walk-in clinic setting.

A complex care patient is defined as:

- A patient with multiple (two or more) chronic conditions

**Billing Guidelines**

ADON Restricted to:

03.03 Office visit
03.03A Geriatric Office Visit (for patients age 65+)
03.03E Adults with Developmental Disabilities

- Reportable only if the visit occurs in the primary care physician's office or the patient's home within 14 calendar days after hospital discharge (consider discharge date as Day zero).
- Hospital length of stay must be greater than or equal to 48 hours.
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver by the physician or their office staff within 2 business days of discharge must be documented in the health record. If unsuccessful, the reason must be documented in the health record.
- Not reportable if the admission to hospital was for the purpose of performing elective surgery (major or minor) or fracture care (major or minor).
- Not reportable if the admission to hospital was for the purpose of obstetrical delivery.
- Not reportable if the admission to hospital was for the purpose of newborn care.
- Not reportable for services rendered in other locations such as Nursing Homes, Residential Care Facilities, or Hospice.
- The physician claiming the service must be the provider most responsible for the patient's ongoing complex care.
- Claimable once per patient per inpatient admission.
- Not reportable for any subsequent discharges within 30 days.
- Not reportable in the same month as other monthly care fees - such as 13.99C – Supervision of long-term anticoagulant therapy.
- Maximum of 4 claims per physician per patient per year.

**Specialty Restriction**
GENP
**Location**
LO=OFFC, HOME

*Revised March 31, 2020 – See April 2020 Bulletin for updated information*

| Category | Code | Description | Base Units |
|---|---|---|---|
| ADON | 03.03P | **First Visit after In-Patient Hospital Discharge – Maternal and Newborn Care**<br><br>This is an additional fee for the first maternal/newborn office visit within 14 days of in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care.<br>• The primary care physician or their office staff must make every effort to communicate with the patient and/or caregiver within 2 business days of discharge.<br>• Not reportable in the walk-in clinic setting.<br><br>**Billing Guidelines**<br>ADON Restricted to:<br>• 03.03 Office visit<br>• 03.03 Well Baby Care<br>Reportable only if the visit occurs in the primary care physician's office or the patient's home within 14 calendar days after hospital discharge (consider discharge date as Day zero).Every effort to establish communication with the patient and/or caregiver by the physician ortheir office staff within 2 business days of dischargemust be documented in the health record. If unsuccessful, the reason must be documentedin the health record.<br>Only reportable if the reason for admission to hospital was for the purpose of obstetrical delivery.<br>Physician must be the provider most responsible for the mother and child's ongoing care.<br>Claimable once per patient per inpatient admission for obstetrical delivery.<br>Not reportable for any subsequent discharges within 30 days.<br>Maximum of 1 claim per pregnancy (mother)<br>Maximum 1 claim per infant<br><br>**Specialty Restriction**<br>GENP<br>**Location**<br>LO=OFFC, HOME | 10 MSU |

| Category | Code | Description | Base Units |
|---|---|---|---|
| ADON | HOVM1 | **Blended Mileage and travel detention for Home Visits (1 multiple = 1 km)**<br><br>This health service code is added on to a home visit health service code when the physician must travel to the patient's home in order to provide clinical services to a homebound patient.<br><br>**Billing Guidelines**<br>Text for the claim must include:<br>• the start and finish time of the visit<br>• point of origin<br>• destination address<br>• the distance in kilometers<br>maximum MU=70<br><br>**Specialty Restriction**<br>GENP<br>**Multiples**<br>1 MU = 1 km, maximum multiples = 70<br>**Location**<br>LO=HOME | 0.46 MSU + MU |

## BILLING REMINDERS

**Endoscopy transurethral electro-resection (HSC 72.1B)**
Physicians are reminded that health service codes 69.0A cystoscopy with removal of foreign body/calculus, 01.34A cystoscopy with or without catheterization of ureters, and 01.34B cystoscopy with urethral dilation, cannot be claimed in the same encounter as 72.1B –endoscopy transurethral electro-resection, and vice versa.

**Insertion of indwelling urinary catheter by Urologist**
Health service code 69.94 – Insertion of indwelling urinary catheter performed by urologists cannot be claimed with any other procedures during the same encounter.

**Clarification Health Service Codes 03.03Q Scheduled Specialist Telephone Management/Follow-up with Patient and 03.03R Scheduled Family Physician Telephone Management/Follow-Up with Patient**

HSC 03.03Q and 03.03R were introduced earlier this year.

HSC 03.03Q may be reported for a scheduled 15 minute telephone communication between the specialist physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face consultation, visit or procedure by the same physician within the last 9 months and has not been seen within the last 7 days **for the same condition by the same provider or another provider within the same group practice**.

This service is not reported if the outcome of the scheduled call is to see the patient at the next available appointment in the office. This communication is intended to take the place of an office follow up visit that would have otherwise been scheduled, when a physical examination of the patient is not required.

A group practice is defined as the arrangement whereby two or more physicians are in practice, and each physician maintains and has access to medical records and histories of the patients.

HSC 03.03R may be reported for a scheduled 15 minute telephone communication between the family physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face visit by the same physician within the last 9 months and has not been seen within the last 7 days **for the same condition by the same provider or another provider within the same group practice.**

A group practice is defined as the arrangement whereby two or more physicians are in practice, and each physician maintains and has access to medical records and histories of the patients.

This telephone communication is intended to take the place of an office visit initiated by the patient (or the patient's parent, guardian or proxy as established by written consent) for a new condition or an exacerbation of an existing condition, or a follow up visit that would have
otherwise been scheduled by either the physician or the patient, when a physical examination of the patient is not required.

The patient population eligible must be either 65 years and older or be suffering from mental illness or multiple (two or more) chronic diseases.

Chronic disease is defined as:
• A condition expected to last at least 12 months or until the death of the patient
• The chronic condition must place the patient at significant risk of acute exacerbation/decompensation, functional decline, or death

Mental illness is defined as:
• A condition that meets criteria for a DSM diagnosis

The service is not reported if the decision is to see the patient at the next available appointment in the office.

**Both HSC 03.03Q and 03.03R have complex billing guidelines and documentation requirements and physicians are urged to review the May 18, 2017 MSI Bulletin to familiarize themselves with these before claiming these HSCs.**

Scenarios:

Q: I am a cardiologist whose office practice is co-located with another cardiologist. My colleague saw Mrs. Green two days ago with increasing dyspnea due to congestive heart failure. May I claim HSC 03.03Q for a follow-up telephone call with her?
A: As noted above, you may only claim this HSC if she has not been seen by you or another physician in your group within the past 7 days. As your office colleague saw her two days ago, you may not claim HSC 03.03Q for a follow-up telephone call.

Q: I am a family physician. My longstanding patient, Mr. Blue, was recently admitted to our local hospital with pneumonia. I was away and one of my office colleagues cared for him and discharged him 5 days ago. Today, he has called looking to discuss some new GI symptoms. May I claim HSC 03.03R?
A: As this is a different problem from the one your office colleague provided care for 5 days ago, you may claim HSC 03.03R provided all other billing guidelines and documentation requirements have been satisfied.

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| AD068 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE HSC 03.03P HAS PREVIOUSLY BEEN PAID. |
| AD069 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST CLAIM AN APPROPRIATE OFFICE VISIT BEFORE CLAIMING THIS ADD ON FEE FOR THE SAME ENCOUNTER. |
| AD070 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED THIS FIRST VISIT AFTER DISCHARGE ADD ON FEE FOR THIS PERIOD. |
| AD071 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED THIS FIRST VISIT AFTER DISCHARGE ADD ON FEE THE MAXIMUM OF FOUR TIMES IN THE PAST YEAR. |
| AD072 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED A MONTHLY CARE FEE IN THE SAME CALENDAR MONTH. |
| AD073 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED HSC 03.03S IN THE SAME CALENDAR MONTH. |
| AD076 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE HSC 03.03P CANNOT BE CLAIMED FOR PATIENT AGES 1-10. |
| DE029 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR CARE PLAN OVERSIGHT OR LONG TERM CARE CLINICAL GERIATRIC ASSESSMENT HAS PREVIOUSLY BEEN MADE FOR THIS PATIENT DURING THE SAME CALENDAR MONTH. |
| DE030 | SERVICE ENCOUNTER HAS BEEN REFUSED A CLAIM FOR CARE PLAN OVERSIGHT HAS PREVIOUSLY BEEN MADE FOR THIS PATIENT DURING THE SAME CALENDAR MONTH. |
| DE031 | SERVICE ENCOUNTER HAS BEEN DISALLOWED. WHEN BOTH A CLINICAL GERIATRIC ASSESSMENT AND CARE PLAN OVERSIGHT FEE HAVE BEEN CLAIMED FOR A PATIENT IN THE SAME CALENDAR YEAR, THE SECOND CGA FEE REQUIRES TEXT EXPLAINING NECESSITY. PLEASE RESUBMIT THIS CLAIM WITH TEXT REFERRING TO THE NECESSITY OF THIS SERVICE. |

| Code | Description |
|---|---|
| GN099 | SERVICE HAS BEEN DISALLOWED, INSERTION OF THE INWELLING URINARY CATHETER CAN NOT BE CLAIMED WITH ANY OTHER PROCEDURE FEES DURING THE SAME ENCOUNTER |
| MJ060 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A CLAIM FOR CYSTOSCOPY HAS ALREADY BEEN SUBMITTED FOR THIS PATIENT AT THE SAME ENCOUNTER. IF AN ADDITIONAL CYSTOSCOPIC PROCEDURE IS REQUIRED PLEASE RESUBMIT WITH SUPPORTING TEXT. |
| MJ061 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED HSC 72.1B AT THE SAME ENCOUNTER. IF AN ADDITIONAL CYSTOSCOPIC PROCEDURE IS REQUIRED PLEASE RESUBMIT WITH SUPPORTING TEXT. |
| VA045 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS HSC 50.99A AND 69.94 REQUIRE TEXT INDICATING WHY THE INTRAVENOUS/CATHETER INSERTION WAS PERFORMED BY THE PHYSICIAN |
| VA082 | SERVICE HAS BEEN DISALLOWED, INSERTION OF THE INWELLING URINARY CATHETER CAN NOT BE CLAIMED WITH ANY OTHER PROCEDURE FEES DURING THE SAME ENCOUNTER |
| VA083 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED HSC 72.1B AT THE SAME ENCOUNTER. IF AN ADDITIONAL CYSTOSCOPIC PROCEDURE IS REQUIRED PLEASE RESUBMIT WITH SUPPORTING TEXT. |
| VT142 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A DAILY HOSPITAL VISIT RATE FOR THE MOST RESPONSIBLE PHYSICIAN HAS ALREADY BEEN CLAIMED FOR THE PATIENT ON THIS DAY. |
| VT143 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE DA=DA23 MODIFIER MAY ONLY BE USED ON THE 2ND AND 3RD ADMISSION DATES (OR DAYS OUT OF ICU). |
| VT144 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE DA=DA47 MODIFIER MAY ONLY BE USED ON THE 4TH TO 7TH ADMISSION DATES (OR DAYS OUT OF ICU). |
| VT145 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED A VISIT SERVICE FOR THIS PATIENT ON THE SAME DAY. |
| VT146 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED THE ACUTE CARE HOSPITAL DISCHARGE DAY MANAGEMENT VISIT FEE FOR THIS PATIENT ON THE SAME DAY. |
| VT154 | SERVICE HAS BEEN DISALLOWED, RESUBMIT AS A LIMITED VISIT, A SUBSEQUENT COMPREHENSIVE VISIT OR RESUBMIT PROVIDING ELECTRONIC TEXT EXPLAINING THE MEDICAL NECESSITY OF AN INITIAL COMPREHENSIVE VISIT WITHIN 30 DAYS OF A PREVIOUS VISIT |

## UPDATED FILES

Updated files reflecting changes are available for download on Friday November 17, 2017. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT), explanatory codes (EXPLAIN.DAT), and modified values (MODVALS.DAT).

## HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

http://msi.medavie.bluecross.ca/

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

## 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

In partnership with

# 2018 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

| PAPER CLAIMS | ELECTRONIC CLAIMS | PAYMENT DATE | SALARY CONTRACT PAY PERIOD |
|---|---|---|---|
| **December 20, 2017**** | **December 27, 2017**** | January 3, 2018 | December 15-28, 2017 |
| January 8, 2018 | January 11, 2018 | January 17, 2018 | December 29, 2017 – January 11, 2018 |
| January 22, 2018 | January 25, 2018 | January 31, 2018 | January 12-25, 2018 |
| February 5, 2018 | February 8, 2018 | February 14, 2018 | January 26-February 8, 2018 |
| **February 16, 2018**** | February 22, 2018 | February 28, 2018 | February 9-22, 2018 |
| March 5, 2018 | March 8, 2018 | March 14, 2018 | February 23-March 8, 2018 |
| March 19, 2018 | March 22, 2018 | March 28, 2018 | March 9-22, 2018 |
| April 2, 2018 | April 5, 2018 | April 11, 2018 | March 23-April 5, 2018 |
| April 16, 2018 | April 19, 2018 | April 25, 2018 | April 6-19, 2018 |
| April 30, 2018 | May 3, 2018 | May 9, 2018 | April 20-May 3, 2018 |
| **May 11, 2018**** | **May 16, 2018**** | May 23, 2018 | May 4-17, 2018 |
| May 28, 2018 | May 31, 2018 | June 6, 2018 | May 18-31, 2018 |
| June 11, 2018 | June 14, 2018 | June 20, 2018 | June 1-14, 2018 |
| **June 22, 2018**** | **June 27, 2018**** | July 4, 2018 | June 15-28, 2018 |
| July 9, 2018 | July 12, 2018 | July 18, 2018 | June 29-July 12, 2018 |
| July 23, 2018 | July 26, 2018 | August 1, 2018 | July 13-26, 2018 |
| **August 3, 2018**** | August 9, 2018 | August 15, 2018 | July 27-August 9, 2018 |
| August 20, 2018 | August 23, 2018 | August 29, 2018 | August 10-23, 2018 |
| **August 31, 2018**** | September 6, 2018 | September 12, 2018 | August 24-September 6, 2018 |
| September 17, 2018 | September 20, 2018 | September 26, 2018 | September 7-20, 2018 |
| **September 28, 2018**** | **October 3, 2018**** | October 10, 2018 | September 21-October 4, 2018 |
| October 15, 2018 | October 18, 2018 | October 24, 2018 | October 5-18, 2018 |
| October 29, 2018 | November 1, 2018 | November 7, 2018 | October 19-November 1, 2018 |
| **November 9, 2018**** | November 15, 2018 | November 21, 2018 | November 2-15, 2018 |
| November 26, 2018 | November 29, 2018 | December 5, 2018 | November 16-29, 2018 |
| December 10, 2018 | December 13, 2018 | December 19, 2018 | November 30-December 13, 2018 |
| **December 19, 2018**** | **December 24, 2018**** | January 2, 2019 | December 14-27, 2018 |
| **11:00 AM CUT OFF** | **11:59 PM CUT OFF** | | |
| | | | |

**NOTE:**

Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Sessional Payments and Locum Claim Forms. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut off date to ensure processing for that payment period.

BACK TO CONTENTS

**PLEASE NOTE, THE ** INDICATES A DATE VARIATION**

| Please make a note in your schedule of the following dates MSI will accept as "Holidays". | |
|---|---|
| NEW YEAR'S DAY | MONDAY, JANUARY 1, 2018 |
| HERITAGE DAY | MONDAY, FEBRUARY 19, 2018 |
| GOOD FRIDAY | FRIDAY, MARCH 30, 2018 |
| EASTER MONDAY | MONDAY, APRIL 2, 2018 |
| VICTORIA DAY | MONDAY, MAY 21, 2018 |
| CANADA DAY | MONDAY, JULY 2, 2018 |
| CIVIC HOLIDAY | MONDAY, AUGUST 6, 2018 |
| LABOUR DAY | MONDAY, SEPTEMBER 3, 2018 |
| THANKSGIVING DAY | MONDAY, OCTOBER 8, 2018 |
| REMEMBRANCE DAY | MONDAY, NOVEMBER 12, 2018 |
| CHRISTMAS DAY | TUESDAY, DECEMBER 25, 2018 |
| BOXING DAY | WEDNESDAY, DECEMBER 26, 2018 |
| NEW YEAR'S DAY | TUESDAY, JANUARY 1, 2019 |

BACK TO CONTENTS


Season's
Greetings
From the staff of MSI Programs

# PHYSICIAN'S BULLETIN

October 18, 2017: Vol. LVII, ISSUE 10


NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## MSI News

This special bulletin is being issued in order to introduce the new Health Service Codes that will replace the Comprehensive Care Incentive Program (CCIP) which ends, as negotiated in the current Master Agreement, on October 31, 2017.

The purpose of the introduction of these new codes is to transition from an incentive based payment to a health service code based payment for primary care physicians.

Codes will be effective November 1, 2017, Physicians are asked to hold these claims until November 17, 2017 at which time the codes will be implemented into the MSI system and made available for billing.

In regard to the Health Service Codes with fee value adjustments, physicians are asked to continue billing these codes, and a retroactive payment will be provided at a later date for claims billed between November 1, 2017 and November 17, 2017.

## NEW FEES

Effective November 17, 2017 the following health service codes will be available for billing:
Physicians are asked to hold these claims until November 17, 2017.

*Revised March 31, 2020 – See future 2020 Bulletin for updated information*

| Category | Code | Description | Base Units |
|---|---|---|---|
| DEFT | CPO1 | **CPO Nursing Home, Residential Care Facility, or Hospice**<br>A)<br>B)<br>Supervision of care for a nursing home, residential care facility, or hospice patient<br>**Billing Guidelines**<br>• Do not report with other telephone service or non face to face codes such as:<br>○ 13.99C Supervision of long-term anticoagulant therapy - in the same calendar month.<br>○ ENH1 Long Term Care Medication Review - in the same calendar year.<br>**Specialty Restriction**<br>GENP<br>**Location**<br>LO=NRHM, Residential Care Facility, or Hospice | <br>15 MSU<br>30 MSU |

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03 | **Subsequent Daily Hospital Visit (LO=HOSP, FN=INPT, DA= DA23 or DA=DA47)**<br>A) Days 2, 3, and first day out of ICU (DA=DA23)<br>B) Days 4 – 7 (DA=DA47)<br>These adjusted MSU values apply to health service code 03.03 LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, a subsequent limited visit provided to patients admitted to hospital where the family doctor is the most responsible physician.<br>**Billing Guidelines**<br>• May only be claimed once per patient per day by the most responsible physician (MRP).<br>First day out of ICU should be considered equivalent to day 2 and subsequent inpatient days as 3,4,5,6,7 for the purpose of reporting these increased code values.<br>**Specialty Restriction**<br>GENP<br>**Location**<br>LO=HOSP, FN=INPT | <br>23 MSU<br>19 MSU |

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.04F | **Complex Comprehensive Acute Care Hospital Discharge** | 45 MSU |

The comprehensive hospital discharge code is intended to be used when services provided on the day of discharge require greater than 30 minutes of the physician's time. This HSC includes all services provided to the patient on the day of discharge from the acute care hospital. Every effort is to be made by the discharge physician to communicate with the community physician who will be most responsible for the patient's care after discharge.
It is recognized that for complex comprehensive discharges, the discharge process may occur over 2 days. For example the discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge summary, prescriptions and referrals may be completed on one day and the final examination of the patient and discharge order the following day.
If this situation arises, the code must be reported on the date of discharge, the cumulative time spent must be greater than 30 minutes, the code may only be reported once by the MRP and may not be unbundled to accommodate splitting the workload

- A visit is considered an integral part of this service and is not reportable in addition.
- Documentation of the services provided and time spent must be documented in the health record.

**Billing Guidelines**

Preamble Rules 5.1.30 - 5.1.31 apply. Not reportable if the patient is admitted and discharged on the same day or 24 hour period.

- Reportable by the Most Responsible Physician only. The Most Responsible Physician (MRP) is defined as the physician in charge of the patient's care for any given day (24 hour period).
- Only once per patient per inpatient hospital admission.
- The physician claiming this health service may not report any other visit service for the same patient, same day. In addition, HSC 03.02A (Hospital Discharge Free) may not be claimed as the service is included in the Complex Comprehensive Acute Care Hospital Discharge Health Service Code.
- Efforts made to establish communication with the health care provider who will be most responsible for the patient's care after discharge must be documented in the health record.
- Not reportable for hospital deaths.

Do not count time for services performed after the patient physically leaves the hospital.

**Specialty Restriction**
GENP
**Location**
LO=HOSP, FN=INPT

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| ADON | 03.03S | **First Visit After Acute Care In-Patient Hospital Discharge – Complex Care**<br><br>This is an additional fee for the first office visit of the patient requiring ongoing complex care within 14 days of acute care in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care.<br>• The physician or their office staff must make every effort to communicate (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.<br>• Not reportable in the walk-in clinic setting.<br><br>A complex care patient is defined as:<br>• A patient with multiple (two or more) chronic conditions<br><br>**Billing Guidelines**<br><br>ADON Restricted to:<br>03.03 Office visit<br>03.03A Geriatric Office Visit (for patients age 65+)<br>03.03E Adults with Developmental Disabilities<br><br>• Reportable only if the visit occurs in the primary care physician's office or the patient's home within 14 calendar days after hospital discharge (consider discharge date as Day zero).<br>• Hospital length of stay must be greater than or equal to 48 hours.<br>• Communication (direct contact, telephone, electronic) with the patient and/or caregiver by the physician or their office staff within 2 business days of discharge must be documented in the health record. If unsuccessful, the reason must be documented in the health record.<br>• Not reportable if the admission to hospital was for the purpose of performing elective surgery (major or minor) or fracture care (major or minor).<br>• Not reportable if the admission to hospital was for the purpose of obstetrical delivery.<br>• Not reportable if the admission to hospital was for the purpose of newborn care.<br>• Not reportable for services rendered in other locations such as Nursing Homes, Residential Care Facilities, or Hospice.<br>• The physician claiming the service must be the provider most responsible for the patient's ongoing complex care.<br>• Claimable once per patient per inpatient admission.<br>• Not reportable for any subsequent discharges within 30 days.<br>• Not reportable in the same month as other monthly care fees - such as 13.99C – Supervision of long-term anticoagulant therapy.<br>• Maximum of 4 claims per physician per patient per year.<br><br>**Specialty Restriction**<br>GENP<br>**Location**<br>LO=OFFC, HOME | 10 MSU |

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| ADON | 03.03P | **First Visit after In-Patient Hospital Discharge – Maternal and Newborn Care**<br><br>This is an additional fee for the first maternal/newborn office visit within 14 days of in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care.<br>• The primary care physician or their office staff must make every effort to communicate with the patient and/or caregiver within 2 business days of discharge.<br>• Not reportable in the walk-in clinic setting.<br><br>**Billing Guidelines**<br>ADON Restricted to:<br>• 03.03 Office visit<br>• 03.03 Well Baby Care<br>Reportable only if the visit occurs in the primary care physician's office or the patient's home within 14 calendar days after hospital discharge (consider discharge date as Day zero).<br>Every effort to establish communication with the patient and/or caregiver by the physician or their office staff within 2 business days of discharge must be documented in the health record. If unsuccessful, the reason must be documented in the health record.<br>Only reportable if the reason for admission to hospital was for the purpose of obstetrical delivery.<br>Physician must be the provider most responsible for the mother and child's ongoing care.<br>Claimable once per patient per inpatient admission for obstetrical delivery.<br>Not reportable for any subsequent discharges within 30 days.<br>Maximum of 1 claim per pregnancy (mother)<br>Maximum 1 claim per infant<br><br>**Specialty Restriction**<br>GENP<br>**Location**<br>LO=OFFC, HOME | 10 MSU |

| Category | Code | Description | Base Units |
|---|---|---|---|
| ADON | HOVM1 | **Blended Mileage and travel detention for Home Visits (1 multiple = 1 km)**<br><br>This health service code is added on to a home visit health service code when the physician must travel to the patient's home in order to provide clinical services to a homebound patient.<br><br>**Billing Guidelines**<br>Text for the claim must include:<br>• the start and finish time of the visit<br>• point of origin<br>• destination address<br>• the distance in kilometers<br>maximum MU=70<br><br>**Specialty Restriction**<br>GENP<br>**Multiples**<br>1 MU = 1 km, maximum multiples = 70<br>**Location**<br>LO=HOME | 0.46 MSU + MU |

*Refer to preamble change in relation to the definition of homebound patients and home visit travel fee

BACK TO CONTENTS

## FEE ADJUSTMENTS

Physicians are asked to continue billing these codes, and a retroactive payment will be provided at a later date for claims billed between November 1, 2017 and November 17, 2017.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | Select 03.03 and 03.04 codes | **Fee Adjustments for Home Visits**<br><br>These adjusted health service code values apply to a homebound patient where the physician must travel to the patient's home in order to provide the clinical service.<br><br>**Adjusted Fee Values**<br>03.03 - Home Visit 0800-1700<br>03.03 - Home Visit 1701-2359, weekends and holidays<br>03.03 - Home Visit 0000-0800<br>03.03 - Home Visit emergency<br>03.03 - Home Visit extra patient<br>03.03 - Home Visit extra patient aged 65 years and older<br>03.04 - Home Complete examination<br><br>**Specialty Restriction**<br>GENP<br>**Location**<br>LO=HOME | <br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br>36 MSU<br>47.8 MSU<br>64.7 MSU<br>59.5 MSU<br>13 MSU<br>16.5 MSU<br>40.6 MSU |

*Refer to preamble change in relation to the definition of homebound patients and home visit travel fee

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.04 | **First Examination – Newborn Care Healthy Infant**<br><br>This adjusted fee applies to health service code 03.04 LO=HOSP, FN=INPT, RO=NBCR, RP=INTL, an initial comprehensive visit provided to a healthy newborn in hospital by the family doctor.<br><br>**Specialty Restriction**<br>GENP<br>**Location**<br>LO=HOSP, FN=INPT | 24 MSU |

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| MISG | | These 3 adjusted fee values apply to health services provided by GENP only: | |
| | 98.22 | **Suture of skin and subcutaneous tissue of other sites** | 20 MSU |
| | 98.22A | **Suture of simple wounds or lacerations – child`s face** | 25 MSU |
| | 98.03 | **Other incision with drainage of skin and subcutaneous tissue (AN = LOCL)** | 10 MSU |
| | | These 2 HSCs will be termed and other pre-existing HSC used: | |
| | 98.04A | **Suture minor laceration with removal of foreign body** | Term |
| | 98.22E | **Suture minor lacerations or simple wounds** | Term |
| | | 98.04A and 98.22E are replaced by:<br>98.22D Suture minor laceration or foreign body wound 20 MSU<br><br>**Specialty Restriction**<br>GENP | |

## PREAMBLE CHANGES

**Definition of a Homebound Patient**

| Current Definition | New Definition |
|---|---|
| **Rules Specific to Location (5.1.44)**<br><br>c) A Home Visit: Is a service rendered by a physician to a patient or patients following travel to the patient's home. The patient or patient's representative must request the physician to visit. A home visit may only be claimed when the patient's condition or situation justifies the service. If the nature of the patient's condition requires periodic scheduled home visits, a daily home visit can be claimed. (5.1.48) | **Rules Specific to Location (5.1.44)**<br><br>c) A Home Visit: Is a service rendered by a physician to a **homebound** patient or patients following travel to the patient's home. The patient or patient's representative has requested a visit with the physician. A home visit may only be claimed when the patient's condition or situation justifies the service and the patient is homebound.<br>A patient is considered to be homebound when one or more of the following conditions are met and documented in the health record:<br>I. Leaving the home isn't recommended because of the patient's condition;<br>II. The patient's condition keeps him or her from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person);<br>III. Leaving home takes a considerable and taxing effort.<br>If the patient is not considered homebound, the visit is considered to be rendered at home for convenience. In this situation, the visit may be claimed at the normal office visit rate and travel may not be claimed. |

As per Preamble 1.1.36 "All claims submitted to MSI must be verifiable from the patient records associated with the services claimed and be billed in accordance with the Preamble." Therefore, physicians must document within the clinical record, e.g. in the CPP/Problem List the specific circumstances that have led to the patient being deemed homebound.

BACK TO CONTENTS

**Home Visit Travel Fee**

| Current Definition | New Definition |
|---|---|
| **Services, supplies and other materials provided through the physician's office when such supplies are not normally considered part of office overhead (2.2.37)**<br><br>• Mileage or travelling time except as defined in (See Section 5(5.1.67)) relating to detention time or blended mileage/travel detention for acute home care home visits. (2.2.43)<br>• For patients registered in acute home care, physicians may claim blended mileage/travel detention to compensate for travel expenses and time incurred for home visits. This fee does not apply to patients registered in the chronic home care program. Blended mileage/travel detention will be reimbursed only for those home visits initiated by the care coordinator or health care professionals of Home Care Nova Scotia. The mileage/travel detention fee is a blended rate based on kilometers travelled for the round trip. The distance in kilometers should be entered in the multiple field of the service encounter. A record should be kept in your office of the starting and destination points. (2.2.44) | • Mileage or travelling time except as defined in (See Section 5(5.1.67)) relating to detention time or blended mileage/travel detention for acute home care home visits, or for home visits. (2.2.43)<br>• For patients registered in acute home care, physicians may claim blended mileage/travel detention to compensate for travel expenses and time incurred for home visits. This fee does not apply to patients registered in the chronic home care program. Blended mileage/travel detention will be reimbursed only for those home visits initiated by the care coordinator or health care professionals of Home Care Nova Scotia.<br>• Mileage for home visits will be reimbursed only when a visit has been requested by the patient or patient's representative and the patient is considered homebound. The mileage/travel detention fee is a blended rate based on kilometers travelled for the round trip. Text for the claim must include: the start and finish time of the visit, point of origin, destination address, and the distance in kilometers. The distance in kilometers should be entered in the multiple field of the service encounter. A record should be kept in the physician's office of the starting and destination points. (2.2.44) |

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### UPDATED FILES

Updated files reflecting changes are available for download on Friday November 17, 2017. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT) and, explanatory codes (EXPLAIN.DAT).

### HELPFUL LINKS

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BACK TO TOC CONTENTS

# PHYSICIAN'S BULLETIN

September 22, 2017: Vol. LVI, ISSUE 9


NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## ★ Fees New Fees and Highlighted Fees

## HIGHLIGHTED FEES

**Provincial Immunization Changes**

Effective September 22, 2017, the following immunization health service codes have been revised:

| HSC | Modifier | Description |
|---|---|---|
| **13.59L** | RO=MMAR | MMR - Measles, Mumps, Rubella Vaccine<br><br>Billing Guidelines<br>This vaccine can only be billed if the first and second doses are given at least 4 weeks apart, and if the patient was born after January 1, 1970. If the 2nd injection is given within this 4 week period, the claim will be refused. Patient can only receive 2 doses per lifetime. Non-immune postpartum women are eligible to receive extra dose(s) as necessary. An explanation for the additional dose(s) must be added to the text field of the claim. |
| **13.59L** | RO=MENC | Men-C-C – Meningococcal conjugate<br><br>Billing Guidelines<br>This vaccine cannot be billed if the patient's birthdate is before January 1, 2004. Patients are eligible between 12 months to less than 5 years of age. An explanation for the addition of a high risk modifier must be added to the text field of the claim. |

BACK TO CONTENTS

BACK TO CONTENTS

## BILLING REMINDERS

**Catheter Insertion (HSC 69.94)**

Physicians are reminded that HSC 69.94; insertion of indwelling urinary catheter, should only be claimed as a stand-alone procedure. Physicians may only claim for insertion of a catheter when they have personally performed the service. Preamble Rule 1.1.19 states "All insured services claimed must reflect services rendered personally by the physician in an appropriate clinical setting." Therefore these health service codes may not be claimed when they are carried out by another health care provider such as a nurse, nurse practitioner or X-Ray technologist as part of their usual duties. Text will be required on all claims explaining the reason why the physician had to personally perform the catheter insertion.

**Electromyography or Nerve Conduction Studies (HSC 07.08A, 07.08B, 07.08C)**

Physicians are reminded the above codes are used when the appropriate studies are performed as part of a diagnostic work-up. It is not appropriate to use these codes as proxies for intraoperative nerve integrity testing. Such testing is considered an integral part of surgical procedures performed near vital nerve structures.

**Anaesthesia Modifier Clarification**

Reminder on the intended use of Controlled Hypotension CO=CHYO:

The use of controlled hypotension is intended for longer cases with excessive bleeding to minimize blood loss and reduce the need for transfusions provided there are no contraindications for this technique. Also it is intended for specific cases in order to optimize surgical view. MSI requires explanatory text when claiming for controlled hypotension.

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| AD074 | SERVICE ENCOUNTER HAS BEEN REFUSED AS PATIENT IS 5 YEARS OF AGE OR OVER. |
| AD075 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS TEXT IS REQUIRED INDICATING THE NEED FOR ADDITIONAL DOSES OF THE MMAR VACCINE. |
| MA073 | CLAIM FOR RADICAL NECK DISSECTION HAS BEEN REFUSED AS IT IS NOT PAYABLE AT THE SAME ENCOUNTER AS A GLOSSECTOMY, PAROTIDECTOMY OR FLOOR OF MOUTH TUMOUR CODES. COMPOSITE FEES EXIST THAT SHOULD BE USED INSTEAD. |
| MA074 | CLAIM FOR GLOSSECTOMY, PAROTIDECTOMY OR FLOOR OF MOUTH TUMOUR HAS BEEN REFUSED AS IT IS NOT PAYABLE AT THE SAME ENCOUNTER AS A RADICAL NECK DISSECTION. COMPOSITE FEES EXIST THAT SHOULD BE USED INSTEAD. |
| MA075 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOUR SPECIALTY IS NOT APPROVED TO BILL THIS SERVICE. IF THE EXPLORATION OF A PERIPHERAL NERVE HAS BEEN DONE AS A SEPARATE AND DISTINCT PROCEDURE, THE SERVICE CAN BE SUBMITTED AS EC WITH TEXT AND INCLUDE THE OPERATIVE REPORT WHICH WILL BE REVIEWED PRIOR TO PAYMENT. |
| VT153 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS AN URGENT VISIT APPLIES WHEN A PHYSICIAN TRAVELS TO SEE A REGISTERED INPATIENT AT THE REQUEST OF HOSPITAL STAFF. PREAMBLE 5.1.54. RESUBMIT WITH TEXT STATING THE NECESSITY OF THE SERVICE AND TRAVEL DETAILS. |

BACK TO CONTENTS

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BACK TO CONTENTS

BACK TO CONTENTS

# PHYSICIAN'S BULLETIN

August 25, 2017: Vol. LV, ISSUE 8

NOVA SCOTIA MEDICAL SERVICES INSURANCE


## CONTENTS



## ★ Fees New Fees and Highlighted Fees

## NEW INTERIM FEES (2015-2019 MASTER AGREEMENT)

Mindfulness-Based Cognitive Therapy (MBCT)

As of August 25, 2017 eligible services can now be submitted for dates of service July 28, 2017 onward. Physicians have 90 days from the date of this Bulletin to submit these claims. Please contact MSI directly for detailed instructions on how to submit these outdated eligible services.

***PLEASE NOTE:*** **Physicians eligible to claim this code are restricted to PSYC trained in MBCT or GENP trained in group psychotherapy and MBCT.** Credentials must be submitted to MSI directly. Once MSI receives a physician's credentials and grants approval, the physician will be permitted to claim for this fee after the next system update. **Once the physician has contacted MSI with their credentials, the physician is advised to hold their claims until the next system update**.

| Category | Code | Description | Base Units |
|---|---|---|---|
| PSYC | **08.44A** | **Mindfulness-Based Cognitive Therapy (MBCT)**<br>**Group therapy fee per patient per two hour session (minimum 8 to maximum 12 patients per group)**<br><br>MBCT is defined as a specific psychological intervention incorporating elements of cognitive behavioural therapy and mindfulness. This fee is for each two hour session of the eight week MBCT course provided for a group of 8 to 12 patients with recurrent episodes of depression.<br><br>**Billing Guidelines**<br><br>Fee is per patient, per two hour session.<br><br>Session dates and start/stop times must be documented in the health record of each participant.<br><br>One series of 8 sessions per patient per 365 days. | 14.3MSU |

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| | | Additional fees may be charged to the patient for non-billable services such as the provision of course materials and for the services of a privately paid non-MD therapist if applicable.<br><br>**Specialty restriction**<br>• GENP with approval from MSI.<br>• PSYC with approval from MSI.<br><br>Physicians approved to report this HSC will be required to provide proof that they have completed a minimum five day intensive training in MBCT for MBCT providers within the last five years (for example, a seven day retreat in Mind-Body Medicine from the Centre for Mindfulness in Medicine, Health Care and Society or equivalent), and attest to an ongoing personal mindfulness practice.<br><br>GENP will, in addition to the above, need to provide evidence of training in the provision of group psychotherapy from a recognized training program and of ongoing practice in mental health and group therapy. PSYC are considered to have had training in the provision of group psychotherapy through their respective residency programs.<br><br>Start and stop time to be documented in health record; however session outline and activities are standardized to be completed in 2 hours.<br><br>**Location**<br>LO=OFFC, HOSP, OTHR | |

## INTERIM FEES MADE PERMANENT

Effective August 25, 2017, the following interim fees have been made permanent.

| Category | Code | Description | Base Units | Anaes Units |
|---|---|---|---|---|
| MASG | 65.59D | **Total Abdominal Wall Reconstruction with myofascial advancement flaps**<br><br>This is a comprehensive fee for the repair of a massive, complex abdominal wall hernia. The procedure includes the reduction of the hernia, all lysis of adhesions, and bowel resection as required, removal of pre-existing mesh as required, rectus muscle mobilization, fascial bipartition with component separation, with or without placement of mesh or biologic graft, and skin excision. Operative report and record of operation must be submitted with billing claim.<br><br>**Billing Guidelines**<br>Not to be billed with lysis of adhesions, bowel resection or any other intra-abdominal procedure same patient same day. Payment calculated based on “skin to skin” operating time as documented in the record of operation.<br><br>**Please note** that as per the July 2014 bulletin, the operative report and record of operation must be submitted with the billing claim.<br><br>**Specialty Restriction** GNSG, PLAS<br>**Location** HOSP | IC at 130 MSU per hour | 8+T |

BACK TO CONTENTS

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| AN006 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE CONSECUTIVE ANAESTHETIC HEALTH SERVICE CODE CLAIMED DOES NOT MATCH FIRST ANAESTHETIC HEALTH SERVICE CODED. PLEASE RESUBMIT USING THE CORRECT HEALTH SERVICE CODE. |
| GN096 | PRE PAYMENT REVIEW. PLEASE SUBMIT DOCUMENTATION TO FURTHER ASSIST IN ASSESSING THIS CLAIM. |
| GN097 | SERVICE ENCOUNTER HAS BEEN DISALLOWED. ENSURING THE FUNCTIONAL INTEGRITY OF VITAL STRUCTURES DURING A SURGICAL PROCEDURE IS INCLUDED IN THE SURGICAL HSC. |
| GN098 | SERVICE ENCOUNTER HAS BEEN DISALLOWED. THERE WAS NO SEPARATE AND DISTINCT SURGICAL SERVICE. THE HSC CLAIMED WAS PART OF ANOTHER PAID SERVICE ENCOUNTER. |
| MA072 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.12 WAS BILLED AT THE SAME ENCOUNTER AND IS A COMPONENT OF THIS PROCEDURE. |
| NR086 | REQUEST FOR READJUDICATION HAS BEEN REFUSED. DELETE THIS SUBMISSION AND SUBMIT A NEW SERVICE ENCOUNTER BASED ON THE INFORMATION YOU HAVE PROVIDED. |
| PC035 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM OF 8 SESSIONS FOR MINDFULNESS BASED COGNITIVE THERAPY IN A 365 DAY PERIOD HAS BEEN REACHED. |
| PP024 | SERVICES PROVIDED BY A NON-PHYSICIAN ARE NOT INSURED. (EX. CHIROPRACTOR, PHYSIOTHERAPIST, PAC-PHYSICIANS ASSISTANT, PODIATRIST, NURSE PRACTITIONER). |
| VA080 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 27.72, 27.72B, 27.73, 27.73A OR 27.73B WAS BILLED AT THE SAME ENCOUNTER AND INCLUDES THIS PROCEDURE. |
| VA081 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A CLAIM FOR 51.95 RP=INTL HAS ALREADY BEEN CLAIMED FOR THIS PATIENT. |
| VT152 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THE TEXT DOES NOT WARRANT PAYMENT OF A COMPREHENSIVE VISIT, PLEASE RESUBMIT AS A LIMITED VISIT. |

BACK TO CONTENTS

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BACK TO CONTENTS

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BACK TO CONTENTS

# PHYSICIAN'S BULLETIN

August 4, 2017: Vol. LIV, ISSUE 6


NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## MSI News

### WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT UPDATE

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been applied to the listed WCB specific fees for fiscal years 2015-16 and 2016-17.

Due to the increase in CPI for fiscal year April 1st, 2015 - March 31st, 2016 any of the WCB specific services listed below provided over this time will have their values retroactively increased by 1.74%. Physicians will be remunerated for the outstanding value of any services rendered over this period via a onetime payment on August 2, 2017.

Also due to the further increase in CPI for fiscal year April 1st, 2016- January 26th, 2017 any of the WCB specific services listed below provided over this time will have their values retroactively increased by a cumulative 2.137% (1.74% for 2015-2016, 0.39% for 2016-2017). Physicians will also be remunerated for the outstanding value of any services rendered over this period via a one-time payment on August 2, 2017.

| CODE | DESCRIPTION | VALUE |
|---|---|---|
| WCB12 | EPS physician assessment Service.<br>Combined office visit and completion of Form 8/10<br><br>For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15 minute increments to a maximum of 1 additional hour | **Initial visit:**<br>$174.93 + $51.11 per 15 minutes to a maximum 4x<br>(RO=EPS1 and RP=INTL)<br><br>**Subsequent visit:**<br>$174.93<br>(RO=EPS1 and RP=SUBS) |
| WCB13 | Chart Summaries / Written Reports.<br>Detailed reports billed in 15-minute intervals - plus multiples, if applicable | GPs.....$42.72 per 15 min<br>EPS(RO=EPS1)$51.11 per 15 min<br>Specialists.....$57.49 per 15 min |
| WCB15 | Case Conferencing and Teleconferencing (Treating Physician)<br>Conferencing billed by the Treating Physician - plus multiples, if applicable | GPs.....$42.72 per 15 min<br>EPS(RO=EPS1)$51.11 per 15 min<br>Specialists.....$57.49 per 15 min |
| WCB17 | Photocopies of Chart Notes | 10 pgs or less (ME=UP10)..$25.56<br>11-25 pgs (ME=UP25).....$51.11<br>26-50 pgs (ME=UP50)..... $102.17<br>Over 50 pgs (ME=OV50)...$153.25 |
| WCB20 | Carpal Tunnel Syndrome (CTS) Assessment Report | $65.56 |
| WCB21 | Follow-up visit report | $38.33 |
| WCB22 | Completed Mandatory Generic Exemption Request Form | $12.80 per form |
| WCB23 | Completed Non-Opioid Special Authorization Request Form | $12.80 per form |
| WCB24 | Completed Opioid Special Authorization Request Form | $42.96 per form |
| WCB25 | Completed WCB Substance Abuse Assessment Form | $28.62 |
| WCB26 | Return to Work Report – Physician's Report Form 8/10 | $65.56 |
| WCB27 | Eye Report | $57.49 |
| WCB28 | Comprehensive Visit for Work Related Injury or Illness | $65.96 |

BACK TO CONTENTS

BACK TO CONTENTS

## MEDICAL ASSISTANCE IN DYING (MAID)

The MAID fees are currently interim while data is gathered. They are categorized as independent consideration (IC) and have no automatic MSU value in the system. Each claim submitted is held by MSI and manually adjudicated based on the information provided by the submitter in the claim text. As this is an interim fee the collection of data is important in considering a permanent fee in the future.

Claims will be processed independently of other physicians involved in the MAID services. This means that health service codes for the first, second and prescribing physicians will be reviewed as received and not held waiting for other MAID claims. All other applicable billing guidelines will apply in the processing of these health service codes.

# Fees New Fees and Highlighted Fees

## NEW INTERIM FEES (2015-2019 MASTER AGREEMENT)

Mindfulness-Based Cognitive Therapy (MBCT)

**Physicians are asked to hold these claims until notified that they may be submitted for payment.**

***PLEASE NOTE:*** **Physicians eligible to claim this code are restricted to PSYC trained in MBCT or GENP trained in group psychotherapy and MBCT.** Credentials must be submitted to MSI directly. Once MSI receives a physician's credentials and grants approval, the physician will be permitted to claim for this fee after the next system update. **Once the physician has contacted MSI with their credentials, the physician is advised to hold their claims until the next system update**.

| Category | Code | Description | Base Units |
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| PSYC | **08.44A** | **Mindfulness-Based Cognitive Therapy (MBCT)**<br>**Group therapy fee per patient per two hour session (minimum 8 to maximum 12 patients per group)**<br><br>MBCT is defined as a specific psychological intervention incorporating elements of cognitive behavioural therapy and mindfulness. This fee is for each two hour session of the eight week MBCT course provided for a group of 8 to 12 patients with recurrent episodes of depression.<br><br>**Billing Guidelines**<br><br>Fee is per patient, per two hour session.<br><br>Session dates and start/stop times must be documented in the health record of each participant.<br><br>One series of 8 sessions per patient per 365 days.<br><br>Additional fees may be charged to the patient for non-billable services such as the provision of course materials and for the services of a privately paid non-MD therapist if applicable. | 14.3MSU |

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| | | **Specialty restriction**<br><br>• GENP with approval from MSI.<br>• PSYC with approval from MSI.<br><br>Physicians approved to report this HSC will be required to provide proof that they have completed a minimum five day intensive training in MBCT for MBCT providers within the last five years (for example, a seven day retreat in Mind-Body Medicine from the Centre for Mindfulness in Medicine, Health Care and Society or equivalent), and attest to an ongoing personal mindfulness practice.<br><br>GENP will, in addition to the above, need to provide evidence of training in the provision of group psychotherapy from a recognized training program and of ongoing practice in mental health and group therapy. PSYC are considered to have had training in the provision of group psychotherapy through their respective residency programs.<br><br>Start and stop time to be documented in health record and also in the text field of the claim to MSI. However session outline and activities are standardized to be completed in 2 hours.<br><br>**Location**<br>LO=OFFC, HOSP, OTHR | |

BACK TO CONTENTS

BACK TO CONTENTS

BACK TO CONTENTS

## BILLING CLARIFICATIONS

**The following communication is to clarify information published in the May 18, 2017 MSI Physicians Bulletin regarding Ophthalmology Services. As a reminder, the Preamble and related MSI Physicians Bulletins are the authority for the proper interpretation of the fee schedule. All inquiries on appropriate billing should be directed to MSI.**

**Vision Screening for Type 2 Diabetes**

As per the Canadian Diabetes Association guidelines for vision screening, effective April 1 2017, residents with type 2 diabetes will only be eligible for a complete eye examination every 2 years. Residents with type 1 diabetes and residents with type 2 diabetes and retinopathy will be eligible for a complete eye examination every year. Diagnosis must be confirmed in the resident's medical chart.

**Clarification: The information posted was to bring awareness to the Canadian Diabetes Association's vision screening guidelines which will be applied to Nova Scotia's optometry benefits. The change to Nova Scotia's optometry benefits was done in consultation with the Nova Scotia Association of Optometrists, the Diabetes Care Program of Nova Scotia and an Ophthalmologist practicing in Nova Scotia. There have been no changes applied to the policy for vision screening provided by physicians; physicians should continue to provide vision screening as medically required.**

**Cataract Surgery**

Ophthalmologic surgeons are reminded that monitoring of intraocular pressure is a part of the customary operative or post-operative care when providing cataract surgery. Health Service Code 03.12 should not be reported in addition.

**Clarification: This would apply only to the day of surgery and not over the remainder of the postoperative period.**

**Trabeculectomy and Trabeculoplasty**

Health service codes for Trabeculectomy (HSC 26.25, 26.25B, 26.25C and 26.25D) and trabeculoplasty (HSC 26.29D and 26.29E) are for invasive major surgical procedures and as such may only be claimed for services provided in an operating room.

**Clarification: Physicians may continue to bill HSC 26.29D Trabeculoplasty in an office or hospital setting. The May bulletin reminder still applies to the Trabeculectomy codes. These procedures must be performed in an operating room.**

## BILLING REMINDERS

**Complete care codes**

As per Physician's Manual Preamble section 7.4.1, 'Complete care codes are minor surgical procedures, which include the visit the same day and related visits by the same physician for 14 days following the procedure'.
Counselling related to the procedure cannot be claimed during this period.

**Other repair and plastic operations on trachea, tracheal splint, transthoracic**

HSC 43.69 other repair and plastic operations on trachea, tracheal splint, transthoracic may only be claimed by GNSG and THSG.

**Exploration of peripheral nerve**

17.5A – Exploration of peripheral nerve transplant or nerve transposition with or without neurolysis (excluding median nerve at carpal tunnel) is only to be claimed when the surgery is performed on peripheral nerves. This code may not be used for operations on cranial nerves.

BACK TO CONTENTS

## Surgical access

Physicians are reminded that procedures used to provide the surgical exposure (e.g.-laparoscopy, sinusoscopy, cystoscopy, etc.) necessary to perform a definitive procedure are included in the surgical HSC and may not be claimed separately. As per Physician's Manual Preamble section 5.3.71, 'When one physician performs a definitive procedure on an organ or within a body cavity, only that service should be claimed. The procedure used to provide surgical exposure should not be claimed; e.g. a laparotomy is not to be claimed to provide access to the abdominal cavity except when no definitive procedure is performed within the abdomen. When one physician provides surgical exposure for a procedure performed by a physician in another specialty, the exposure and definitive procedures may be claimed separately by the respective physicians.'

## Surgical procedure claims

Physicians are reminded that it is not appropriate to claim for parts of a procedure that would normally be considered the defined technique. Procedures such as ligation of blood vessels to prevent hemorrhage, that are performed as preventative measures are considered to be part of the defined technique. As per Physician's Manual Preamble section 5.3.68, 'Procedural codes and their associated tariff are intended to remunerate the physician for all parts of the procedure that would normally be considered the defined technique for that procedure. It is not appropriate to deconstruct (unbundle) the procedure into constituent parts and bill MSI for these codes in addition to the procedural codes.'

## Composite fee

Physicians are reminded to use composite fees that were devised to encompass several procedures that are commonly performed together rather than claiming the procedures separately. As per Physician's Manual Preamble section 5.3.68, 'Procedural codes and their associated tariff are intended to remunerate the physician for all parts of the procedure that would normally be considered the defined technique for that procedure. It is not appropriate to deconstruct (unbundle) the procedure into constituent parts and bill MSI for these codes in addition to the procedural codes.'

**Example:**

When a partial glossectomy is accompanied by a radical neck dissection the code that should be claimed is 37.1A-hemiglossectomy plus radical neck dissection.

It is not appropriate to claim code 37.1 and in addition claim one of the following codes; 52.32, 52.32A, 52.33, 52.33A.

## Comprehensive visits

Comprehensive Visits (HSC 03.04) may be claimed when medical necessity exists for a physician to conduct an in-depth evaluation of a patient due to the seriousness, complexity or obscurity of the patient's complaints or medical condition. It includes ensuring a complete history is recorded in the medical record and performing a physical examination appropriate to the physician's specialty and the working diagnosis.

As has been outlined in previous Bulletins, documentation of **all** of the following provides a clear indication that a comprehensive visit has taken place:

1. A detailed patient history including:
    - Relevant history of presenting complaint
    - Relevant past medical and surgical history
    - Medication list
    - Allergies
    - Family history, as appropriate
    - Social history, as appropriate

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

In situations in which these criteria are not met, it would be appropriate to claim the visit as a limited visit i.e. HSC 03.03.

Preamble rules also stipulate that a comprehensive visit may not be claimed within 30 days of a previous limited or comprehensive visit. However, a subsequent comprehensive visit service may be claimed by the specialties of internal medicine, neurology, and paediatrics.

BACK TO CONTENTS

These three specialties – internal medicine, neurology and paediatrics – have two types of comprehensive visits available to them for services provided in the office i.e. Initial and Subsequent. An Initial Comprehensive Visit may be claimed provided **all** of the above requirements above are met, **and** the patient is being seen for a new condition or complication of an existing condition. If the patient is not being seen for a new condition or complication of an existing condition, an initial visit may not be claimed and either a subsequent 03.04 or 03.03 should be claimed, depending on whether the requirements above have been satisfied.

BACK TO CONTENTS

It is not appropriate to claim either an initial or subsequent 03.04 for all follow-up visits after 30 days have passed; the requirements noted above must be satisfied

**Non-Face to Face Health Service Codes (HSCs 03.09K, 03.09L, 03.03Q, 03.03R)**

Upon review of the new non-face to face HSCs which were implemented April 1, 2017 MSI has noted that some claims were for services ineligible to be claimed using these HSCs. Common errors included the following:

- The telephone call was not scheduled;
- The purpose of the call was to provide a prescription renewal;
- The purpose of the call was to inform the patient of the results of diagnostic investigations with no change in management plan.
- The service was claimed when the decision is to see the patient at the next available appointment in the office.

The requirements for claiming these HSCs were outlined in previous MSI Bulletins. Once again, physicians are asked to carefully review these requirements to be sure they are in compliance. If services have been claimed that are not in compliance, please delete these claims.

**Physicians and their billing clerks are asked to carefully review the requirements for these new Health Service codes before submitting them.**

## QUESTION AND ANSWER

**New Non-Face to Face Health Service Codes (HSCs 03.09K, 03.09L, 03.03Q, 03.03R)**

**Q: I am a specialist in a tertiary care centre. A family physician phones me to discuss a patient with an urgent problem but there was no written request. Does this mean I cannot claim HSC 03.09K Specialist Telephone Advice (Consultant Physician)?**

A: Provided the family physician sends the written request before or on the day of the call – including after the telephone call – you may claim this service using HSC 03.09K. As a reminder, the telephone call needs to be scheduled.

**Q: I regularly speak by telephone with the radiologists at my local hospital to discuss my patients' imaging results and obtain advice on planning future imaging studies. Can HSCs 03.09K/03.09L be used for these calls?**

A: Telephone calls with radiologists may not be claimed using these HSCs. The intent of the telephone consultation HSCs is to replace an in-person consultation with the specialist and calls to relay the results of imaging studies or plan future studies do not satisfy that intent.

**Q: Can I claim HSC 03.09K/03.09L for providing advice to a psychologist or if I ask a psychologist for advice?**

A: HSCs 03.09K and 03.09L are for telephone consultations between physicians. The only exception is that a Nurse Practitioner may also request consultation advice from a specialist physician. Telephone consultations with psychologists may not be claimed.

**Q: When claiming HSC 03.03Q Scheduled Specialist Telephone Management/Follow-up with Patient or 03.03R Scheduled Family Physician Telephone Management/Follow-Up with Patient do I need to inform the patient of the scheduled time of the call?**

A: Yes, you need to schedule the call with the patient and advise them of the time of the call just as you would for an in-person appointment.

BACK TO CONTENTS

**Q: I am a specialist in a tertiary care centre. Because of the nature of my subspecialty, I look after patients from other Maritime provinces. Can I claim HSCs 03.09K and 03.03Q for these patients?**

A: Yes, you may claim these HSCs for these patients. However, in the case of the consultation codes, the referring physician or Nurse Practitioner in the other province cannot claim the referring practitioner code i.e. HSC 03.09L.

**Q: A referral arrived from a family physician asking me to see a patient. After reviewing the referral, I was certain that I could sort out the questions the family physician had over the phone, saving the patient a two hour drive. Can I claim 03.09K in these circumstances or does the family physician have to have requested a telephone rather than an in-person consultation?**

A: You may claim 03.09K under these circumstances, provided you've met the other requirements for the HSC, including scheduling the call with the family physician.

**Q: I am a family physician. I referred my patient to a specialist several months ago. However, his clinical condition has worsened and he needs to be seen by the specialist urgently. Can I claim 03.09L if I call the specialist to ask for a sooner appointment?**

A: HSCs 03.09K and 03.09L cannot be claimed when the purpose of the call is to expedite an in-person assessment; the intent of the telephone consultation is to replace an in-person consultation.

**Q: I am a billing clerk for a family doctor. How do I claim for calling a patient with their test results?**

A: When calling patients concerning the results of diagnostic investigations HSC 03.09R (and 03.09Q for specialists) may only be claimed when there is a change in the management plan for the patient. As a reminder, the call must be made by the physician personally and not delegated to neither office staff nor medical trainees such as residents.

**Q: Can 03.09K be used when a specialist is requesting advice from a GP?**

A: HSC 03.09K requires the physician providing the advice to be a specialist. A specialist is defined as one whose name appears in the specialist register of the College of Physicians & Surgeons of Nova Scotia.

**Q: As a family physician, can I claim both 03.03 and 03.09L on the same day for the same patient?**

A: Yes, it's recognized that in some circumstances you will see a patient with an urgent problem who requires a consultation with a specialist the same day. In those circumstances, you may claim for your visit with the patient and additionally for a scheduled telephone consultation with the specialist that day. As a reminder, you are required to send a written referral to the specialist for the consultation service.

BACK TO CONTENTS

BACK TO CONTENTS

BACK TO CONTENTS

## In every issue Helpful links, contact information

### HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

http://msi.medavie.bluecross.ca/

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

### CONTACT INFORMATION

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BACK TO CONTENTS

PHYSICIAN'S BULLETIN
July 18, 2017: Vol. LIII, ISSUE 5

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## ELIGIBLE MASTER AGREEMENT PAYMENTS

**Canadian Medical Protective Association ("CMPA") Assistance Payment and Other Eligible Master Agreement Related Payments**

Canadian Medical Protective Association ("CMPA") Assistance Payment

The Department of Health and Wellness (through MSI) will provide reimbursement of all eligible CMPA premium fees, directly to eligible physicians. This is a new process, as in the past, reimbursement was provided from Doctors Nova Scotia.

Reimbursement of eligible CMPA premium fees for the period covering January 1, 2017 up to and including June 30, 2017 will be deposited through an electronic funds transfer on the next regularly scheduled MSI payment date – July 19, 2017.

Should you have any questions regarding this payment, please send them to masteragreement@novascotia.ca.

# PHYSICIAN'S BULLETIN

May 18, 2017: Vol. LII, ISSUE 4


NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## MSI News

### VISION SCREENING FOR TYPE 2 DIABETES

As per the Canadian Diabetes Association guidelines for vision screening, effective April 1 2017, residents with type 2 diabetes will only be eligible for a complete eye examination every 2 years. Residents with type 1 diabetes and residents with type 2 diabetes and retinopathy will be eligible for a complete eye examination every year. Diagnosis must be confirmed in the resident's medical chart.

### INTERPROVINCIAL RECIPROCAL BILLING

Service providers may be required to render medical services to patients from other provinces within Canada who are visiting or travelling within Nova Scotia. Effective April 1, 1988, all provinces and territories, except Quebec, agreed to participate in a reciprocal billing agreement under which a service provider would submit service encounters directly to their own provincial medical plan for eligible Canadian patients. Attached is a sample of Valid Insured Health Services Plan Cards for Reciprocal Billing. Please see Preamble section 2.4.0 for detailed Reciprocal Billing Agreement information, including eligibility criteria.


BACK TO CONTENTS



BACK TO CONTENTS

## INTERIM FEES MADE PERMANENT

Effective May 18, 2017, the following interim fees have been made permanent.

| Category | Code | Description | Base Units |
|---|---|---|---|
| CONS | 03.09I | **Anatomic Pathology Consultation**<br>**Diagnostic Consultation, with review of records and specimens, with report on referred material prepared elsewhere.** | 45 MSU |
| CONS | 03.09J | **Anatomic Pathology Consultation**<br>**Special Diagnostic Consultation, with review of records and specimens, with report on referred material and requiring preparation of additional slides, and/or ordering and interpretation of special tests.** | 60 MSU |
| VEDT | 03.38B | **Exercise Induced Asthma Assessment, interpretation.**<br>**Includes interpretation of all serial spirometry, flow/volume loops, bronchodilation responsiveness, and oximetry required to assess the patient.** | 20 MSU |
| VEDT | 03.38C | **Interpretation of Spirometry Pre and Post Bronchodilator** *(Revised March 31,2020 – See May 2020 Bulletin for updated information)* | 10 MSU |
| VEDT | 03.38D | **Six Minute Walk Test, interpretation, when this is the sole procedure.** | 2 MSU |
| VEDT | 05.99A | **Immunofluorescence, interpretation of any and all markers required for diagnosis; any method.** | 30 MSU |
| VEDT | 05.99B | **Molecular testing, interpretation of any and all analyses/tests required for diagnosis; any method.** | 40 MSU |

BACK TO CONTENTS

## NEW INTERIM FEES (2015-2019 MASTER AGREEMENT)

BACK TO CONTENTS

New Health Service Codes for Non-Face to Face Services

Eligible services can now be submitted for dates of service April 1, 2017 onward. Physicians have 90 days from the date of this Bulletin to submit these claims. Please contact MSI directly for detailed instructions on how to submit these outdated eligible services.

**Physicians and their billing clerks are asked to carefully review the requirements for these new Health Service codes before submitting them.**

**The new non face-to-face HSCs will replace HSCs 03.03F, 03.03I, 03.09D, 03.09E and 03.09F and therefore physicians should, effective March 31, 2017, cease using them. Services that would have been submitted using these discontinued HSCs should be held and claimed using the new HSCs.**

| Category | Code | Description | Base Units |
|---|---|---|---|
| CONS | **03.09K** | **Specialist Telephone Advice – Consultant Physician – Providing Advice** | 25 MSU |
| CONS | **03.09L** | **Specialist Telephone Advice – Referring Physician – Requesting Advice** | 11.5 MSU |

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

The referring physician may be a family physician or other specialist seeking an expert opinion from the consulting physician due to the complexity and severity of the case and with the intent of continuing to provide the patient's care closer to home. The consultant specialist may also receive requests for advice from a nurse practitioner.

The referring physician (or NP) must submit a written request for an elective consultation to the specialist. The specialist will schedule a 15 minute telephone call with the referring provider. There must be by a two-way verbal communication discussing the clinical situation followed by a management decision and a written report from the specialist to the referring provider.

For urgent consultations that do not result in transfer of the patient, the telephone call and the written request to the specialist may occur on the same day.

The written referral and the formal consultation report must be available in the patient's medical record; both the referring physician (or NP) and the specialist must maintain copies of both documents. Both medical records must include the date and time of the service and any contemporaneous notes, in addition to the written documents.

The service is reportable by the specialist for a new patient or an established patient with a new condition or an exacerbation of an existing condition.

**Billing Guidelines**
The HSC includes a review of the patient's history, family history and history of present complaint, and a review of any laboratory data, PACS images, medical records or other data as needed to provide advice.

The health service includes a discussion of the physical findings as reported by the referring provider.

If subsequent phone calls are necessary within 14 days to complete the consultation they are considered included in the HSC for the telephone consultation.

The Consultant Physician HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|

The Referring Physician HSC may be reported when the telephone call for an urgent consultation occurs on the same day as the patient visit that generated the consultation.

The HSC is 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 not reportable for other forms of communication such as:

- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another health professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student

The service is not reportable by the consulting physician if the patient has had a face to face visit with the consultant or any member of his/her call group within the previous 14 days for the same condition or if the telephone consultation results in a face to face service within the next 14 days or the next available appointment of the consultant.

The service is not reportable for telephone calls of less than 5 minutes of two way medical discussion.

The service is not reportable for calls between a referring provider and specialist in the same institution or practice location.

**Documentation Requirements**

- A written referral must be sent to the specialist and be available in the patient's medical record.
- Both the specialist consultant and the referring provider must document the patient name, identifying data and date and start and stop time of the call in their respective charts or EMRs.
- The names of the referring physician (or NP) and the consultant physician must be documented by both physicians.
- The diagnosis, reason for referral, elements of the history and physical as relayed by the referring provider, the opinion of the consultant physician and the plan for future management must be documented.
- A written report must be sent to the referring provider by the specialist consultant.
- The referring physician's billing number must be noted on the electronic MSI service Report (claim).
- The specialist must enter the date of the receipt of the referral in the text field on the MSI service report (claim).
- Both physicians must submit the start and stop time of the call in the text field on the MSI service report (claim).
- There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service.

**Location**
LO=OFFC

**Note**
As these codes replace HSCs 03.09E, 03.09F, 03.09D these three codes will be termed on implementation of these health services codes.

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | **03.03Q** | **Scheduled Specialist Telephone Management/Follow-up with Patient**<br><br>This health service code may be reported for a scheduled 15 minute telephone communication between the specialist physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face consultation, visit or procedure by the same physician within the last 9 months and has not been seen within the last 7 days.<br><br>This service is not reported if the outcome of the scheduled call is to see the patient at the next available appointment in the office.<br><br>This communication is intended to take the place of an office follow up visit that would have otherwise been scheduled, when a physical examination of the patient is not required.<br><br>**Billing Guidelines**<br>This health service is reportable for a scheduled telephone (or synchronous electronic verbal communication) between the specialist physician and the patient (or the patient's parent, guardian or proxy as established by written consent).<br><br>Telephone management requires communication between the patient and physician on a clinical level; the HSC is not reportable for administrative tasks.<br><br>The call must include a discussion of the clinical problem and a management decision.<br><br>The HSC is reportable for scheduled telephone appointments only. The specialist physician must have seen and examined the patient within the preceding 9 months.<br><br>The HSC is reportable a maximum of 4 times per patient per physician per year.<br><br>The HSC is not reportable for facility based patients.<br><br>The HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.<br><br>The service is not reportable when the purpose of the communication is to:<br>• Arrange a face to face appointment<br>• Notify the patient of an appointment<br>• Provide a prescription renewal<br>• Arrange a laboratory, other diagnostic test or procedure<br>• Inform the patient of the results of diagnostic investigations with no change in management plan.<br><br>The service is not reportable for other forms of communication such as:<br>• Written, e-mail or fax communication<br>• Electronic verbal forms of communication that are not PHIA compliant<br><br>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 professional such as:<br>• Nurse practitioner<br>• Resident in training<br>• Clinical fellow<br>• Medical student<br>• Clerical staff<br><br>The service is not reportable for telephone calls of less than 5 minutes of two way medical discussion.<br><br>**Documentation requirements**<br>• The date, start and stop times of the conversation must be noted in the medical record.<br>• The medical record must indicate the content of the discussion, the management plan and that the patient understands and acknowledges the information provided. | 11.5 MSU |

BACK TO CONTENTS

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| | | • A written report must be sent to the referring physician or family physician by the specialist consultant.<br>• The start and stop time of the call must be included in the text field on the MSI service report (claim).<br>• There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service.<br><br>**Location**<br>LO=OFFC<br><br>**Note**<br>As this HSC replaces HSCs 03.03F and 03.03I these will be termed on implementation of this health service code. | |

BACK TO CONTENTS

*Revised March 31, 2020 – See May 2020 Bulletin for updated information*

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | **03.03R** | **Scheduled Family Physician Telephone Management/Follow-Up with Patient**<br><br>This health service code may be reported for a scheduled 15 minute telephone communication between the family physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face visit by the same physician within the last 9 months and has not been seen within the last 7 days for the same condition.<br><br>This telephone communication is intended to take the place of an office visit initiated by the patient (or the patient's parent, guardian or proxy as established by written consent) for a new condition or an exacerbation of an existing condition, or a follow up visit that would have otherwise been scheduled by either the physician or the patient, when a physical examination of the patient is not required.<br><br>The patient population eligible must be either 65 years and older or be suffering from mental illness or multiple (two or more) chronic diseases.<br><br>Chronic disease is defined as:<br><br>Mental illness is defined as:<br>• A condition that meets criteria for a DSM diagnosis<br><br>The service is not reported if the decision is to see the patient at the next available appointment in the office.<br><br>**Billing Guidelines**<br>This health service is reportable for a scheduled telephone (or synchronous electronic verbal communication) between the family physician and the patient (or the patient's parent, guardian or proxy as established by written consent).<br><br>Telephone management requires communication between the patient and physician on a clinical level; the HSC is not reportable for administrative tasks.<br><br>The call must include a discussion of the clinical problem and a management decision.<br><br>The HSC is reportable for scheduled telephone appointments only. The family physician must have seen and examined the patient within the preceding 9 months.<br><br>The HSC is reportable a maximum of 4 times per patient per physician per year by the family physician and/or the practice providing ongoing comprehensive care to the patient. The HSC is not reportable by walk in clinics. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no requirement for an appointment, and episodic care with little or no follow-up. There is no standard patient roster and the patient list is constantly changing. | 11.5 MSU |

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|

The HSC is not reportable for facility based patients.

The HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.

The service is not reportable when the purpose of the communication is to:

- Arrange a face to face appointment
- Notify the patient of an appointment
- Prescription renewal
- Arranging to provide a sick note
- Arrange a laboratory, other diagnostic test or procedure
- Inform the patient of the results of diagnostic investigations with no change in management plan.

The service is not reportable for other forms of communication such as:

- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant
-

The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student
- Clerical staff

The service is not reportable for telephone calls of less than 5 minutes of medical discussion.

**Documentation requirements**

- The date, start and stop times of the conversation must be noted in the medical record.
- The medical record must indicate the content of the discussion, the management plan and that the patient (or the patient's parent, guardian or proxy as established by written consent) understands and acknowledges the information provided.
- For patient initiated appointment requests that result in a telephone management service on the same day, the following text should be entered in the MSI text field:
  Same day access
- The start and stop time of the call must be included in the text field on the MSI service report (claim).
- There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service.

**Location**
LO=OFFC

BACK TO CONTENTS

BACK TO CONTENTS

BACK TO CONTENTS

## BILLING REMINDERS

**Methadone Management Health Service Codes**

Physicians are reminded that methadone treatment and management health service codes are reportable only by the physician most responsible for the ongoing care of the patient inclusive of the patient's substance use disorder and concurrent medical conditions. These health service codes are not reportable by physicians providing methadone management alone.

**Cataract Surgery**

Ophthalmologic surgeons are reminded that monitoring of intraocular pressure is a part of the customary operative or post-operative care when providing cataract surgery. Health Service Code 03.12 should not be reported in addition.

**Percutaneous Ureteroscopy with ultrasonic lithotripsy and/or ureteroscopy with electrohydraulic lithrotripsy (HSC 68.95B)**

Procedural codes remunerate physicians for all aspects of the procedure that would normally be considered part of the defined technique for that procedure. Preamble rules prohibit unbundling procedural codes into constituent parts and claiming for them separately.

HSC 68.95B Percutaneous ureteroscopy with ultrasonic lithotripsy and/or ureteroscopy with electrohydraulic lithotripsy should not be claimed with any of the following as all are inherent parts of this procedure:

- HSC 68.95C ureteroscopy plus basket,
- HSC 68.99A removal of J-stent including cystoscopy, or
- HSC 68.99C calibration and/or dilation of ureter – one/both sides

**Trabeculectomy and Trabeculoplasty**

Health service codes for Trabeculectomy (HSC 26.25, 26.25B, 26.25C and 26.25D) and trabeculoplasty (HSC 26.29D and 26.29E) are for invasive major surgical procedures and as such may only be claimed for services provided in an operating room.

**Suture of Lacerations (HSC's 98.22, 98.22A, 98.22B, 98.22D and 98.22E)**

These health service codes may be claimed when suturing of lacerations is provided as a stand-alone procedure. These HSCs may not be claimed where skin suturing is an integral aspect of another procedure such as removal of a cutaneous lesion.

Multiples for these HSCs may only be claimed when multiple lacerations are sutured. It is not appropriate to claim multiples for each suture.

BACK TO CONTENTS

# NEW AND UPDATED EXPLANATORY CODES

BACK TO CONTENTS

| Code | Description |
|---|---|
| GN092 | SERVICE ENCOUNTER HAS BEEN REFUSED AS TEXT IS REQUIRED FOR NON FACE TO FACE SERVICES. |
| GN093 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY BILLED A NON FACE TO FACE SERVICE FOR THIS PATIENT ON THE SAME DAY. |
| GN094 | YOU HAVE BILLED FOR A NON FACE TO FACE SERVICE AND WE ARE REQUESTING THE SUPPORTING DOCUMENTATION TO AID IN THE EVALUATION OF THIS CLAIM. |
| GN095 | SERVICE ENCOUNTER HAS BEEN REDUCED TO THE APPROPRIATE FEE FOR THE SERVICE PROVIDED. |
| MA072 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 27.72, 27.72B, 27.73, 27.73A, OR 27.73B HAS ALREADY BEEN BILLED AT THE SAME ENCOUNTER AND IS A COMPONENT OF THIS PROCEDURE. |
| VA080 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.12 IS A COMPONENT OF THIS PROCEDURE. |
| VT147 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PATIENT MUST HAVE PREVIOUSLY BEEN SEEN FOR A FACE TO FACE ENCOUNTER BY THIS PROVIDER WITHIN THE LAST 9 MONTHS. |
| VT148 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.09K MAY NOT BE BILLED IN ADDITION TO ANY OTHER SERVICE FOR THIS PATIENT ON THE SAME DAY. |
| VT149 | SERVICE ENCOUNTER HAS BEEN REFUSED AS CALLS BETWEEN A REFERRING PROVIDER AND SPECIALIST IN THE SAME INSTITUTION OR PRACTICE LOCATION ARE NOT PERMITTED FOR THIS SERVICE. |
| VT150 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED FOR SPECIALIST TELEPHONE ADVICE FOR THIS PATIENT WITHIN THE PREVIOUS 14 DAYS WHICH INCLUDES ANY SUBSEQUENT CALLS NECESSARY TO COMPLETE THE CONSULTATION. |
| VT151 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE ALREADY BILLED A FACE TO FACE VISIT FOR THIS PATIENT IN THE PREVIOUS 14 DAYS. |

BACK TO CONTENTS

BACK TO CONTENTS

## UPDATED FILES

Updated files reflecting changes are available for download on Thursday May 18, 2017. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT) and, explanatory codes (EXPLAIN.DAT).

## 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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BACK TO CONTENTS

# PHYSICIAN'S BULLETIN

March 24, 2017: Vol. LII, ISSUE 3


NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## MSI News

### MSI UNIT VALUE CHANGES

**MEDICAL SERVICE UNIT/ANAESTHESIA UNIT CHANGE**

Effective April 1, 2017, the Medical Service Unit (MSU) value will be increased from $2.42 to $2.44 and the Anaesthesia Unit (AU) value will be increased from $20.55 to $20.76.

**PSYCHIATRY FEES**

Effective April 1, 2017 the hourly Psychiatry rate for General Practitioners will increase to $111.66 while the hourly rate for Specialists increases to $151.40 as per the tariff agreement.

**SESSIONAL PAYMENTS**

Effective April 1, 2017 the hourly Sessional rate for General Practitioners will increase to $146.40 while the hourly rate for Specialists increases to $170.80 as per the tariff agreement.

**WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC**

Effective April 1, 2017 the Workers' Compensation Board MSU Value will increase from $2.69 to $2.71 and the Workers' Compensation Board Anaesthetic Unit Value will increase from $22.83 to $23.07.

**WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT UPDATE**

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been calculated to the listed WCB specific fees for fiscal year 2017-18.

Due to the increase in CPI for 2016, all of the WCB specific services listed below will have their values increased by 1.24% effective April 1st, 2017:

| CODE | DESCRIPTION | NEW VALUE |
|---|---|---|
| WCB12 | EPS physician assessment Service.<br>Combined office visit and completion of Form 8/10<br><br>For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15 minute increments to a maximum of 1 additional hour | **Initial visit:**<br>$177.10 + $51.76 per 15 minutes to a maximum 4x(RO=EPS1 and RP=INTL)<br><br>**Subsequent visit:**<br>$177.10 (RO=EPS1 and RP=SUBS) |
| WCB13 | Chart Summaries / Written Reports.<br>Detailed reports billed in 15-minute intervals<br>- plus multiples, if applicable | GPs……$43.25 per 15 min<br>EPS(RO=EPS1)……..$51.76 per 15 min<br>Specialists……$58.21 per 15 min |
| WCB15 | Case Conferencing and Teleconferencing (Treating Physician)<br>Conferencing billed by the Treating Physician<br>- plus multiples, if applicable | GPs……$43.25 per 15 min<br>EPS(RO=EPS1)……..$51.76 per 15 min<br>Specialists……$58.21 per 15 min |
| WCB17 | Photocopies of Chart Notes | 10 pgs or less (ME=UP10)……....$25.88<br>11-25 pgs (ME=UP25)……$51.76<br>26-50 pgs (ME=UP50)……$103.44<br>Over 50 pgs (ME=OV50).....$155.15 |
| WCB20 | Carpal Tunnel Syndrome (CTS) Assessment Report | $66.37 |
| WCB21 | Follow-up visit report | $38.81 |
| WCB22 | Completed Mandatory Generic Exemption Request Form | $12.98 per form |
| WCB23 | Completed Non-Opioid Special Authorization Request Form | $12.98 per form |
| WCB24 | Completed Opioid Special Authorization Request Form | $43.50 per form |
| WCB25 | Completed WCB Substance Abuse Assessment Form | $28.97 |
| WCB26 | Return to Work Report – Physician's Report Form 8/10 | $66.37 |
| WCB27 | Eye Report | $58.21 |
| WCB28 | Comprehensive Visit for Work Related Injury or Illness | $66.80 |

BACK TO CONTENTS

## NEW FEES

Effective March 24, 2017 the following health service code will be available for billing:

| Category | Code | Modifier | Description | Base Units |
|---|---|---|---|---|
| VADT | 03.19H | **RO=INTP** | **Corneal Topography of both eyes for corneal disease (not refractive eye surgery)**<br><br>Physician interpretation of computerised corneal topography for;<br>• Central corneal ulcer<br>• Corneal dystrophy, bullous keratopathy, and complications of transplanted cornea<br>• Diagnosis and monitoring of keratoconus and pellucid marginal corneal degeneration<br>• Corneal astigmatism<br><br>**Billing Guidelines**<br>• Post corneal transplant-maximum 6 per patient per year.<br>• Fee includes both eyes, whether one at a time or on two separate visits<br>• For keratoconus and pellucid degeneration where progressive changes greater than 1 diopter in a year has been documented this HSC is payable twice per year per patient.<br>• Not payable for pre or postoperative cataract patients except where there is evidence of irregular astigmatism<br>• Not payable when done in association with laser refractive surgery or the pre or postoperative care of these patients with laser refractive surgery<br><br>**Specialty Restriction**<br>OPHT With Fellowship in Corneal Disease<br><br>**Location**<br>LO=OFFC, LO=HOSP | 5.8 MSU |

Effective March 24, 2017 the following health service code will be available for billing:

| Category | Code | Description | Base Units | ANAES Units |
|---|---|---|---|---|
| MASG | 97.79A | **Masculinization of the Female Chest**<br><br>Complete masculinization of the chest wall for the surgical treatment of gender dysphoria to include bilateral subcutaneous mastectomy, nipple-areolar repositioning, chest contouring and initial scar camouflage as required.<br><br>**Billing Guidelines**<br>• Must have prior approval by MSI.<br>• Not to be billed with any other mastectomy, nipple or breast reconstruction or tissue shift codes.<br><br>**Specialty Restriction**<br>PLAS<br><br>**Location**<br>LO=HOSP | IC at 110MSU/hr | 4+T |

BACK TO CONTENTS

Effective March 24, 2017 the following health service code will be available for billing:

*Revised March 31, 2020 – See May 2020 Bulletin for updated information*

| Category | Code | Modifier | Description | Base Units | ANAES Units |
|---|---|---|---|---|---|
| MASG | 57.6D | **RO=FPHN**<br>**RO=SPHN** | **Total proctocolectomy with ileostomy and abdominal perineal resection**<br><br>This fee is for the complete resection of the entire colon, rectum, and anus with perineal dissection to remove the anal sphincter, and the creation of an ileostomy. Includes mobilization of colon, identification of ureter, dissection of mesocolic vessels, division and suture of bowel, excision of rectum and anus, omental flap for repair as required.<br><br>To bill as SPHN, the second surgeon must actively participate for 75% of the procedure time. When the second surgeon fee is billed no other assistant fee may be billed.<br><br>* This fee is replacing health service code 57.6A - Enterectomy with colostomy, caecostomy or ileostomy, which was termed for March 23, 2017.<br><br>**Billing Guidelines**<br>Not to be billed with any other fees for resection or suture of bowel or formation of ileostomy on the same patient same day i.e.,HSC's:<br>• 57.04 (A or B) Enterotomy or colostomy or multiple Colostomy<br>• 57.42 (A or B) Enterectomy with anastomosis<br>• 58.52 Closure enterostomy plus resection<br>• 58.53 Closure of colostomy<br>• 58.73 Other suture of intestine<br><br>Not to be billed with:<br>• 1.24C Sigmoidoscopy<br>• 58.21 Ileostomy for ulcerative colitis<br>• 58.39A Ileostomy with tube<br>• 66.64 (A or B) Omental flap to repair extra-abdominal defect<br><br>If reported with Vaginectomy or vaginal reconstruction the operative report and record of operation must be submitted for manual assessment i.e.,HSC's:<br>• 82.23 Excision of lesion of vagina<br>• 82.3 (also A, B, C) Obliteration of vagina<br>• 82.52 Vaginal reconstruction<br>• 82.62 Repair of Fistula of Vagina<br>• 82.69 (A or B) Vaginoplasty<br><br>**Premium**<br>No – but may submit OR Report and Record of Operation for manual assessment if service is provided in premium time for medical necessity<br><br>**Assistant**<br>Reportable only when RO=SPHN is not reported<br><br>**Specialty Restriction**<br>GNSG, RO=SPHN also restricted to GNSG<br><br>**Location**<br>LO=HOSP | 550MSU<br>400MSU | 8+T |

BACK TO CONTENTS

## NEW INTERIM FEES (2015-2019 MASTER AGREEMENT)

New Health Service Codes for Non-Face to Face Services

In the coming weeks, a number of new Health Service Codes will be available to physicians for select non-face to face services rendered on or after April 1, 2017. Physicians are asked to hold these claims until notified that they may be submitted for payment. An update regarding submission dates will be published in the next MSI Physician's Bulletin on May 18, 2017.

**Physicians and their billing clerks are asked to carefully review the requirements for these new Health Service codes before submitting them.**

**The new non face-to-face HSCs will replace HSCs 03.03F, 03.03I, 03.09D, 03.09E and 03.09F and therefore physicians should, effective March 31, 2017, cease using them. Services that would have been submitted using these discontinued HSCs should be held and claimed using the new HSCs.**

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | **03.09K** | **Specialist Telephone Advice – Consultant Physician – Providing Advice** | 25 MSU |
| VIST | **03.09L** | **Specialist Telephone Advice – Referring Physician – Requesting Advice** | 11.5 MSU |

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

The referring physician may be a family physician or other specialist seeking an expert opinion from the consulting physician due to the complexity and severity of the case and with the intent of continuing to provide the patient's care closer to home. The consultant specialist may also receive requests for advice from a nurse practitioner.

The referring physician (or NP) must submit a written request for an elective consultation to the specialist. The specialist will schedule a 15 minute telephone call with the referring provider. There must be by a two-way verbal communication discussing the clinical situation followed by a management decision and a written report from the specialist to the referring provider.

For urgent consultations that do not result in transfer of the patient, the telephone call and the written request to the specialist may occur on the same day.

The written referral and the formal consultation report must be available in the patient's medical record; both the referring physician (or NP) and the specialist must maintain copies of both documents. Both medical records must include the date and time of the service and any contemporaneous notes, in addition to the written documents.

The service is reportable by the specialist for a new patient or an established patient with a new condition or an exacerbation of an existing condition.

**Billing Guidelines**
The HSC includes a review of the patient's history, family history and history of present complaint, and a review of any laboratory data, PACS images, medical records or other data as needed to provide advice.

The health service includes a discussion of the physical findings as reported by the referring provider.

If subsequent phone calls are necessary within 14 days to complete the consultation they are considered included in the HSC for the telephone consultation.

The Consultant Physician HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.

BACK TO CONTENTS

The Referring Physician HSC may be reported when the telephone call for an urgent consultation occurs on the same day as the patient visit that generated the consultation.

The HSC is 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 not reportable for other forms of communication such as:

- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another health professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student

The service is not reportable by the consulting physician if the patient has had a face to face visit with the consultant or any member of his/her call group within the previous 14 days for the same condition or if the telephone consultation results in a face to face service within the next 14 days or the next available appointment of the consultant.

The service is not reportable for telephone calls of less than 5 minutes of two way medical discussion.

The service is not reportable for calls between a referring provider and specialist in the same institution or practice location.

**Documentation Requirements**

- A written referral must be sent to the specialist and be available in the patient's medical record.
- Both the specialist consultant and the referring provider must document the patient name, identifying data and date and start and stop time of the call in their respective charts or EMRs.
- The names of the referring physician (or NP) and the consultant physician must be documented by both physicians.
- The diagnosis, reason for referral, elements of the history and physical as relayed by the referring provider, the opinion of the consultant physician and the plan for future management must be documented.
- A written report must be sent to the referring provider by the specialist consultant.
- The referring physician's billing number must be noted on the electronic MSI service Report (claim).
- The specialist must enter the date of the receipt of the referral in the text field on the MSI service report (claim).
- Both physicians must submit the start and stop time of the call in the text field on the MSI service report (claim).
- There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service.

**Location**
LO=OFFC

**Note**
As these codes replace HSCs 03.09E, 03.09F, 03.09D these three codes will be termed on implementation of these health services codes.

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | **03.03Q** | **Scheduled Specialist Telephone Management/Follow-up with Patient**<br><br>This health service code may be reported for a scheduled 15 minute telephone communication between the specialist physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face consultation, visit or procedure by the same physician within the last 9 months and has not been seen within the last 7 days.<br><br>This service is not reported if the outcome of the scheduled call is to see the patient at the next available appointment in the office.<br>This communication is intended to take the place of an office follow up visit that would have otherwise been scheduled, when a physical examination of the patient is not required.<br><br>**Billing Guidelines**<br>This health service is reportable for a scheduled telephone (or synchronous electronic verbal communication) between the specialist physician and the patient (or the patient's parent, guardian or proxy as established by written consent).<br>Telephone management requires communication between the patient and physician on a clinical level; the HSC is not reportable for administrative tasks.<br>The call must include a discussion of the clinical problem and a management decision.<br>The HSC is reportable for scheduled telephone appointments only. The specialist physician must have seen and examined the patient within the preceding 9 months.<br>The HSC is reportable a maximum of 4 times per patient per physician per year.<br>The HSC is not reportable for facility based patients.<br>The HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.<br>The service is not reportable when the purpose of the communication is to:<br>• Arrange a face to face appointment<br>• Notify the patient of an appointment<br>• Provide a prescription renewal<br>• Arrange a laboratory, other diagnostic test or procedure<br>• Inform the patient of the results of diagnostic investigations with no change in management plan.<br>The service is not reportable for other forms of communication such as:<br>• Written, e-mail or fax communication<br>• Electronic verbal forms of communication that are not PHIA compliant<br>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 professional such as:<br>• Nurse practitioner<br>• Resident in training<br>• Clinical fellow<br>• Medical student<br>• Clerical staff<br><br>The service is not reportable for telephone calls of less than 5 minutes of medical discussion.<br><br>**Documentation requirements**<br>• The date, start and stop times of the conversation must be noted in the medical record.<br>• The medical record must indicate the content of the discussion, the management plan and that the patient understands and acknowledges the information provided.<br>• A written report must be sent to the referring physician or family physician by the specialist consultant.<br>• The start and stop time of the call must be included in the text field on the MSI service report (claim).<br>• There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service.<br><br>**Location**<br>LO=OFFC<br><br>**Note**<br>As this HSC replaces HSCs 03.03F and 03.03I these will be termed on implementation of this health service code. | 11.5 MSU |

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | **03.03R** | **Scheduled Family Physician Telephone Management/Follow-Up with Patient** | 11.5 MSU |

This health service code may be reported for a scheduled 15 minute telephone communication between the family physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face visit by the same physician within the last 9 months and has not been seen within the last 7 days for the same condition.
This telephone communication is intended to take the place of an office visit initiated by the patient (or the patient's parent, guardian or proxy as established by written consent) for a new condition or an exacerbation of an existing condition, or a follow up visit that would have otherwise been scheduled by either the physician or the patient, when a physical examination of the patient is not required.
The patient population eligible must be either 65 years and older or be suffering from mental illness or multiple (two or more) chronic diseases.

Mental illness is defined as:
- A condition that meets criteria for a DSM diagnosis

The service is not reported if the decision is to see the patient at the next available appointment in the office.

**Billing Guidelines**
This health service is reportable for a scheduled telephone (or synchronous electronic verbal communication) between the family physician and the patient (or the patient's parent, guardian or proxy as established by written consent).
Telephone management requires communication between the patient and physician on a clinical level; the HSC is not reportable for administrative tasks.
The call must include a discussion of the clinical problem and a management decision.
The HSC is reportable for scheduled telephone appointments only. The family physician must have seen and examined the patient within the preceding 9 months.
The HSC is reportable a maximum of 4 times per patient per physician per year by the family physician and/or the practice providing ongoing comprehensive care to the patient. The HSC is not reportable by walk in clinics. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no requirement for an appointment, and episodic care with little or no follow-up. There is no standard patient roster and the patient list is constantly changing.
The HSC is not reportable for facility based patients.
The HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.

The service is not reportable when the purpose of the communication is to:
- Arrange a face to face appointment
- Notify the patient of an appointment
- Prescription renewal
- Arranging to provide a sick note
- Arrange a laboratory, other diagnostic test or procedure
- Inform the patient of the results of diagnostic investigations with no change in management plan.

The service is not reportable for other forms of communication such as:
- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another professional such as:
- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student
- Clerical staff

The service is not reportable for telephone calls of less than 5 minutes of medical discussion.

BACK TO CONTENTS

**Documentation requirements**

- The date, start and stop times of the conversation must be noted in the medical record.
- The medical record must indicate the content of the discussion, the management plan and that the patient (or the patient's parent, guardian or proxy as established by written consent) understands and acknowledges the information provided.
- For patient initiated appointment requests that result in a telephone management service on the same day, the following text should be entered in the MSI text field:
  Same day access
- The start and stop time of the call must be included in the text field on the MSI service report (claim).
- There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service.

**Location**
LO=OFFC

# Billing Matters Billing Reminders, New Explanatory Codes

## BILLING REMINDERS

**Complete Hearing Tests**
Physicians are reminded that health service code 09.41D complete hearing testing includes pure tone audiometry (air and bone), tympanometry, and a speech test, and all components must be performed to claim this fee.

**Laser Treatment of Malignant Neoplasms of Esophagus, Bronchi, etc. in Addition to Scope**
Physicians are reminded that health service code 44.0A laser treatment of malignant neoplasms of esophagus, bronchi, etc. in addition to scope is an add-on fee and should only be claimed after an appropriate base fee for bronchoscopy or esophagoscopy is paid.

**Pap Smears**
Physicians are reminded that health service code 03.26A pap smear may not be claimed in addition to a visit, consultation or procedure for a gynaecological or obstetrical diagnosis, nor is it payable in addition to a complete physical exam.

**Hemodialysis**
Physicians providing dialysis services are reminded that only one claim per patient may be made for initial hemodialysis i.e. HSC 51.95 RP=INTL

**Clinical Records Supporting Claims to MSI**
On occasion, MSI requires physicians to provide supporting clinical documentation to verify claims made to MSI. As per Preamble 1.1.36 "All claims submitted to MSI must be verifiable from the patient records associated with the services claimed and be billed in accordance with the Preamble."

**Medical Assistance in Dying (MAID)**
Physicians are reminded that time spent discussing MAID with legal representatives, the College of Physicians and Surgeons of Nova Scotia, the Canadian Medical Protective Association or other associations not involved in direct patient care cannot be claimed.

The health service code for the second physician (03.03O) cannot be processed if a claim has not been submitted for the role of first physician (03.03M).

The health service code for the prescribing physician (03.03N) cannot be processed if claims have not been made for first and second physician.

BACK TO CONTENTS

## Canadian Medical Protective Association ("CMPA") Assistance Payment and other eligible Master Agreement related payments

*****If you have already taken action, please disregard this communication*****

The 2015-2019 Physician Master Agreement provides funding for reimbursement of eligible physician fees paid to The Canadian Medical Protective Association. As of September 9, 2016, the Department of Health and Wellness (through MSI) will provide compensation directly to all eligible physicians. This is a new process, as in the past, reimbursement was provided from Doctors Nova Scotia. All physicians registered with MSI have been mailed a package on February 15, 2017 to coordinate this process.

To ensure receipt of eligible reimbursement, all physicians are required to complete and submit the business arrangement form. The original deadline was March 17, 2017, but if you have not submitted, please submit as soon as possible. This new business arrangement will be used to process your CMPA payments as well as all other contractual incentive payments under the current Master Agreement. This new process, including the submission of required information to MSI, will allow for a transition away from a cheque based payment to an electronic funds transfer in the near future. You will continue to receive any/all eligible incentive based payments by cheque while we transition to electronic funds transfer.

Should you have any questions, please contact the MSI Provider Coordinators at msiproviders@medavie.bluecross.ca or by telephone 902-496-7011 (toll free: 1-866-553-0585).

## Documentation Reminder

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribed, and start and stop times for time based codes.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptions, or emotional problems, the physician "deliberately established a professional relationship with the patient for the purposes of removing, modifying or alleviating existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional well being of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy," etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service on that date, then the service is not paid for or a lesser benefit is given. When the clinical record does not support the service claimed, there will be a recovery to MSI at the time of audit. Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

BACK TO CONTENTS

## NEW EXPLANATORY CODES

| Code | Description |
|---|---|
| AD067 | SERVICE ENCOUNTER HAS BEEN REFUSED. RESUBMIT USING THE APPROPRIATE HEALTH SERVICE CODE AND MODIFIER COMBINATION WITH THE PT=RISK MODIFIER AND TEXT EXPLAINING HIGH RISK. |
| BK060 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE FOLLOWING HSCS I1310, I1312, AND I1313 MAY ONLY BE BILLED ONCE PER PATIENT PER DAY. |
| GN028 | SERVICE ENCOUNTER HAS BEEN DISALLOWED. RESUBMIT INDICATING DURATION OF SERVICE. |
| GN043 | SERVICE ENCOUNTER HAS BEEN DISALLOWED. RESUBMIT INDICATING THE START AND FINISH TIME FOR THE PROCEDURE PERFORMED. |
| GN088 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR HSC 57.6D HAS BEEN APPROVED ON THIS DAY. |
| GN089 | SERVICE ENCOUNTER HAS BEEN DISALLOWED. PLEASE RESUBMIT WITH TEXT INDICATING SPECIFIC AREAS INVOLVED. |
| GN090 | SERVICE ENCOUNTER HAS BEEN DISALLOWED BECAUSE THE PROCEDURE IS NECESSARY TO ALLOW ACCESS/VISUALIZATION TO PERFORM THE SURGERY. |
| GN091 | SERVICE ENCOUNTER HAS BEEN REFUSED. PLEASE RESUBMIT USING THE APPROPRIATE MODIFIER(S). |
| MI007 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 03.03, 09.02C OR 09.02F ON THIS DAY. |
| MJ018 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THIS SERVICE REQUIRES ELECTRONIC TEXT OR A PRIOR APPROVAL NUMBER. |
| MJ021 | SERVICE ENCOUNTER HAS BEEN DISALLOWED. RESUBMIT WITH A COPY OF THE OUT PATIENT REPORT TO AID IN THE ADJUDICATION OF YOUR SERVICE ENCOUNTER. |
| MJ058 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 29.94A, 29.94B AND 29.94C MAY NOT BE CLAIMED TOGETHER AT THE SAME ENCOUNTER. |
| MJ059 | DATE OF SERVICE ON CLAIM DOES NOT MATCH DATE OF SERVICE ON OPERATIVE REPORT. |
| NR006 | SERVICE ENCOUNTER HAS BEEN DISALLOWED. INDICATE ACTUAL PROCEDURE PERFORMED WHEN RESUBMITTING. |
| NR014 | SERVICE ENCOUNTER HAS BEEN DISALLOWED. RESUBMIT WITH A COPY OF THE PATHOLOGY REPORT TO AID IN THE ADJUDICATION OF YOUR SERVICE ENCOUNTER. |
| NR085 | SERVICE ENCOUNTER HAS BEEN PAID AS THE RESULT OF A PRE-PAYMENT ASSESSMENT REVIEW. |
| OP033 | SERVICE ENCOUNTER HAS BEEN REFUSED AS ONE OF THE REQUIRED DIAGNOSTIC CODES (37160,37148,37171,V425) WAS NOT INCLUDED ON THE SERVICE ENCOUNTER. |
| OP042 | SERVICE ENCOUNTER HAS BEEN REFUSED AS AN INITIAL VISIT HAS ALREADY BEEN CLAIMED FOR THIS DIAGNOSIS. |
| OP043 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS AN ADDITIONAL COMPLETE EXAM HAS ALREADY BEEN APPROVED IN THE PAST YEAR. |
| OP044 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THIS FEE IS ONLY PAYABLE ONCE EVERY 2 YEARS FOR THE DIAGNOSIS SPECIFIED. |

BACK TO CONTENTS

| Code | Description |
|---|---|
| OP045 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED CORNEAL TOPOGRAPHY THE MAXIMUM OF SIX TIMES FOR THIS PATIENT WITHIN THE PAST YEAR. |
| OP046 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A PREVIOUS OPTOMETRIC VISION ANALYSIS HAS BEEN APPROVED WITHIN THE PREVIOUS 2 YEARS. |
| OP047 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED CORNEAL TOPOGRAPHY FOR KERATOCONUS AND PELLUCID DEGENERATION THE MAXIMUM OF TWO TIMES FOR THIS PATIENT WITHIN THE PAST YEAR. |
| VA047 | SERVICE ENCOUNTER HAS BEEN REFUSED. HSC 03.26A AND 03.26C ARE INCLUDED IN THE COMPLETE CARE CODE 81.8 WHICH WAS PREVIOUSLY BILLED FOR THIS PATIENT ON THIS DAY. |
| VA077 | SERVICE ENCOUNTER HAS BEEN DISALLOWED, PLEASE RESUBMIT WITH DOCUMENTATION INDICATING THAT THE SERVICE WAS PROVIDED BY THE PHYSICIAN, NOT ANOTHER PROFESSIONAL. |
| VA078 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY BILLED AN ESOPHAGOGASTRODUODENOSCOPY CODE AT THE SAME ENCOUNTER. |
| VA079 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST BILL THE APPROPRIATE BASE FEE FOR BRONCHOSCOPY OR ESOPHAGOSCOPY |
| VT100 | SERVICE ENCOUNTER HS BEEN REFUSED AS A 03.26A OR 03.26C HAS PREVIOUSLY BEEN BILLED FOR THIS PATIENT ON THE SAME DAY. |
| VT138 | SERVICE ENCOUNTER HAS BEEN REFUSED AND CANNOT BE PROCESSED UNTIL AFTER THE FIRST PHYSICIAN CLAIM HAS BEEN RECEIVED AND PROCESSED. |
| VT139 | SERVICE ENCOUNTER HAS BEEN REFUSED AS MSI REQUIRES FIRST AND SECOND PHYSICIAN CLAIMS TO PROCESS THE PRESCRIBING PHYSICIAN CLAIM. |
| VT140 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A MINIMUM OF ONE HALF HOUR MUST BE SPENT FOR MAID FEES TO BE PAYABLE. |
| VT141 | SERVICE ENCOUNTER HAS BEEN REDUCED AS A MAXIMUM OF 2 HOURS IS PAYABLE PER PATIENT FOR THIS HEALTH SERVICE CODE. |

BACK TO CONTENTS

## UPDATED FILES

Updated files reflecting changes are available for download on Friday March 24, 2017. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT) and, explanatory codes (EXPLAIN.DAT).

## HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

http://msi.medavie.bluecross.ca/

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

## 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

In partnership with

NOVA SCOTIA

BACK TO CONTENTS

PHYSICIAN'S BULLETIN
February 16, 2017: Vol. LII, ISSUE 2

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## ELIGIBLE MASTER AGREEMENT PAYMENTS

**Canadian Medical Protective Association ("CMPA") Assistance Payment and Other Eligible Master Agreement Related Payments**

Canadian Medical Protective Association ("CMPA") Assistance Payment and other eligible Master Agreement related payments

The 2015-2019 Physician Master Agreement provides funding for reimbursement of eligible physician fees paid to The Canadian Medical Protective Association. As of September 9, 2016, the Department of Health and Wellness (through MSI) will provide compensation directly to all eligible physicians. This is a new process, as in the past, reimbursement was provided from Doctors Nova Scotia. All physicians registered with MSI will be receiving a package in the mail to coordinate this process.

To ensure receipt of eligible reimbursement, all physicians are required to complete and submit the attached business arrangement form no later than March 17, 2017. This new business arrangement will be used to process your CMPA payments as well as all other contractual incentive payments under the current Master Agreement. This new process, including the submission of required information to MSI, will allow for a transition away from a cheque based payment to an electronic funds transfer in the near future. You will continue to receive any/all eligible incentive based payments by cheque while we transition to electronic funds transfer.

Should you have any questions, please contact the MSI Provider Coordinators at msiproviders@medavie.bluecross.ca or by telephone 902-496-7011 (toll free: 1-866-553-0585).

NOVA SCOTIA MEDICAL SERVICES INSURANCE
P.O. BOX 500 HALIFAX, N.S. B3J 2S1

NOVA SCOTIA

# MSI PROVIDER BUSINESS ARRANGEMENT (BA) FORM

(Please complete and return to MSI)

## PROVIDER INFORMATION

Service Provider Number (If known): _____ **MSI USE ONLY** *LICENSE No: (NEW PHYSICIAN)* _____

Service Provider Name: _____

Incorporated Name (If applicable): _____

Email Address: _____

Service Provider Address: _____

_____

Phone Number: _____ Fax Number: _____

**Please indicate which of the following applies:**

☐ 1. **New / Additional Business Arrangement - Same Bank Account

☐ 2. *New Bank Account / New Business Arrangement

## BANKING INFORMATION

***ONLY BANKING FROM CANADIAN INSTITUTIONS WILL BE ACCEPTED***

***A LINE OF CREDIT ACCOUNT WILL NOT BE ACCEPTED***

Name of Financial Institution: _____

Address: _____

_____

Phone Number: _____

## BANK ACCOUNT INFORMATION

Bank Number: _____ Branch: _____ Account: _____

***PLEASE ENCLOSE A VOID CHEQUE (COPIES ACCEPTED)***

I/We hereby authorize Nova Scotia Medical Services Insurance to make deposits to my/our account at the financial institution described above. I/We will advise MSI of any changes in my/our account information.

**Signature:** _____ **Please Print Name:** _____

# PHYSICIAN'S BULLETIN

January 27, 2017: Vol. LII, ISSUE 1


NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



# MSI News

## WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT UPDATE

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been applied to the listed WCB specific fees for fiscal years 2015-16 and 2016-17.

Due to the increase in CPI for fiscal year April 1st, 2015 - March 31st, 2016 any of the WCB specific services listed below provided over this time will have their values retroactively increased by 1.74%. Physicians will be remunerated for the outstanding value of any services rendered over this period via a onetime payment in Spring 2017.

Also due to the further increase in CPI for fiscal year April 1st, 2016- January 26th, 2017 any of the WCB specific services listed below provided over this time will have their values retroactively increased by a cumulative 2.137% (1.74% for 2015-2016, 0.39% for 2016-2017). Physicians will also be remunerated for the outstanding value of any services rendered over this period via a one-time payment in Spring 2017.

| CODE | DESCRIPTION | VALUE |
|---|---|---|
| WCB12 | EPS physician assessment Service. Combined office visit and completion of Form 8/10<br><br>For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15 minute increments to a maximum of 1 additional hour | **Initial visit:**<br>$174.93 + $51.11 per 15 minutes to a maximum 4x<br>(RO=EPS1 and RP=INTL)<br><br>**Subsequent visit:**<br>$174.93<br>(RO=EPS1 and RP=SUBS) |
| WCB13 | Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable | GPs……..$42.72 per 15 min<br>EPS(RO=EPS1)$51.11 per 15 min<br>Specialists……..$57.49 per 15 min |
| WCB15 | Case Conferencing and Teleconferencing (Treating Physician)<br>Conferencing billed by the Treating Physician - plus multiples, if applicable | GPs……..$42.72 per 15 min<br>EPS(RO=EPS1)$51.11 per 15 min<br>Specialists……..$57.49 per 15 min |
| WCB17 | Photocopies of Chart Notes | 10 pgs or less (ME=UP10)..$25.56<br>11-25 pgs (ME=UP25)……..$51.11<br>26-50 pgs (ME=UP50)….. $102.17<br>Over 50 pgs (ME=OV50)...$153.25 |
| WCB20 | Carpal Tunnel Syndrome (CTS) Assessment Report | $65.56 |
| WCB21 | Follow-up visit report | $38.33 |
| WCB22 | Completed Mandatory Generic Exemption Request Form | $12.80 per form |
| WCB23 | Completed Non-Opioid Special Authorization Request Form | $12.80 per form |
| WCB24 | Completed Opioid Special Authorization Request Form | $42.96 per form |
| WCB25 | Completed WCB Substance Abuse Assessment Form | $28.62 |
| WCB26 | Return to Work Report – Physician's Report Form 8/10 | $65.56 |
| WCB27 | Eye Report | $57.49 |
| WCB28 | Comprehensive Visit for Work Related Injury or Illness | $65.96 |

BACK TO CONTENTS

## NON-RESIDENT PHYSICIAN LICENSE

Physicians licensed in Nova Scotia as "non-resident physicians" are asked to notify the MSI Provider Coordinators (msiproviders@medavie.ca) when they return to ensure all billing arrangement numbers are active. This will avoid delay in processing their billings while working in Nova Scotia. MSI will no longer be notified by the College when a physician holding a non-resident license returns to Nova Scotia to provide medical services through MSI

# Fees New Fees and Highlighted Fees

## FEE CHANGES

Effective January 27, 2017 the following health service code will no longer be active:

| Category | Code | Description | Base Units |
|---|---|---|---|
| VADT | 09.01B | Ophthalmic tests – plus multiples, if applicable | 1 MSU |

# Billing Matters Billing Reminders, New Explanatory Codes

## BILLING REMINDERS

MRI Repeat Sequence

Physicians are reminded that a repeat sequence code cannot be submitted until after the matching base MRI code has been submitted.

Hypnotherapy

Effective April 1, 2017 physicians practicing hypnotherapy must provide proof of current Full Membership in the Canadian Federation of Clinical Hypnosis (CFCH) to bill hypnotherapy. These credentials can be forwarded to MSI_Assessment@medavie.bluecross.ca for review. It has been a longstanding requirement that physicians practicing hypnotherapy require appropriate training equivalent to that provided by the Nova Scotia Society of Clinical Hypnosis. This society no longer exists and membership in the CFCH ensures practitioners are appropriately trained to provide this service.

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| AN005 | CONSECUTIVE ANAESTHETIST CLAIMS CANNOT BE PROCESSED UNTIL AFTER THE FIRST ANAESTHETIST CLAIM HAS BEEN SUBMITTED. AS PER PREAMBLE 5.2.52 |
| BK053 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A REPEAT SEQUENCE CAN ONLY BE CLAIMED AFTER THE MATCHING BASE MULTISECTION MRI FEE IS CLAIMED FOR THE SAME OCCURRENCE. PLEASE CLAIM THE BASE FEE FOR THIS MRI BEFORE SUBMITTING THE REPEAT SEQUENCE CLAIM. |
| GN051 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A SERVICE OCCURRENCE ONE (1) HAS NOT BEEN CLAIMED FOR THIS DAY BY THIS PHYSICIAN. |
| GN087 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 68.95B AT THE SAME ENCOUNTER. |
| MA071 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 01.34A, 68.83A, 68.95C, 68.99A OR 68.99C HAS ALREADY BEEN BILLED AT THE SAME ENCOUNTER. |
| MJ056 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED HEALTH SERVICE CODE 68.95B FOR THIS PATIENT AT THE SAME ENCOUNTER. PLEASE SUBMIT A REASSESS (ACTION CODE R) ALONG WITH THE OR REPORT TO AID IN THE ASSESSMENT OF YOUR CLAIM. |
| MJ057 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED HEALTH SERVICE CODE 68.0A FOR THIS PATIENT AT THE SAME ENCOUNTER. PLEASE SUBMIT A REASSESS (ACTION CODE R) ALONG WITH A COPY OF THE OPERATIVE REPORT TO AID IN THE ASSESSMENT OF YOUR CLAIM |
| PC034 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU DO NOT HAVE APPROVAL TO BILL FOR THIS SERVICE. PLEASE SUBMIT YOUR QUALIFICATIONS TO PROVIDE HYPNOTHERAPY TO MSI. |
| RF006 | SERVICE ENCOUNTER HAS BEEN REFUSED. CLAIMED UNIT VALUE IS NOT PAYABLE RE AGE OF PATIENT, RESUBMIT WITH CORRECT UNIT AMOUNT. |
| VA074 | SERVICE ENCOUNTER HAS BEEN REFUSED AS ONLY ONE FEE FOR EITHER HSC 09.41E, 09.41F OR 09.41G SHOULD BE CLAIMED PER PATIENT PER DAY. |
| VA075 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 09.41D AT THE SAME ENCOUNTER WHICH INCLUDES THIS PROCEDURE. |
| VA076 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 09.41A, 09.41B OR 09.41H HAS ALREADY BEEN BILLED AT THE SAME ENCOUNTER AND IS A COMPONENT OF THIS PROCEDURE. |

BACK TO CONTENTS

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

## UPDATED FILES

Updated files reflecting changes are available for download on Friday January 27, 2017. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT) and, explanatory codes (EXPLAIN.DAT).

## HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

http://msi.medavie.bluecross.ca/

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

## 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

In partnership with

BACK TO CONTENTS

BACK TO CONTENTS

* Please note that the 2017 cut-off dates have been updated.

## 2017 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

| PAPER CLAIMS | ELECTRONIC CLAIMS | PAYMENT DATE | SALARY CONTRACT PAY PERIOD |
|---|---|---|---|
| **December 21, 2016**** | **December 28, 2016**** | January 4, 2017 | December 16-29, 2016 |
| January 9, 2017 | January 12, 2017 | January 18, 2017 | December 30-January 12, 2017 |
| January 23, 2017 | January 26, 2017 | February 1, 2017 | January 13-26, 2017 |
| February 6, 2017 | February 9, 2017 | February 15, 2017 | January 27-February 9, 2017 |
| **February 17, 2017**** | February 23, 2017 | March 1, 2017 | February 10-23, 2017 |
| March 6, 2017 | March 9, 2017 | March 15, 2017 | February 24-March 9, 2017 |
| March 20, 2017 | March 23, 2017 | March 29, 2017 | March 10-23, 2017 |
| April 3, 2017 | April 6, 2017 | April 12, 2017 | March 24-April 6, 2017 |
| April 17, 2017 | April 20, 2017 | April 26, 2017 | April 7-20, 2017 |
| May 1, 2017 | May 4, 2017 | May 10, 2017 | April 21-May 4, 2017 |
| **May 12, 2017**** | **May 17, 2017**** | May 24, 2017 | May 5-18, 2017 |
| May 29, 2017 | June 1, 2017 | June 7, 2017 | May 19-June 1, 2017 |
| June 12, 2017 | June 15, 2017 | June 21, 2017 | June 2-15, 2017 |
| June 26, 2017 | **June 28, 2017**** | July 5, 2017 | June 16-29, 2017 |
| July 10, 2017 | July 13, 2017 | July 19, 2017 | June 30-July 13, 2017 |
| July 24, 2017 | July 27, 2017 | August 2, 2017 | July 14-27, 2017 |
| August 4, 2017 | August 10, 2017 | August 16, 2017 | July 28-August 10, 2017 |
| August 21, 2017 | August 24, 2017 | August 30, 2017 | August 11-24, 2017 |
| **September 1, 2017**** | September 7, 2017 | September 13, 2017 | August 25-September 7, 2017 |
| September 18, 2017 | September 21, 2017 | September 27, 2017 | September 8-21, 2017 |
| **September 29, 2017*** | **October 4, 2017**** | October 11, 2017 | September 22-October 5, 2017 |
| October 16, 2017 | October 19, 2017 | October 25, 2017 | October 6-19, 2017 |
| October 30, 2017 | November 2, 2017 | November 8, 2017 | October 20-November 2, 2017 |
| November 13, 2017 | November 16, 2017 | November 22, 2017 | November 3-16, 2017 |
| November 27, 2017 | November 30, 2017 | December 6, 2017 | November 17-30, 2017 |
| December 11, 2017 | December 14, 2017 | December 20, 2017 | December 1-14, 2017 |
| **December 20, 2017**** | **December 27, 2017**** | January 3, 2018 | December 15-28, 2017 |
| **11:00 AM CUT OFF** | **11:59 PM CUT OFF** | | |

**NOTE:**

Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Sessional Payments and Locum Claim Forms. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut-off date to ensure processing for that payment period.

**PLEASE NOTE, THE ** INDICATES A DATE VARIATION**

## HOLIDAY DATES FOR 2017

| Please make a note in your schedule of the following dates MSI will accept as "Holidays." | |
|---|---|
| NEW YEAR'S DAY | MONDAY, JANUARY 2, 2017 |
| HERITAGE DAY | MONDAY, FEBRUARY 20, 2017 |
| GOOD FRIDAY | FRIDAY, APRIL 14, 2017 |
| EASTER MONDAY | MONDAY, APRIL 17, 2017 |
| VICTORIA DAY | MONDAY, MAY 22, 2017 |
| CANADA DAY | MONDAY, JULY 3, 2017 |
| CIVIC HOLIDAY | MONDAY, AUGUST 7. 2017 |
| LABOUR DAY | MONDAY, SEPTEMBER 4, 2017 |
| THANKSGIVING DAY | MONDAY, OCTOBER 9, 2017 |
| REMEMBRANCE DAY | MONDAY, NOVEMBER 13, 2017 |
| CHRISTMAS DAY | MONDAY, DECEMBER 25, 2017 |
| BOXING DAY | TUESDAY, DECEMBER 26, 2017 |
| NEW YEAR'S DAY | MONDAY, JANUARY 1, 2018 |

BACK TO CONTENTS

BACK TO CONTENTS

PHYSICIAN'S BULLETIN
November 18, 2016: Vol. LI, ISSUE 17

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



# MSI News

## IMPORTANT UPDATE

Canadian Medical Protective Insurance (CMPA) Assistance

Effective January 1, 2017, the Department of Health and Wellness will be responsible for the coordination and processing of all eligible CMPA reimbursement, as per the 2015-2019 Master Agreement.

CMPA premium reimbursement to eligible physicians will be facilitated by MSI, through a bottom line adjustment to the physician's preferred business arrangement in place with MSI. Semi-annual payments will be made based on the following payment schedule:

- June 2017
- December, 2017
- June, 2018
- December, 2018
- June, 2019
- December, 2019

Early in the New Year you will receive a package from MSI requesting completion of a Business Arrangement form and supporting banking documentation. A new business arrangement will be set up by MSI for each physician specifically for the Canadian Medical Protective Insurance (CMPA) Assistance reimbursement.

BACK TO CONTENTS

BACK TO CONTENTS

# NEW FEES

Methadone Management

Effective November 18, 2016 the following 5 new health services codes will be available for reporting methadone management.

***PLEASE NOTE:*** **Physician's wishing to claim these 5 codes must be registered with the College of Physicians and Surgeons of Nova Scotia (CPSNS) as having a current valid Health Canada exemption to prescribe methadone for dependency *AND* must contact CPSNS to give them permission to release their name to MSI**. MSI cannot directly request this information for privacy reasons. Once MSI receives a physician's name from CPSNS the physician will be permitted to claim for these fees after the next system update. **Once the physician has contacted CPSNS to release their name, the physician is advised to hold their claims until the next system update**.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03J | **Initial Opioid Use Disorder Assessment in a community setting for initiation of Methadone Treatment – (30 minutes)**<br><br>This is a time based fee for the complete assessment of the patient entering into opioid agonist treatment (OAT) with methadone for the first time. The required elements of this service are outlined in the College of Physicians and Surgeons of Nova Scotia (CPSNS) Methadone Maintenance Treatment (MMT) Handbook and must be documented in the patient's health record. Required elements include:<br>i. A complete substance use history including illicit, prescription and OTC medications with a risk of abuse and a DSM diagnosis for each problematic drug<br>ii. A complete addiction treatment history;<br>iii. Past medical and surgical history;<br>iv. Family history;<br>v. Psychosocial history, including living situation, source of income and education;<br>vi. Review of systems;<br>vii. A focused physical examination, when indicated;<br>viii. Review of treatment options;<br>ix. Formulation of a treatment plan;<br>x. Communication with the patient and/or family to obtain information for the assessment as well as for support staff working in the treatment environment;<br>xi. Communication with previous care providers, including family doctors, pharmacists, addiction services staff, etc. as necessary.<br>xii. Obtain a patient profile for the previous 12 months through the Nova Scotia Prescription Monitoring Program (NSPMP) and register the patient in the NSPMP Methadone Program Monitoring Service.<br>xiii. Obtain a urine drug screen<br>xiv. The physician should request blood work serology (screening for HIV, and Hepatitis A, B and C) during initiation or within a reasonable amount of time after initiation of OAT (not required if patient is a transfer from another physician or from a specialized treatment program unless blood serology has not previously been completed).<br>xv. Consider obtaining an ECG if indicated.<br><br>Start and stop times are to be documented in the health record.<br><br>It is recognized that the required elements may be gathered over several visits with the patient. This fee is for the initial visit only. Regular visit fees may be billed for subsequent visits.<br><br>**Billing Guidelines**<br>• Billable only by the physician working outside of the Provincial Methadone Treatment Clinic who is most actively supervising/responsible for the patient's use of methadone.<br>• Multiples of 15 minutes may be billed in addition to the base fee code to a maximum of 2<br>• 80% of the time must be spent in face to face contact with the patient and/or family.<br>• If time less than 25 minutes, bill as regular visit.<br>• Once per physician per patient.<br><br>**Specialty restriction**<br>Physicians registered with the CPSNS as having a current valid Health Canada exemption to prescribe methadone for dependency.<br><br>**Location** OFFC | 50 MSU + MU (1 MU/15min = 25 MSU) |

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03K | **Initial Opioid Use Disorder Assessment for Methadone Treatment – Transfer from Methadone Maintenance Treatment Clinic to Community Physician**<br><br>This is a fixed fee for the complete assessment of the patient being transferred from an established Methadone Maintenance Treatment (MMT) Clinic to the care of the physician who will be most responsible for that patient's ongoing OAT with methadone. The required elements of this service are outlined in the College of Physicians and Surgeons of Nova Scotia (CPSNS) MMT Handbook and must be documented in the patient's health record. Required elements include:<br>i. A complete or updated substance use history including illicit, prescription and OTC medications with a risk of abuse and a DSM diagnosis for each problematic drug<br>ii. A complete or updated addiction treatment history;<br>iii. A complete or updated past medical and surgical history;<br>iv. A family history;<br>v. A psychosocial history, including current living situation, source (s) of income and education;<br>vi. Review of systems;<br>vii. A focused physical examination, when indicated;<br>viii. Review of treatment options;<br>ix. Formulation of a treatment plan;<br>x. Communication with the patient and/or family to obtain information for the assessment as well as for support staff working in the treatment environment;<br>xi. Communication with previous care providers, including family doctors, pharmacists, addiction services staff, etc. as necessary.<br>xii. Obtain a patient profile for the previous 12 months through the Nova Scotia Prescription Monitoring Program (NSPMP) and register the patient in the NSPMP Methadone Program Monitoring Service.<br>xiii. Obtain a urine drug screen<br>xiv. The physician should request blood work serology (screening for HIV, and Hepatitis A, B and C) if not done recently by the previous provider.<br>xv. Consider obtaining an ECG if indicated<br><br>It is recognized that the required elements may be gathered over several visits with the patient. This fee is for the initial visit only. Regular visit fees may be billed for subsequent visits.<br><br>**Billing Guidelines**<br>• Billable only by the physician who is most responsible for the patient's ongoing methadone treatment.<br>• Once per physician per patient.<br><br>**Specialty Restriction**<br>Physicians registered with the CPSNS as having a current valid Health Canada exemption to prescribe methadone for dependency.<br><br>**Location** OFFC | 50 MSU |

BACK TO CONTENTS

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03L | **Permanent Transfer of patient on active Methadone Treatment for substance use disorder – Full acceptance of responsibility for ongoing care - Initial Visit with accepting physician**<br><br>This is a fixed fee available to the physician accepting full and ongoing responsibility for OAT with methadone for the patient's substance use disorder from the community physician currently providing care due to a patient's relocation or desire for permanent change in care provider. The required elements of this service are outlined in the College of Physicians and Surgeons of Nova Scotia (CPSNS) MMT Handbook and must be documented in the patient's health record. Required elements include:<br>i. A complete or updated substance use history including illicit, prescription and OTC medications with a risk of abuse and a DSM diagnosis for each problematic drug<br>ii. A complete or updated addiction treatment history;<br>iii. A complete or updated past medical and surgical history;<br>iv. A family history;<br>v. A psychosocial history, including current living situation, source (s) of income and education;<br>vi. Review of systems;<br>vii. A focused physical examination, when indicated;<br>viii. Review of treatment options;<br>ix. Formulation of a treatment plan;<br>x. Communication with the patient and/or family to obtain information for the assessment as well as for support staff working in the treatment environment;<br>xi. Communication with previous care providers, including family doctors, pharmacists, addiction services staff, etc. as necessary.<br>xii. Obtain a patient profile for the previous 12 months through the Nova Scotia Prescription Monitoring Program (NSPMP) and register the patient in the NSPMP Methadone Program Monitoring Service.<br>xiii. Obtain a urine drug screen<br>xiv. The physician should request blood work serology (screening for HIV, and Hepatitis A, B and C) if not done recently by the previous provider.<br>xv. Consider obtaining an ECG if indicated<br><br>It is recognized that the required elements may be gathered over several visits with the patient. This fee is for the initial visit only. Regular visit fees may be billed for subsequent visits.<br><br>**Billing Guidelines**<br>• Billable only by the physician who is assuming responsibility for the patient's ongoing OAT with methadone.<br>• Billable once per physician per patient.<br>• Billable only by the accepting physician.<br><br>**Specialty Restriction**<br>Physicians registered with the CPSNS as having a current valid Health Canada exemption to prescribe methadone for dependency.<br><br>**Location** OFFC | 50 MSU |

BACK TO CONTENTS

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| DEFT | MMM1 | **Methadone Treatment Monthly Management Fee: Intensive**<br>For physicians working in a primary care setting who are managing patients in the induction and stabilization phase of OAT with methadone. These patients will be seen by the physician for a visit at least twice per month (not including visits for urine drug screening alone) for support and dose adjustments. These visits may be billed in addition to the management fee.<br><br>**Description**<br>This fee may be billed once per month by the physician, outside of the Methadone Treatment Clinic, who is most responsible for the care of the patient in the induction and initial stabilization phase of opioid agonist treatment (OAT) with methadone for a substance use disorder as defined by DSM V criteria. The patient will be seen by the physician at least twice per month in their general practice (not including visits for urine drug screening alone). The following items are considered to be included in this service:<br>• All medication reviews and methadone dosage adjustments as required;<br>• Communicating on a regular and timely basis with the pharmacy responsible for administering the patient's opioid agonist (methadone) dose for the provision of safe and effective OAT: managing missed doses, checking on daily presentation at the pharmacy, helping coordinate prescriptions going to multiple pharmacies if there are Sunday or holiday closures or if a patient is travelling;<br>• Coordinating care for the patient's concurrent medical conditions;<br>• Counseling the patient on issues related to their substance use disorder;<br>• Connecting the patient to appropriate community resources;<br>• Providing case management and coordination of care functions, and facilitating connection with other addiction care providers;<br>• Arranging random point of care (POC) urine drug screening (UDS) as required by the College of Physicians and Surgeons of Nova Scotia Methadone Maintenance Treatment guidelines appropriate for the patient's phase of treatment; To include generation of random UDS encounters, collection of urine, interpretation of results, documentation of process of randomization and results of the screen in the health care record, and provision of feedback to the patient based on the results.<br>• A visit may not be claimed if the sole purpose of the patient's office encounter is to provide a urine sample.<br><br>**Billing Guidelines**<br>• Only one claim per patient per month. Maximum six per patient per year.<br>• Regular visit fees may be billed in addition to the monthly fee.<br>• Billable only by the physician working outside of the Provincial Methadone Treatment Clinic who is most actively supervising/responsible for the patient's use of methadone.<br>• If there is no evidence to support randomization of the point of care urine drug screen then the fee will not be paid.<br>• Payment stops when the patient stops methadone or moves to the maintenance phase of treatment.<br><br>**Specialty restriction**<br>Physicians registered with the CPSNS as having a current valid Health Canada exemption to prescribe methadone for dependency.<br><br>**Location** OFFC | 125 MSU |

BACK TO CONTENTS

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| DEFT | MMM2 | **Methadone Treatment Monthly Management Fee: Maintenance**<br>For physicians working in a primary care setting who are managing patients in the maintenance phase of OAT with methadone. These patients will be seen by the physician for a visit at least once per month (not including visits for urine drug screening alone) for support and dose adjustments. These visits may be billed in addition to the management fee.<br><br>**Description**<br>This fee may be billed once per month by the physician, outside of the Methadone Treatment Clinic, who is most responsible for the care of the patient in the maintenance phase of opioid agonist treatment (OAT) with methadone for a substance use disorder as defined by DSM V criteria. The patient will be seen by the physician at least once per month in their general practice (not including visits for urine drug screening alone). The following items are considered to be included in this service:<br>• All medication reviews and methadone dosage adjustments as required;<br>• Communicating on a regular and timely basis with the pharmacy responsible for administering the patient's opioid agonist (methadone) dose for the provision of safe and effective OAT: managing missed doses, checking on daily presentation at the pharmacy, helping coordinate prescriptions going to multiple pharmacies if there are Sunday or holiday closures or if a patient is travelling;<br>• Coordinating care for the patient's concurrent medical conditions;<br>• Counseling the patient on issues related to their substance use disorder;<br>• Connecting the patient to appropriate community resources;<br>• Providing case management and coordination of care functions, and facilitating connection with other addiction care providers;<br>• Arranging random point of care (POC) urine drug screening (UDS) as required by the College of Physicians and Surgeons of Nova Scotia Methadone Maintenance Treatment guidelines appropriate for the patient's phase of treatment; To include generation of random UDS encounters, collection of urine, interpretation of results, documentation of process of randomization and results of the screen in the health care record, and provision of feedback to the patient based on the results.<br>• A visit may not be claimed if the sole purpose of the patient's office encounter is to provide a urine sample.<br><br>**Billing Guidelines**<br>• Only one claim per patient per month.<br>• May bill for visits in addition to the monthly fee.<br>• Billable only by the physician working outside of the Provincial Methadone Treatment Clinic who is most actively supervising/responsible for the patient's use of methadone.<br>• If there is no evidence to support randomization of the POC UDS then the fee will not be paid.<br>• Payment stops when the patient stops methadone.<br><br>**Specialty restriction**<br>Physicians registered with the CPSNS as having a current valid Health Canada exemption to prescribe methadone for dependency.<br><br>**Location** OFFC | 68 MSU |

BACK TO CONTENTS

BACK TO CONTENTS

BACK TO CONTENTS

# BILLING REMINDERS

Echocardiograms Reminder

When submitting claims for echocardiograms, physicians may claim either I1312 (Doppler – quantitative) or I1313 (Doppler – qualitative), but not both. A quantitative study includes the elements of a qualitative study.

Premiums for Radiology Services Reminder

MSI has had a number of inquiries from radiologists concerning the use of premium fees (i.e. services claimed with the modifiers US=PREM and US=PR50). As per Preamble section 5.1.82, premium fees may be claimed for certain services provided on an emergency basis during designated time periods. An emergency basis is defined as services that must be performed without delay because of the medical condition of the patient.

Premium fees may be claimed for eligible diagnostic imaging services when the patient's condition requires that the imaging service be done without delay during a designated time period and the interpretation by the radiologist and the formal report are completed during the same designated time period.

Services of a non-emergency nature provided during premium hours do not qualify for premium rates.
It is not appropriate for radiologists to claim services using premium modifiers in the following circumstances:

- during times the radiologist or resident he/she is supervising is scheduled to be onsite in the radiology department
- for non-emergent studies

Additionally, radiologists are reminded that they may only claim for the services provided by a resident if they, as the attending, are onsite. A physician may claim either for the resident's procedure or for his or her own services, but not both, when they are performed at the same time. (Preamble (5.2.9))

At the time of implementation of premium fees for radiology in 2002, radiologists were advised that they must maintain a log of bulk billed services that were submitted with premium codes. Although services are no longer bulk billed, all physicians claiming premium fees are required to be able to provide documentation that verifies Preamble requirements for these services have been met.

Services Related to Research Studies Reminder

Physicians are reminded that costs of medical services that are primarily related to research or experimentation are not the responsibility of the patient or MSI. (*Preamble 2.2.25*).

Audiometry Reminder

09.41E - Impedance audiometry including tympanometry, static compliance, multiple frequency acoustic reflex and/or reflex decay testing including interpretation
09.41F - Impedance audiometry interpretation only of tympanogram, impedance/compliance and stapedial reflex tests
09.41G - Impedance audiometry including tympanometry, static compliance, single frequency acoustic reflex and/or reflex decay testing including interpretation

HSC 09.41E or G should only be claimed when the physician personally performs and interprets the test. HSC 09.41F should only be claimed when the physician personally interprets either of the tests (09.41E or G). Only one of these HSCs may be claimed per patient per day.

BACK TO CONTENTS

BACK TO CONTENTS

Medical Assistance in Dying (MAID) Fee Summary

The following new interim visit Health service codes were introduced in September 2016 to reimburse physicians for MAID services provided:

03.03M - Medical assistance in dying – First physician

This fee is to reimburse the first physician for time spent providing MAID services outlined in the CPSNS Professional Standard Regarding Medical Assistance in Dying. It includes, but not limited to, the time spent engaging the patient in a discussion of their diagnosis, prognosis, and treatment options, discussing the availability of palliative care for terminally ill patients, assessment of patient for MAID criteria, and arrangement for a second physician to assess the patient.

03.03O - Medical assistance in dying – Second physician

This fee is to reimburse the second physician for time spent providing MAID services outlined in the CPSNS Professional Standard Regarding Medical Assistance in Dying. It includes, but not limited to, the time spent conducting the subsequent assessment of the patient for MAID criteria.

03.03N - Medical assistance in dying – Prescribing physician

This fee is to reimburse the prescribing physician for time spent providing MAID services outlined in the CPSNS Professional Standard Regarding Medical Assistance in Dying. It includes, but not limited to, procuring the medication and administration at the patient's request.

More detail on the services required for medical assistance in dying can be found on the CPSNS website at http://www.cpsns.ns.ca/Standards-Guidelines/Medical-Assistance-in-Dying

Each code pays at 30 MSU for the first 30 minutes and 15 MSU per 15 minutes thereafter to a maximum of 2 hours.

The MAID fees are currently interim while billing information is gathered. They are also categorized as independent consideration (IC) and have no automatic MSU value in the system. Each claim submitted is held by MSI and manually adjudicated based on the information provided by the submitter in the claim text.

Billing Guidelines:

Physicians must document in the patient's medical record all steps described in the CPSNS Professional Standard Regarding Medical Assistance in Dying. The physician must also record the start and stop times for the face to face component of the service and the start and stop times for the non-face to face components in the patient's medical record. Both of these times must be submitted in the text field on the electronic claim made to MSI for proper claim assessment.

Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family if required, and administration process where applicable. The total duration of all components may be claimed. Physicians may not claim for services provided by non-medical personnel such as nurses and nurse practitioners nor for the services of medical trainees such as residents.

If the first or second physician is a specialist and the patient has been formally referred the physician may bill the appropriate specialist prolonged consult fee with the same time documentation requirements as noted above. MAID must be noted in text on the MSI claim form. If the prescribing or administering physician is a specialist the 03.03N code noted above will apply.

Physicians are permitted to claim the MAID fees across multiple encounters and should submit a separate claim for each day the service was provided. Each daily service must meet the minimum 30 minute requirement; shorter encounters should be claimed as a normal visit. Beyond the first 30 minutes, payment for each claim will be rounded down to the nearest 15 minute increment. The maximum of two hours per MAID code per patient applies to each encounter.

Long Term Care Fees Reminder

As per the Homes for Special Care Regulations "Every resident of a nursing home or a home for the aged shall be personally seen by a qualified medical practitioner at least once every six months and the medical practitioner shall examine the medical records of the resident and determine on each occasion whether the resident requires a physical examination."

Physicians are reminded that they may report CGA1, which includes at least one visit with the patient, twice per fiscal year following the billing guidelines listed in Preamble section 5.1.168. Physicians may also report additional visits when required by medical necessity (or necessity for follow up of an ongoing medical problem) and there has been a request from the patient, their family or nursing home staff for the visit.

BACK TO CONTENTS

# NEW AND REVISED EXPLANATORY CODES

| Code | Description |
|---|---|
| DE024 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE HAS ALREADY BEEN APPROVED FOR THIS MONTH. |
| DE025 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR MMM2 (MAINTENANCE) HAS ALREADY BEEN BILLED FOR THIS PATIENT. |
| DE026 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MMM1 FEE HAS ALREADY BEEN CLAIMED THE MAXIMUM OF SIX TIMES FOR THIS PATIENT DURING THIS CALENDAR YEAR. |
| DE027 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR MMM2 HAS ALREADY BEEN BILLED FOR THIS PATIENT DURING THIS MONTH. |
| DE028 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR MMM1 HAS ALREADY BEEN BILLED FOR THIS PATIENT DURING THIS MONTH. |
| GN082 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU ARE NOT CURRENTLY PERMITTED TO BILL THIS SERVICE. PLEASE CONTACT CPSNS TO REGISTER. REFER TO NOVEMBER 2016 PHYSICIANS BULLETIN. |
| VT134 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE INITIAL OPIOID USE DISORDER ASSESSMENT HAS BEEN PREVIOUSLY PAID |
| VT135 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE INITIAL OPIOID USE DISORDER ASSESSMENT FOR METHADONE TREATMENT - TRANSFER FROM CLINIC TO PHYSICIAN HAS BEEN PAID |
| VT136 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PERMANENT TRANSFER OF PATIENT ON ACTIVE METHADONE TREATMENT FOR SUBSTANCE USE DISORDER - INITIAL VISIT WITH ACCEPTING PHYSICIAN HAS BEEN PREVIOUSLY PAID |
| BK058 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED FOR A QUANTITATIVE OR QUALITATIVE DOPPLER INTERPRETATION ON THE SAME DAY. PLEASE RESUBMIT THIS CLAIM WITH ELECTRONIC TEXT EXPLAINING THE NECESSITY OF THE 2ND INTERPRETATION. |
| PR014 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A MAXIMUM FOR THIS CODE HAS ALREADY BEEN REACHED. |
| GN083 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THE DOCUMENTATION DOES NOT INCLUDE A DESCRIPTION OF THE CLAIMED PROCEDURE. |
| GN084 | SERVICE ENCOUNTER HAS BEEN DISALLOWED BECAUSE THE PROCEDURE IS A NECESSARY PART OF ANOTHER PAID SERVICE ENCOUNTER. |
| GN085 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS ASSISTANT FEES CANNOT BE CLAIMED IN THESE CIRCUMSTANCES. |
| GN086 | FOR ATTENDANCE ON THE PATIENT FOR THE PURPOSE OF PRONOUNCEMENT OF DEATH, A LIMITED VISIT ONLY MAY BE CLAIMED, PER PREAMBLE 5.3.223. |
| VT137 | IT IS NOT APPROPRIATE TO BILL MSI FOR A MEET AND GREET VISIT WITH A NEW PATIENT UNLESS A HEALTH RELATED CONCERN/COMPLAINT HAS BEEN ADDRESSED AT THE VISIT. |
| AD066 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A COLONOSCOPY ADD ON FEE MAY ONLY BE CLAIMED AFTER A COLONOSCOPY IS BILLED FOR THE SAME OCCURRENCE |
| OP041 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE DIAGNOSTIC CODE BILLED IS NOT VALID FOR THIS SERVICE |
| MJ055 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS MSI REQUIRES THE START AND END TIMES OF THIS PROCEDURE TO ASSESS. PLEASE RESUBMIT THIS CLAIM WITH THE START AND END TIMES IN THE TEXT FIELD |
| VA073 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR DIALYSIS HAS ALREADY BEEN BILLED FOR THIS PATIENT ON THIS DAY |
| PP023 | YOUR CLAIM FOR DENTAL SERVICES HAS BEEN FORWARDED TO GREEN SHIELD FOR REVIEW. |

BACK TO CONTENTS

BACK TO CONTENTS

## UPDATED FILES

Updated files reflecting changes are available for download on Friday November 18, 2016. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT) and, explanatory codes (EXPLAIN.DAT).

## HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

http://msi.medavie.bluecross.ca/

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

## 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

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BACK TO CONTENTS

# 2017 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

| PAPER CLAIMS | ELECTRONIC CLAIMS | PAYMENT DATE | SALARY CONTRACT PAY PERIOD |
|---|---|---|---|
| **December 21, 2016**** | **December 28, 2016**** | January 4, 2017 | December 16-29, 2016 |
| January 9, 2017 | January 12, 2017 | January 18, 2017 | December 30-January 12, 2017 |
| January 23, 2017 | January 26, 2017 | February 1, 2017 | January 13-26, 2017 |
| February 6, 2017 | February 9, 2017 | February 15, 2017 | January 27-February 9, 2017 |
| **February 17, 2017**** | February 23, 2017 | March 1, 2017 | February 10-23, 2017 |
| March 6, 2017 | March 9, 2017 | March 15, 2017 | February 24-March 9, 2017 |
| March 20, 2017 | March 23, 2017 | March 29, 2017 | March 10-23, 2017 |
| April 3, 2017 | April 6, 2017 | April 12, 2017 | March 24-April 6, 2017 |
| April 17, 2017 | April 20, 2017 | April 26, 2017 | April 7-20, 2017 |
| May 1, 2017 | May 4, 2017 | May 10, 2017 | April 21-May 4, 2017 |
| **May 12, 2017**** | **May 17, 2017**** | May 24, 2017 | May 5-18, 2017 |
| May 29, 2017 | June 1, 2017 | June 7, 2017 | May 19-June 1, 2017 |
| June 12, 2017 | June 15, 2017 | June 21, 2017 | June 2-15, 2017 |
| June 26, 2017 | **June 28, 2017**** | July 5, 2017 | June 16-29, 2017 |
| July 10, 2017 | July 13, 2017 | July 19, 2017 | June 30-July 13, 2017 |
| July 24, 2017 | July 27, 2017 | August 2, 2017 | July 14-27, 2017 |
| August 4, 2017 | August 10, 2017 | August 16, 2017 | July 28-August 10, 2017 |
| August 21, 2017 | August 24, 2017 | August 30, 2017 | August 11-24, 2017 |
| **September 1, 2017**** | September 7, 2017 | September 13, 2017 | August 25-September 7, 2017 |
| September 18, 2017 | September 21, 2017 | September 27, 2017 | September 8-21, 2017 |
| **September 29, 2017*** | **October 4, 2017**** | October 11, 2017 | September 22-October 5, 2017 |
| October 16, 2017 | October 19, 2017 | October 25, 2017 | October 6-19, 2017 |
| October 30, 2017 | November 2, 2017 | November 8, 2017 | October 20-November 2, 2017 |
| November 13, 2017 | November 16, 2017 | November 22, 2017 | November 3-16, 2017 |
| November 27, 2017 | November 30, 2017 | December 6, 2017 | November 17-30, 2017 |
| December 11, 2017 | December 14, 2017 | December 20, 2017 | December 1-14, 2017 |
| **December 20, 2017**** | **December 27, 2017**** | January 3, 2018 | December 15-28, 2017 |
| **11:00 AM CUT OFF** | **11:59 PM CUT OFF** | | |

**NOTE:**

Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Sessional Payments and Locum Claim Forms. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut-off date to ensure processing for that payment period.

**PLEASE NOTE, THE ** INDICATES A DATE VARIATION**

## HOLIDAY DATES FOR 2017

| Please make a note in your schedule of the following dates MSI will accept as "Holidays." | |
|---|---|
| NEW YEAR'S DAY | MONDAY, JANUARY 2, 2017 |
| HERITAGE DAY | MONDAY, FEBRUARY 20, 2017 |
| GOOD FRIDAY | FRIDAY, APRIL 14, 2017 |
| EASTER MONDAY | MONDAY, APRIL 17, 2017 |
| VICTORIA DAY | MONDAY, MAY 22, 2017 |
| CANADA DAY | MONDAY, JULY 3, 2017 |
| CIVIC HOLIDAY | MONDAY, AUGUST 7. 2017 |
| LABOUR DAY | MONDAY, SEPTEMBER 4, 2017 |
| THANKSGIVING DAY | MONDAY, OCTOBER 9, 2017 |
| REMEMBRANCE DAY | MONDAY, NOVEMBER 13, 2017 |
| CHRISTMAS DAY | MONDAY, DECEMBER 25, 2017 |
| BOXING DAY | TUESDAY, DECEMBER 26, 2017 |
| NEW YEAR'S DAY | MONDAY, JANUARY 1, 2018 |

BACK TO CONTENTS

BACK TO CONTENTS

PHYSICIAN'S BULLETIN
November 10, 2016: Vol. LI, ISSUE 16

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# Notice to Physicians

## PHYSICIAN STATMENTS

MSI is aware that some statement files from the November 9th, 2016 payment are not accessible via elink.

We are working to make these statements available.

In the interim, if you require your payment totals please contact us at (902) 496-7342 or email the assessment department at MSI_Assessment@medavie.bluecross.ca with a contact name, the business arrangement number, group name, provider id, and a phone or fax number we may contact with the requested information.

We apologize for any inconvenience this may cause and thank you for your patience.

PHYSICIAN'S BULLETIN
September 23, 2016: Vol. LI, ISSUE 16

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



# MSI News

## UNIT VALUES AND PAYMENT RATES

### MEDICAL SERVICE UNIT/ANAESTHESIA UNIT VALUE

Effective April 1, 2016, the Medical Service Unit (MSU) value will remain at $2.42 and the Anaesthesia Unit (AU) value will remain $20.55.

### WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC

Effective April 1, 2016 the Workers' Compensation Board MSU value will remain $2.69 and the Workers' Compensation Board Anaesthetic Unit value will remain $22.83.

### SESSIONAL PAYMENTS

Effective April 1, 2016 the Sessional payment rates for General Practitioners will remain at 60 MSUs and the rate for Specialists will remain at 70 MSUs.

### PSYCHIATRY FEES

Effective April 1, 2016 the hourly Psychiatry rate for General Practitioners will remain $110.55 and the hourly rate for Specialists will remain $146.96 as per the tariff agreement.

BACK TO CONTENTS

BACK TO CONTENTS

## FEE REVISIONS

Effective September 23, 2016 the following health services codes are no longer active.

| Category | Code | Description | Base Units |
|---|---|---|---|
| MAAS | 67.02A | **Percutaneous nephrostomy and stent insertion** | IC |
| MAAS | 67.02B | **Percutaneous nephrostomy and ureteric dilatation** | IC |

## INTERIM FEES

Effective September 22, 2016 the following interim health service codes are available for billing.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03M | **Medical assistance in dying – First physician**<br><br>This fee is to reimburse the first physician for time spent providing MAID services outlined in the CPSNS Professional Standard Regarding Medical Assistance in Dying. It includes, but not limited to, the time spent engaging the patient in a discussion of their diagnosis, prognosis, and treatment options, discussing the availability of palliative care for terminally ill patients, assessment of patient for MAID criteria, and arrangement for a second physician to assess the patient.<br><br>**Billing Guidelines**<br><br>Start and stop times must be recorded in the patient's medical record for the face to face component of the service and on the MSI claim. Similarly start and stop times for the non-face to face components must be documented in the patient's medical record and on the MSI claim. Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family if required. Total duration of all components may be claimed. If the physician is a specialist and the patient has been formally referred the physician may bill the appropriate specialist prolonged consult fee with the same time documentation requirements as noted above. MAID must be noted in text on the MSI claim. | IC<br><br>(30 MSU for first ½ hour, 15 MSU for each additional 15 minutes up to a maximum of 2 hours) |

BACK TO CONTENTS

| | | | |
|---|---|---|---|
| VIST | 03.03N | **Medical assistance in dying – Prescribing physician**<br><br>This fee is to reimburse the prescribing physician for time spent providing MAID services outlined in the CPSNS Professional Standard Regarding Medical Assistance in Dying. It includes, but not limited to, procuring the medication and administration at the patient's request. This physician must be either the first physician or the second physician.<br><br>**Billing Guidelines**<br><br>Start and stop times must be recorded in the patient's medical record for the face to face component of the service and on the MSI claim. Similarly start and stop times for the non-face to face components must be documented in the patient's medical record and on the MSI claim. Non face to face components include all documentation required by the pharmacist and the administration process. Total duration of all components may be claimed. | IC<br><br>(30 MSU for first ½ hour, 15 MSU for each additional 15 minutes up to a maximum of 2 hours) |
| VIST | 03.03O | **Medical assistance in dying – Second physician**<br><br>This fee is to reimburse the second physician for time spent providing MAID services outlined in the CPSNS Professional Standard Regarding Medical Assistance in Dying. It includes, but not limited to, the time spent conducting the subsequent assessment of the patient for MAID criteria.<br><br>**Billing Guidelines**<br><br>Start and stop times must be recorded in the patient's medical record for the face to face component of the service and on the MSI claim. Similarly start and stop times for the non-face to face components must be documented in the patient's medical record and on the MSI claim. Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family if required. Total duration of all components may be claimed. | IC<br><br>(30 MSU for first ½ hour, 15 MSU for each additional 15 minutes up to a maximum of 2 hours) |

BACK TO CONTENTS

# Billing Matters Billing Reminders, New Explanatory Codes

## BILLING REMINDERS

**Reminder – Immunizations Administered by Pharmacists**

Over the past few years, MSI Audit has identified numerous instances in which a physician has claimed for an immunization administered by a pharmacist. With the upcoming launch of this year's influenza immunization program, physicians are again reminded that they may not claim for these immunizations.

**Reminder – Phototherapy Services for Dermatologic Conditions**

A visit may only be claimed at the time a patient attends for phototherapy for a dermatologic condition if Preamble requirements for a visit are met. This means that the physician must personally render the visit (Preamble section 1.4) and document history and physical findings in the clinical record (Preamble section 7.)

BACK TO CONTENTS

## BILLING REMINDERS CONTINUED

**Reminder – Release of Tongue Tie in Newborn**

Physicians are reminded that release of newborn tongue tie has been an uninsured service since 1997. Therefore, physicians may not claim visit or procedural HSCs related to this.

**Reminder – Colonoscopy Add On Fees**

Health service code 01.22B - polypectomy is an add on code for the removal of colonic polyps, and should only be claimed with a colonoscopy fee. It should not be claimed for the removal of polyps found during other endoscopic procedures such as a gastroscopy. Likewise, health service codes 01.22A - colonoscopy with one/more biopsies, and 01.22F - Balloon dilation of colonic stricture, are also add on fees specific to a colonoscopy.

## UPDATE

**Remote Practice on Call - Funding Update**

As per the new Master Agreement, effective September 9, 2016 the Remote Practice on call stipend has been reduced from $28,217 to $20,000 pro-rated annually for the remainder of the 2016/17 fiscal year. For all physicians receiving remote practice on call funding, you will see the change reflected on the September 28, 2016 payment date.

## NEW EXPLANATORY CODES

| Code | Description |
|---|---|
| GN081 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE HOSPITAL ADMIT DATE IS BEFORE THE DATE OF BIRTH |

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

### UPDATED FILES

Updated files reflecting changes are available for download on Friday Sept 23, 2016. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT), explanatory codes (EXPLAIN.DAT), and modifier values (MODVALS.DAT).

### HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

http://msi.medavie.bluecross.ca/

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

### CONTACT INFORMATION

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

Phone: 902-496-7011
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Fax: 902-490-2275
Email: MSI_Assessment@medavie.bluecross.ca

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

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

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PHYSICIAN'S BULLETIN
July 28, 2016: Vol. LI, ISSUE 14

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



# MSI News

## PHYSICIAN REGISTRATION PROCESS FOR THE INTERIM FEDERAL HEALTH PROGRAM

The Interim Federal Health Program (IFHP) provides limited, temporary coverage of health-care benefits to people in the following groups who are not eligible for provincial or territorial health insurance:

- protected persons, including resettled refugees;
- refugee claimants; and
- certain other groups.

**Basic coverage** (similar to health-care coverage provided by provincial/territorial health insurance plans)

- in-patient and out-patient hospital services
- services provided by medical doctors, registered nurses and other health-care professionals licensed in Canada, including pre- and post-natal care
- laboratory, diagnostic and ambulance services

**Physicians interested in registering to direct bill for services through this program must register with Medavie Blue Cross to provide services and products to Interim Federal Health Program (IFHP) beneficiaries.** To access the provider registration form, please visit: https://provider.medavie.bluecross.ca/.

There is an information handbook for health care professionals available on the Government of Canada website. Please visit: http://www.cic.gc.ca/english/refugees/outside/arriving-healthcare/practitioners.asp for more information.

BACK TO CONTENTS

BACK TO CONTENTS

## FEE REVISIONS

Effective July 28, 2016 the billing guidelines associated with the following health service code have been updated to include R1213 and R1264.

| Category | Code | Modifiers | Description | Base Units |
|---|---|---|---|---|
| ADON | 02.89C | | **Ultrasound performed by radiologist during premium time**<br><br>This add-on fee is to be used when an ultrasound must be performed directly by the radiologist due to the absence of an ultrasound technologist, and when it must be done without delay due to the medical condition of the patient during designated times where premium fees may be claimed (Preamble 5.1.84). Each ultrasound must be performed directly by the radiologist (not the resident or fellow) and must include archived diagnostic ultrasound images, a written permanent report, and a verbal report when requested.<br><br>**Billing Guidelines**<br>Add on to the following HSC's only when US=PREM, or US=PR50:<br>R1205 Ultrasound Abdomen General 25.39<br>R1212 Ultrasound Appendix 18.75<br>R1220 Ultrasound Pelvis 18.75<br>R1225 Endovaginal 26.95<br>R1226 Endovaginal with pelvic 38.70<br>R1275 Ultrasound Scrotum 25.45<br>R1345 Doppler – extremities 18.75<br>**R1213 Ultrasound Kidneys 18.75**<br>**R1264 Cerebral 33.49 (IWK Only)**<br>Not to be billed when the scan is performed by the radiology resident or fellow.<br><br>**Specialty Restriction**<br>DIRD, RADI<br><br>**Location**<br>HOSP | 30 MSU |

Effective April 1, 2016 the surgical assist modifier has been added to the following health service code.

| Category | Code | Modifiers | Description | Base Units |
|---|---|---|---|---|
| MAAS | 98.11 | **RO=SRAS** | **Debridement of wound or infected tissue** | IC |

BACK TO CONTENTS

## FEE REVISIONS CONTINUED

BACK TO CONTENTS

Effective April 1, 2016 premium modifiers US=PREM and US=PR50 have been added to the following health service code.

| Category | Code | Modifiers | Description | Base Units |
|---|---|---|---|---|
| BULK | R1264 | US=PREM<br>US=PR50 | **Cerebral Ultrasound**<br><br>In specific clinical circumstances at the IWK Health Centre a cerebral ultrasound and interpretation may be required without delay due to the medical condition of the patient, such as an emergency procedure for neonates with suspected intracranial haemorrhage. In these cases it would be appropriate for the radiologist to claim premium time on the interpretation.<br><br>**Billing Guidelines**<br>Premiums on R1264 may only be claimed from the IWK<br><br>**Specialty Restriction**<br>DIRD, RADI<br><br>**Location**<br>HOSP | 33.49 MSU |

## INTERIM BILLING PROCESS

**Medical Assistance in Dying (MAID)**

Physicians providing MAID are now able to bill MSI for providing this service. New health service codes are being created for this purpose. In the interim, physicians may bill EC for the following:

**First physician:**
EC - 30 MSU for the first 30 mins and 15 MSU per 15 mins thereafter to a maximum of 2 hours.
Start and stop times must be recorded in the patient's medical record for the face to face component of the service and on the MSI claim form. Start and stop times for the non-face to face components must also be documented in the patient's medical record and on the MSI claim form. Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family if required. Total duration of all face-to-face and non-face-to face components of the patient's care may be claimed. Physicians may not claim for services provided by non-medical personnel such as nurses and nurse practitioners nor for the services of medical trainees such as residents.

**Second Physician:**
EC - 30 MSU for the first 30 mins and 15 MSU per 15 mins thereafter to a maximum of 2 hours.
Start and stop times must be recorded in the patient's medical record for the face to face component of the service and on the MSI claim form. Start and stop times for the non-face to face components must also be documented in the patient's medical record and on the MSI claim form. Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family if required. Total duration of all face-to-face and non-face-to face components of the patient's care may be claimed. Physicians may not claim for services provided by non-medical personnel such as nurses, nurse practitioners and pharmacists nor for the services of medical trainees such as residents.

BACK TO CONTENTS

## INTERIM BILLING PROCESS CONTINUED

**Prescribing or Administering Physician:**
This physician must be either the first physician or the second physician.
EC - 30 MSU for the first 30 mins and 15 MSU per 15 mins thereafter to a maximum of 2 hours.
Start and stop times must be recorded in the patient's medical record for the face to face component of the service and on the MSI claim form. Start and stop times for the non-face to face components must also be documented in the patient's medical record and on the MSI claim form. Non face to face components include all documentation required by the pharmacist and the administration process. Total duration of all face-to-face and non-face-to face components of the patient's care may be claimed. Physicians may not claim for services provided by non-medical personnel such as nurses, nurse practitioners and pharmacists nor for the services of medical trainees such as residents.

If the first or second physician is a specialist and the patient has been formally referred the physician may bill the appropriate specialist prolonged consult fee with the same time documentation requirements as noted above.

If the prescribing or administering physician is a specialist the same EC code noted above will apply.

MAID must be noted in text on the MSI claim form.

## PROVINCIAL IMMUNIZATION CORRECTION

Please disregard the fee revision notification of RO=ADPO, which was included in the May 19, 2016 Physician's Bulletin. This modifier has been replaced by RO=TDPP.

# Billing Matters Billing Reminders, New Explanatory Codes

## BILLING REMINDERS

**Reminder – Pathology Consultations**

MSI has received a number of queries from pathologists concerning how to claim for review of material submitted by another institution for a second opinion.

Effective April 1, 2016 MSI implemented two interim health service codes for anatomical pathology consultations. These were communicated in the March, 2016 Bulletin and are as follows:

| Category | Code | Description | Base Units |
|---|---|---|---|
| CONS | 03.09I | **Anatomic Pathology Consultation**<br>**Diagnostic Consultation, with review of records and specimens, with report on referred material prepared elsewhere.**<br><br>This is a comprehensive, diagnostic consultation on materials prepared in a separate licensed pathology laboratory. The service includes: a review of the consultation documents submitted by the referring physician, including clinical reports and laboratory data, discussion with the referring pathologist, as appropriate, literature review, and generation of the report to the referring physician.<br><br>**Billing Guidelines**<br>May not be billed with any other diagnostic tests on the same case.<br><br>**Specialty Restriction**<br>PATH<br><br>**Location**<br>HOSP | 45 MSU |

| Category | Code | Description | Base Units |
|---|---|---|---|
| CONS | 03.09J | **Anatomic Pathology Consultation**<br>**Special Diagnostic Consultation, with review of records and specimens, with report on referred material and requiring preparation of additional slides, and/or ordering and interpretation of special tests.**<br><br>This is a comprehensive, special diagnostic consultation on materials prepared in a separate licensed pathology laboratory that require the ordering and interpretation of additional slides and routine staining (e.g. H&E), and/or the ordering and interpretation of special diagnostic tests such as electron microscopy, immunohistochemistry, and molecular tests. The service includes: a review of the consultation documents submitted by the referring physician, including clinical reports and laboratory data, discussion with the referring pathologist, as appropriate, ordering and interpretation of additional slides and routine staining (e.g. H&E), literature review, and generation of the report to the referring physician. The following special tests maybe reported in addition to the consultation: electron microscopy, immunohistochemistry, and molecular tests.<br><br>**Billing Guidelines**<br>The interpretation of the following special tests:<br>• Electron Microscopy<br>• Immunohistochemistry<br>• Molecular Tests<br>May be billed in addition to the consultation, as required, using the same service date as the consultation.<br><br>**Specialty Restriction**<br>PATH<br><br>**Location**<br>HOSP | 60 MSU |

BACK TO CONTENTS

These HSCs are for use when a pathologist has been asked to review material sent by an outside institution or when a second opinion is medically necessary from a pathologist who has additional training/expertise in the area of concern. They may not be claimed for quality assurance activities. When claiming these HSCs the date of service on the claim should reflect the date the pathologist has rendered the opinion.

## Reminder – Botox Guidelines

MSI insures the injection of Botox by physicians for the following clinical indications only:

- focal spasticity related to stroke, multiple sclerosis, spinal cord or traumatic brain injury
- laryngeal dystonia
- equinus foot deformity in cerebral palsy patients 2 years of age and older
- cervical dystonia
- blepharospasm, hemifacial spasm (VII nerve disorder) or strabismus in patients 12 years of age and older
- achalasia
- urinary incontinence due to neurogenic detrusor overactivity resulting from neurogenic bladder associated with multiple sclerosis (MS) or subcervical spinal cord injury (SCI) in patients who have failed to respond to behavioural modification and anticholinergics and/or are intolerant to anticholinergics
- idiopathic overactive bladder unresponsive to behaviour modification, medications and peripheral nerve stimulation

## Reminder - Storage and Maintenance of Clinical Records

As per Preamble section 1.1.40, physicians are required to 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.

BACK TO CONTENTS

BACK TO CONTENTS

**Reminder – Psychotherapy and Counselling Services**

Physicians are reminded that the following services require a minimum of two time intervals/three multiples be claimed (i.e. a minimum of 30 minutes):

HSC 08.19A Child Psychiatric Assessment
HSC 08.43A Behavioural Management
HSC 08.49B Psychotherapy
HSC 08.44 Group Psychotherapy
HSC 08.45 Family Therapy
HSC 08.41 Hypnotherapy
HSC 08.5B Psychiatric Care by a Psychiatrist

HSC 08.5A Clinical Psychiatry by a Psychiatrist requires a minimum of four time intervals/five multiples (i.e. 60 minutes) be claimed.

As always, start and finish times must be recorded on the patient record and additionally in the text field in the claim. Physicians must spend at least 80% of the time claimed in direct intervention with the patient(s).

**Reminder – Comprehensive Visits**

Physicians are reminded that health service codes exist for both comprehensive and limited visit services. Health service code 03.04 is an un-referred comprehensive visit and health service code 03.03 is an un-referred limited visit.

The referred equivalents are health service codes 03.08 (comprehensive consultation) and 03.07 (limited consultation).

Comprehensive visits may be claimed when necessitated by the seriousness, complexity or obscurity of the patient's complaint(s) or medical condition and ensuring a complete history is recorded and a physical examination appropriate to the physician's specialty and working diagnosis are documented. This is outlined in Preamble sections 5.1.7 and 5.1.8.

Documentation of all of the following provide a clear indication that a comprehensive visit or comprehensive consultation has taken place:

A detailed patient history including:

- Relevant history of presenting complaint
- Relevant past medical and surgical history
- Medication list
- Allergies
- Family history, as appropriate
- Social history, as appropriate

As well as a physical exam including:

- A complete physical examination, appropriate to the physician’s specialty and relevant to the presenting complaint.
- Documentation describing the pertinent positive and negative findings of the physical examination. It is not adequate to indicate that the “physical exam is normal” without indicating what was examined.

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

BACK TO CONTENTS

## BILLING REMINDERS CONTINUED

BACK TO CONTENTS

**Reminder – Telemedicine Fees**

Physicians are reminded that the modifier ME=TELE is to be used to indicate telemedicine consultation when using the provincial telehealth network. It cannot be used when providing services utilizing other platforms, such as Skype, email or telephone.

**Reminder – The "Meet and Greet"**

Physicians are reminded that Preamble rules stipulate that all services billed to MSI must be medically necessary i.e. there must be a specific health related concern/complaint that has led the patient to seek medical attention. It is not appropriate to bill MSI for a "meet and greet" visit with a new patient unless a health related concern/complaint has been addressed at the visit. Similarly, it is not appropriate to bill a comprehensive visit or counselling for such encounters unless the visit is medically necessary and Preamble requirements for these codes have been satisfied.

**Reminder – HLA Typing and HLA Identification/Crossmatch**

HLA typing (04.49A) is a service provided for a patient awaiting a transplant, HLA identification/crossmatch is conducted on the potential donor. A patient should not receive both of these services on the same day as an individual cannot be both a donor and a recipient at the same time.

## NOTICE

**Payment Statement Recreation**

During the period of December 23, 2015 – April 13, 2016 it was identified that reversed claims were not represented on the pay statements accessed via your software vendor.
Upon request, MSI will begin regenerating statements for the following payment dates:

December 23, 2015
January 6, 2016
January 20, 2016
February 3, 2016
February 17, 2016
April 13, 2016

**Please note, if you have already made a request for a corrected statement, you do not need to send in your request a second time.** We have all requests on file and will begin the process of sending these statements out effective immediately. We appreciate your patience during this time while we work through the back log.

For any physicians who have not yet made a request for a regenerated statement, you can do so by sending a fax to MSI at 902-490-2275. Please send the fax on letter head and include the provider number, business arrangement, contact number and payment date for which you require the statement regenerated.

BACK TO CONTENTS

## NEW EXPLANATORY CODES

| Code | Description |
|---|---|
| VE017 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 04.49B HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY. |
| VE018 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 04.49A HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY. |
| BK057 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE CANNOT BE BILLED FROM THIS FACILITY. |
| GN080 | MSI RESULT |

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

### UPDATED FILES

Updated files reflecting changes are available for download on Thursday, July 28, 2016. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT), explanatory codes (EXPLAIN.DAT).

### HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

http://msi.medavie.bluecross.ca/

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

### CONTACT INFORMATION

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

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Toll-Free: 1-800-387-6665 (in Nova Scotia)
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# PHYSICIAN'S BULLETIN

May 19, 2016: Vol. LI, ISSUE 13


NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## MSI News

### NEW PHYSICIAN WEBSITE LOCATION

The platform that the MSI Physician's Website is housed on has been upgraded to more current technology. In doing so, we have updated the URL. The Website can now be found at http://msi.medavie.bluecross.ca/

The former URL (www.medavie.bluecross.ca/msiprograms) remains active and will redirect to the current site. For efficiency, it would be advisable to update any saved bookmarks and favourites.

BACK TO CONTENTS

BACK TO CONTENTS

## FEE REVISIONS

Effective May 20, 2016 the following health service codes have been revised to allow for 5 multiples to be claimed.

| Category | Code | Description | Value |
|---|---|---|---|
| DEFT | WCB22 | Completed Mandatory Generic Exemption Request Form | $12.50 |
| DEFT | WCB23 | Completed Non-Opioid Special Authorization Request Form | $12.50 |
| DEFT | WCB24 | Completed Opioid Special Authorization Request Form | $42.00 |

## PROVINCIAL IMMUNIZATION CHANGES

Effective May 19, 2016 the following new immunization is available for billing:

| HSC | Modifier | Description | Base Units |
|---|---|---|---|
| 13.59L | RO=IPVV | IPV-Inactivated Polio Vaccine<br><br>Billing Guidelines<br>May only be claimed once per lifetime. If the patient was previously incompletely immunized, the physician may bill EC with explanatory text. | 6 MSU |

Effective May 19, 2016 the following billing guidelines will be implemented:

| HSC | Modifier | Description |
|---|---|---|
| 13.59L | RO=MMAR | MMR - Measles, Mumps, Rubella Vaccine<br><br>Billing Guidelines<br>This vaccine cannot be billed if the first and second doses are not given at least 4 weeks apart, if patient was born on January 1, 1970 or later. If the 2nd injection is given within this 4 week period, the claim will be refused. |
| 13.59L | RO=TDAP | Tdap - Tetanus, Toxoid, Diphtheria, Acellular Pertussis Vaccine<br><br>Billing Guidelines<br>This vaccine cannot be claimed if the same immunization was previously billed while the patient was 18 years of age or older. |
| 13.59L | RO=TEDV | Td - Tetanus Toxoid, Diphtheria Vaccine<br><br>Billing Guidelines<br>This vaccine cannot be claimed if the same immunization was previously given to the patient within the previous 10 years unless the new claim also has the high risk modifier (PT=RISK). If the claim has the high risk modifier it will require explanatory text and will be manually assessed. |

BACK TO CONTENTS

## FEE REVISIONS CONTINUED

Effective May 19, 2016 the following billing guideline has been modified:

| HSC | Modifier | Description |
|---|---|---|
| 13.59L | RO=ADPO | Adacel-Polio (Tdap-IPV)<br><br>Billing Guideline<br>The previous restriction, if patient has already had the injection for diptheria, pertussis, tetanus and poliomyelitis (RO=QUAD) has been removed. |

# Billing Matters Billing Reminders, New Explanatory Codes

## BILLING REMINDERS

**Reminder - Claims for Pathology Interpretation of Surgical Specimens (Gross and Microscopic)**

When more than one surgical specimen is received from a patient, the following rules apply:

- P2325 may be claimed for each specimen taken from anatomically distinct surgical sites.
- P2345 may be claimed when three or more separate surgical specimens are taken from the same anatomic site.
- P2346 may be claimed when a single large complex cancer specimen, which includes lymph nodes, is examined for the purposes of providing a pathologic cancer staging.

For the purposes of correctly interpreting anatomic pathology fee code P2325 and P2345, the body is considered to be divided into the following distinct anatomical areas:

- head and neck
- upper limbs
- lower limbs
- trunk anterior and posterior

The following organ systems are also considered to be distinct surgical sites:

- upper GI tract
- lower GI tract
- female reproductive system
- male reproductive system
- separate organs within the abdominal or thoracic cavities may be claimed as distinct sites

For example:

P2325

- two colonic polyps from the transverse and descending colon are to be claimed as HSC P2325 (no multiples) as both come from the lower GI tract
- examination of tissue from the colon (two specimens) and liver (two specimens) are claimed as P2325 with two multiples as the colon and liver are anatomically distinct sites.

P2345

- three colonic polyps from the ascending, transverse and descending colons are to be claimed using HSC P2345 (no multiples)
- examination of tissue from four cervical biopsy sites and a single endocervical curettage sample should be claimed as HSC P2345 (no multiples) as all specimens are from the female reproductive system

P2325 + P2345

- examination of tissue from the colon (three specimens) and liver (two specimens) are to be claimed as P2345 (for the three colonic specimens) and P2325 (for the two liver specimens)

P2346

- a single complex gynaecologic cancer specimen which includes lymph nodes is to be claimed as HSC P2346 and not as multiples or second service occurrences using HSCs P2325 and/or P2345

BACK TO CONTENTS

**Reminder - Sleep Studies**

Health Service Codes exist in Nova Scotia for Level 1, Level 2 and Level 3 Sleep Studies. When claiming these studies, the following requirements apply:

HSC 03.19C - Sleep Studies (Level 1)

HSC 03.19C is for a Level 1 study (overnight polysomnography) a full sleep study in a hospital sleep laboratory with a sleep technologist in attendance.
At a minimum all of the following must be recorded:

- 2-3 leads of electroencephalogram
- 2 leads of electrooculogram
- submental EMG
- ECG
- airflow nose and mouth by thermistor or nasal pressure cannulae
- respiratory effort
- oxygen saturation
- snoring
- anterior tibialis electromyogram
- body position

Physicians must have formal fellowship level training and be credentialed to interpret Level 1 sleep studies by the Nova Scotia Health Authority in order to claim this health service code.

HSC 03.19F - Level 2 Sleep Apnea Testing

At a minimum all of the following parameters must be measured:

- electrooculogram
- heart rate
- air flow
- respiratory effort
- oxygen saturation
- anterior tibialis EMG
- body position

Physicians must have completed fellowship level training including interpretation of sleep studies

HSC 03.19G - Level 3 Sleep Apnea Testing

All of the following parameters must be measured:

- heart rate
- air flow
- respiratory effort
- oxygen saturation
- body position

BACK TO CONTENTS

Physicians must have completed fellowship level training including interpretation of sleep studies.

Physicians claiming these services are asked to review their billing practices to confirm that they are selecting the appropriate health service code.

## NEW EXPLANATORY CODES

| Code | Description |
|---|---|
| AD060 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE SECOND DOSE OF THE MEASLES, MUMPS, AND RUBELLA VACCINE CANNOT BE ADMINISTERED WITHIN 28 DAYS OF THE FIRST DOSE. |
| AD061 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE TETANUS TOXOID, DIPHTHERIA, AND ACELLULAR PERTUSSIS IMMUNIZATION HAS PREVIOUSLY BEEN CLAIMED FOR THIS PATIENT WHILE OVER 18 YEARS OF AGE. |
| AD062 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF IPVV INJECTIONS HAS BEEN REACHED. |
| AD063 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A TETANUS TOXOID, DIPTHERIA INJECTION HAS ALREADY BEEN APPROVED IN THE PREVIOUS 10 YEARS. |
| MA019 | SERVICE ENCOUNTER HAS BEEN REFUSED. WHEN A BLEPHAROPLASTY IS PERFORMED FOR A DIAGNOSIS OF BLEPAROCHALASIS OR DERMATOCHALASIS, CODE 22.5C SHOULD BE USED, NOT A LID PTOSIS CODE. PRIOR TO SUBMITTING 22.5C, PLEASE CONTACT THE ASSESSMENT DEPT FOR A PA NUMBER. |
| WBPPC | PHYSICIAN COMPLIANCE. FEES ADJUSTED OR REVERSED DUE TO NON-COMPLIANCE OF THE DOCS NS CONTRACT. |

## In every issue Helpful links, contact information, updated files

### UPDATED FILES

Updated files reflecting changes are available for download on Thursday, May 19, 2016. The files to download are health service (SERVICES.DAT), explanatory codes (EXPLAIN.DAT) and modifier values (MODVALS.DAT).

### HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

http://msi.medavie.bluecross.ca/

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

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### CONTACT INFORMATION

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# PHYSICIAN'S BULLETIN

March 24, 2016: Vol. LI, ISSUE 12

NOVA SCOTIA MEDICAL SERVICES INSURANCE


## CONTENTS



## ★ Fees New Fees and Fee Revisions

### NEW INTERIM FEES

Effective April 1, 2016 the following interim health service codes will be available for billing.

| Category | Code | Description | Base Units |
|---|---|---|---|
| CONS | 03.09I | **Anatomic Pathology Consultation**<br>**Diagnostic Consultation, with review of records and specimens, with report on referred material prepared elsewhere.**<br><br>This is a comprehensive, diagnostic consultation on materials prepared in a separate licensed pathology laboratory. The service includes: a review of the consultation documents submitted by the referring physician, including clinical reports and laboratory data, discussion with the referring pathologist, as appropriate, literature review, and generation of the report to the referring physician.<br><br>**Billing Guidelines**<br>May not be billed with any other diagnostic tests on the same case.<br><br>**Specialty Restriction**<br>PATH<br><br>**Location**<br>HOSP | 45 MSU |

BACK TO CONTENTS

## NEW INTERIM FEES CONTINUED

Effective April 1, 2016 the following interim health service codes will be available for billing.

| Category | Code | Description | Base Units |
|---|---|---|---|
| CONS | 03.09J | **Anatomic Pathology Consultation**<br>**Special Diagnostic Consultation, with review of records and specimens, with report on referred material and requiring preparation of additional slides, and/or ordering and interpretation of special tests.**<br><br>This is a comprehensive, special diagnostic consultation on materials prepared in a separate licensed pathology laboratory that require the ordering and interpretation of additional slides and routine staining (e.g. H&E), and/or the ordering and interpretation of special diagnostic tests such as electron microscopy, immunohistochemistry, and molecular tests. The service includes: a review of the consultation documents submitted by the referring physician, including clinical reports and laboratory data, discussion with the referring pathologist, as appropriate, ordering and interpretation of additional slides and routine staining (e.g. H&E), literature review, and generation of the report to the referring physician. The following special tests maybe reported in addition to the consultation: electron microscopy, immunohistochemistry, and molecular tests.<br><br>**Billing Guidelines**<br>The interpretation of the following special tests:<br>• Electron Microscopy<br>• Immunohistochemistry<br>• Molecular Tests<br>May be billed in addition to the consultation, as required, using the same service date as the consultation.<br><br>**Specialty Restriction**<br>PATH<br><br>**Location**<br>HOSP | 60 MSU |
| VEDT | 05.99A | **Immunofluorescence, interpretation of any and all markers required for diagnosis; any method.**<br><br>This code is used to reflect the physician's work in reviewing slides stained with a fluorescent dye under a fluorescent microscope, recording the results, photographing the results, downloading the images, re-reviewing the images when performing the final review of the case, recording the results in the final report, and integrating the results when making a final diagnosis.<br><br>**Billing Guidelines**<br>Once per case. Case is defined as "all specimens gathered at one clinical encounter."<br><br>**Specialty Restriction**<br>Anatomical Pathology<br><br>**Location**<br>HOSP | 30 MSU |

BACK TO CONTENTS

BACK TO CONTENTS

## NEW INTERIM FEES CONTINUED

Effective April 1, 2016 the following interim health service codes will be available for billing.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VEDT | 05.99B | **Molecular testing, interpretation of any and all analyses/tests required for diagnosis; any method.**<br><br>This code is used to reflect the physician's work in selecting the appropriate tissue block and test (s) to be performed, interpretation of the results/analyses, and generating the report.<br><br>**Billing Guidelines**<br>Once per case no matter how many analyses or tests are performed. Case is defined as "all specimens gathered at one clinical encounter."<br><br>**Specialty Restriction**<br>Anatomical Pathology<br><br>**Location**<br>HOSP | 40 MSU |

## FEE REVISIONS

Effective March 24, 2016 the following health service code will be paid according to Independent Consideration (IC).

| Category | Code | Description | Base Units | Anaes Units |
|---|---|---|---|---|
| MASG | 65.59D | **Total Abdominal Wall Reconstruction with myofascial advancement flaps**<br><br>This is a comprehensive fee for the repair of a massive, complex abdominal wall hernia. The procedure includes the reduction of the hernia, all lysis of adhesions, and bowel resection as required, removal of pre-existing mesh as required, rectus muscle mobilization, fascial bipartition with component separation, with or without placement of mesh or biologic graft, and skin excision. Operative report and record of operation must be submitted with billing claim.<br><br>**Billing Guidelines**<br>Not to be billed with lysis of adhesions, bowel resection or any other intra-abdominal procedure same patient same day. Payment calculated based on "skin to skin" operating time as documented in the record of operation.<br><br>**Please note** that as per the July 2014 bulletin, the operative report and record of operation must be submitted with the billing claim.<br><br>**Specialty Restriction**<br>GNSG, PLAS<br><br>**Location**<br>HOSP | IC at 130 MSU per hour | 8+T |

BACK TO CONTENTS

## BILLING REMINDERS

HSC 26.52 – Iridotomy

The fee for iridotomy (HSC 26.52) should only be used when treating glaucoma. It is not appropriate to bill iridotomy when the procedure is solely used as a means of access for another procedure.

As per section 5.3.71 of the Preamble

"When one physician performs a definitive procedure on an organ or within a body cavity, only that service should be claimed. The procedure used to provide surgical exposure should not be claimed."

## EXPLANATORY CODES

| Code | Description |
|---|---|
| BK056 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THIS ECHOCARDIOGRAPH SERVICE HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY. PLEASE RESUBMIT WITH ELECTRONIC TEXT EXPLAINING THE REASON FOR THE SUBSEQUENT SERVICE. |
| ED106 | PAYMENT RESPONSIBILITY IS INCORRECT FOR THE HEALTH CARD NUMBER PROVIDED |
| MA070 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED ANOTHER SURGERY ON THIS EYE DURING THE SAME ENCOUNTER. THE FEE FOR IRIDOTOMY SHOULD ONLY BE USED WHEN IT IS A STAND ALONE PROCEDURE. |
| VE016 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PATIENT REQUIRES ONE PREVIOUSLY BILLED CATARACT SURGERY IN THE PAST YEAR TO CLAIM FOR THE THIRD EXAMINATION IN A YEAR, OR TWO CATARACT SURGERIES FOR THE FOURTH EXAMINATION. |

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### UPDATED FILES

Updated files reflecting changes are available for download on Thursday, March 24, 2016. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT), explanatory codes (EXPLAIN.DAT).

### HELPFUL LINKS

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BACK TO CONTENTS

PHYSICIAN'S BULLETIN
January 29, 2016: Vol. LI, ISSUE 11

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



# MSI News

## MSI DOCUMENTATION REMINDER

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribed, and start and stop times for time based codes.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptions, or emotional problems, the physician "deliberately established a professional relationship with the patient for the purposes of removing, modifying or alleviating existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional well being of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy," etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service on that date, then the service is not paid for or a lesser benefit is given. **When the clinical record does not support the service claimed, there will be a recovery to MSI at the time of audit.** Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

## INTERIM FEES - REVISED

The effective date of the following interim health services codes have been extended to March 1, 2015. These codes were originally introduced in the October 2015 bulletin with an effective date of April 1, 2015.

*Note: Physicians holding eligible services must submit their claims from the month of March 2015 within 90 days of the date of this bulletin. Please ensure previously paid claims for these services are deleted prior to resubmitting a new claim. Please contact MSI directly for detailed instructions on how to submit these outdated eligible services.*

*Revised March 31, 2020 – See May 2020 Bulletin for updated information*

| Category | Code | Description | Base Units |
|---|---|---|---|
| VEDT | 03.38B | **Exercise Induced Asthma Assessment, interpretation. Includes interpretation of all serial spirometry, flow/volume loops, bronchodilation responsiveness, and oximetry required to assess the patient.**<br><br>This code is used to report the interpretation of all spirometry, flow/volume loops, oximetry, and bronchodilation responsiveness, as required, to properly assess the response of the patient to exercise.<br><br>**Billing Guidelines**<br>Only for interpretation of tests performed in a hospital pulmonary function laboratory (Preamble 5.3.190).<br>Do not report with:<br>• I1110 Simple spirometry<br>• I1140 Flow /volume loops<br>• 03.38C Interpretation of spirometry Pre and Post Bronchodilator<br><br>**Specialty Restriction**<br>RSMD, INMD<br><br>**Location**<br>HOSP | 20 MSU |

BACK TO CONTENTS

## INTERIM FEES - REVISED CONTINUED

*Revised March 31, 2020 – See May 2020 Bulletin for updated information*

| Category | Code | Description | Base Units |
|---|---|---|---|
| VEDT | 03.38C | **Interpretation of spirometry Pre and Post Bronchodilator**<br><br>This code is used to report the interpretation of spirometry before and after the administration of a bronchodilator. This includes all testing required to properly assess the response of the patient<br><br>**Billing Guidelines**<br>Only for interpretation of tests performed in a hospital pulmonary function laboratory (Preamble 5.3.190).<br>Do not report with:<br>• I1110 Simple spirometry<br>• I1140 Flow /volume loops<br>• 03.38B Exercise testing for assessment of asthma.<br><br>**Specialty Restriction**<br>RSMD, INMD<br><br>**Location**<br>HOSP | 10 MSU |
| VEDT | 03.38D | **Six Minute Walk Test, interpretation, when this is the sole procedure.**<br><br>For the interpretation of the results of the six minute walk test when this is the only pulmonary function test performed for that patient that day. Results must include: the distance walked, pulse oximetry readings, heart rate, and subjective exertion.<br><br>**Billing Guidelines**<br>Only for interpretation of tests performed in a hospital pulmonary function laboratory (Preamble 5.3.190).<br>Do not report with:<br>• Any other pulmonary function tests same patient same day.<br><br>**Specialty Restriction**<br>RSMD, INMD<br><br>**Location**<br>HOSP | 2 MSU |

## FEE REVISIONS

Please visit the Bulk Billing Transition section of the MSI website for updates to the Radiology Rules Communication document.

BACK TO CONTENTS

## BILLING REMINDERS

WCB Physician Report Form 8/10s

The Workers' Compensation Board continues to monitor the submission of Physician Report Form 8/10s for quality, completeness and legibility and for inappropriate submission of reports in Long Term Benefits cases. The WCB will reverse the report portion of the fee ($64.16) if the contract conditions are not met. The WCB 28 (visit) will continue be paid in these instances.

HSC 13.53A and 13.53C Insertion and Removal of Intradermal Progestin Contraceptive Device

Physicians are reminded that these HSCs are for the insertion or removal of intradermal progestin contraceptive devices only. They may not be used for insertion or removal of intrauterine progestin contraceptive devices.

MRI Interpretation-Repeat Sequence

The claim for a MRI interpretation repeat sequence fee should only be made after the matching base spin echo or inversion recovery MRI interpretation has been claimed and accepted at the same occurrence. All interpretation requests generated from the same encounter should be claimed using the same service occurrence number.

## NEW EXPLANATORY CODES

| Code | Description |
|---|---|
| BK052 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED THIS MRI INTERPRETATION SERVICE FOR THE SAME PATIENT ON THE SAME DAY. |
| BK053 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A REPEAT SEQUENCE CAN ONLY BE CLAIMED AFTER THE MATCHING BASE MULTISECTION MRI FEE IS CLAIMED FOR THE SAME OCCURRENCE. PLEASE CLAIM THE BASE FEE FOR THIS MRI BEFORE SUBMITTING A RE-ADJUDICATE FOR THIS CLAIM. |
| BK054 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED THIS SERVICE FOR THE SAME PATIENT ON THE SAME DAY. |
| BK055 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A FEE FOR GATING MAY ONLY BE CLAIMED AFTER A MRI THORAX WITH MULTIPLE SEQUENCES HAS BEEN CLAIMED DURING THE SAME ENCOUNTER. |
| MJ054 | HSC 46.41 DECORTICATION OF LUNG MAY NOT BE BILLED WITH ANY OTHER MAJOR SURGERY. |
| WB004 | WCB HAS ADJUSTED THIS CLAIM BASED ON AN AUDIT OF THE FORM 8/10 FOR LEGIBILITY, COMPLETENESS OR QUALITY AS PER CONTRACT CONDITIONS. THE VISIT FEE ONLY (WCB28) WILL BE PAID ON THIS CLAIM. |
| WB024 | WCB HAS ADJUSTED THIS CLAIM TO THE APPROPRIATE VISIT FEE AS THE CLIENT IS ON LONG TERM BENEFITS AND FORM 8/10 IS ONLY NECESSARY WHEN THERE IS A CHANGE IN CONDITION OR TREATMENT AS PER CONTRACT CONDITIONS. |
| MA069 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PATIENT IS OVER 6 MONTHS OLD. |
| VA072 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THERE IS ALREADY A CLAIM AT THE SAME ENCOUNTER FOR A PROCEDURE THAT INCLUDES INTRAVENOUS INSERTION. |
| GN079 | SERVICE ENCOUNTER HAS BEEN DISALLOWED. IV INSERTION IS CONSIDERED A PART OF THIS PROCEDURE AND IT HAS ALREADY BEEN CLAIMED AT THE SAME SERVICE ENCOUNTER. |
| VT133 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC WCB28 FOR THIS PATIENT ON THE SAME DAY. |

BACK TO CONTENTS

# In every issue Helpful links, contact information, updated files

## UPDATED FILES

Updated files reflecting changes are available for download on Friday, January 29, 2016. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT), explanatory codes (EXPLAIN.DAT).

## HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

www.medavie.bluecross.ca\msiprograms

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

## 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

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BACK TO CONTENTS

PHYSICIAN'S BULLETIN
November 25, 2015: Vol. LI, ISSUE 10

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# Notice to Physicians

## MSI TECHNOLOGY TRANSITION AND IMPORTANT CHANGE TO CUT-OFF TIME

Medavie Blue Cross, as the administrator of the MSI Program is in the process of transitioning to a new corporate claims system.

As part of the roll-out of this new system MSI will require sufficient time to process claims on the old system prior to switching over to the new claims system.

In order to eliminate risk during this process we will require the cut-off time to be 11:29pm on December 3, 2015 instead of the usual time of 11:59pm.

Should you have any enquiries you can contact MSI:

Local Phone: 902-496-7011
Toll-Free Phone: 1-866-553-0585
Email: MSI_Assessment@medavie.ca
Available 8:00am to 5:00pm Monday to Friday (excluding holidays)

PHYSICIAN'S BULLETIN
October 23, 2015: Vol. LI, ISSUE 9

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



# MSI News

## NEW MSI CLAIMS PROCESSING AND PAYMENT SYSTEM

In the coming months, MSI will be transitioning to a new claims processing system. While physicians will not see a change in the way their claims are processed once the transition is complete in early December, there are a number of items related to submission of claims that we would like to make physicians and billing clerks aware of.

1. In order to maintain the claims history of Nova Scotia residents in the MSI database, it is important that an individuals' claims history be stable over a period of time during the transition. This means that between November 20 and December 3, 2015 physicians will be required to hold all deletions and readjudications of claims. New claims will be able to be processed in the usual manner; only deletions and readjudications will be impacted.
2. During the transition dates above, there will be a delay in sending adjudication responses. When the transition to the new claims system is complete at midnight on December 3, the system will be fully functional and deletions and readjudications will be able to be processed. However, adjudication responses will not be available from December 4th – 6th. **As the November 20th date approaches, we ask that all physician offices and billing clerks work to review any outstanding claims requiring deletion and/or re-adjudication to minimize the impact during the technology transition.**
3. The Preamble to the MSI Physician's Manual stipulates that claims must be submitted within 90 days of the date of service. Effective December 3, 2015, this 90-day rule will be enforced for **both fee for service and shadow-billed services** with the following exceptions only:
    - Reciprocal billing claims (out of province) must be submitted within 12 months of the date of service.
    - Resubmission of refused claims or incorrect billings must be resubmitted to MSI within 185 days of the date of service. Each resubmission must contain an annotation in the text field of the Service Encounter submission referencing the previous Service Encounter Number.

**Physicians who shadow bill and have outstanding claims that have not yet been submitted are asked to work with their billing clerk to ensure compliance with the 90 day limit.** Effective December 3, all claims outside this window will be adjudicated as "pay at zero" and returned to the provider. Shadow claims that are submitted more than 90 days from the date of service will fall under the purview of the Outdated Claims Policy which states:

Outdated claims will only be considered by MSI if extenuating circumstances can be demonstrated for a late submission and are within a reasonable time frame past the 90 day limit. Requests for an extension must be made to MSI in writing and will be approved on a case by case basis. The time frame for submitting the request to MSI for late submission should be within one month following the 90 day limit.

## MSI News continued

Claims for registered hospital in-patients must also be submitted within the 90-day time limit whether the patient has been discharged or continues as an in-patient.

MSI is committed to a smooth transition with minimal impact on physicians during our technology transition. Should you have any questions or concerns we may be reached as follows between 8 a.m. and 5 p.m. Monday through Friday.

Local Phone: 902-496-7011
Toll-Free Phone: 1-866-553-0585
Email: MSI_Assessment@medavie.ca

## Fees New Fees and Highlighted Fees

### INTERIM FEES

*Note: Physicians holding eligible services must submit their claims from April 1, 2015 onward within 90 days of the date of this bulletin. Please ensure previously paid claims for these services are deleted prior to resubmitting a new claim. Please contact MSI directly for detailed instructions on how to submit these outdated eligible services.*

Effective April 1, 2015 the following interim health service codes are available for billing.
*Revised March 31, 2020 – See May 2020 Bulletin for updated information*

| Category | Code | Description | Base Units |
|---|---|---|---|
| VEDT | 03.38B | **Exercise Induced Asthma Assessment, interpretation. Includes interpretation of all serial spirometry, flow/volume loops, bronchodilation responsiveness, and oximetry required to assess the patient.**<br><br>This code is used to report the interpretation of all spirometry, oximetry, and bronchodilation responsiveness, as required, to properly assess the response of the patient to exercise.<br><br>**Billing Guidelines**<br>Only for interpretation of tests performed in a hospital pulmonary function laboratory (Preamble 5.3.190).<br>Do not report with:<br>• I1110 Simple spirometry<br>• I1140 Flow /volume loops<br>• 03.38C Interpretation of Spirometry Pre and Post Bronchodilator<br><br>**Specialty Restriction**<br>RSMD, INMD<br><br>**Location**<br>HOSP | 20 MSU |

BACK TO CONTENTS

*Revised March 31, 2020 – See May 2020 Bulletin for updated information*

| Category | Code | Description | Base Units |
|---|---|---|---|
| VEDT | 03.38C | **Interpretation of Spirometry Pre and Post Bronchodilator**<br><br>This code is used to report the interpretation of spirometry, before and after the administration of a bronchodilator. This includes all testing required to properly assess the response of the patient<br><br>**Billing Guidelines**<br>Only for interpretation of tests performed in a hospital pulmonary function laboratory (Preamble 5.3.190).<br>Do not report with:<br>• I1110 Simple spirometry<br>• I1140 Flow /volume loops<br>• 03.38B Exercise testing for assessment of asthma.<br><br>**Specialty Restriction**<br>RSMD, INMD<br><br>**Location**<br>HOSP | 10 MSU |
| VEDT | 03.38D | **Six Minute Walk Test, interpretation, when this is the sole procedure.**<br><br>For the interpretation of the results of the six minute walk test when this is the only pulmonary function test performed for that patient that day. Results must include: the distance walked, pulse oximetry readings, heart rate, and subjective exertion.<br><br>**Billing Guidelines**<br>Only for interpretation of tests performed in a hospital pulmonary function laboratory (Preamble 5.3.190).<br>Do not report with:<br>• Any other pulmonary function tests same patient same day.<br><br>**Specialty Restriction**<br>RSMD, INMD<br><br>**Location**<br>HOSP | 2 MSU |

BACK TO CONTENTS

## FEE REVISIONS

Effective April 1, 2015 the following health service code has been revised to allow for two multiples to be claimed.

*Radiologists looking to claim two tomographies on prior submitted encounters are asked to submit a delete for the previously paid single multiple service before resubmitting a new claim with a multiple of two. Physicians must submit their claims from April 1, 2015 onward within 90 days of the date of this bulletin. Please contact MSI directly for detailed instructions on how to submit these outdated eligible claims.*

| Category | Code | Group | Description | Base Units |
|---|---|---|---|---|
| BULK | R1950 | Nuc. Med. | **Tomography (add on)** | 12.50 MSU |

Effective October 22, 2015 the following health services code is no longer active.

| Category | Code | Description | Base Units |
|---|---|---|---|
| DEFT | WCB10 | **WCB completion of Form 10 in conjunction with an expedited non-emergency Orthopaedic Major Surgical Procedure** | IC |

# Billing Matters Billing Reminders, New Explanatory Codes

## BILLING REMINDERS

Claims for HSC R403 – Fluoroscopy

As per Preamble section 5.3.149, this health service code may only be used when the radiologist is not claiming another procedure. For example, it may be used when a radiologist personally provides fluoroscopy support for another physician who is doing a procedure such as a hysterosalpingogram, bronchoscopy or ERCP. It cannot be claimed when the radiologist has claimed another procedure such as insertion of a PICC line, abscess drainage or gastrostomy tube insertion either as part of the same service encounter or a subsequent service encounter.

## ADDITIONAL BILLING INFORMATION

Optic Nerve Imaging HSC 02.02B Diagnostic Codes

Please see the current list of acceptable diagnostic codes that may be used when claiming Optic Nerve Imaging (02.02B):

36252 - Exudative Senile Macular Degeneration
36201 - Background Diabetic Retinopathy
36235 - Central Retinal Vein Occlusion
36236 - Venous Tributary Occlusion
37927 - Vitreomacular Adhesion
3659 - Unspecified Glaucoma

BACK TO CONTENTS

## NEW EXPLANATORY CODES

| Code | Description |
|---|---|
| AN004 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE FIRST ANAE START TIME SPECIFIED ON THIS CLAIM DOES NOT MATCH THE TIME PROVIDED ON THE PREVIOUSLY SUBMITTED CLAIM FOR THE FIRST ANAESTHESIOLOGIST SERVICE. |
| BK050 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.38B OR 03.38C HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY |
| CR020 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A CLAIM FOR DIRECTIVE CARE OR CONTINUING CARE HAS ALREADY BEEN APPROVED FOR THIS PATIENT ON THE SAME DAY. |
| GN076 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE ALREADY BILLED A VISIT AT THE SAME ENCOUNTER. PLEASE SUBMIT A DELETE FOR THE VISIT BEFORE RESUBMITTING FOR THE CGA1. |
| GN077 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE ALREADY CLAIMED A SERVICE THAT INCLUDES SUTURING AT THE SAME ENCOUNTER. |
| GN078 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PROVIDER NUMBER IS NOT VALID FOR THIS SERVICE. |
| MN015 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU PREVIOUSLY BILLED AT THE SAME ENCOUNTER A SERVICE WHERE SUTURING OF THE SKIN IS INCLUDED IN THE PROCEDURE. |
| VE013 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A PHYSICIAN HAS PREVIOUSLY BILLED ANOTHER PULMONARY FUNCTION TEST FOR THIS PATIENT ON THE SAME DAY. |
| VE014 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A PHYSICIAN HAS PREVIOUSLY BILLED FOR STAND ALONE FEE 03.38D FOR THIS PATIENT ON THE SAME DAY. |
| VE015 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU CANNOT BILL 03.38B AND 03.38C ON THE SAME DAY |
| VT132 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A CLAIM FOR CRITICAL CARE HAS ALREADY BEEN APPROVED FOR THIS PATIENT ON THE SAME DAY. |
| WB035 | SERVICE ENCOUINTER HAS BEEN REFUSED AS A CLAIM FOR WCB17 HAS ALREADY BEEN APPROVED FOR THIS DATE. |

BACK TO CONTENTS

# In every issue Helpful links, contact information, updated files

## UPDATED FILES

Updated files reflecting changes are available for download on Friday, October 23, 2015. The files to download are health service (SERVICES.DAT), health service description (SERVDSC.DAT), explanatory codes (EXPLAIN.DAT).

## HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

www.medavie.bluecross.ca\msiprograms

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

## CONTACT INFORMATION

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

Phone: 902-496-7011
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**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

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Toll-Free: 1-800-387-6665 (in Nova Scotia)
TTY/TDD: 1-800-670-8888

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BACK TO CONTENTS

## 2016 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

| PAPER CLAIMS | ELECTRONIC CLAIMS | PAYMENT DATE |
|---|---|---|
| **December 23, 2015**** | **December 30, 2015**** | January 6, 2016 |
| January 11, 2016 | January 14, 2016 | January 20, 2016 |
| January 25, 2016 | January 28, 2016 | February 3, 2016 |
| **February 5, 2016**** | **February 10, 2016**** | February 17, 2016 |
| February 22, 2016 | February 25, 2016 | March 2, 2016 |
| March 7, 2016 | March 10, 2016 | March 16, 2016 |
| **March 18, 2016**** | **March 23, 2016**** | March 30, 2016 |
| April 4, 2016 | April 7, 2016 | April 13, 2016 |
| April 18, 2016 | April 21, 2016 | April 27, 2016 |
| May 2, 2016 | May 5, 2016 | May 11, 2016 |
| **May 13, 2016**** | **May 18, 2016**** | May 25, 2016 |
| May 30, 2016 | June 2, 2016 | June 08, 2016 |
| June 13, 2016 | June 16, 2016 | June 22, 2016 |
| **June 24, 2016**** | **June 29, 2016**** | July 6, 2016 |
| July 11, 2016 | July 14, 2016 | July 20, 2016 |
| **July 22, 2016**** | **July 27, 2016**** | August 3, 2016 |
| August 08, 2016 | August 11, 2016 | August 17, 2016 |
| August 22, 2016 | August 25, 2016 | August 31, 2016 |
| **September 2, 2016**** | September 08, 2016 | September 14, 2016 |
| September 19, 2016 | September 22, 2016 | September 28, 2016 |
| **September 30, 2016**** | **October 5, 2016**** | October 12, 2016 |
| October 17, 2016 | October 20, 2016 | October 26, 2016 |
| October 31, 2016 | November 3, 2016 | November 09, 2016 |
| November 14, 2016 | November 17, 2016 | November 23, 2016 |
| November 28, 2016 | December 1, 2016 | December 7, 2016 |
| December 12, 2016 | December 15, 2016 | December 21, 2016 |
| **December 21, 2016**** | **December 28, 2016**** | January 4, 2017 |
| **11:00 AM CUT OFF** | **11:59 PM CUT OFF** | |

**NOTE:**

Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Sessional Payments and Locum Claim Forms. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut off date to ensure processing for that payment period.

**PLEASE NOTE, THE ** INDICATES A DATE VARIATION**

## HOLIDAY DATES FOR 2016

| Please make a note in your schedule of the following dates MSI will accept as "Holidays." | |
|---|---|
| NEW YEAR'S DAY | FRIDAY, JANUARY 1, 2016 |
| HERITAGE DAY | MONDAY, FEBRUARY 15, 2016 |
| GOOD FRIDAY | FRIDAY, MARCH 25, 2016 |
| EASTER MONDAY | MONDAY, MARCH 28, 2016 |
| VICTORIA DAY | MONDAY, MAY 23, 2016 |
| CANADA DAY | FRIDAY, JULY 1, 2016 |
| CIVIC HOLIDAY | MONDAY, AUGUST 1. 2016 |
| LABOUR DAY | MONDAY, SEPTEMBER 5, 2016 |
| THANKSGIVING DAY | MONDAY, OCTOBER 10, 2016 |
| REMEMBRANCE DAY | FRIDAY, NOVEMBER 11, 2016 |
| CHRISTMAS DAY | MONDAY, DECEMBER 26, 2016 |
| BOXING DAY | TUESDAY, DECEMBER 27, 2016 |
| NEW YEAR'S DAY | MONDAY, JANUARY 2, 2017 |

# MEDICAL CONSULTANT JOB POSTING

**Job Title:** Medical Consultant
**Internal/External:** Internal/External
**Department:** Medicare Programs
**Competition:** 2015-543
**Employment Type:** Consultant Position – 3 year contract
**Location(s):** Dartmouth, NS
**Salary:** Competitive Compensation
**Reports to:** Team Leader
**Closing Date:** November 1, 2015

"We care about the work we do-and we're looking for new colleagues who do, too."

**The Company:**

For over 70 years, and across six provinces we've been a leading diversified health services partner for individuals, plan sponsors, plan advisors and governments across Canada. We are proud to be a not-for-profit organization committed to giving back to the communities where we live and work. We support the health and wellness of our employees and their families with various wellness programs and resources to support their personal and professional growth.

We're a team of 1,900 colleagues dedicated to collaboration, innovation, customer service, and committed to work-life balance, community involvement and career development which is why Medavie Blue Cross is recognized as one of Canada's 10 Most Admired Corporate Cultures. We care about the work we do-and we're looking for new colleagues who do, too.

**Role Summary:**

We are currently accepting applications for a part time Medical Consultant. The successful candidate will work onsite with the Medicare Programs team in our Dartmouth office and will be responsible for providing professional medical guidance in support of the MSI assessment and audit functions. In this role, the successful candidates will be responsible for providing a professional link between physicians, government and patients.

**As a Medical Consultant, your key responsibilities will include:**

- Providing direction and guidance to the Claims Assessment team regarding claims adjudication and payment.
- Reviewing requests for pre-authorization of in-province physician services; out-of- province/country physician services or hospitalization and retroactive payment of out- of-province/country physician services or hospitalization claims.
- Ensuring all administrative processes are followed for out-of-province/country referrals for addiction and mental health services.
- Providing or assisting in the first level of appeals for citizen/provider complaints regarding issues of medical insurability, medical necessity and treatment not normally insured as well as provider appeals regarding claims payment.
- Conduct fee for service and shadow billing audits in collaboration with the Medicare Auditors.
- Support the evaluation of select alternative funding contracts; includes interviews with providers, associations and other parties.
- Assist in the development of the annual audit plan, procedures to enhance pre and post payment monitoring operations, and the development of risk analysis strategies to utilize departmental resources efficiently.
- Providing assistance to the Department of Health and Wellness Medical Consultant to support medical policy, medical tariff development and activities related to claims assessment
- Participate on various Department of Health and Wellness and professional committees as required.
- Resolve issues and maintain productive, professional relationships with medical provider community and Department of Health and Wellness; inform providers through bulletin articles of changing audit policies, administrative procedures and billing issues.

- Responding to enquiries from patients, physicians, Doctors NS, Nova Scotia College of Physicians and Surgeons, Medical Directors and the Department of Health and Wellness with respect to individual patient claims and the insurability of specific services for an individual according to Department of Health and Wellness policy.

**As the ideal candidate, you possess the following qualifications:**

Education: University degree with a Doctorate in Medicine.

Work Experience: Ten to 15 years' experience as a physician in a range of practice settings. Surgical and administrative experience would be an asset.

Other Qualifications: Strong interpersonal skills and the ability to resolve conflicts and deal with stressful situations.

Computer Skills: General computer knowledge.

Communication Skills: Excellent written and verbal communication skills are fundamental to the position.

**You also demonstrate the following core competencies**:

Knowledge: Uses knowledge and industry best practices to provide guidance and/or advice to leaders and coworkers on key issues in own area of expertise. Demonstrates a specialized knowledge of all processes, policies and precedents to do the job and solve day to day issues independently.

Analytical Thinking: Uses knowledge and experience to solve a variety of routine and complex technical problems. Identifies the cause of problems and implements the most appropriate solution.

Communication: Able to communicate complex information effectively through both oral and written means. Demonstrates the full range of effective verbal communication skills in a variety of settings such as formal meetings, presentations, and any one on one situation.

Customer Orientation: Independently processes many unusual and demanding customer requests. Maintains library/database/network of all customer information and materials to meet both routine and complex customer needs.

Execution and Organization Skills: Exceptional organizational and time-management skills. Able to prioritize work within in a changing work environment under the pressure of deadlines.

Team Work: Provides professional advice and direction to team members and leads work processes and proactively searches for ways to improve team effectiveness and performance.

If you are interested in working with a team of professionals in a challenging role and you possess the necessary qualifications, please follow the instructions for applying online via the Medavie Blue Cross Corporate website by clicking on the link below.

**Apply Now**

We would like to thank all candidates for expressing interest. Please note only those selected for interviews will be contacted.

**Canadian Citizenship - Please indicate in your application the reason you are entitled to work in Canada: Canadian citizenship, permanent resident status or work permit.**

**Reliability screening will be required.**

**Medavie Blue Cross is an equal opportunity employer.**

BACK TO CONTENTS

PHYSICIAN'S BULLETIN
August 14, 2015: Vol. LI, ISSUE 8

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



# MSI News

## NEW MSI CLAIMS PROCESSING AND PAYMENT SYSTEM

Medavie Blue Cross, as the administrator of the MSI program, has undertaken a technology transition to a new corporate claims system. The implementation of this new corporate claims system is scheduled for fall 2015. **Physicians will see no changes in the claims submission or payment processing as a result of this technology project.** As part of the roll-out of this new system MSI will need to convert claims history from the old system to the new system. During this conversion period, MSI will require a period of time where the Medicare history is stable with no changes.

During the claims history conversion, physicians will be required to hold all deletions and re-adjudicates of claims for a period of time. The length of time physicians will be required to hold all deletions and re-adjudicates will be minimal and result in the least disruption for physicians. New claims will continue to be accepted. Further information, including specific dates for conversion, will be communicated via mail as we near the implementation date.

In the meantime, it is important for offices to re-adjudicate claims in a timely manner to minimize the impact during the conversion period.

### Important Shadow Billing Information

All physicians must submit original claims to MSI within 90 days of the date of service. This includes physicians who shadow bill.

With the implementation of the new corporate claims system the 90 day time limit for shadow claims will be enforced. Effective fall 2015 shadow claims over the 90-day time limit will be considered outdated claims. These claims will be adjudicated and processed as 'paid as zero' with the following exceptions:

- Reciprocal billing claims (out of province) must be submitted within 12 months of the date of service.
- Resubmission of refused claims or incorrect billings must be resubmitted to MSI within 185 days of the date of service. Each resubmission must contain an annotation in the text field of the Service Encounter submission referencing the previous Service Encounter Number.

BACK TO CONTENTS

## MSI News continued

Important Shadow Billing Information - continued

Shadow claims that are greater than 90 days of the date of service will fall under the purview of the Outdated Claims Policy. Outdated claims will only be considered by MSI if extenuating circumstances can be demonstrated for a late submission and are within a reasonable time frame past the 90-day limit. Request for an extension must be made to MSI in writing and will be approved on a case by case basis.
The time frame for submitting the request to MSI for late submission should be within one month following the 90-day limit. Examples of extenuating circumstances may include physical damage to office, such as fire or flood and/or a serious technical issue.

Circumstances relating to staffing issues/shortages and mislaid, misfiled, or lost claims cannot be accepted by MSI as valid explanations for a late submission.

Claims for registered hospital in-patients must also be submitted within the 90-day time limit regardless of the patient having been discharged or continuing on an in-patient basis. It is incumbent on the physician to obtain the required billing information for these patients and submit claims within the prescribed time limit.
Explanations relating to late discharge summaries, or facilities not consolidating the required information for the physician, cannot be accepted as a valid explanation for a late submission.

All physicians who submit shadow claims will receive direct communication in the mail notifying them of the implementation date.

## Fees New Fees and Highlighted Fees

### NEW FEES

Effective June 15, 2015 the following health service code is available for billing:

| Category | Code | Description | Value |
|---|---|---|---|
| DEFT | WCB28 | **Comprehensive Visit for Work Related Injury or Illness**<br>Please note: The WCB28 should be billed with the WCB26 (the report) | $64.56 |

The following health service code has been reinstated effective May 22, 2015.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VADT | 03.26C | **Female Pelvic Examination with Speculum** | 10.5 MSU |

## NEW FEES CONTINUED

BACK TO CONTENTS

Effective August 14, 2015 the following new health service codes are available for billing:

| Category | Code | Description | Base Units |
|---|---|---|---|
| VADT | 02.02B | **Optic Nerve Imaging**<br><br>Optic Nerve Imaging by any means (e.g. OCT, HRT) for patients with a diagnosis of glaucoma, wet AMD, retinal vein occlusion, diabetic macular edema.<br><br>This fee is for the interpretation of scanning computerized ophthalmic diagnostic imaging, with interpretation and written report, unilateral or bilateral, of the optic nerve and/or retina regardless of the technology used to perform the imaging. Not to be used for glaucoma screening.<br><br>**Billing Guidelines**<br>Billable:<br>1. Glaucoma diagnosis - once per year.<br>2. Diabetic macular edema, retinal vein occlusion or wet age related macular degeneration having been treated once in the past year with intravitreal anti-VEGF drugs - up to 6 times per year<br><br>**Specialty Restriction**<br>OPTH<br><br>**Location**<br>OFFC, HOSP | 8 MSU |
| VEDT | 09.02H | **Comprehensive Eye Examination of both eyes including refraction**<br><br>This fee is for the comprehensive examination of the entire visual system to diagnose or obtain information to allow proper ongoing care of more complex conditions and includes history, general medical observation with sensorimotor examination, external and ophthalmoscopic examinations, refraction, and testing with analysis of non-automated visual fields. It may include biomicroscopic examination with mydriasis or cycloplegia, tonometry, retinoscopy, manual keratometry, gonioscopy, colour vision testing, ocular alignment using prisms, indirect ophthalmoscopic examination of the fundus, axial length measurement, and corneal pachymetry as required.<br><br>Auto or manual refraction for diagnostic purposes (not simply writing a prescription) is included. This examination will result in a diagnosis and initiation of treatment program with follow up arrangements.<br><br>Specific treatment interventions such as laser coagulation, intravitreal injection, or removal of a foreign body are billable in addition to the comprehensive eye examination.<br><br>**Billing Guidelines**<br>Billable to a maximum of two times per year, unless for pre and post cataract surgery, then can be billed as required to a maximum of four times in one year if the patient has cataract surgery on both eyes during that year. May be billed per eye when performed pre and post | 29 MSU |

BACK TO CONTENTS

| Category | Code | Description | Base Units |
|---|---|---|---|
| | | cataract surgery.<br><br>Restricted to patients with a diagnosis of retinal vascular conditions including, but not limited to, diabetes, glaucoma, uveitis, retinopathy of prematurity outside of the NICU, and paediatric strabismus/amblyopia treatment. When performed in conjunction with cataract surgery, the post surgical exam must be at least 30 days after the surgery.<br><br>Not to be billed with:<br>VADT 03.12 Tonometry<br>VADT 09.01A Gonioscopy<br>VADT 09.05 Visual field study<br>VADT 09.13B Axial length measurement by ultrasound<br>Corneal pachymetry<br>Automated or manual keratometry<br><br>**Specialty Restriction**<br>OPTH<br><br>**Location**<br>OFFC, HOSP | |

BACK TO CONTENTS

Effective August 14, 2015 the following health service codes have been revised to include specialty and location restrictions, which align the payment system with existing policy.

| Category | Code | Description | Base Units |
|---|---|---|---|
| VADT | 03.19C | **Sleep Studies**<br><br>**Specialty Restriction**<br>NEUR, RESP<br><br>**Location**<br>HOSP | 60 MSU |
| VADT | 03.19F | **Level II Sleep Apnea Testing Interpretation**<br><br>**Specialty Restriction**<br>NEUR, INMD, OTOL, RESP<br><br>**Location**<br>OFFC, HOSP | 35 MSU |
| VADT | 03.19G | **Level III Sleep Apnea Testing Interpretation**<br><br>**Specialty Restriction**<br>NEUR, INMD, OTOL, RESP<br><br>**Location**<br>OFFC, HOSP | 25 MSU |

BACK TO CONTENTS

Effective August 13, 2015 the following health service code will no longer be active:

| Category | Code | Description | Base Units |
|---|---|---|---|
| VADT | 02.02A | **Optical Coherence Tomography** | 8 MSU |

BACK TO CONTENTS

## PROVINCIAL IMMUNIZATION CHANGES

Effective July 31, 2015 the following immunizations are available for billing:

| HSC | Modifier | Description |
|---|---|---|
| 13.59L | RO=MENB (PT=RISK) | MenB - Meningococcal B vaccine (high risk patient)<br><br>Billing Guidelines<br>For post exposure prophylaxis, outbreaks, and those with high risk conditions. |
| 13.59L | RO=MENQ | Men-C-ACYW-135- Meningococcal Conjugate Quadrivalent vaccine<br><br>Billing Guidelines<br>Grade 7 students only |
| 13.59L | RO=GAIG (PT=RISK) | GAIg - Measles Immunoglobulin (high risk patient) |
| 13.59L | RO=HAIG (PT=RISK) | HAIg - Hepatitis A Immunoglobulin (high risk patient) |
| 13.59L | RO=HAVV (PT=RISK) | HA - Hepatitis A vaccine (high risk patient) |
| 13.59L | RO=MENC (PT=RISK) | Men-C-C- Meningococcal conjugate (high risk patient) |

Effective July 31, 2015 the following provincial immunization description has changed:

| Modifier | Old Description | New Description |
|---|---|---|
| RO=MMRT | MMRV - Measles, Mumps, Rubella and Varicella for travel only to areas of risk for Measles. | MMR- Measles, Mumps and Rubella for travel only to areas of risk for Measles. |

* This is a description change only; the original intent for this immunization is to vaccinate children between 6 months and within one week of 12 months of age, against Measles for travel to high risk areas with the MMR (Measles, Mumps and Rubella) vaccine.

Please note that effective August 14, 2015 the following billing guidelines will be enforced:

| HSC | Modifier | Billing Guideline |
|---|---|---|
| 13.59L | RO=HPV4 | PT=RISK modifier will be required when a 3rd dose of RO=HPV4 is given |
| 13.59L | RO=MMRV | Maximum of two injections per patient per lifetime<br>Only allowed if patient is at least 12 months or within 1 week of 12 months |
| 13.59L | RO=PNEU | Only one injection to be billed if the patient is greater than or equal to 65 years of age |

BACK TO CONTENTS

## PROVINCIAL IMMUNIZATION CHANGES CONTINUED

BACK TO CONTENTS

Please note that effective August 14, 2015 the following billing guidelines have been modified:

| HSC | Modifier | Billing Guideline |
|---|---|---|
| 13.59L | RO=PNEU | Maximum of three injections per patient per lifetime (previous guideline only allowed two) |
| 13.59L | RO=HPV4 | Previous gender restrictions removed |

Please note a communication change. MMRV and MMAR Vaccines are to be given at 12 months and again between 18 months and 6 years of age. (This is a change from the previously published 12 months and 4-6 years).

The Nova Scotia Immunization Schedules are attached in the appendices section of this bulletin.

The NS Publicly Funded Vaccine/Immunoglobulin Eligibility Policy (July 2015), the NS Publicly Funded Vaccine Eligibility for Individuals at High Risk of Acquiring Vaccine Preventable Diseases Policy Version 2.0 (July 2015) and the NS Routine Childhood Immunization Schedule Poster (July 2015) can be found at:
http://novascotia.ca/dhw/CDPC/info-for-professionals.asp

# Billing Matters Billing Reminders, New Explanatory Codes

## BILLING REMINDERS

Pathology: Health Service Codes P2345 and P2325

P2325 (Surgicals, gross and microscopic) may be claimed for each specimen taken from anatomically distinct surgical sites. The following is a list of anatomically distinct surgical sites:

- head and neck
- upper limbs
- lower limbs
- trunk anterior and posterior
- upper GI tract
- female reproductive system
- male reproductive system
- separate organs within the abdominal or thoracic cavities may be claimed as distinct sites

P2345 (Surgicals, gross and microscopic – three or more separate surgical specimens) may be claimed when three of more separate surgical specimens are taken from the same anatomic site.

Examples: two separate skin specimens from the right and left arms are considered one site, specimens from the uterus and ovary are one site, specimens from the colon and liver are two sites.

**Note: The multiples permitted for HSC P2345 or P2325 may not be the same as the number of specimens received and examined. Please ensure the multiples claimed are submitted correctly.**

Pathology: Second Opinion Consults

Pathologists are reminded that they may not bill second opinion consults for cases that are part of a Quality Assurance program.

BACK TO CONTENTS

## BILLING REMINDERS CONTINUED

BACK TO CONTENTS

Pathology: Cytology Screener and Interpretation

In the May 22nd 2015 Bulletin there was a reminder that HSC P2330 (cytology with a screener) is not to be claimed with HSC P2331 (interpretation and report – GYN slides) for the same specimen. To accommodate for reviews done by screeners claimed prior to an interpretation MSI will now accept claims for the interpretation (P2331) for a previously paid review by a screener (P2330). However, the payment amount for interpretation (P2331) will be reduced by the value of the previously paid screener review (P2330). Deleting the screener code (P2330) claim is no longer necessary.

Bulk Billing Transition Updated Documentation

Please visit the **Bulk Billing Transition section** of the MSI website for updated rules.

Physician Claims for Vaccines Administered by Pharmacists

It has come to MSI's attention that some family physicians claimed for influenza vaccinations administered by pharmacists during last year's influenza vaccination program. Family physicians may claim only for vaccines they have either personally administered or those administered by nurses under direct supervision and employment of the physician. In the latter circumstance, the physician may only claim for the procedure if the physician is personally on the premises when the nurse administers the vaccine. Physicians may not claim for vaccines administered by pharmacists.

Comprehensive Prenatal Visits (HSC 03.04)

MSI has received a number of complaints from family physicians who are asked to follow antenatal patients of colleagues who do not provide obstetrical services. The concern raised is that the referring physician is claiming a comprehensive antenatal visit without meeting Preamble requirements for a comprehensive visit which includes conducting and documenting a complete history and physical. For antenatal patients, this includes conducting a gynaecologic examination and documenting full details of the history and physical on the standardized Nova Scotia prenatal record form. As only one comprehensive antenatal visit is payable per pregnancy, the receiving physician who conducts and documents a complete history and physical cannot claim a comprehensive visit if one has been claimed by the regular family physician prior to referring the patient for obstetrical care. As a reminder, this health service code should be claimed only after all the Preamble requirements have been met. It is the responsibility of the coordinating physician to also coordinate billing with the receiving physician.

Second and Subsequent Service Occurrences

MSI has noted instances in which previously bulk billed codes are being incorrectly submitted using second or subsequent service occurrence numbers. As a reminder, second and subsequent service occurrences may only be submitted for separate and distinct episodes of care.

For example, if a patient has an ECG done in the cardiac investigation unit in the morning that is read by an internist and the same internist sees the patient in consultation later that day in the emergency department the consultation should be claimed as service occurrence #2.

However, if a patient attends the pulmonary function lab and has both spirometry and plethysmography carried out and reported by a respirologist, both health service codes should be submitted in the same service occurrence.

Similarly, if a patient has both a chest CT and an abdominal CT scan carried out in a single visit to the diagnostic imaging department and reported by the same radiologist one service occurrence should be submitted for the two studies. However, if the patient has a chest radiograph done and returns later in the day for a follow-up study these should be reported as separate service occurrences.

BACK TO CONTENTS

## BILLING REMINDERS CONTINUED

BACK TO CONTENTS

Pulmonary Function Tests

As per MSI's previous communication, if a physician has interpreted two or more pulmonary function studies that meet the definition of multiple service encounters as outlined above and these have not been paid the claims should be submitted with action code 'R' (readjudication) together with a copy of the clinical record.

In the fall new health service codes will be implemented for the following studies:

- Pulmonary function studies to assess bronchodilator responsiveness
- Six minute walk test, interpretation, when this is the sole procedure
- Exercise induced asthma assessment, interpretation

Physicians are requested to hold claims for these studies until the new health service codes are implemented. These codes will be retroactive to April 1, 2015.

## NEW EXPLANATORY CODES

| Code | Description |
|---|---|
| AD038 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A MAXIMUM OF THREE 13.59L RO=PNEU IMMUNIZATIONS HAVE BEEN PREVIOUSLY PAID |
| AD056 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED HSC 95.94A AT THE SAME ENCOUNTER. |
| AD057 | SERVICE ENCOUNTER HAS BEEN REFUSED AS AN INFLUENZA INJECTION HAS ALREADY BEEN APPROVED IN THE PREVIOUS 6 MONTHS. |
| AD058 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A THIRD INJECTION FOR RO=HPV4 REQUIRES MODIFIER PT=RISK |
| AD059 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF HPV4 INJECTIONS HAS BEEN REACHED |
| BK043 | SERVICE ENCOUNTER HAS BEEN ACCEPTED AT A REDUCED VALUE AS A CLAIM FOR CYTOLOGY SCREENER CODE P2330 HAS PREVIOUSLY BEEN MADE FOR THIS SPECIMEN. |
| BK044 | SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM HAS PREVIOUSLY BEEN MADE FOR THE INTERPRETATION AND REPORT OF THESE GYN CYTOLOGY SLIDES (HSC P2331). |
| BK045 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR A DOPPLER QUANTITATIVE INTERPRETATION AT THE SAME ENCOUNTER. |
| BK046 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR A DOPPLER QUALITATIVE INTERPRETATION AT THE SAME ENCOUNTER. |
| BK047 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR A GENETIC SONOGRAM AT THE SAME ENCOUNTER. A GENETIC SONOGRAM INCLUDES ALL NECESSARY IMAGING. |
| BK048 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED A CRITICAL OR COMPREHENSIVE CARE FEE FOR THE PATIENT ON THIS DAY WHICH INCLUDES ALL EKG INTERPRETATION PERFORMED. |
| BK049 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED AN EKG INTERPRETATION FEE FOR THE PATIENT ON THIS DAY. PLEASE SUBMIT A DELETE FOR THE EKG INTERPRETATION BEFORE MAKING A SUBMISSION FOR A CRITICAL OR COMPREHENSIVE CARE FEE. |
| GN070 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE CAN NOT BE BILLED FROM THIS FACILITY |
| GN071 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED FOR SOLE OPERATIVE PROCEDURE FEE 90.69D AT THE SAME ENCOUNTER. |

BACK TO CONTENTS

| Code | Description |
|---|---|
| GN072 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED ANOTHER SERVICE AT THE SAME ENCOUNTER. HSC 90.69D CAN ONLY BE BILLED IF THE REMOVAL OF FIXATION DEVICE IS THE SOLE OPERATIVE PROCEDURE. |
| GN073 | PLEASE SUBMIT DOCUMENTATION TO FURTHER ASSIST IN ASSESSING THIS CLAIM |
| GN074 | THE INFORMATION PROVIDED ON YOUR CLAIM DOES NOT MATCH THE SURGEONS SUBMISSION |
| GN075 | PLEASE PROVIDE TEXT INDICATING APPROVAL WAS GIVEN BY PUBLIC HEALTH |
| VA067 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 09.02H AT THE SAME ENCOUNTER |
| VA068 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED HSC 13.59L AT THE SAME ENCOUNTER. |
| VA069 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR AN ULTRASOUND FEE AT THE SAME ENCOUNTER. GENETIC SONOGRAM INCLUDES ALL NECESSARY IMAGING. PLEASE SUBMIT A DELETE FOR ORIGINAL INTERPRETATION BEFORE RESUBMITTING GENETIC SONOGRAM. |
| VA070 | SERVICE ENCOUNTER HAS BEEN REFUSED AS ONLY ONE OPTIC NERVE IMAGING FEE CAN BE BILLED PER YEAR FOR THIS DIAGNOSIS |
| VA071 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM OF 6 CLAIMS ALLOWED PER YEAR FOR THIS SERVICE HAVE BEEN APPROVED |
| VE011 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED ONE OF THE FOLLOWING SERVICES AT THE SAME ENCOUNTER 03.12, 09.01A, 09.05 OR 09.13B |
| VE012 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THE MAXIMUM LIMIT PER YEAR HAS ALREADY BEEN APPROVED FOR THIS SERVICE |

BACK TO CONTENTS

## In every issue Helpful links, contact information, updated files

### UPDATED FILES

Updated files reflecting changes are available for download on Friday, August 14, 2015. The files to download are health service (SERVICES.DAT), health service description (SERVDSC.DAT), explanatory codes (EXPLAIN.DAT) and modifier values (MODVALS.DAT).

### HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

www.medavie.bluecross.ca\msiprograms

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

### 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

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BACK TO CONTENTS

# Routine Childhood Immunization Schedule

Childhood immunizations have changed in the past few years. This schedule reflects these changes and may be different from what you or your children may have received in the past.

The immunizations shown on this schedule are those that are given **free of charge**.

**High-risk children may be eligible for additional vaccines.** For more information, talk to your health care provider or call your local Public Health Services office.

| VACCINES | SCHEDULE | | | | | |
|---|---|---|---|---|---|---|
| | 2 months | 4 months | 6 months | 12 months | 18 months | 4-6 years |
| **DTaP-IPV-Hib** Diphtheria, tetanus, acellular pertussis (whooping cough), polio, and Haemophilus influenzae type b vaccine | ✓ | ✓ | ✓ | | ✓ | |
| **Pneumo Conj.** Pneumococcal conjugate vaccine | ✓ | ✓ | | ✓ | | |
| **Men C Conj.** Meningococcal group C conjugate vaccine | | | | ✓ | | |
| **MMRV*** Measles, mumps, rubella and varicella vaccine | | | | ✓ | ✓* | ✓* |
| **Tdap-IPV** Tetanus, diphtheria, acellular pertussis (whooping cough), and polio vaccine | | | | | | ✓ |

**The second dose of MMRV can be given only once between 18 months and 6 years of age.*

## Seasonal Flu Vaccines

- Seasonal flu vaccines are free for all Nova Scotians. They are recommended for all adults and children EXCEPT for babies under 6 months.
- Seasonal flu vaccines are strongly recommended for anyone who lives with or takes care of a child under 5 years, and for anyone living in a home where a newborn is expected during influenza season (October to April). This includes both adults and older children.
- Seasonal flu vaccines are also strongly recommended for children with a health condition that places them at high risk and for anyone who lives with or takes care of these children.
- Children under 9 years old getting their first flu vaccine need 2 doses.

**For more information about seasonal flu vaccines, see: novascotia.ca/DHW/CDPC/flu.asp**

Aussi disponible en français

NOVA SCOTIA

13151/APR15 REV15-16

# Nova Scotia Routine Childhood Immunization Schedule

## Publicly Funded Vaccines: Information for Health Professionals

| Age | Vaccine | Site | Route | Needle Size *(based on assessment of child)* |
|---|---|---|---|---|
| **2 months** | DTaP-IPV-Hib | vastus lateralis (thigh) | I/M | 25g 1 inch |
| | Pneumococcal | vastus lateralis (thigh) | I/M | 25g 1 inch |
| **4 months** | DTaP-IPV-Hib | vastus lateralis (thigh) | I/M | 25g 1 inch |
| | Pneumococcal | vastus lateralis (thigh) | I/M | 25g 1 inch |
| **6 months** | DTaP-IPV-Hib | vastus lateralis (thigh) | I/M | 25g 1 inch |
| **12 months** | MMRV | upper arm | S/C | 25g 5/8 inch |
| | Meningococcal C | vastus lateralis (thigh) | I/M | 25g 1 inch |
| | Pneumococcal | vastus lateralis (thigh) | I/M | 25g 1 inch |
| **18 months** | DTaP-IPV-Hib | deltoid | I/M | 25g 1 inch |
| | (MMRV)[1] | upper arm | S/C | 25g 5/8 inch |
| **4-6 years** *(before starting school)* | Tdap-IPV | deltoid | I/M | 25g 1 inch |
| | (MMRV)[1] | upper arm | S/C | 25g 5/8 inch |

[1] *(MMRV): The second dose of MMRV can be given only once between 18 months and 6 years of age.*

### Seasonal Influenza Vaccine

- The influenza vaccine is recommended annually for all children 6 months and older.
- Children under 9 years old getting their first influenza vaccine need 2 doses at least 4 weeks apart.

### School-based Program

- Hepatitis B, Tetanus, Diphtheria and Acellular Pertussis (Tdap), Meningococcal Quadrivalent (A, C, Y, W 135) and Human Papillomavirus (HPV) vaccines are offered in the school-based immunization program.
- Please call Public Health if you have any questions about the school-based immunization program.

### Information for the Unimmunized or Partially Immunized Child

- In relation to the publicly funded program, for information on the number of doses and timing of vaccine administration for the **unimmunized child 1-6 years of age** please consult the Canadian Immunization Guide: **phac-aspc.gc.ca/publicat/cig-gci/p01-12-eng.php**
- In relation to the publicly funded program, for information on the number of doses and timing of vaccine administration for the **unimmunized child 7-17 years of age** please consult the Canadian Immunization Guide: **phac-aspc.gc.ca/publicat/cig-gci/p01-12-eng.php**
- In relation to the publicly funded program, for information on the number of doses and timing of vaccine administration for the **partially immunized child** please consult the Canadian Immunization Guide: **phac-aspc.gc.ca/publicat/cig-gci/p01-12-eng.php**
- Interruption of a vaccine schedule does not require restarting the series, regardless of length of time since last dose.
- **MMRV** is indicated for use in children less than 13 years of age. **Eligible individuals** ages 13 years and older should receive **MMR and Varicella vaccines separately.**

### Other Important Information

- For children **medically at high risk of acquiring vaccine-preventable diseases** please refer to Vaccine Eligibility for High Risk Conditions: **novascotia.ca/dhw/CDPC/info-for-professionals.asp**
- Record date given, vaccine name, lot number, site and route of administration, and vaccine provider's name on reciprocal form or into PHIM.
- Use only the specific diluents provided for each vaccine to reconstitute the vaccine. Diluents are not interchangeable.
- For unusual or serious **adverse reactions** to vaccines, complete AEFI form: **phac-aspc.gc.ca/im/aefi-form-eng.php** and submit to Public Health.
- **Cold chain:** Vaccines must be kept at a temperature of +2 to +8°C. In the event of a fridge failure, keep vaccine refrigerated and contact Public Health immediately for advice on vaccine use.
- **Immunization Resources / Websites:**
  - Nova Scotia Department of Health and Wellness: **novascotia.ca/dhw/cdpc/info-for-professionals.asp**
  - Public Health Agency of Canada: **phac-aspc.gc.ca/im/index-eng.php**
  - Immunize Canada: **immunize.ca**
  - Canadian Paediatric Society: **cps.ca**


### Public Health Contact Information

**Amherst**
Tel: 902-667-3319

**Antigonish**
Tel: 902-867-4500
ext. 4800

**Bridgewater**
Tel: 902-543-0850

**Dartmouth**
Tel: 902-481-5800

**New Glasgow**
Tel: 902-752-5151

**Sydney**
Tel: 902-563-2400

**Truro**
Tel: 902-893-5820

**Wolfville**
Tel: 902-542-6310

**Yarmouth**
Tel: 902-742-7141


NOVA SCOTIA

13078/MAY15 REV15-16

# School Immunization Schedule

The immunizations shown on this schedule are those that are given **free of charge.**

**Children at high risk may be eligible for additional vaccines.** For more information, talk to your health care provider or talk to your local Public Health Office.

| | | School Year |
|---|---|---|
| | | Grade 7 |
| VACCINES | **HPV (for both boys and girls)**<br>Human papillomavirus vaccine (2 doses) | ✓ |
| | **Hepatitis B (HB)**<br>Hepatitis B vaccine (2 doses) | ✓ |
| | **Tdap**<br>Tetanus, diphtheria, and acellular pertussis (whooping cough) vaccine | ✓ |
| | **Meningococcal Quadrivalent**<br>Meningococcal Quadrivalent vaccine (Groups A, C, Y and W 135) | ✓ |

13153 /APR15 REV15-16

PHYSICIAN'S BULLETIN
June 24, 2015: Vol. LI, ISSUE 7

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# Notice to Physicians WCB interim change in billing process

## INTERIM BILLING PROCESS

In the June 5, 2015 Physician's Bulletin, physicians were advised to bill Health Service Code 03.04 plus WCB26 for an injured worker visit and Form 810 report, in place of the former WCB11. We are aware of a current issue that is preventing some claims from processing.

In the interim please bill former WCB11 claims as follows:

- Health Service Code **EC (Exceptional Circumstances)** plus **WCB26** for the visit and report. When billing **EC**, please request **24 units** and ensure that an annotation **"Interim code for Comprehensive WCB visits"** is made in the "text" field.

If you have eligible rejected claims, you may resubmit them now according to the instructions above.

BACK TO CONTENTS

PHYSICIAN'S BULLETIN
June 5, 2015: Vol. LI, ISSUE 6

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# Notice to Physicians WCB fee revisions

## NEW FEES

Effective June 15, 2015 the following new health service codes will be available for billing for services on or after June 15, 2015. For further details on WCB, please see the WCB website at https://www.wcb.ns.ca/Health-Services/Physicians.

| Code | Description | Value |
|---|---|---|
| **WCB26** | **Return to Work Report – Physician's Report Form 8/10**<br><br>**Billing Guidelines**<br>Can be billed with 03.04, comprehensive office visit, same service date for Return to Work Services.<br><br>**Can be billed as Long Term Benefits (LTB) Follow-up Report.**<br>Only required if there is a change in medical status or treatment. Not required for changes in medication.<br>Can be billed with 03.03 or 03.03A office visit, same service date.<br><br>**Specialty Restriction**<br>GENP, EMMD | $64.16 |
| **WCB27** | **Eye Report**<br><br>**Billing Guidelines**<br>Only to be used on request of the WCB.<br>Can be billed with an office visit, if needed, same service date.<br><br>**Specialty Restriction**<br>OPTH | $56.25 |

## MODIFIED FEES

Effective June 15, 2015 the following fees will be modified with the following information.

| Code | Description | Modification |
|---|---|---|
| WCB12 | **Enhanced Physician Services (EPS) Return to Work Office Visit & Report.**<br><br>**Billing Guidelines**<br>Can be billed with other WCB codes on the same service date. Multiples on initial visit only, max of 4 multiples paid at $50 each.<br><br>**Specialty Restriction**<br>Can only be billed by EPS physician (RO=EPS1). | Added the following modifiers and updated the fees.<br><br>RO=INTL……..$171.24+MU<br>RO=SUBS……$171.24 |

BACK TO CONTENTS

## MODIFIED FEES CONTINUED

| Code | Description | Modification |
|---|---|---|
| WCB13 | **WCB Requested Reports**<br><br>**Billing Guidelines**<br>Only to be used on request of the WCB.<br>Can be billed with other WCB codes on the same service date. | Updated to include different fee depending on type of physician.<br><br>GPs……..$41.82 per 15 min<br>EPS (RO=EPS1)……$50.00 per 15 min<br>Specialists……...$56.25 per 15 min |
| WCB15 | **Case conference and teleconferencing**<br><br>**Billing Guidelines**<br>Can be billed with other WCB codes on the same service date. WCB case worker or medical advisor must be in attendance unless otherwise approved. | Updated to include different fee depending on type of physician.<br><br>GPs……..$41.82 per 15 min<br>EPS (RO=EPS1)……$50.00 per 15 min<br>Specialists……...$56.25 per 15 min |
| WCB17 | **Photocopies of chart notes**<br><br>**Billing Guidelines**<br>Only to be used on request of the WCB.<br>Can be billed with other WCB codes on the same service date. | Updated to include different fee depending on the size of the chart to be copied.<br><br>10 pages or less (ME=UP10).....$25.00<br>11-25 pages (ME=UP25)……..$50.00<br>26-50 pages (ME=UP50)…….$100.00<br>Over 50 pages (ME=OV50)…...$150.00 |
| WCB20 | **Carpal Tunnel Syndrome (CTS) Assessment Report**<br><br>**Billing Guidelines**<br>Only to be used upon request of the WCB.<br>Can be billed with an office visit if needed, same service date.<br><br>**Specialty Restriction**<br>GENP | Updated value to……$64.16 |

## DISCONTINUED FEES

Effective June 14, 2015 the following fees will be discontinued.

| Code | Description |
|---|---|
| **WCB11** | **Physician Assessment Service** (replaced by 03.04 and WCB26) |
| **WCB14** | **Chart Summaries / Written Reports** (replaced by WCB13) |
| **WCB16** | **Case Conferencing and Teleconferencing (EPS Physician)** (replaced by WCB15) |
| **WCB98** | **Second Opinion Consultation Specifically requested by WCB Regarding Back Surgery** |

PHYSICIAN'S BULLETIN
May 22, 2015: Vol. LI, ISSUE 4

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



# MSI News

## BILLING UPDATE

Claiming a consultation at the time of colonoscopy for FIT positive Colon Cancer Prevention Program (CCPP) patients

Prior to April 1, 2015, physicians providing colonoscopy services to FIT positive CCPP patients booked for colonoscopy by the Program could not claim a consultation fee at the time of the procedure.

Effective April 1, 2015, DHW has agreed that the CCPP Medical Director will formally refer these patients through the district screening nurses. When a patient is referred from the Colon Cancer Prevention Program for a colonoscopy with a formal referral from the Program's Medical Director, a limited consultation HSC 03.07 may be billed at the time of the colonoscopy procedure, in accordance with the Preamble rules, if the patient has not previously been seen in consultation.

When a patient is referred from the CCPP with a formal referral from the Program's Medical Director for a medical assessment prior to booking a colonoscopy a comprehensive (HSC 03.08) or limited (HSC 03.07) consultation may be billed depending on the situation, in accordance with the Preamble rules.

See March 27, 2015 Bulletin for details on the requirements for a comprehensive consult claim.

BACK TO CONTENTS

BACK TO CONTENTS

## NEW FEES

Effective May 22, 2015 the following new health service code is available for billing:

| Category | Code | Modifiers | Description | Base Units | Anaes Units |
|---|---|---|---|---|---|
| MASG | 60.59B | | **Proctectomy with rectal mucosectomy, ileoanal anastomosis, and creation of ileal reservoir (Ileal Pouch Anal Anastomosis)**<br><br>This is a comprehensive fee for a partial proctectomy, with rectal mucosectomy, ileoanal anastomosis, and creation of an ileal reservoir. Includes sigmoidoscopy when performed.<br><br>**Billing Guidelines**<br>May not be billed with:<br>1.24C Sigmoidoscopy<br>May be billed with (usual surgical rules apply):<br>58.21A Ileostomy (LV50)<br>57.6B Colectomy (LV 50)<br><br>**Specialty Restriction**<br>Colorectal surgeon, Surgical oncologist<br><br>**Location**<br>HOSP | 630 MSU | 8+T |

## FEE REVISIONS

Effective May 22, 2015 the following health service code will no longer be active.

| Category | Code | Modifiers | Description | Base Units | Anaes Units |
|---|---|---|---|---|---|
| VADT | 03.26C* | | **Female pelvic examination with speculum** | 10.5 MSU | |
| MASG | 60.31A | | **Proctectomy - mucosectomy, ilio-anal anastomosis and ileal pouch** | 500 MSU | 8+T |
| | | RO=ABAS | | 135 MSU | |
| | | RO=ABDM | *Replaced by HSC 60.59B | 400 MSU | |
| | | RO=PEAS | | 68 MSU | |
| | | RO=PRIN | | 200 MSU | |

* MSI Physician's Bulletin Update – May 27, 2015*
The terming of HSC 03.26C Female pelvic examination with speculum, on May 22, 2015 was an error.
In the interim, please submit claims using exceptional circumstances (HSC EC).
Please ensure that an annotation is made in the "text" field indicating: 'as per HSC 03.26C'.

BACK TO CONTENTS

BACK TO CONTENTS

## NEW DIAGNOSTIC CODE

New Diagnostic Code for Vitreomacular Adhesion

A new diagnostic code 37927 for vitreomacular adhesion (VMA) will be added to the list of approved "specified retinal diseases" when billing for:

- HSC 02.02A – Optical Coherence Tomography for Macular Analysis in specific retinal diseases
- HSC 28.73F - Intravitreal injection of a pharmacologic agent for the treatment of specific retinal diseases.

The addition of this diagnostic code is being implemented to accommodate the DHW Pharmacare decision to include Jetrea® (ocriplasmin), as an Exception Status Benefit. Please refer to the January 2015 Pharmacare News, Physicians' Edition Bulletin for details on the Exception Status Criteria.

## BILLING CLARIFICATION

Please see the following codes that have expanded descriptions to assist with billing the appropriate code:

| Category | Code | Modifiers | Description | Base Units | Anaes Units |
|---|---|---|---|---|---|
| MASG | 97.14 | ME=RADI | **Unilateral extended simple mastectomy**<br><br>This code applies to both radical and modified radical mastectomies.<br>• **Radical mastectomy**: Excision of breast (skin, parenchyma, nipple and areola), the pectoralis major and minor including axillary lymph nodes<br>• **Modified radical mastectomy**: Excision of breast (skin, parenchyma, nipple and areola), the fascia overlying the pectoralis major with or without the pectoralis minor muscle, including axillary lymph nodes.<br>Removal of axillary lymph nodes includes formal axillary node dissection or lymph node sampling or sentinel node dissection for staging.<br><br>***Billing Guidelines**<br>This code may not be billed with:<br>• 52.89E Sentinel Lymph Node Biopsy for cancer<br>• 52.42 Radical excision of axillary lymph nodes | 280 MSU | |

BACK TO CONTENTS

## BILLING CLARIFICATION CONTINUED

BACK TO CONTENTS

| Category | Code | Modifiers | Description | Base Units | Anaes Units |
|---|---|---|---|---|---|
| MASG | 97.15 | ME=RADI | **Bilateral extended simple mastectomy**<br><br>This code applies to both radical and modified radical mastectomies.<br>• Radical mastectomy: Bilateral excision of breast (skin, parenchyma, nipple and areola), the pectoralis major and minor including axillary lymph nodes<br>• Modified radical mastectomy: Bilateral excision of breast (skin, parenchyma, nipple and areola), the fascia overlying the pectoralis major with or without the pectoralis minor muscle, including axillary lymph nodes.<br>Removal of axillary lymph nodes includes formal axillary node dissection or lymph node sampling or sentinel node dissection for staging.<br><br>***Billing Guidelines**<br>This code may not be billed with:<br>• 52.89E Sentinel Lymph Node Biopsy for cancer<br>• 52.42 Radical excision of axillary lymph nodes | 420 MSU | |

* In addition HSC 97.27A Quadrant resection, lumpectomy, radical mastectomy with axillary dissection may not be billed with the following codes:

- 52.89E Sentinel Lymph Node Biopsy for cancer
- 52.42 Radical excision of axillary lymph nodes

## BILLING REMINDERS

Consecutive Anaesthetists

As per Preamble section 5.2.51 where one anaesthetist starts a procedure and is replaced by another during an anaesthetic procedure, the first anaesthetist should claim the appropriate basic fee plus time units for the time he/she is present and the second anaesthetist should claim the time units for which he or she is present. The start time of the first anaesthetist shall dictate when double time units begin, for either and both anaesthetists. Services may only be claimed by a physician if they have personally rendered the service (see Preamble section 1.1.6). Anaesthetists are therefore reminded that when consecutive anaesthetists are used each must claim for his/her own anaesthetic time. This applies to both fee-for-service and shadow-billed claims.

Echocardiograms Reminder

When submitting claims for echocardiograms, physicians may claim either I 1312 (Doppler - quantitative) or I1313 (Doppler - qualitative), but not both. A quantitative study includes the elements of a qualitative study.

Cytology Codes

Pathologists are reminded that they may claim either HSC P2330 (cytology with a screener) or P2331 - (interpretation and report - GYN cytology slides) but not both for the same specimen. If a pathologist claims a P2330, then later signs out the case and wishes to change the claim to a P2331, he/she must delete the claim for the P2330 first.

BACK TO CONTENTS

## BILLING REMINDERS CONTINUED

BACK TO CONTENTS

Billing of Radiology Services with Premium Fees

MSI has had a number of inquiries from radiologists concerning the use of premium fees (i.e. services claimed with the modifiers US=PREM and US=PR50).

As per Preamble section 5.1.81, premium fees may be claimed when a service (i.e. interpretation of an imaging study), must be performed without delay during designated time periods because of the medical condition of the patient. Premium fees can, therefore, be claimed in situations in which there has been a direct request made to a radiologist for an emergency interpretation of a specific study because of the condition of the patient and the radiologist responds without delay to the request. Services of a non-emergency nature or services of an emergency nature but not performed without delay during these times do not qualify for premium rates. This includes booked procedures performed during premium hours and interpretations done after hours for which there has not been a specific request made to the radiologist about a specific imaging study. If a study has been ordered but the radiologist has not been specifically contacted by the attending physician and requested to provide an emergency interpretation, a premium cannot be claimed.

At the time of implementation of premium fees for radiology in 2002, radiologists were advised that they must maintain a log of bulk billed services that were submitted with premium codes. Although services are no longer bulk billed, all physicians claiming premium fees are required to be able to provide documentation that verifies Preamble requirements for these services have been met.

Intensive Care Units *(5.1.122)*

Intensive care unit (ICU) services refers to services rendered in ICUs approved by the Department of Health and Wellness by physicians who have been assigned by a hospital to the ICU staff by reason of special training or experience. *(5.1.123)*

b) There should only be one day 1 (first day) claimed during the same ICU admission even if the patient's status changes. Day 1 is normally the date of admission to the ICU. However, if the physician does not actually see the patient until the next day, e.g. because a resident is covering, then day 1 can be the date when the patient is first seen by the physician. Day 1 can only be claimed again if the patient is readmitted to the ICU at least 24 hours after discharge. This does not preclude ventilatory care day 1 and critical care day 1 being claimed on the same day. *(5.1.126)*

## NEW AND UPDATED EXPLANATORY CODES

| Code | Description |
|---|---|
| CN020 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS AN 03.09B HAS PREVIOUSLY BEEN APPROVED FOR THIS DAY. |
| CR019 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THE DAY ONE FEE HAS ALREADY BEEN CLAIMED FOR THIS PATIENT DURING THE SAME ICU ADMISSION. PLEASE SUBMIT A NEW CLAIM WITH THE APPROPRIATE DAILY MODIFIER. |
| GN069 | SERVICE ENCOUNTER HAS BEEN DISALLOWED (REFUSED) AS THE SERVICE DATE IS NOT WITHIN THE APPROVED DATE RANGE. |
| MA061 | SERVICE ENCOUNTER HAS BEEN DISALLOWED. PLEASE SUBMIT A REASSESS (ACTION CODE R) ALONG WITH A COPY OF THE OPERATIVE REPORT, AND INDICATE SKIN TO SKIN TIME IN TEXT TO AID IN THE ASSESSMENT. |
| MJ053 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 01.24C AT THE SAME ENCOUNTER. |
| VA066 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 60.59B AT THE SAME ENCOUNTER. |
| VT131 | CLAIM HAS BEEN DISALLOWED AS THIS SERVICE SHOULD BE BILLED IN GROUPS OF 3. IF 4 OR MORE ARE NECESSARY, SUBMIT AN ADDITIONAL SERVICE OCCURRENCE FOR EACH ADDITIONAL GROUP OF 3 WITH TEXT. |

BACK TO CONTENTS

## UPDATED FILES

Updated files reflecting changes are available for download on Friday, May 22, 2015. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanatory codes (EXPLAIN.DAT), modifier values (MODVALS.DAT) and diagnostic codes (DIAG_CD.DAT).

## HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

www.medavie.bluecross.ca\msiprograms

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

## CONTACT INFORMATION

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Fax: 902-490-2275
Email: MSI_Assessment@medavie.bluecross.ca

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

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Toll-Free: 1-800-387-6665 (in Nova Scotia)
TTY/TDD: 1-800-670-8888

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BACK TO CONTENTS

PHYSICIAN'S BULLETIN
May 8, 2015: Vol. LI, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

# Notice to Physicians

## WCB SPECIAL AUTHORIZATION

In order to accommodate the WCB Special Authorization process the following new health service codes will be available for billing effective May 11, 2015.

| Category | Code | Description | Value |
|---|---|---|---|
| DEFT | WCB22 | Completed Mandatory Generic Exemption Request Form | $12.50 |
| DEFT | WCB23 | Completed Non-Opioid Special Authorization Request Form | $12.50 |
| DEFT | WCB24 | Completed Opioid Special Authorization Request Form | $42.00 |
| DEFT | WCB25 | Completed WCB Substance Abuse Assessment Form | $28.00 |

For further information please refer to the toolkit that was mailed to you or visit www.wcb.ns.ca/formulary

BACK TO CONTENTS

PHYSICIAN'S BULLETIN
March 27, 2015: Vol. LI, ISSUE 2

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



# MSI News

## BULK BILLING TRANSITION PROJECT

**CLAIMS SYSTEM UNDERGOING MODERNIZATION – AN ARTICLE BY DR. RHONDA CHURCH**

Historically, many hospital based services provided by some specialties such as pathology, radiology and internal medicine have had a unique payment system known as bulk billing. Physicians submit claims for services based on the number of services provided. MSI is in the process of transitioning to the standard patient-specific claims system for these services. Rather than these claims being submitted as the total number of services provided, a standard claim which includes information such as the patient's name, health card number, and date of service will be needed.

The primary reasons why this transition is taking place are as follows:

- The current bulk billing structure creates critical information gaps, most notably in patient history. The move to patient specific billing will result in improvements to the longitudinal patient record.
- Under the current bulk-billed system, the Department of Health and Wellness cannot reciprocally bill for services provided to out of province residents. The transition to an electronic claims submission system remedies that situation, as this method requires patient specific details with each billing code.

**Transition timeline**
A detailed communications package was mailed (September 2014) to physicians who will be affected by this change. Internal Medicine services successfully transitioned from bulk billing to electronic claims on March 1, 2015. Pathology and Radiology services will transition on April 1, 2015.

**New health codes**
Billing rules as established in the Preamble, Physician's Manual and Bulletins remain unchanged. However, some existing health service codes have been deleted and replaced with modifiers to allow claims for 35% and 50% premium modifiers.

**Service date requirement**
One other notable requirement is that the date of service on the claim must reflect the date the patient received the service rather than the date the physician interpreted the study or signed the final report. For example, if a chest radiograph or a surgical biopsy is taken on April 5th but the study was reported on the April 6th and the report signed on the April 7th, the date on the claim should be April 5th. This will provide consistency in billing practices and assist in retrieval of the clinical record, should it be required to substantiate the claim.

BACK TO CONTENTS

BACK TO CONTENTS

Medavie Blue Cross, as the administrator of the MSI program, is committed to a smooth transition for all Internal Medicine, Pathology and Radiology physicians and stakeholders. As we continue with the transition to electronic billing, we will continue the important dialogue with all stakeholders that has already begun.

Project news and changes will continue to be shared with all affected specialties through the various documents on MSI Website, emails and official bulletin updates. For up-to-date information, please visit the Bulk Billing Transition page on the MSI website.

The following documents are a few of the important information documents that have been published on the MSI Website for your reference:

Internal Medicine Rules Communication

Radiology Rules Communication

Pathology Rules Communication

Questions concerning new or existing business arrangements may be directed to msiproviders@medavie.ca and those concerning the claims submission process to MSI_Assessment@medavie.ca

**Rhonda Church, MD,**
**Medical Consultant, MSI Programs, Medavie Blue Cross**

BACK TO CONTENTS

BACK TO CONTENTS

## NEW FEES

Effective April 1, 2015 the following new health service code is available for billing:

| Category | Code | Modifiers | Description | Base Units | Anaes Units |
|---|---|---|---|---|---|
| ADON | 02.89C | | **Ultrasound performed by radiologist during premium time**<br><br>This add-on fee is to be used when an ultrasound must be performed directly by the radiologist due to the absence of an ultrasound technologist, and when it must be done without delay due to the medical condition of the patient during designated times where premium fees may be claimed (Preamble 5.1.84). Each ultrasound must be performed directly by the radiologist (not the resident or fellow) and must include archived diagnostic ultrasound images, a written permanent report, and a verbal report when requested.<br><br>**Billing Guidelines**<br>Add on to the following HSC's only when US=PREM, or US=PR50:<br>R1205 Ultrasound Abdomen General 25.39<br>R1212 Ultrasound Appendix 18.75<br>R1220 Ultrasound Pelvis 18.75<br>R1225 Endovaginal 26.95<br>R1226 Endovaginal with pelvic 38.70<br>R1275 Ultrasound Scrotum 25.45<br>R1345 Doppler – extremities 18.75<br>Not to be billed when the scan is performed by the radiology resident or fellow.<br><br>**Specialty Restriction**<br>DIRD, RADI<br><br>**Location**<br>HOSP | 30 MSU | |

BACK TO CONTENTS

# PREAMBLE REVISIONS

BACK TO CONTENTS

PREMIUM FEES

Effective March 27, 2015, select interventional cardiology procedures will be eligible for premium fees, when performed in a cardiac catheterization laboratory.

Eligible interventional cardiology procedures:

| Category | Code | Description |
|---|---|---|
| VADT | 49.96B | Left heart catheterization with angiograms and selective coronary arteriogram |
| VADT | 48.0A | Percutaneous coronary angioplasty (including selective coronary arteriography and right heart catheterization) |
| VADT | 48.0F | Insertion of intracoronary stent - includes one angiogram When a stentor is called in to place a stent during angioplasty by another interventional cardiologist, only 50 units is payable to the stentor. When three or more stents are placed, an additional 25 units is payable regardless of the number of additional stents) - plus multiples, if applicable |

Note: Documentation of the time of the procedure and the reason for it being performed during premium hours must appear on the health record for audit purposes. Electively booked procedures do not qualify for premium billing.

BACK TO CONTENTS

BACK TO CONTENTS

## BILLING CLARIFICATION

Non-insured Services - Psychotherapy

Effective April 1, 2015 the following are excluded from the definition of insured psychotherapy and will be added to the list of services not insured by MSI:

- Mindfulness, movement therapy, energy therapy, and other types of alternative or integrative treatments.

## BILLING REMINDERS

Immunizations Given by Pharmacists

Beginning in 2013, Nova Scotia pharmacists have been authorized to provide some immunizations to Nova Scotia residents. It has come to MSI's attention that some physicians are claiming for vaccines administered by pharmacists. A physician cannot claim for vaccines administered by a pharmacist.

Synoptic Reporting

This is a reminder that no matter how a patient health record is reported (dictation, synoptic reporting, hand written, etc.) all elements associated with an appropriate claim are still required. Physicians are responsible for ensuring that an appropriate medical record is maintained for all services claimed to MSI (Preamble Section 1.1.33), regardless of the reporting method. In particular, where a procedural code is claimed, the patient record of that procedure must contain information that is sufficient to verify the type and extent of the procedure according to the fees claimed (Preamble Section 1.1.35). While we recognize the potential benefits of synoptic reporting, physicians need to ensure the report is complete. Synoptic reporting software used should enable free text to assist physicians to tailor the information in the medical report, as needed, to reflect the services provided to the patient. If a free text option is not available, it is the physician's responsibility to ensure supporting documentation is incorporated into the medical report as required.

Shadow Billing

All Physicians must submit original claims to MSI within 90 days of the date of service. This includes physicians who shadow bill.

Claims for registered hospital in-patients must also be submitted within the 90-day time limitation regardless if the patient has been discharged or continues on an in-patient basis. It is incumbent on the physician to obtain the required billing information for these patients and submit claims within the prescribed time limitations. Explanations relating to late discharge summaries, or facilities not consolidating the required information for the physician, cannot be accepted as a valid explanation for a late submission.

Service Encounters submitted over the 90-day time limitation will be adjudicated to pay "zero" with the following exceptions:

- Reciprocal billing claims (out of province) must be submitted within 12 months of the date of service.
- Resubmission of refused claims or incorrect billings. These claims must be resubmitted to MSI within 185 days of the date of service. Each resubmission must contain an annotation in the text field of the Service Encounter submission referencing the previous Service Encounter Number.

BACK TO CONTENTS

# BILLING REMINDERS CONTINUED

Comprehensive Visit Services

Health service codes exist for both comprehensive and limited visit services. Health service code 03.04 is an unreferred comprehensive visit and health service code 03.03 is an unreferred limited visit. The referred equivalents are health service codes 03.08 (comprehensive consultation) and 03.07 (limited consultation).

Comprehensive visits may be claimed when necessitated by the seriousness, complexity or obscurity of the patient's complaint(s) or medical condition and ensuring a complete history is recorded and a physical examination appropriate to the physician's specialty and working diagnosis are documented. This is outlined in Preamble sections 5.1.7 and 5.1.8.

Documentation of all of the following provide a clear indication that a comprehensive visit or comprehensive consultation has taken place:

A detailed patient history including:

- Relevant history of presenting complaint
- Relevant past medical and surgical history
- Medication list
- Allergies
- Family history, as appropriate
- Social history, as appropriate

As well as a physical exam including:

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

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

Services Not Insured by MSI

Services available to residents of Nova Scotia under the Workers' Compensation Act or through the Department of Veterans Affairs are not insured by MSI. Please refer to Preamble sections 2.2.1 and 2.2.2. The physician must determine who has responsibility for payment, if any.

For example:

- Physician services related to a Workers' Compensation Board (WCB) covered work injury. WCB claims are to be billed to WCB, these services are not insured by MSI.
- Physician services related to a Veterans Affairs Canada (VAC) recognized service disability. These claims are to be billed to VAC, they are not insured by MSI.

BACK TO CONTENTS

## NEW AND UPDATED EXPLANATORY CODES

BACK TO CONTENTS

New explanatory codes effective March 27, 2015

| Code | Description |
|---|---|
| **AD055** | SERVICE ENCOUNTER HAS BEEN REFUSED AS THERE IS NO CLAIM FOR AN ELIGIBLE PREMIUM SERVICE BILLED AT THE SAME ENCOUNTER. |
| **BK041** | SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS FACILITY IS NOT PERMITTED TO CLAIM FOR THESE MAMMOGRAM FEES. |
| **BK042** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR RENAL STATIC IMAGING AT THE SAME ENCOUNTER. |

Below is an explanatory code that will be updated effective March 27, 2015 to state the following:

| Code | Description |
|---|---|
| **GN064** | SURGICAL ASSIST CLAIMS (RO=SRAS) CANNOT BE CLAIMED UNTIL AFTER THE SURGEONS CLAIM HAS BEEN RECEIVED AND PROCESSED. ONCE THIS IS COMPLETE, YOU MAY RESUBMIT USING THE SAME HSC AS THE SURGEON. |

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

### UPDATED FILES

Updated files reflecting changes are available for download on Friday, March 27, 2015. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanatory codes (EXPLAIN.DAT), modifier values (MODVALS.DAT) and diagnostic codes (DIAG_CD.DAT).

### HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

www.medavie.bluecross.ca\msiprograms

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

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**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

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TTY/TDD: 1-800-670-8888

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BACK TO CONTENTS

# PHYSICIAN'S BULLETIN

January 30, 2015: Vol. LI, ISSUE 1


NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



## MSI News

### BULK BILLING TRANSITION PROJECT

**IMPORTANT DATE CHANGES**

The Department of Health and Wellness and MSI have undertaken a project to align physician billing across Nova Scotia. This will move all physicians to electronic claims submissions.

This project involves key physician groups (Radiology, Internal Medicine and Pathology) who are receiving direct communications on the project. There will be, from time to time, important project updates shared in the MSI Bulletin & on the MSI website.

www.medavie.bluecross.ca/msiprograms

Important update:

Throughout the Bulk Billing Transition project rollout, stakeholders have raised concerns regarding implementation timelines and technical requirements. Ongoing discussions have led to an agreement to extend the transition timelines for all groups.

The aim is to provide physicians with additional time to update and/or modify billing systems to meet the technical requirements for patient specific billing. It is the responsibility of the physician to determine the business process they will implement to submit claims in the required MSI patient specific format.

New transition dates:

| |
|---|
| Internal Medicine – new go live date March 1, 2015 |
| Radiology – new go live date April 1, 2015 |
| Pathology – new go live date April 1, 2015 |

As we continue with the transition to electronic billing, we will continue this important dialogue with all stakeholders. Project news and changes will continue to be shared with all impacted groups through the FAQ, emails and official bulletin updates.

There will be an opportunity in the coming weeks to engage in dialogue and address questions. Additional information on the stakeholder discussions will be shared soon.

**We would welcome the opportunity to address any and all questions. Your questions can be forwarded by telephone 1-902-496-7011 or via e-mail at MSI_Assessment@medavie.bluecross.ca**

BACK TO CONTENTS

# MSI News Internal Medicine Health Services Codes and Rules

BACK TO CONTENTS

Effective March 1, 2015 the health service codes & MSU values used to bulk bill Internal Medicine services will remain the same for the switch to electronic billing.

| CATEGORY | HEALTH SERVICE CODE | DESCRIPTIONS/MODIFIERS | BASE UNITS |
|---|---|---|---|
| BULK | I1168 | Electrocardiogram – interpretation LO=HOSP | 4.60 |
| BULK | I1171 | Electroencephalogram - interpretation only LO=HOSP | 10.50 |
| BULK | I6208 | Holter monitoring - interpretation only LO=HOSP | 25.00 |
| BULK | I1110 | Simple spirometry LO=HOSP | 5.00 |
| BULK | I1140 | Flow / volume loops LO=HOSP | 5.00 |
| BULK | I1210 | Helium dilution LO=HOSP | 5.00 |
| BULK | I1410 | Carbon monoxide single breath LO=HOSP | 5.00 |
| BULK | I1710 | Pulmonary stress test LO=HOSP | 20.00 |
| BULK | I1120 | Bedside spirometry LO=HOSP | 5.00 |
| BULK | I1230 | Body plethysmography LO=HOSP | 5.00 |
| BULK | I1311 | M – mode LO=HOSP | 25.44 |
| BULK | I1310 | Two dimensional LO=HOSP | 47.56 |
| BULK | I1312 | Doppler – quantitative LO=HOSP | 30.45 |
| BULK | I1313 | Doppler – qualitative LO=HOSP | 15.23 |

Billing Tips:

- The service date for electronic claims should be the date the patient had the procedure conducted and not the date the interpretation was completed (if they differ). The fee is for the interpretation. Examples would include echocardiograms, electrocardiograms and pulmonary function tests.
- When a clinical service is provided by a physician to a patient this is referred to as a service occurrence. If the patient had a single encounter with the physician on a specific day for a specific clinical service, then the service occurrence would be set as one. If a second encounter occurred at a later time on the same day for a similar clinical service it would be submitted as service occurrence two. An example would be if a patient has spirometry performed at 10:00am, clinically deteriorates and has another medically necessary spirometry performed at 8:00 pm on the same day. For claims related to the second and subsequent encounters, text is required in order for those claims to be paid. This text must indicate the medical necessity of the subsequent service as well as the time of the occurrence. Any claims submitted with an occurrence number greater than one without text will be paid at zero. The only exemption to this will be claims for electrocardiograms, these will not require text.
- Location HOSP is required for all the above health service codes.
- Normally the payment responsibility for most services is entered as MSI. However, there are instances where the payment responsibility will change, for example; service encounters under Workers' Compensation Board (WCB) and Out of Province (OOP). If the service encounter is for a service provided to a non-resident registered with another provincial health plan except Quebec the home province code is entered in this field, e.g. NB, ON, PE. The service also requires a person data record for the non-resident. More information can be found in the Physician's Manual under section 3.2.115.
- Workers' Compensation Board service encounters for a non‐resident cannot be submitted electronically to MSI for payment. Service encounters for services provided, as a result of an on the job injury, to a non‐resident temporarily working for a Nova Scotia company, should be submitted directly to the Nova Scotia Workers' Compensation Board. More information can be found in the Physician's Manual under section 2.5.6.

BACK TO CONTENTS

BACK TO CONTENTS

## NEW FEES

Effective January 30, 2015 the following new health service codes are available for billing:
*revised Mar 31, 2020 - see May 2020 bulletin for updated information*

| Category | Code | Modifiers | Description | Base Units | Anaes Units |
|---|---|---|---|---|---|
| MASG | 57.59B | RO=FPHN<br>RO=SPHN | **Colectomy, partial with coloproctostomy (low pelvic anastomosis)**<br><br>Anterior resection of the rectosigmoid including mobilization of the colon, identification of the ureter, dissection of mesocolic vessels, with anastomosis of the bowel including all stapling as required (EEA stapler).<br><br>When an ileostomy is required an ADON fee may be used to bill for this portion of the procedure.<br><br>To bill as SPHN, the second surgeon must actively participate for 75% of the procedure time. When the second surgeon fee is billed no other assistant fee may be billed.<br><br>**Billing Guidelines**<br>Not to be billed with:<br>01.24C Sigmoidoscopy<br>58.11 Colostomy<br>58.21 Ileostomy for ulcerative colitis<br>58.39A Ileostomy with tube<br><br>**Specialty Restriction**<br>RO=FPHN restricted to GNSG<br>RO=SPHN restricted to GNSG<br><br>**Location:**<br>HOSP | 405 MSU<br>300 MSU | 8+T |
| ADON | 58.01A | RO=SPHN | **Ileostomy (loop or defunctioning)**<br><br>ADON to HSC 57.59B and 60.52B | 90 MSU<br>67.50 MSU | |

BACK TO CONTENTS

| Category | Code | Modifiers | Description | Base Units | Anaes Units |
|---|---|---|---|---|---|
| MASG | 60.4C | RO=FPHN<br>RO=SPHN | **Open Abdominoperineal resection; complete proctectomy with colostomy**<br><br>This fee is for the complete resection of the distal sigmoid colon, rectum, and anus with creation of end sigmoid colostomy and perineal dissection to remove the appropriate segment of bowel along with the anal sphincter. Includes mobilization of colon, identification of ureter, dissection of mesocolic vessels, division of colon, excision of rectum and delivery of sigmoid colon, rectum, and anus through the perineal incision.<br><br>To bill as SPHN, the second surgeon must actively participate for 75% of the procedure time. When the second surgeon fee is billed no other assistant fee may be billed.<br><br>**Billing Guidelines**<br>Not to be billed with any other fees for resection of bowel or formation of colostomy or ileostomy on the same patient same day.<br>Not to be billed with:<br>01.24C Sigmoidoscopy<br>58.11 Colostomy<br>58.21 Ileostomy for ulcerative colitis<br>58.39A Ileostomy with tube<br><br>**Specialty Restriction**<br>RO=FPHN restricted to GNSG<br>RO=SPHN restricted to GNSG<br><br>**Location**<br>HOSP | 550 MSU<br>400 MSU | 8+T |
| MISG | 23.99B | AG=CH03 | **Chemodenervation of extraocular muscle(s) for strabismus**<br><br>Botulinum toxin injections of the extraocular muscle(s) for strabismus, unilateral or bilateral, in patients up to three years of age.<br><br>**Billing Guidelines**<br>This fee is for the injection of one or more extraocular muscles in one or both eyes, same patient, same physician, same day.<br><br>**Specialty Restriction**<br>Paediatric OPHT<br><br>**Location**<br>HOSP | 25 MSU | 4+T |

*revised March 31, 2020 - see May 2020 bulletin for updated information*

BACK TO CONTENTS

| Category | Code | Modifiers | Description | Base Units | Anaes Units |
|---|---|---|---|---|---|
| MASG | 82.64D | | **Abdominal Sacral Colpopexy**<br><br>This fee is for the repair of a post-hysterectomy vaginal vault prolapse via the abdominal approach. This comprehensive fee includes lysis of adhesions, exposure of the ureter(s) as required, the attachment of mesh to the vaginal vault apex and suspension to the anterior sacrum, any enterocele repair, and cystoscopy if performed.<br><br>**Billing Guidelines**<br>May not be billed with:<br>1.34 Cystoscopy<br>71.02 Ureterolysis<br>82.7 Enterocele repair<br>68.98A Exploration of ureter<br><br>**Specialty Restriction**<br>OBGY<br><br>**Location**<br>HOSP | 350 MSU | 6+T |
| MASG | 82.64E | | **Laparoscopic Sacral Colpopexy**<br><br>This is a comprehensive, time-based fee for the laparoscopic repair of a post-hysterectomy vaginal vault prolapse. This comprehensive fee includes all procedures performed during the operative period on the same patient, same day. In order to bill this HSC the entire abdominal portion of the procedure must be performed laparoscopically.<br><br>**Billing Guidelines**<br>No other HSC's may be billed same physician, same patient, same service encounter.<br><br>**Specialty Restriction**<br>OBGY<br><br>**Location**<br>HOSP | IC at 140MSU/hr | 6+T |
| MASG | 82.64F | | **Colpopexy, vaginal; fixation to sacrospinous ligament(s)**<br><br>This fee is for the vaginal approach to vaginal vault suspension post-hysterectomy via attachment to the sacrospinous ligament(s) either unilateral or bilateral.<br><br>**Billing Guidelines**<br>Not to be billed with any other enterocele repair:<br>HSC 82.7<br>HSC 82.64B<br><br>**Specialty Restriction**<br>OBGY<br><br>**Location**<br>HOSP | 200 MSU | 6+T |

BACK TO CONTENTS

BACK TO CONTENTS

## FEE REVISIONS

Effective January 30, 2015 the following health service code has been revised.

| Category | Code | Modifiers | Description | Base Units | Anaes Units |
|---|---|---|---|---|---|
| MASG | 60.52B | RO=FPHN<br>RO=SPHN | **Laparoscopically Assisted Anterior Resection**<br><br>Laparoscopic resection of the appropriate segment of colon with coloproctostomy (low pelvic anastomosis). Includes mobilisation of colon, identification of the ureter, dissection of mesocolic vessels, division of colon, delivery of colon through the extraction site, with intra- or extra-corporeal anastomosis of bowel (including EEA stapling), to include all stapling, and closure of the extraction site.<br><br>When an ileostomy is required an ADON fee may be used to bill for this portion of the procedure.<br><br>To bill as SPHN, the second surgeon must actively participate for 75% of the procedure time. When the second surgeon fee is billed no other assistant fee may be billed.<br><br>**Billing Guidelines**<br>This is intended to be a comprehensive fee for the entire procedure.<br>Not to be billed with:<br>1.24C Sigmoidoscopy<br>58.11 Colostomy<br>58.21 Ileostomy for ulcerative colitis<br>58.39A Ileostomy with tube<br>66.19 Other Laparotomy,<br>66.83 Laparoscopy,<br>60.52A Lower anterior Resection where EEA stapler is used.<br><br>**Specialty Restriction**<br>Primary surgeon: Minimally Invasive Surgeon MIS<br>RO=SPHN restricted to GNSG<br><br>**Location**<br>HOSP | 420 MSU<br>315 MSU | 8+T |

Effective January 29, 2015 the following health service code will no longer be active

| Category | Code | Modifiers | Description | Base Units | Anaes Units |
|---|---|---|---|---|---|
| MASG | 60.4A | | **Abdominal-perineal resection plus colostomy** | 450 MSU | 8+T |

BACK TO CONTENTS

BACK TO CONTENTS

## BILLING REMINDERS

Surgeon and Surgical Assistant Claims

As outlined in the July 18, 2014 and November 21, 2014 Physician's Bulletin, surgical assistants are remunerated at 33.8% of the fee paid to the surgeon and the health service codes claimed for surgical assistant services are expected to align with those submitted by the primary surgeon and must adhere to Preamble rules. If a claim for a surgical assistant fee is received in the absence of a claim from the surgeon, the claim will be returned with explanatory code GN064 indicating that the claim cannot be paid as no claim has been submitted by a surgeon for this service. It is therefore important that the surgeon's claims are submitted to MSI in a timely manner and within the 90 day time frame to allow the surgical assistant to also be paid for these services. This includes billings from all revenue streams including shadow claims.

## NEW EXPLANATORY CODES

| Code | Description |
|---|---|
| **GN055** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED THE SURGEON / SURGICAL ASSIST FEE FOR THIS SERVICE. |
| **GN067** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 82.64D AT THE SAME ENCOUNTER. |
| **GN068** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY BILLED HSC 82.64E AT THE SAME ENCOUNTER. |
| **MA064** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR A SIGMOIDOSCOPY, COLOSTOMY, OR ILEOSTOMY AT THE SAME ENCOUNTER. |
| **MA065** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR 57.59B, 60.4C OR 60.52B AT THIS ENCOUNTER. IF YOU ARE ATTEMPTING TO CLAIM AN ILEOSTOMY WITH THIS PROCEDURE PLEASE USE THE ADDON HSC 58.01A |
| **MA066** | SERVICE ENCOUNTER HAS BEEN REFUSED AS A SECOND PHYSICIAN CLAIM EXISTS FOR THIS ENCOUNTER. A SURGICAL ASSIST CANNOT ALSO BE CLAIMED. |
| **MA067** | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 60.52B CANNOT BE CLAIMED WITH HSC 66.19, 66.83 OR 60.52A AT THE SAME ENCOUNTER |
| **MA068** | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 66.19 OR 66.83 CANNOT BE CLAIMED WITH HSC 60.52B AT THE SAME ENCOUNTER |
| **MJ050** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED ONE OF THE FOLLOWING HSCS 01.34A, B, C, D, E, F, G, H, 71.02, 82.7, OR 68.98A AT THE SAME ENCOUNTER. |
| **MJ051** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY BILLED AN ENTEROCELE REPAIR (HSC 82.7 OR 82.64B) AT THE SAME ENCOUNTER. |
| **MJ052** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY BILLED HSC 82.64F AT THE SAME ENCOUNTER. |
| **MN012** | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE ALREADY CLAIMED THIS SERVICE FOR THIS PATIENT ON THE SAME DAY. |
| **MN014** | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 60.52A CANNOT BE CLAIMED WITH 60.52B AT THE SAME ENCOUNTER |
| **VA065** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR A COLECTOMY WITH COLOPROCTOSTOMY AT THIS ENCOUNTER |
| **VT129** | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 82.64E IS A COMPREHENSIVE SERVICE AND YOU HAVE ALREADY CLAIMED ANOTHER SERVICE AT THE SAME ENCOUNTER. |
| **VT130** | SERVICE ENCOUINTER HAS BEEN REFUSED. THE DOCUMENTATION PROVIDED SUPPORTS AN INITIAL VISIT WITH COMPLETE EXAMINATION, NOT A CONSULT (SEE PREAMBLE 5.1.7). PLEASE RESUBMIT WITH THE APPROPRIATE HSC. |
| **WB033** | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE REQUIRED WCB FORM WAS NOT RECEIVED WITHIN THE APPROPRIATE TIME. |

BACK TO CONTENTS

BACK TO CONTENTS

## UPDATED FILES

Updated files reflecting changes are available for download on Friday, January 30, 2015. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanatory codes (EXPLAIN.DAT), and modifier values (MODVALS.DAT).

## HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

www.medavie.bluecross.ca\msiprograms

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

## 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

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BACK TO CONTENTS

PHYSICIAN'S BULLETIN
November 21, 2014: Vol. L, ISSUE 6

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



# MSI News

## PREPAYMENT ASSESSMENT CHANGES

**FALL 2014**

The team working on implementing the recommendations in John Carter's Physician Audit and Appeal Practices Report has reached a significant milestone. The threshold for pre-payment assessment of multiple claims in major surgery cases on the same patient, same day by the same provider has been increased from two to four.

MSI will implement the revised thresholds in the computer system effective November 21, 2014. Prepayment assessments will still be conducted on claims with less than four health service codes on a random basis.

Doctors Nova Scotia, Department of Health and Wellness (DHW) and MSI have been working to address the recommendations in John Carter's Physician Audit and Appeal Practices report. As recommended by the Carter report, DHW has reviewed the results of prepayment assessment and based on this review, the thresholds have been raised.

## BULK BILLING TRANSITION PROJECT

**FALL 2014**

The Department of Health and Wellness and MSI have undertaken a project to align physician billing across Nova Scotia. It is titled **The Bulk Billing Transition Project.** This will move all physicians to electronic claims submissions by the end of 2015.

This project impacts key physician groups who are receiving direct communications on the project. There will be, from time to time, important project updates shared in the MSI Bulletin. These updates apply only to those impacted physician groups.

**About the project:**

Currently the majority of Radiology, Pathology and some Internal Medicine claims are submitted to MSI under a bulk billing method which consists of manual, non-patient specific claims. By contrast, electronic claim submission, which is used for all other physician billing in the province, provide detailed patient information on every digital claim. This difference between billing systems creates a number of challenges (including incomplete MSI patient histories and an inability to reciprocally bill for non-resident procedures) that can be remedied by moving all billing to an electronic system.

**Update to impacted physician groups:**

Since the Bulk Billing Transition project implementation began, there have been concerns raised around potential impacts of the new electronic billing requirements, specifically the timing of the transitions.

MSI is committed to working with all stakeholders to ensure a smooth transition we recognize that changes come with challenges. There have been recent discussions between the Department of Health and Wellness, Doctors Nova Scotia, MSI and a number of impacted physician groups regarding project timelines and logistical requirements.

In response to those concerns, and to better assist physicians with their transitions to the new electronic billing system, we are **moving all go-live dates from December 1, 2014 to February 1, 2015.**

This is a new date change for Internal Medicine physicians. This does not impact Radiology or Pathology physicians as the go-live date for both groups was February 1, 2015 prior to this notice.

As we continue with the transition to electronic billing, we will continue this important dialogue with all stakeholders. Project news and changes will be shared in a timely manner with all impacted groups through the FAQ, emails and official bulletin updates.

If you have questions at any time, please contact us at 1-902-496-7011 or visit us online.
www.medavie.bluecross.ca/msiprograms

BACK TO CONTENTS

## NEW FEES

Effective November 21, 2014 the following new health service codes are available for billing:
*Updated March 31, 2020 – See May 2020 Bulletin for updated information*

| Category | Code | Modifiers | Description | Base Units | Anaes Units |
|---|---|---|---|---|---|
| MASG | 60.55C | | **Closure of Enterostomy, large or small intestine; with resection and colorectal/ileorectal anastomosis (eg, closure of Hartmann type procedure)**<br><br>This comprehensive fee includes all of the procedures required to perform the closure of an existing enterostomy including mobilization of the intestine, resection of bowel to remove the enterostomy site, lysis of adhesions, pelvic dissection, exploration and identification of ureter, mobilization of the rectum with resection of the upper rectum as required, and repair of any existing parastomal or incisional hernia. Open, laparoscopic, or combined approach.<br><br>**Billing Guidelines**<br>Not to be billed with:<br>MASG 57.59 Other partial excision of large intestine<br>MASG 60.52 Other anterior resection<br><br>**Specialty Restriction:**<br>GNSG<br><br>**Location:**<br>HOSP | 390 MSU | 8+T |
| VEDT | 03.38A | RO=INTP | **Bronchial Challenge Testing with methacholine or similar compounds – includes baseline spirometry and all spirometric determinations post administration of agent(s)**<br><br>This fee is for the interpretation of the testing and a written report. The physician must be present in the pulmonary function laboratory during the time of the testing to be available to deal with adverse events.<br><br>**Billing Guidelines:**<br>Billable only once per patient per day.<br>Not to be billed with any additional spirometry same patient same day.<br>I1110 Simple Spirometry<br>I1140 Flow Volume Loops<br>Billable only when the testing is done in the hospital based pulmonary function laboratory.<br><br>**Specialty Restriction:**<br>INMD, PEDI<br><br>**Location:**<br>HOSP | 19 MSU | |

BACK TO CONTENTS

## FEE REVISIONS

Effective November 21, 2014 the following health service code will have a specialty restriction of UROL.

| Category | Code | Modifiers | Description | Base Units | Anaes Units |
|---|---|---|---|---|---|
| MASG | 71.02 | | **Ureterolysis with freeing or repositioning of ureter for peri-ureteral fibrosis (Regions required)**<br><br>**Specialty Restriction:**<br>UROL<br><br>**Location:**<br>HOSP | 215 MSU | 6+T |

Effective November 20, 2014, the following health service codes will no longer be active:

| Category | Code | Modifiers | Description | Base Units | Anaes Units |
|---|---|---|---|---|---|
| MASG | 60.55A | | **Colon/rectal reanastomosis after segmental resection where mucus fistula or Hartman procedure exists** | 250 MSI | 8+T |

## PROVINCIAL IMMUNIZATION CHANGES

Effective November 20, 2014 the following immunizations are termed:

| HSC | Modifier |
|---|---|
| 13.59L | RO=HAHB |
| 13.59L | RO=MENQ |
| 13.59L | RO=MMRT |
| 13.59L | RO=RABI |
| 13.59L | RO=RABV |
| 13.59L | RO=TEIG |
| 13.59L | RO=VAIG |

These immunizations are to be administered in high risk/post exposure situations only (as communicated through Public Health). Therefore, the base fee codes (without the high risk modifier) have been termed and replaced by the equivalent with the high risk modifier.

Effective November 21, 2014 the following immunizations are effective:

| HSC | Modifier |
|---|---|
| 13.59L | RO=HAHB with PT=RISK (previously implemented in September) |
| 13.59L | RO=MENQ with PT=RISK |
| 13.59L | RO=MMRT with PT=RISK |
| 13.59L | RO=RABI with PT=RISK |
| 13.59L | RO=RABV with PT=RISK |
| 13.59L | RO=TEDV with PT=RISK |
| 13.59L | RO=TEIG with PT=RISK (previously implemented in September) |
| 13.59L | RO=VAIG with PT=RISK (previously implemented in September) |

BACK TO CONTENTS

Immunization Information - Clarification

After release of the last Bulletin, MSI staff received inquiries about criteria for eligibility of some vaccines.

We have been advised by Public Health of the following:

Hepatitis B vaccine is covered for Nova Scotia residents under the following circumstances only:

- Grade 7 students when provided through the school based immunization program
- Post exposure prophylaxis for Hepatitis B
- *Pre-exposure prophylaxis for the following high risk groups:
    - Chronic liver disease
    - Chronic renal disease and dialysis
    - Congenital immunodeficiency
    - Hematopoietic stem cell transplant (HSCT)
    - HIV
    - Illicit drug use
    - High risk sexual practices
    - Solid organ transplant
    - Hemophiliacs and other people receiving repeated infusions of blood or blood products e.g. sickle cell disease.

Rabies vaccine and immunoglobulin are covered for post-exposure prophylaxis only.

Further information may be found at the following site: http://novascotia.ca/dhw/cdpc/documents/Immunization-Manual.pdf

# Billing Matters Billing Reminders, New Explanatory Codes

## BILLING REMINDERS

Health Service Codes 28.73F (Intravitreal injection of a pharmacologic agent for the treatment of specific retinal diseases) and 02.02A (Optical Coherence Tomography)

Effective November 12, 2013, changes were made to billing rules concerning health service code 28.73F (intravitreal injection of a pharmacologic agent for the treatment of specific retinal diseases) such that this health service code could be claimed for patients with wet age-related macular degeneration (AMD), diabetic macular edema (DME) or retinal vein occlusion (RVO) when treating with an appropriate pharmacologic agent (i.e. intravitreal drugs).

Health service code 02.02A (Optical Coherence Tomography) may be claimed by the ophthalmologist treating a patient with one of these pharmacologic agents for one of the conditions listed above. The OCT may only be billed in association with the injection or to guide whether an injection is required. OCT may be claimed to a maximum of six times per patient per year and a written report of the image interpretation is to be recorded in the clinical record.

Surgical Assistant Claims

As outlined in the July 18, 2014 Physician's Bulletin, surgical assistants are remunerated at 33.8% of the fee paid to the surgeon and the health service codes claimed for surgical assistant services are expected to align with those submitted by the primary surgeon and must adhere to Preamble rules. If a claim for a surgical assistant fee is received in the absence of a claim from the surgeon, the claim will be returned with explanatory code GN064 indicating that the claim cannot be paid as no claim has been submitted by a surgeon for this service.

ICU Day 1

If a patient is transferred from one ICU to a second ICU within the same facility, both physicians may claim ICU codes on the day of transfer but the physician attending the patient in the receiving ICU cannot claim another Day 1. However, if a patient is transferred to a new facility i.e., another hospital, a new ICU day 1 may be claimed.

Within the same facility, a second ICU Day 1 may only be claimed if the patient is discharged from the ICU and readmitted at least 24 hours after the ICU discharge.

BACK TO CONTENTS

## BILLING REMINDERS CONTINUED

MSI Documentation Reminder

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribe, and start and stop times if applicable.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptions, or emotional problems, the physician "deliberately established a professional relationship with the patient for the purposes of removing, modifying or alleviating existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional well being of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy," etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service on that date, then the service is not paid for or a lesser benefit is given. **When the clinical record does not support the service claimed, there will be a recovery to MSI at the time of audit.** Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

## NEW EXPLANATORY CODES

| Code | Description |
|---|---|
| AD054 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 90.09G FOR THIS PATIENT ON THIS DAY. |
| BK017 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR AN ULTRASOUND OF THE AORTA, APPENDIX, KIDNEYS, OR PYLORUS AT THE SAME ENCOUNTER. THESE ARE MEANT TO BE INCLUDED IN THE ABDOMEN GENERAL ULTRASOUND FEE. |
| BK018 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR AN ABDOMEN GENERAL ULTRASOUND AT THE SAME ENCOUNTER. AN ULTRASOUND OF THE AORTA, APPENDIX, KIDNEYS, OR PYLORUS IS MEANT TO BE INCLUDED IN THE ABDOMEN GENERAL ULTRASOUND FEE. |
| BK019 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR AN U/S OF THE AORTA, APPENDIX, KIDNEYS, OR PYLORUS AT THE SAME ENCOUNTER. THESE FEES ARE NOT CUMULATIVE. AN ABDOMINAL GENERAL U/S (HSC R1205) IS THE COMPOSITE FEE FOR THESE SERVICES. |
| BK020 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS FEE IS CONSIDERED TO BE AN ADD ON CODE AND MAY ONLY BE CLAIMED AFTER A BASE SERVICE HAS BEEN BILLED. |

BACK TO CONTENTS

| | |
|---|---|
| BK021 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR AN ENDOVAGINAL U/S (R1225) AT THE SAME ENCOUNTER. TO CLAIM FOR BOTH, PLEASE SUBMIT A DELETE FOR THE ENDOVAGINAL U/S AND CREATE A NEW CLAIM FOR ENDOVAGINAL WITH PELVIC (R1226). |
| BK022 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR AN PELVIC ULTRASOUND (R1220) AT THE SAME ENCOUNTER. TO CLAIM FOR BOTH, PLEASE SUBMIT A DELETE FOR THE PELVIC ULTRASOUND AND CREATE A NEW CLAIM FOR ENDOVAGINAL WITH PELVIC (R1226). |
| BK023 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR THE ENDOVAGINAL AND PELVIC ULTRASOUND COMBINATION FEE AT THE SAME ENCOUNTER. |
| BK024 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED A CLAIM FOR EITHER THE STAND ALONE PELVIS ULTRASOUND OR ENDOVAGINAL ULTRASOUND FEE. |
| BK025 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED FOR ANOTHER CODE AT THE SAME ENCOUNTER. WHEN THE INTRAOPERATIVE CODE IS USED, NO OTHER CODE MAY BE CLAIMED FOR THAT EXAMINATION. |
| BK026 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED FOR AN INTRAOPERATIVE ULTRASOUND FEE AT THE SAME ENCOUNTER. WHEN THE INTRAOPERATIVE CODE IS USED, NO OTHER CODE MAY BE CLAIMED FOR THAT EXAMINATION. |
| BK027 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.38A HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY. |
| BK028 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED THE BILATERAL FEE CODE FOR THIS SERVICE AT THE SAME ENCOUNTER. |
| BK029 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED THE UNILATERAL FEE CODE FOR THIS SERVICE AT THE SAME ENCOUNTER. PLEASE SUBMIT A DELETE FOR THE UNILATERAL SERVICE BEFORE CLAIMING THE BILATERAL FEE. |
| BK030 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED A VENOGRAM EXTREMITY CLAIM AT THE SAME ENCOUNTER. THE VENOGRAM EXTREMITY FEE INCLUDES THE CENTRAL FILM. |
| BK031 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED A CENTRAL FILM CLAIM AT THE SAME ENCOUNTER. A VENOGRAM EXTREMITY FEE INCLUDES THE CENTRAL FILM. PLEASE SUBMIT A DELETE FOR HSC R605 BEFORE RESUBMITTING THE VENOGRAM EXTREMITY FEE. |
| BK032 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED A RENAL SCAN AND RENOGRAM CLAIM AT THE SAME ENCOUNTER. |
| BK033 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED AN A.C.E. RENAL SCAN CLAIM AT THE SAME ENCOUNTER. |
| BK034 | SERVICE ENCOUNTER HAS BEEN DISALLOWED. PLEASE RESUBMIT, INDICATING IN THE TEXT FIELD WHO PERFORMED THE INJECTION. |
| BK035 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS FEE IS CONSIDERED TO BE AN ADD ON CODE AND MAY ONLY BE CLAIMED AFTER A RENAL SCAN (R1875, R1880, OR R1881) HAS BEEN BILLED. |
| BK036 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR THE MULTIPLE AREAS FEE AT THE SAME ENCOUNTER. |
| BK037 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR THE SINGLE AREA FEE AT THE SAME ENCOUNTER. |
| BK038 | SERVICE ENCOUNTER HAS BEEN REFUSED AS AN AUTOPSY HAS ALREADY BEEN CLAIMED FOR THIS INDIVIDUAL. |
| BK039 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED A VISIT FOR THIS INDIVIDUAL AT THE SAME ENCOUNTER. |
| BK040 | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED A CONSULT FOR THIS INDIVIDUAL AT THE SAME ENCOUNTER. |
| MJ047 | SERVICE ENCOUINTER HAS BEEN REFUSED AS HSC 57.59 OR 60.52 HAS PREVIOUSLY BEEN BILLED FOR THIS PATIENT ON THE SAME DAY. |

BACK TO CONTENTS

| | |
|---|---|
| MJ048 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 60.55C HAS PREVIOUSLY BEEN BILLED FOR THIS PATIENT ON THE SAME DAY. |
| MJ049 | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 90.06B FOR THIS PATIENT ON THIS DAY. |
| VE009 | SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THE SAME DAY. |
| VE010 | SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC I 1110 OR I 1140 HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY. |

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

### UPDATED FILES

Updated files reflecting changes are available for download on Friday, November 21, 2014. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanatory codes (EXPLAIN.DAT), and modifier values (MODVALS.DAT).

### HELPFUL LINKS

**NOVA SCOTIA MEDICAL INSURANCE (MSI)**

www.medavie.bluecross.ca\msiprograms

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

www.novascotia.ca/dhw/

### CONTACT INFORMATION

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BACK TO CONTENTS

## 2015 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

| PAPER CLAIMS | ELECTRONIC CLAIMS | PAYMENT DATE |
|---|---|---|
| **December 23, 2014 **** | **December 31, 2014**** | January 7, 2015 |
| January 12, 2015 | January 15, 2015 | January 21, 2015 |
| January 26, 2015 | January 29, 2015 | February 4, 2015 |
| **February 6, 2015**** | **February 11, 2015**** | February 18, 2015 |
| February 23, 2015 | February 26, 2015 | March 4, 2015 |
| March 9, 2015 | March 12, 2015 | March 18, 2015 |
| March 23, 2015 | March 26, 2015 | April 1, 2015 |
| April 6, 2015 | April 9, 2015 | April 15, 2015 |
| April 20, 2015 | April 23, 2015 | April 29, 2015 |
| May 4, 2015 | May 7, 2015 | May 13, 2015 |
| **May 15, 2015**** | May 21, 2015 | May 27, 2015 |
| June 1, 2015 | June 4, 2015 | June 10, 2015 |
| June 15, 2015 | June 18, 2015 | June 24, 2015 |
| **June 26, 2015**** | July 2, 2015 | July 8, 2015 |
| July 13, 2015 | July 16, 2015 | July 22, 2015 |
| **July 24, 2015**** | **July 29, 2015**** | August 5, 2015 |
| August 10, 2015 | August 13, 2015 | August 19, 2015 |
| August 24, 2015 | August 27, 2015 | September 2, 2015 |
| **September 4, 2015**** | September 10, 2015** | September 16, 2015 |
| September 21, 2015 | September 24, 2015 | September 30, 2015 |
| **October 2, 2015**** | **October 7, 2015**** | October 14, 2015 |
| October 19, 2015 | October 22, 2015 | October 28, 2015 |
| **October 30, 2015**** | **November 4, 2015**** | **November 10, 2015**** |
| November 16, 2015 | November 19, 2015 | November 25, 2015 |
| November 30, 2015 | December 3, 2015 | December 9, 2015 |
| December 14, 2015 | December 17, 2015 | December 23, 2015 |
| **December 23, 2015**** | **December 30, 2015**** | January 6, 2016 |
| **11:00 AM CUT OFF** | **11:59 PM CUT OFF** | |
| | | |

**NOTE:**

Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Radiology, Pathology, Internal Medicine Monthly Statistical Reports, Sessional Payments and Locum Claim Forms. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut off date to ensure processing for that payment period.

**PLEASE NOTE, THE ** INDICATES A DATE VARIATION**

## HOLIDAY DATES FOR 2015

| Please make a note in your schedule of the following dates MSI will accept as "Holidays." | |
|---|---|
| NEW YEAR'S DAY | THURSDAY, JANUARY 1, 2015 |
| HERITAGE DAY | MONDAY, FEBRUARY 16, 2015 |
| GOOD FRIDAY | FRIDAY, APRIL 3, 2015 |
| EASTER MONDAY | MONDAY, APRIL 6, 2015 |
| VICTORIA DAY | MONDAY, MAY 18, 2015 |
| CANADA DAY | WEDNESDAY, JULY 1, 2015 |
| CIVIC HOLIDAY | MONDAY, AUGUST 3. 2015 |
| LABOUR DAY | MONDAY, SEPTEMBER 7, 2015 |
| THANKSGIVING DAY | MONDAY, OCTOBER 12, 2015 |
| REMEMBRANCE DAY | WEDNESDAY, NOVEMBER 11, 2015 |
| CHRISTMAS DAY | FRIDAY, DECEMBER 25, 2015 |
| BOXING DAY | MONDAY, DECEMBER 28, 2015 |
| NEW YEAR'S DAY | FRIDAY, JANUARY 1, 2016 |

PHYSICIAN'S BULLETIN
SEPTEMBER 26, 2014: Vol. L, ISSUE 5

NOVA SCOTIA MEDICAL SERVICES INSURANCE

## CONTENTS



# MSI News

## PHYSICIAN'S MANUAL UPDATE

**2014**

The Department of Health and Wellness in collaboration with Medavie Blue Cross and Doctors Nova Scotia are pleased to announce that the MSI Physician's Manual has undergone an update as result of the Nova Scotia Physician's Manual Modernization Project (NS PMMP). This newly updated Physician's Manual is a significant deliverable of the NS PMMP. A key goal of the NS PMMP is to prepare and sustain accurate and supporting documentation. As a result of this, the NS PMMP Steering Committee recommended that one of the first activities be to improve existing documentation for physicians and billing clerks.

The most significant change physicians and their billing clerks will notice is that the new manual merges the content of the previous Physician's Manual and the Billing Instructions Manual. Policy changes made from January to December 2013 including those approved by the Master Agreement Steering Group has been included in this version; however it may be necessary to refer to Bulletins for additional detailed information.

The work completed to achieve this goal included:

- Simplifying the document layout to improve readability.
- Analyzing and merging the content of the NS MSI Physician's Manual 2012 and the NS MSI Billing Instructions Manual 2012 in logical order.
- Critical appraisal to ensure the merging did not affect the content meaning.
- NS PMMP Working Group and Steering Committee review of the document structure, layout and content changes required to address duplication.
- Formal tracking of the content of each document as the merged Nova Scotia Medical Services Insurance Physician's Manual 2014 was created.
- Integrating policy changes made from January to December - 2013 including those approved by the Master Agreement Steering Group.

Other changes that have been made to the new version of the Physician's Manual are as follows:

- The introductory page to each section provides an overview of the content of the section and includes the definitions of key terms.
- Italicized numeric paragraph identifiers (e.g. 1.0.2) are included at the end of all headings and paragraphs in Section 1 to 7. These identifiers can be used when needing to refer to a specific item, for example when a billing clerk is contacting MSI with a question.
- There are more cross‐references across Sections.
- Linked table of contents, updated index, and overall updated look & formatting changes

We are very pleased about the achievement of this deliverable and would like to thank everyone who contributed. The 2014 MSI Physician's Manual is now available at www.medavie.bluecross.ca/msiprograms

BACK TO CONTENTS

# MSI News

## BULLETIN REDESIGN

**NEW THIS ISSUE!**

The Department of Health and Wellness, in collaboration with Medavie Blue Cross and Doctors Nova Scotia is very pleased to announce the launch of the new redesigned Physician's Bulletin.

This critical document, which communicates key information on physician billing, now has a full table of contents that is web enabled for easy navigation. With a mouse click or a tap, readers will be able to swiftly navigate to content of interest or back to the main page. This front page contains an MSI news section to keep physicians and billing staff informed on latest developments. MSI's contact information is easily found on each page and content is grouped in categories making the flow of the document better and more intuitive.

Physician feedback has helped form the new design. Before the redesign began, physicians were surveyed for opportunities to improve the bulletin. Based on that feedback, a sample bulletin was created and the physicians were asked to test it. They were specifically asked to find key information, report the information and rate the ease with which they found the answers. They were also asked to provide additional thoughts on the new design.

The MSI Physician's Bulletin is only available electronically; physicians and billing staff must subscribe to receive the bulletin to ensure they are billing with the most up-to-date information.

Click here to subscribe

# ★ Fees New fees and highlighted fees

## PROVINCIAL IMMUNIZATION CHANGES

Changes have been made to the immunization modifiers and descriptions to align them more closely with national standards. This will assist with the production of provincial immunization coverage rates. Schedule of Provincial Immunizations is attached in Appendix A.

Effective September 25, 2014, the following provincial immunization modifiers have been termed:

| HSC | Modifier |
|---|---|
| 13.59L | RO=ADAC |
| 13.59L | RO=ADPO |
| 13.59L | RO=BOTR |
| 13.59L | RO=HPVV |
| 13.59L | RO=PAND |
| 13.59L | RO=TEDI |
| 13.59L | RO=VARI |

Effective September 26, 2014, the following new provincial immunization codes are available for billing:

| HSC | Modifier | Description |
|---|---|---|
| 13.59L | RO=HAHB | HAHB - Hepatitis A and B Vaccine |
| 13.59L | RO=HAHB(PT=RISK) | HAHB - Hepatitis A and B Vaccine (high risk patient) |
| 13.59L | RO=HBIG(PT=RISK) | HBIg - Hepatitis B Immunoglobulin (high risk patient) |
| 13.59L | RO=HBVV | HB - Hepatitis B Vaccine |
| 13.59L | RO=HBVV(PT=RISK) | HB - Hepatitis B Vaccine (high risk patient) |
| 13.59L | RO=HIBV | Hib - Haemophilus Influenzae Type B Vaccine |
| 13.59L | RO=HIBV(PT=RISK) | Hib - Haemophilus Influenzae Type B Vaccine (high risk patient) |
| 13.59L | RO=HPV4 | HPV -4 - Human Papillomavirus Vaccine |
| 13.59L | RO=PNEC(PT=RISK) | Pneu-P-13 - Pneumococcal-conjugate-valent Vaccine (high risk patient) |
| 13.59L | RO=PNEU(PT=RISK) | Pneu-P-23 - Pneumococcal-Polysaccharide-valent Vaccine (high risk patient) |
| 13.59L | RO=RABI | RabIg - Rabies Immunoglobulin |
| 13.59L | RO=RABV | Rab - Rabies Vaccine |
| 13.59L | RO=TDAP | Tdap - Tetanus, Toxoid, Diphtheria, Acellular Pertussis Vaccine |
| 13.59L | RO=TDPP | Tdap-IPV - Tetanus toxoid, Diphtheria, Acellular Pertussis, Polio |
| 13.59L | RO=TEDV | Td - Tetanus Toxoid, diphtheria Vaccine |
| 13.59L | RO=TEIG | Tetanus Immunoglobulin |
| 13.59L | RO=VAIG | VarIg - Varicella-Zoster Immunoglobulin |
| 13.59L | RO=VARV | Var - Varicella vaccine |
| 13.59L | RO=VARV(PT=RISK) | Var - Varicella vaccine (high risk patient) |

Effective September 26, 2014, the following provincial immunization descriptions have been changed:

| Modifier | Old Description | New Description |
|---|---|---|
| RO=INFL | Injection for various strains of Influenza | Inf – Influenza-Inactivated Vaccine |
| RO=MENC | Meningococcal type C Conjugate Vaccine | Men-C-C - Meningococcal conjugate Vaccine |
| RO=MENQ | Meningococcal Quadrivalent | Men-C-ACYW-135 - Meningococcal conjugate quadrivalent Vaccine |
| RO=MMAR | Injection for Measles, Mumps and Rubella | MMR - Measles, Mumps, Rubella Vaccine |
| RO=MMRT | Injection for Measles, Mumps and Rubella for travel only to areas of risk for Measles | MMRV - Measles, Mumps, Rubella and varicella for travel only to areas of risk for Measles |
| RO=MMRV | MMAR/VARI Injections | MMRV - Measles, Mumps, Rubella and Varicella Vaccine |
| RO=PENT | Injection for Diphtheria, Pertussis, Tetanus, Poliomyelitis and Haemophilus | DTaP-IPV-Hib - Diphtheria, Tetanus, Acellular Pertussis, Polio, Haemophilus Influenzae Type B Vaccine |
| RO=PNEC | Pneumococcal Conjugate vaccine (Prevnar) | Pneu-P-13 - Pneumococcal-conjugate-valent Vaccine |
| RO=PNEU | Injection for Pneumococcal Pneumonia, Bacteraemia and Meningitis | Pneu-P-23 - Pneumococcal-Polysaccharide-valent Vaccine |

Please note that effective September 26, 2014, the following billing guidelines will be enforced:

| HSC | Modifier | Billing Guideline |
|---|---|---|
| 13.59L | Any with high risk modifier (PT=RISK) | Modifier PT=RISK requires text stating the patient's clinical high risk diagnosis and reasoning for administration |
| 13.59L | RO=PENT | Not to be billed before 6 weeks of age, the same immunization cannot be claimed within 4 weeks of each other |
| 13.59L | RO=PNEC | Not to be billed before 6 weeks of age |

BACK TO CONTENTS

BACK TO CONTENTS

Examples of Provincial Immunization Schedules:

Childhood Vaccine Schedule:

| Vaccine | Modifier | 2 months | 4 months | 6 months | 12 months | 18 months | 4-6 years |
|---|---|---|---|---|---|---|---|
| **DTaP-IPV-Hib** *Diphtheria, Tetanus, Acellular Pertussis, Polio, Haemophilus influenzae type b vaccine* | RO=PENT | ✓ | ✓ | ✓ | | ✓ | |
| **Pneu-P-13** *Pneumococcal-conjugate-valent vacccine* | RO=PNEC | ✓ | ✓ | | ✓ | | |
| **Men-C-C** *Meningococcal conjugate vaccine* | RO=MENC | | | | ✓ | | |
| **MMRV** *Measles, Mumps, Rubella and Varicella vaccine* | RO=MMRV | | | | ✓ | | ✓ |
| **Tdap - IPV** *Tetanus Toxoid, Diphtheria, Acellular Pertussis, Polio vaccine* | RO=TDPP | | | | | | ✓ |

School Vaccine Schedule:

| Vaccine | Modifier | Grade 7 |
|---|---|---|
| **HPV-4** *Human Papillomavirus vaccine (3 doses)* | RO=HPV4 | ✓ |
| **HB** *Hepatitis B vaccine* | RO=HBVV | ✓ |
| **Tdap** *Tetanus Toxoid, Diphtheria, Acellular Pertussis* | RO=TDAP | ✓ |
| **Men-C-C** *Meningococcal conjugate* | RO=MENC | ✓ |

Adult Vaccine Schedule:

| Vaccine | Modifier | Adults to age 64 | Adults 65 and older |
|---|---|---|---|
| **Inf** *Influenza Vaccine (every flu season)* | RO=INFL | ✓ | ✓ |
| **Td** Td - Tetanus Toxoid, diphtheria Vaccine *(every 10 year)* | RO=TEDV | ✓ | ✓ |

BACK TO CONTENTS

| Vaccine | Modifier | Adults to age 64 | Adults 65 and older |
|---|---|---|---|
| **Pneu-P-23** *Pneumococcal-Polysaccharide-valent (1 dose)* | RO=PNEU | ✓ (high risk only) | ✓ |
| **MMR** *Measles, Mumps, Rubella Vaccine (2 doses)* | RO=MMAR | ✓ (adults born in 1970 or later) | |

BACK TO CONTENTS

## FEE REVISIONS

Effective September 26, 2014, Pre-Authorization will be required for the following health service code:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MISG | 98.12R | DESTRUCTION (DERMABRASION) OF SINGLE AREA (E.G. TRAUMA SCAR) | 35 4+T |

Effective September 25, 2014, the following health service codes will no longer be active:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| DEFT | WCB9 | EXPEDITED NON-EMERGENCY ORTHOPAEDIC CONSULTATIONS | 30.43 |
| MASG | 71.4A* | COMBINED ABDOMINAL VAGINAL FASCIAL SLING PROCEDURE | |
| | | RO=ABDO | 300 6+T |
| | | RO=VGSG | 150 6+T |

*Replaced by MASG 71.4D – Pubo-vaginal sling with autologous fascia for female urinary incontinence, includes cystoscopy as required, 350 MSU, 6+T (as outlined on page 4 of the July 18, 2014 MSI Bulletin.)

# Billing Matters Billing Reminders, New Explanatory Codes

## NEW EXPLANATORY CODES

| Code | Description |
|---|---|
| **AD051** | SERVICE ENCOUNTER HAS BEEN DISALLOWED. WHEN CLAIMING FOR HIGH RISK PATIENTS (PT=RISK), TEXT IS REQUIRED. PLEASE RESUBMIT WITH THE APPROPRIATE TEXT. |
| **AD052** | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PATIENT IS LESS THAN 6 WEEKS OLD |
| **AD053** | SERVICE ENCOUNTER HAS BEEN REFUSED AS A PENT INJECTION HAS BEEN PREVIOUSLY APPROVED IN THE PREVIOUS 4 WEEKS |
| **BK001** | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE NOT INCLUDED TEXT REFERRING TO THE ANATOMICAL SITE SPECIMEN WAS TAKEN FROM. PLEASE RESUBMIT WITH APPROPRIATE TEXT. |
| **BK002** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR AN ABDOMINAL SURVEY FILM AT THE SAME ENCOUNTER. |
| **BK003** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR AN INTRAVENOUS UROGRAM (IVP) AT THE SAME ENCOUNTER. |
| **BK004** | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS AT THE SAME ENCOUNTER YOU HAVE CLAIMED FOR AN INTRAVENOUS UROGRAM (IVP), WHICH CANNOT BE CLAIMED WITH ROUTINE TOMOGRAPHY. IF TOMOGRAPHY WAS NOT ROUTINE, PLEASE RESUBMIT WITH TEXT INDICATING THE SITUATION. |
| **BK005** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR A SERVICE IN WHICH FLUOROSCOPY IS INCLUDED FOR THE SAME ENCOUNTER. |
| **BK006** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR A FLUOROSCOPY DURING THE SAME ENCOUNTER. |

BACK TO CONTENTS

## NEW EXPLANATORY CODES CONTINUED

| Code | Description |
|---|---|
| **BK007** | SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE IS NOT YET ELIGIBLE FOR ELECTRONIC BILLING. |
| **BK008** | SERVICE ENCOUNTER FOR FLUOROSCOPY HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR ANOTHER SERVICE AT THE SAME ENCOUNTER. |
| **BK009** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR A STAND ALONE FLUOROSCOPY FEE AT THE SAME ENCOUNTER. |
| **BK010** | SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PATIENT IS OVER 12 YEARS OLD. PLEASE SUBMIT A CLAIM FOR THE APPLICABLE NON PAEDIATRIC CODE FOR PAYMENT. |
| **BK011** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR AN UPPER G.I. SERIES FOR THIS PATIENT AT THE SAME ENCOUNTER. |
| **BK012** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR A COLON G.I. SERIES FOR THIS PATIENT AT THE SAME ENCOUNTER. |
| **BK013** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR A CYSTOGRAPHY OR CYSTOURETHROGRAM FOR THIS PATIENT AT THE SAME ENCOUNTER. |
| **BK014** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED A CT FEE FOR THE SAME REGION DURING THIS ENCOUNTER. WHEN A CT EXAMINATION IS PERFORMED WITH AND WITHOUT CONTRAST, THE COMBINED CODE SHOULD BE USED. |
| **BK015** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED A SEPARATE CLAIM FOR THIS CT WITH OR WITHOUT CONTRAST AT THE SAME ENCOUNTER. PLEASE SUBMIT A DELETE FOR THE INDIVIDUAL FEE BEFORE CLAIMING THIS COMBINED CODE. |
| **BK016** | SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED A CLAIM FOR THIS CT WITH AND WITHOUT CONTRAST COMBINATION CODE AT THE SAME ENCOUNTER. |
| **CS007** | SERVICE ENCOUNTER HAS BEEN DISALLOWED. WHEN A VISIT AND CAST AND/OR SPLINT ARE PERFORMED AT THE SAME SERVICE ENCOUNTER, ONLY ONE IS APPROVED. |
| **GN064** | SURGICAL ASSIST CLAIMS (RO=SRAS) CANNOT BE CLAIMED UNTIL AFTER THE SURGEON HAS CLAIMED FOR THE SURGICAL SERVICES. PLEASE ENSURE THE PRIMARY SURGEON HAS SUBMITTED CLAIMS FOR THE SAME HSC AND RESUBMIT. |
| **GN065** | SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE HAS ALREADY BEEN CLAIMED BY ANOTHER PROVIDER ON THIS DAY. |
| **M0J46** | SERVICE ENCOUNTER HAS BEEN DISALLOWED AS SURGICAL ASSIST CLAIMS FOR HSC 98.49C OR 98.49D CANNOT BE CLAIMED UNTIL THE SURGEON HAS CLAIMED FOR THE SURGICAL SERVICES. |

BACK TO CONTENTS

BACK TO CONTENTS

## UPDATED FILES

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www.medavie.bluecross.ca/msiprograms

**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

http://novascotia.ca/DHW/

## CONTACT INFORMATION

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**NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS**

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Toll-Free: 1-800-387-6665 (in Nova Scotia)
TTY/TDD:1-800-670-8888

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BACK TO CONTENTS

## APPENDIX A

## SCHEDULE OF PROVINCIAL IMMUNIZATIONS

Refer to the following fee schedule when claiming for individual immunization(s) not billed in conjunction with an office visit or a single immunization billed in conjunction with an office visit:

| IMMUNIZATION | HEALTH SERVICE CODE | MODIFIER | MSUs | DIAGNOSTIC CODE |
|---|---|---|---|---|
| HAHB<br>*Hepatitus A and B vaccine* | 13.59L | RO=HAHB* | 6.0 | *See below |
| HBIg<br>*Hepatitus B Immunoglobulin* | 13.59L | RO=HBIG* | 6.0 | *See below |
| HB<br>*Hepatitis B vaccine* | 13.59L | RO=HBVV | 6.0 | V069 |
| Hib<br>*Haemophilus influenzae type b vaccine* | 13.59L | RO=HIBV* | 6.0 | *See below |
| HPV-4<br>*Human Papillomavirus vaccine* | 13.59L | RO=HPV4 | 6.0 | V069 |
| Inf<br>*Infuenza-Inactivated vaccine* | 13.59L | RO=INFL | 6.0 | V069 |
| Influenza - Pregnant | 13.59L | RO=INFL | 6.0 | V221 |
| Influenza - Males and non-pregnant females | 13.59L | RO=INFL | 6.0 | V048 |
| Men-C-C<br>*Meningococcal conjugate vaccine* | 13.59L | RO=MENC | 6.0 | V069 |
| Men-C-ACYW-135<br>*Meningococcal conjugate quadrivalent vaccine* | 13.59L | RO=MENQ* | 6.0 | *See below |
| MMR<br>*Measles, Mumps, Rubella vaccine* | 13.59L | RO=MMAR | 6.0 | V069 |
| MMRV<br>*Measles, Mumps, Rubella and Varicella vaccine for travel only to areas of risk for Measles* | 13.59L | RO=MMRT* | 6.0 | *See below |
| MMRV<br>*Measles, Mumps, Rubella and Varicella vaccine* | 13.59L | RO=MMRV | 6.0 | V069 |
| DTaP-IPV-Hib<br>*Diphtheria, Tetanus, Acellular Pertussis, Polio, Haemophilus influenzae type b vaccine* | 13.59L | RO=PENT | 6.0 | V069 |
| Pneu-P-13<br>*Pneumococcal-conjugate-valent vaccine* | 13.59L | RO=PNEC | 6.0 | V069 |
| Pneu-P-23<br>*Pneumococcal-Polysaccharide-valent vaccine* | 13.59L | RO=PNEU** | 6.0 | V066 |
| RabIg<br>*Rabies Immunoglobulin* | 13.59L | RO=RABI* | 6.0 | *See below |
| Rab<br>Rabies vaccine | 13.59L | RO=RABV* | 6.0 | *See below |

| | | | | |
|---|---|---|---|---|
| Tdap<br>*Tetanus Toxoid, Diphtheria, Acellular Pertussis vaccine* | 13.59L | RO=TDAP | 6.0 | V069 |
| Tdap-IPV<br>*Tetanus toxoid, Diptheria, Acellular Pertussis, Polio vaccine* | 13.59L | RO=TDPP | 6.0 | V069 |
| Td<br>*Tetanus Toxoid, diphtheria vaccine* | 13.59L | RO=TEDV | 6.0 | V069 |
| TIG<br>*Tetanus Immunoglobulin* | 13.59L | RO=TEIG* | 6.0 | *See below |
| VarIg<br>*Varicella-Zoster Immunoglobulin* | 13.59L | RO=VAIG* | 6.0 | *See below |
| Var<br>*Varicella* | 13.59L | RO=VARV | 6.0 | V069 |

When claiming immunization with a visit, the visit will be paid in full at 100%. The first inoculation will be paid in full at 6.0 MSU and all subsequent inoculations will be paid at 3.0 MSU or 50%. If the purpose of the visit is for immunization only, then the first two inoculations will be paid at 100% and all subsequent inoculations at 50% of the specified MSU.

Refer to the following table when claiming for a provincial immunization tray fee:

| HEALTH SERVICE CODE | DESCRIPTION | MSUs |
|---|---|---|
| 13.59M | Provincial Immunization Tray Fee | 1.5 per multiple (Max 4) |

* Refer to the following diagnostic code table, when claiming for **at risk immunizations**:

| PATIENT'S CONDITION | DIAGNOSTIC CODE |
|---|---|
| At risk irrespective of age | Diagnostic code applicable to condition,<br>e.g. 25000 diabetes mellitus |
| Close contact of at risk individual | V018 |
| Well Senior | V069 |

** Refer to the following diagnostic code table, when claiming for **pneumococcal and varicella immunizations**:

| PATIENT'S CONDITION | DIAGNOSTIC CODE |
|---|---|
| At risk irrespective of age | Diagnostic code applicable to condition,<br>e.g. 25000 diabetes mellitus |
| Close contact of at risk individual | V018 |
| Well Senior | V066 |

# PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

July 18, 2014 Volume L #4


Inside this issue



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www.medavie.bluecross.ca/msiprograms

## NEW FEES

*Note: Physicians holding eligible services must submit their claims from April 1, 2014 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

Effective April 1, 2014 the following new health service codes are available for billing:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| **MASG** | 17.5C | **Nerve Transfer with Microneural Coaptation for the treatment of proximal 3rd, 4th, or 5th degree nerve injury to the brachial plexus or other major peripheral nerve:**<br><br>This is a time-based, comprehensive fee for nerve transfer using microneural coaptation, with the surgical microscope, of a healthy donor nerve (distal) to the injured recipient nerve (proximal). This procedure is for proximal 3rd, 4th, or 5th degree nerve injury to the brachial plexus or other major peripheral nerve. The fee includes all nerve dissection, nerve stimulation, incisions, tendon transfers and repairs required to accomplish the repair. No other HSC's may be billed during the skin-to-skin time period used to calculate the surgical fee. Operative report and record of operation must be submitted for billing.<br><br>**Billing Guidelines**<br>No other HSC's to be billed during the skin-to-skin surgical time used to calculate the surgical fee.<br><br>**Specialty Restriction**<br>PLAS<br><br>**Location**<br>HOSP<br><br>**Regions**<br>Right, left, bilateral | IC at 130 MSU/hr<br><br>4+T |

*Note: Physicians holding eligible services must submit their claims from June 1, 2014 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

Effective June 1, 2014 the following new health service codes are available for billing:

| Category | Code | Description | Unit Value | |
|---|---|---|---|---|
| **MASG** | 65.59D | **Total Abdominal Wall Reconstruction with myofascial advancement flaps (Interim Fee):**<br><br>This is a comprehensive fee for the repair of a massive, complex abdominal wall hernia. The procedure includes the reduction of the hernia, all lysis of adhesions, bowel resection as required, removal of pre-existing mesh as required, rectus muscle mobilization, fascial bipartition with component separation, with or without placement of mesh or biologic graft, and skin excision. Operative report and record of operation must be submitted with billing claim.<br><br>**Billing Guidelines**<br>Not to be billed with lysis of adhesions, bowel resection or any other intra-abdominal procedure same patient same day.<br><br>Physician must document skin-to-skin operating time in the claim as well as in the record of operation.<br><br>In the event that skin-to-skin time exceeds 5 hours and 30 minutes, the physician may bill for this procedure via EC at 130 MSU/hour.<br><br>**Specialty Restriction**<br>GNSG, PLAS<br><br>**Location**<br>HOSP | 585 | 8+T |

| Category | Code | Description | Unit Value | |
|---|---|---|---|---|
| **MAFR** | 91.35G | **Open Reduction and Internal Fixation (ORIF) Bicondylar Tibial Plateau Fracture:**<br><br>This is a comprehensive fee for the repair of a bicondylar tibial plateau fracture to include all surgical exposure, fracture reduction, bone grafting, meniscal repair, stabilization of the fracture including all plates and screws, IM nails, and external fixator as required.<br><br>**Billing Guidelines**<br>Not to be billed with:<br>BOGR 90.06A - Bone graft - tibia<br>ADON 90.09A - Morselized allograft<br>MASG 92.15 - Other arthrotomy<br>MASG 92.89N - Arthroscopic meniscal repair<br>On same patient, same side, same day.<br><br>**Specialty Restriction**<br>ORTH | 250 | 4+T |

**Location**
HOSP

**Regions**
Right, left, bilateral

| Category | Code | Description | Unit Value |
|---|---|---|---|
| **MASG** | 90.69D | **Removal of Complex Internal Fixation Device(s) (IM nail, locking plate) as sole operative procedure:**<br><br>This fee code applies to the removal of intermedullary nails and locking plates when performed as the sole operative procedure at that operative site. Not paid in addition to, or part of, another orthopaedic procedure unless the internal fixation device is removed from a separate operative site. Not to be billed when followed by a revision fixation in which case the MAFR code and MASG 90.69B-Removal of internal fixation should be billed.<br><br>**Billing Guidelines**<br>Not to be billed with:<br>Any other fracture code same patient, same day, same region/site.<br><br>**Specialty Restriction**<br>ORTH<br><br>**Location**<br>HOSP<br><br>**Regions**<br>Right, left, bilateral | 110 4+T |

| Category | Code | Description | Unit Value |
|---|---|---|---|
| **VADT** | 09.03A | **Examination for Retinopathy of Prematurity:**<br><br>To be billed in addition to the visit fee for the comprehensive ophthalmological examination of both eyes, including all ophthalmic testing, in an infant with an underlying diagnosis of retinopathy of prematurity in the neonatal intensive care setting.<br><br>**Billing Guidelines**<br>Billable only when the functional centre is the neonatal intensive care unit.<br><br>Not to be billed with:<br>09.02 - Comprehensive eye examination<br>09.04 - Eye exam under anaesthesia.<br><br>**Specialty Restriction**<br>Paediatric Ophthalmology<br><br>**Location**<br>HOSP, NICU | 15 |

| Category | Code | Description | Unit Value |
|---|---|---|---|
| **MASG** | 71.4C | **Synthetic mid urethral sling for female urinary incontinence, any approach:**<br><br>This is a comprehensive fee for the surgical treatment of female urinary incontinence by the placement of a synthetic mid urethral sling (for example TVT, TOT) by any approach, including cystoscopy when performed.<br><br>**Billing Guidelines**<br>Not to be billed with<br>VADT 01.34A - Cystoscopy same patient same day.<br><br>**Specialty Restriction**<br>UROL, OBGY<br><br>**Location**<br>HOSP<br><br>Please note that this code replaces the previous interim code 71.4B (Urethral sling using prosthetic material such as TVT, TOT etc, by any method) effective June 1, 2014. | 150 4+T |

| Category | Code | Description | Unit Value |
|---|---|---|---|
| **MASG** | 71.4D | **Pubo-vaginal sling with autologous fascia for female urinary incontinence, includes cystoscopy as required:**<br><br>This is a comprehensive fee for the surgical treatment of female urinary incontinence using autologous fascia. This fee includes the harvesting of fascia lata or rectus fascia as required, the placement of the sling using both an abdominal and vaginal approach, and cystoscopy as required.<br><br>If the skin-to-skin operative time extends beyond 4 hours, then bill IC@ 130 MSU/hr including operative report and record of operation with the claim.<br>Not to be billed for synthetic Mid Urethral Sling (e.g. TVT, TOT).<br><br>**Billing Guidelines**<br>Not to be billed with VADT 01.34A – Cystoscopy, same patient, same day.<br><br>Not to be billed for synthetic mid urethral Sling (e.g. TVT, TOT), as described in code above.<br><br>**Specialty Restriction**<br>UROL, OBGY<br><br>**Location**<br>HOSP | 350 6+T |

## UPDATE – MSI ELIGIBILITY FOR NS RESIDENTS ON VACATION OUT OF PROVINCE

The Department of Health and Wellness will be extending the length time Nova Scotia residents are eligible for Medical Services Insurance (MSI) while out of the province for vacation. As of August 1, 2014, Nova Scotians are eligible for MSI benefits for an additional month while on vacation outside of the province for a maximum of 7 months in each calendar year. Vacationers are required to inform MSI of their absence by telephoning 902-496-7008 (local) or 1-800-563-8880 (toll-free) or submitting an email to msi@medavie.ca.

In order to allow vacationers an adequate supply of medications while travelling outside the province for more than 100 days, the Nova Scotia Family and Senior's Pharmacare Programs will allow pharmacies to dispense up to three 90 day refills to allow for a 270 day maximum supply of medication for beneficiaries to bring with them as vacation supply.

## ELECTIVE OUT OF PROVINCE SERVICES (WITHIN CANADA)

Prior approval is required from the Nova Scotia Department of Health and Wellness before referring a patient out of province for insured health services unavailable in Nova Scotia if the patient wishes to be considered for travel and accommodation assistance. Approval must be sought through the Medical Consultant, MSI. The referral must be from a specialist registered in Nova Scotia, who is actively involved in the eligible resident's care. The referral must include the following:

- A description of the eligible resident's relevant medical history.
- A description of the health services requested as well as an estimation of the expected benefit to the patient.
- A description of any follow-up requirements.
- Information on the available health services in Nova Scotia and an explanation of why these are not sufficient for the resident's needs.
- A written recommendation in support of the out-of-province health services, confirming that this is the specialist's recommendation and that the referral is not being provided solely at the request of the patient.
- Written confirmation of the medical evidence, and the patient's medical requirement for travel with an escort, if required.
- The contact information of the physician who will be treating the patient so a copy of the approval documentation can be forwarded to their office.
- The costs for an escort will not be covered by DHW if there is no medical evidence to support the need for an escort. Evidence of medical need for an escort is not required if the resident is under 19 years of age.
- When the proposed health service is a new or emerging health service, documentation must be included of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.

MSI will review the application and provide a response to the appropriate specialist within 30 days of receiving a complete application.

Upon approval of the application, the Department of Health and Wellness will contact the eligible resident and provide the appropriate application forms for travel and accommodation assistance.

## ELECTIVE OUT OF COUNTRY SERVICES

Individuals requiring elective, insured health services that are not available within Canada must be authorized by the DHW prior to making any medical and/or travel arrangement to ensure the service will be insured and in order for the DHW/MSI to negotiate a reasonable and fair compensation with out of country providers prior to the provision of services.

In order for a patient to be referred outside Canada for treatment, prior written approval is required from the Medical Consultant, MSI. The referral must be from a specialist registered in Nova Scotia, who is actively involved in the eligible resident's care. The referral must include the following:

- A description of the eligible resident's relevant medical history.
- A description of the health services requested as well as an estimation of the expected benefit to the patient.
- A description of any follow-up requirements.
- Information on the available health services in Canada and an explanation of why these are not sufficient for the resident's needs.
- A written recommendation in support of the out-of-country health services, confirming that this is the specialist's recommendation and that the referral is not being provided solely at the request of the patient.
- Written confirmation of the medical evidence, and the patient's medical requirement for travel with an escort, if required.
- The contact information of the physician who will be treating the patient so a copy of the approval documentation can be forwarded to their office.
- The costs for an escort will not be covered by DHW if there is no medical evidence to support the need for an escort. Evidence of medical need for an escort is not required if the resident is under 19 years of age.
- When the proposed health service is a new or emerging health service, documentation must be included of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.

MSI will review the application and provide a response to the appropriate specialist within 30 days of receiving a complete application.

Upon approval of the application, the Department of Health and Wellness will contact the eligible resident and provide the appropriate application forms for travel and accommodation assistance.

**AUDIT TIME PERIOD**

When an onsite billing audit is required, the audit is typically based upon a random sample of services, of a selected service type, drawn from the most recent two-year period. The period may be expanded to cover a longer time period depending upon the nature of any identified billing issues or other information.

There may be instances where services are selected in a non-random manner based on specific criteria related to the identified billing issue.

**MMR VACCINE FUNDING**

In Nova Scotia the following groups are eligible to receive measles vaccine as part of the publicly funded immunization program:

**Infants and Children:**

1. Two doses of a measles-containing vaccine MMR(V) are recommended. The first dose should be given on or after the first birthday and the second dose should be given at the 4-6 year old visit but may be given as early as 18 months.

2. For travel to regions where measles is a concern, http://travel.gc.ca/travelling/health-safety/travel-health-notices/measles, MMR may be given as early as six months of age following a risk assessment. Under these circumstances, the routine two dose series must be started on or after the first birthday, for a total of three doses.

   In general, there is no need to provide early vaccination for infants travelling within Canada. There may be exceptions if there is recent measles activity within the family or closed community to which a visit is planned.

To support the addition of immunization of infants 6-11 months of age, new billing codes have been added as follows:

*MSI billing modifier for infants between 6 months and 1 week prior to 12 months of age who are travelling to areas of risk for measles. (There is no change to billing practices for the administration of routine childhood immunizations.)*

| Immunization | Health Service Code | Modifier | MSUs |
|---|---|---|---|
| Injection for Measles, Mumps and Rubella for travel of infants only to areas of risk. | *13.59L* | *RO=MMRT* | *6.0* |
| This immunization is only to be claimed for infants between 6 months and 1 week prior to 12 months of age who are travelling to areas of risk. **Text is also required from the physician stating the reasoning for administering the immunization prior to 12 months.** | | | |

**Adolescents and Adults:**

Adults born in or after 1970 should receive two doses of measles-containing vaccine, unless they have documented immunity (serology) from measles disease, or have documented evidence of receiving two valid doses of measles containing vaccine.

It is generally safe to assume that Canadian residents born **before 1970**, regardless of place of birth, have naturally-acquired immunity against measles, mumps and rubella. However, **international travelers** of this age should receive one dose of measles containing vaccine (**not publically funded**) if they do not have one of the following:

- documented evidence of receiving measles-containing vaccine on or after their first birthday;
- laboratory evidence of immunity (e.g. through blood testing); or
- a history of laboratory confirmed measles disease.

## BILLING REMINDERS

### 3D CT RECONSTRUCTION CODES

Effective August 1, 2014, health service codes 1180, 3180, and 5180 may only be claimed when 3D reconstruction has been carried out. They may not be claimed for 2D reconstruction or multiplanar reconstruction.

### SURGICAL ASSISTANT CLAIMS

Preamble 9.5.1 states that a surgical assistant's surgical encounter is 33.8% of the surgical fee. The health service codes claimed for surgical assistant services are expected to align with those submitted by the primary surgeon and all surgical assistant claims should adhere to the preamble guidelines. Physicians are reminded that all claims, including claims for surgical assistant services, are subject to MSI monitoring and audit processes.

### UNBUNDLING OF CLAIMS

Section 9.3.3 (a) of the Preamble in the Physician's Manual does not permit the unbundling of a procedure into its constituent parts and billing for the parts individually or in combination with the procedure. For example, a laparoscopic assisted vaginal hysterectomy should be billed as 80.4B and not vaginal hysterectomy plus laparoscopy (80.4 + 66.83).

The initiative to assess claims submitted where more than one procedure is claimed for the same patient on the same day is ongoing. Please be advised that as the manual assessment of these claims continues, operative reports may be requested.

### DAILY HOSPITAL AND OFFICE VISITS - SECOND OCCURENCE CLAIMS

As per Preamble section 7.2.4, **limited hospital visits are for the daily care of the patient**. This composite fee includes reviewing lab work, discussions with patients and/or their families and instances in which the physician

electively returns to reassess a patient. Additional visits may not be claimed for such activities as they are included in the daily rate.

If a physician is requested by hospital staff to reassess a patient in an emergent situation and the physician responds immediately, an urgent visit may be claimed. **Urgent visits may only be claimed if the physician travels to see the patient**. As per Preamble section 2.31, movement within a hospital or long term care facility or from an office attached to a hospital is not considered travel and therefore does not meet the requirements for an urgent visit.

If more than one visit is provided by the same physician to the same patient on the same day at separate times, **documentation of the necessity for the extra visit(s) must be recorded on the chart**. Time of service occurrence must be provided on second and subsequent visits, per Preamble 7.2.3. When submitting the claim, the service occurrence field is used to indicate the number of separate service encounters with an occurrence number greater than one. Text is required in order for the claim to be paid. This text must indicate the medical necessity of the subsequent visit as well as the time of the occurrence. Any claims submitted with an occurrence number greater than one without text will be paid at zero.

**EXPLANATORY CODES**

AD049 Service encounter has been refused as the patient's age is not between 6 months and one week prior to 12 months.

AD050 Service encounter has been refused as electronic text is required stating the reasoning for administering the MMRT immunization.

MA061 Service encounter has been disallowed as this claim is incomplete. Please resubmit with text specifying the skin to skin operating time.

MA062 Service encounter has been refused as a cystoscopy has previously been billed for this patient on the same day.

MA063 Service encounter has been refused as cystoscopy is included in the fee for HSC 71.4C which has been previously billed for this patient on this day.

MF006 Service encounter has been refused as you have previously claimed HSC 90.06A, 90.09A, 92.15, or 92.89N for the same patient on the same day.

MF007 Service encounter has been refused as you have previously billed for an ORIF Bicondylar Tibial Plateau Fracture for this patient on this day.

MF008 Service encounter has been refused as you have previously claimed a fracture code for the same site/region on this day.

MJ045 Service encounter has been refused as HSC 01.34A has already been billed for this patient on this day.

VA059 Service encounter has been refused as HSC 71.4D has already been billed on this day which includes cystoscopy.

VA060 Service encounter has been refused as you have previously billed HSC 09.02 or 09.04 for this patient at the same encounter.

VE008 Service encounter has been refused as you have previously billed HSC 09.03A for this patient at the same encounter.

WB031 Service encounter has been refused as the provider indicated is not valid for this service.

**UPDATED FILES AVAILABILITY**

Updated files reflecting changes are available for download on Friday, July 18th, 2014. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanatory codes (EXPLAIN.DAT), and modifier values (MODVALS.DAT).

# PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

May 23, 2014 Volume L #3


Inside this issue




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**On-line documentation available at:**

http://www.medavie.bluecross.ca/msiprograms

## NEW FEES

*Note: Physicians holding eligible services must submit their claims from March 1, 2014 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

Effective March 1, 2014 the following new health service codes are available for billing:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| **ADON** | 52.89E | **Sentinel Lymph Node Biopsy for cancer:**<br><br>This is an "add on" fee to surgical oncologic procedures, payable only for the staging of malignant disease (cancer). It is for the intra-operative identification and sampling of sentinel lymph nodes. The injection of non-radioactive dye is included, when performed.<br><br>**Billing Guidelines**<br>To be added on to surgical oncologic procedures with the diagnosis of "cancer". May be billed per drainage basin to a maximum of three basins in total<br><br>**Specialty Restriction**<br>None<br><br>**Location**<br>HOSP | 50 |

| Category | Code | Description | Unit Value | |
|---|---|---|---|---|
| MASG | 28.54A | **Laser Photocoagulation for the treatment of Retinopathy of Prematurity:**<br><br>This fee is for the treatment of extensive or progressive retinopathy of prematurity in premature infants up to the age of 6 months by laser photocoagulation. | 160 | 6+T |

**Billing Guidelines**
Base fee is for the treatment of one eye.

**Specialty Restriction**
Paediatric Opthalmology
Retinal Opthalmologist

**Location**
HOSP

**Regions**
Right, left, bilateral

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 60.24C | **Transanal Endoscopic Microsurgery:**<br><br>This fee is for the Transanal Endoscopic Microsurgical (TEM) resection of rectal lesion using a transanal operating proctoscope with visualization via the endoscopic camera, with full insufflation and pressure monitoring under general anesthesia. Includes the passage of a sigmoidoscope or proctoscope to ensure luminal patency<br><br>**Billing Guidelines**<br>01.24C Rigid sigmoidoscopy not payable same patient same day.<br><br>**Specialty Restriction**<br>GNSG with colorectal and/or minimally invasive surgery (MIS) fellowship.<br><br>**Location**<br>HOSP | 325 6+T |

**FAMILY PHYSICIAN CHRONIC DISEASE MANAGEMENT INCENTIVE PROGRAM**
**Revised April 1, 2014**

*Please Note: You may now submit any claims since April 1, 2014 for the third chronic disease managed using the new* **RP=CON3** *modifier. Physicians holding eligible services must submit their claims from April 1, 2014 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame. Claims for the first and second chronic disease managed with a service date from April 1, 2014 to May 22, 2014 will be identified and reconciliation will occur in the Fall of 2014*

The current *Physician Services Master Agreement, Schedule "K" 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 Master Agreement Steering Group (MASG) has recently approved changes to the existing Family Physician Chronic Disease Management (CDM) Incentive Program effective April 1, 2014 including:

- **Addition of chronic obstructive pulmonary disease (COPD) as an eligible chronic disease;**

- **Revisions to program requirements and documentation to incorporate COPD, reflect changes to clinical practice guidelines, and improve clarity; and,**
- **Increases to payment rates.**

The existing program strategy and general guidelines remain unchanged.

Qualifying Chronic Diseases
Effective April 1, 2014, the qualifying chronic diseases are:

- **Type 1 and Type 2 Diabetes** as evidenced by FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L; and,

- **Ischaemic Heart Disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram.

- **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator $FEV_1$ < 80% predicted and $FEV_1$/FVC < 0.70

Required Indicators/Risk factors
Effective April 1, 2014, in order to claim a CDM incentive payment the following indicators/risk factors, as applicable, are required to be addressed as part of the annual cycle of care. The required indicators include all relevant common indicators plus the specific indicators for each disease. For example, if diabetes and COPD are present, the three common indicators for diabetes, IHD and COPD plus the three common indicators for diabetes and IHD plus the specific indicators for diabetes and the specific indicators for COPD would all need to be addressed in order to claim annual incentive payments for the two diseases.

*Common Indicators for Diabetes, IHD and COPD*

- Smoking cessation – discussed once per year if smoker (document smoker or nonsmoker)
- Immunizations discussed and/or given – once per year
- Exercise/activity – discussed, including possible referrals, once per year

*Common Indicators for Diabetes and IHD*

- Blood pressure – 2 times per year
- Weight/nutrition counseling – once per year
- Lipids – once per year

*PLUS THE FOLLOWING REQUIRED INDICATORS, DEPENDING ON THE APPLICABLE CHRONIC DISEASE:*

*Indicators for Diabetes only*

- HbA1C – ordered 2 times per year
- Renal function – ACR or eGFR ordered once per year
- Foot exam with 10-g monofilament – referred or completed once per year
- Eye exam – discussed and/or referred once per year for routine dilated eye exam

*Indicators for IHD only*

- Anti-platelet therapy – considered/reviewed once per year
- Beta-blocker – considered/reviewed once per year

- ACEI/ARB – considered/reviewed once per year
- Discuss Nitroglycerin – considered/reviewed once per year
- Consider further cardiac investigations – considered/reviewed once per year

***Indicator for COPD only***

- **COPD Action Plan required – Develop and then review and complete once per year**

CDM Incentive Payments

Effective April 1, 2014 eligible GPs are paid as follows:

- $100 base incentive payment once per fiscal year for managing an annual cycle of care and addressing the required indicators/risk factors for each patient with one qualifying chronic disease.
- $75 additional payment per fiscal year if the same patient is managed for a second qualifying *c*hronic disease (total payment of $175)
- $50 additional payment per fiscal year if the patient is managed for three qualifying chronic diseases (total payment of $225).

**NOTE: Completion of the COPD Action Plan, if applicable, is included in these payments.**

The CDM incentive is claimed through a fee code. APP contract physicians are also eligible for the incentive and are paid by cheque twice a year based on their aggregate shadow billings.

CDM Incentive Billing Rules

1. The CDM Incentive fee can be claimed by family physicians only.
2. 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. 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 diseases (s) for each qualifying disease.
3. The family physician is expected to act as case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations, including for investigations, follow-up visits and/or referrals.
4. Patients must be seen a minimum of two times per year by a licensed health care provider (includes physicians) in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.
5. Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.
6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year by March 31 of that year.
7. The qualifying chronic diseases eligible for the CDM incentive payment are:
   - **Type 1 and Type 2 Diabetes** defined as: FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L; and/or,
   - **Ischaemic Heart Disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram (includes post-MI <=5 yr); and/or,
   - **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator $FEV_1$ < 80% predicted and $FEV_1/FVC$ < 0.70.

8. For patients managed for COPD, a COPD Action Plan must be developed and then reviewed and completed annually, with a copy given to the patient and a copy available in the patient's clinical record.

9. The CDM incentive can be claimed once per fiscal year (April 1 to March 31 inclusive) if the following conditions are met:
    - the patient is 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.

CDM Flow Sheet

The Family Physician Chronic Disease Management Flow Sheet (attached) is revised effective April 1, 2014. Use of the Flow Sheet continues to be optional.

COPD Action Plan

A required indicator for COPD is the development and annual review and completion of a COPD Action Plan using the program COPD Action Plan template (attached).

**BILLING REMINDERS**

Exceptional Clinical Circumstances versus Independent Consideration

Exceptional Clinical Circumstances may warrant a fee other than that listed. In the event a practitioner performs a service he or she believes should be insured, but is unable to find an appropriate service code or finds an appropriate service code but feels the listed tariff does not adequately compensate the service, a request for an exceptional fee may be submitted. The request must be accompanied by complete details, including the duration of the service, adequate to explain and justify the number of units requested. ***An example where EC would apply is when a procedure was performed that does not yet have a fee code.***

Independent Consideration

Independent consideration is applied to certain services that are assigned a health service code but where a wide variation in case to case complexity and time exists and no unit value is listed. Independent consideration services must be accompanied by complete details, including duration of service, adequate to explain and justify the number of units requested. ***An example where IC would apply is HSC 98.11-Debridement of wound or infected tissue ME=COMP.***

The tariff for IC and EC services is agreed to by the Master Agreement Steering Group (MASG) on recommendation from the Fee Schedule Advisory Committee (FSAC) and increased with sessional rate increases as per the Master Agreement. Currently, they are as follows:

- 100 units per hour for surgical and interventional procedures.
- 70 units per hour for specialist, non-surgical, non-interventional services and this rate will increase with the yearly increases for sessional rates as per the Master Agreement.
- 60 units per hour will remain as the rate for any GP non-surgical, non-interventional services until such time as their sessional rate exceeds 60 units per hour.

Payment for surgical services is based upon the skin to skin time.

General Practice Evening and Weekend Office Visit Incentive Program - Reminder

MSI has recently become aware that some physicians are claiming the General Practice Evening and Weekend Office Visit Incentives for services provided at walk in clinics.

By way of reminder, this service may be claimed by eligible fee-for-service general practitioners who open their offices during week day evenings (between 6pm and 10pm) and/or weekends (between 9am to 5pm, Saturday and Sunday). Eligible physicians may claim an incentive for evening and weekend office services provided for their own patients as well as for patients from the stable patient roster of other eligible physicians within the same practice location, providing the patient's record can be assessed and the encounter is recorded.

Services provided in walk-in clinics are not eligible for the evening and weekend office visit incentive funding program and are subject to recovery for inappropriate claims for this incentive. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no requirement for an appointment, and episodic care with little or no follow-up. There is no standard patient roster and the patient list is constantly changing.

In situations in which a clinic provides both care to a stable roster of patients and walk-in clinic services, only physicians who maintain a stable roster of patients at that location may claim the incentive and only for individuals who belong to the stable roster of patients.

## EXPLANATORY CODES

CC004 Service encounter has been disallowed as HSC 03.05 has previously been claimed. Documentation must be provided if re-assessment is required.

DE016 Service encounter has been refused as the third condition amount has already been approved for this year.

MA061 Service encounter has been refused as the patient is over 6 months old.

MJ044 Service encounter has been refused as HSC 01.24C has previously been billed for this patient on this day.

VA058 Service encounter has been refused as HSC 60.24C has previously been billed for this patient on this day.

VT124 Service encounter has been disallowed as an urgent hospital visit applies only when a physician travels from one location to another. Preamble 7.2.7(a). Resubmit with text stating details of the Physicians travel.

VT125 Service encounter has been refused as this claim does not meet the criteria for an urgent visit, per Preamble 7.2.7 (a),(b),(c).

VT126 Service encounter has been disallowed as an additional visit for an OPD or Emerg patient is only payable if the patient is under observation for more than 4 hours. Preamble 7.2.6 (a). Resubmit with text explaining the necessity of an additional visit.

## UPDATED FILES AVAILABILITY

Updated files reflecting changes are available for download on Friday, May 23rd, 2014. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanatory codes (EXPLAIN.DAT), and modifier values (MODVALS.DAT).

# Family Physician Chronic Disease Management (CDM) Flow Sheet

Patient Name: _____ Diabetes: Type 1 ☐ Type 2 ☐ IHD ☐ COPD ☐

Date of birth: _____ (dd/mm/yy) Date(s) of Diagnosis: DM _____ (mm/yy) IHD _____ (mm/yy) COPD _____ (mm/yy)

Co morbidities: ☐ HTN ☐ Dyslipidemia ☐ PAD ☐ Renal Disease ☐ A Fib
☐ TIA/Stroke ☐ Mental Health Diagnosis ☐ CHF
Other: _____

Interventions/Investigations: PCI/Stent _____ ☐ Bare metal ☐ Drug-eluting ☐ Spirometry/PFT
CABG _____ Cardiac Cath. _____
Current Medication: _____
_____

| | | | | | |
|---|---|---|---|---|---|
| REQUIRED COMMON INDICATORS FOR DIABETES, IHD AND COPD | | Date / / | Date / / | Date / / | Date / / |
| ANNUALLY | Smoker ☐ Yes ☐ No If yes, discuss smoking cessation | | | | |
| ANNUALLY | Immunizations Discussed and/or given | | | | |
| ANNUALLY | Exercise/Activity | | | | |
| REQUIRED COMMON INDICATORS FOR DIABETES and IHD | | Date / / | Date / / | Date / / | Date / / |
| 2/YR | Blood pressure | | | | |
| ANNUALLY | Weight/Nutrition Counselling | | | | |
| ANNUALLY | Lipids Discuss statins LDL-C (mmol/L) TC/HDL-C | | | | |
| REQUIRED INDICATORS FOR DIABETES ONLY | | | | | |
| 2/YR | HbA1C | | | | |
| ANNUALLY | Renal Function ACR and eGFR | | | | |
| ANNUALLY | Foot Exam Use 10-g monofilament | | | | |
| ANNUALLY | Eye Exam Discuss and/or refer | | | | |
| REQUIRED INDICATORS FOR IHD ONLY | | | | | |
| ANNUALLY | Anti-platelet Therapy Review | | | | |
| ANNUALLY | Beta-blocker Review | | | | |
| ANNUALLY | ACEI/ARB Review | | | | |
| ANNUALLY | Discuss Nitroglycerin | | | | |
| ANNUALLY | Consider further cardiac investigations | | | | |
| REQUIRED INDICATORS FOR COPD ONLY | | | | | |
| 1/YR | COPD Action Plan Develop. Review and complete annually | | | | |
| *RECOMMENDED ITEMS (Optional for CDM Incentive payment)* | | | | | |

Self Management Referrals: ☐ Diabetes Centre ☐ Cardiac Rehab ☐ Your Way to Wellness ☐ Pulmonary Rehabilitation
Screen for: ☐ Depression/Anxiety ☐ Erectile Dysfunction
Lifestyle: ☐ Alcohol Use ☐ Psychsocial Issues
Economics: ☐ Pharmacare ☐ Third Party Insurance ☐ No Insurance ☐ Financial Issues
End of Life: ☐ Care Discussion

**Date CDM Incentive Code Billed:** _____

## SELECTED CHRONIC DISEASE MANAGEMENT GUIDELINE INDICATORS

| Common Indicators: DM, IHD & COPD | Target | Comments |
|---|---|---|
| Smoking Cessation | Non-smoker | |
| Immunizations | Influenza annually. Pneumococcal once, then for DM & IHD repeat at 65 yr.; for COPD repeat every 5-10 years.. | |
| Exercise/Activity | Discuss appropriate exercise/activity and possible referrals | For DM & IHD: 30 mins/day 5x/wk plus resistance exercise 3 x/wk.<br>For COPD: pulmonary rehab program |
| **Common Indicators: DM & IHD** | **Target** | **Comments** |
| Blood Pressure | IHD without DM or CKD: <140/90<br>DM: <140/80*<br>DM and CKD: <130/80**<br>In children: <95th %ile for age, gender and height | *In DM with no end organ damage<br>** Where this can be achieved safely without undue burden |
| Lipids | For IHD or IHD plus DM LDL-C: < 2.0 >50% reduction<br>For DM only LDL-C: < 2.6 | Test every 1-3 years OR as clinically indicated |
| Weight/Waist circumference/<br>Nutrition counseling | BMI: <25 kg/$m^2$ or<br>In children: <85th %ile for age<br>Waist circumference: M: <102 cm, F: <88 cm | |

| Diabetes Indicators | Target | Comments |
|---|---|---|
| HbA1C | < 7% | -q 6 mo. In stable DM<br>-q 3 mo. For all others<br>Individualize HbA1C based on age, DM duration & co-morbidity |
| Renal Function | ACR: <2.0 for males; <2.8 for females<br>eGFR: >60 mL/min | In presence of CKD, at least every 6 months.<br>Referral to nephrologist/internist if eGFR <30 mL/min |
| Routine foot examination | Annually | Q3-6 mo. In moderate to high risk foot. Assess skin, neuropathy (10 –g monofilament) and perfusion. |
| Routine dilated eye examination | At diagnosis, then every 1-2 years based on degree of retinopathy. | By optometrist or ophthalmologist |

| IHD Indicators | Duration | Comments |
|---|---|---|
| Beta-blocker | STEMI: Indefinitely<br>Non-STEMI: Indefinitely unless low risk | |
| ACEI/ARB | Indefinitely unless low risk | ACEI: Titrate to target dose.<br>Consider ARB if contraindication or intolerance to ACEI |
| Antiplatelet Therapy<br>**ASA** 81 to 325 mg OD<br><br>**Clopidogrel** 75 mg OD<br><br><br><br><br><br>**Ticagrelor** 90 mg BID | **ASA** indefinitely –STEMI, Non-STEMI and Stable Coronary Artery Disease<br><br>**Clopidogrel: STEMI** - Only if had PCI<br>Minimum 1 mo. post bare metal stent<br>Min. 12 mo. post drug-eluting stent<br><br>**Clopidogrel: Non-STEMI**<br>No PCI: Low risk - 3 mo; Inc. risk - 12 mo.; Very high risk - >12 mo.<br>PCI: Low risk & bare metal stent - 3 mo.; Increased risk regardless of stent or ≥1 drug-eluting stent - 12 mo.; very high risk regardless of stent or ≥3 drug-eluting stents or complex PCI - >12 mo<br><br>**Ticagrelor**<br>Prescribed to high risk Acute Coronary Syndrome patients, 12 months of therapy recommended. | **ASA** maximum dose 75-100 mg if on Ticagrelor<br>**Clopidogrel: STEMI**<br>Dependent on type of stent and risk profile<br><br>**Clopidogrel Non-STEMI**<br>Depends on risk of recurrent event & stent type<br><br>**Ticagrelor**: Reduce ASA to 75-100 mg. Transient dyspnea can be early side effect. Usually mild and resolves with continued therapy. |
| Discuss Nitroglycerin | | |
| Consider further cardiac investigations | | |

| COPD Indicators | Target | Comments |
|---|---|---|
| COPD Action Plan | Include medications and emergency instructions for patient. | Copy given to patient. |

**PHARMACOTHERAPY IN COPD**

**INCREASING DISABILITY AND LUNG FUNCTION IMPAIRMENT**

| MILD | MODERATE | VERY SEVERE |
|---|---|---|
| ↓ | | |
| **SABD prn**<br>↓ Persistent dyspnea | **Infrequent AECOPD (average of <1 per year)**<br>**LAAC *or* LABA + SABA prn**<br>↓ Persistent dyspnea | **Frequent AECOPD (≥1 per year)**<br>**LAAC + ICS/LABA +SABA prn**<br>↓ Persistent dyspnea |
| **LAAC + SABA prn**<br>or<br>**LABA + SABD prn** | **LAAC + LABA + SABA prn**<br>↓ Persistent dyspnea<br>**LAAC + ICS/LABA* + SABA prn** | **LAAC + ICS/LABA + SABA prn**<br>±<br>**Theophylline** |

*refers to lower dose ICS/LABA

SABD = Short-acting bronchodilator (e.g. ipatropium or SABA)

LAAC = Long acting anticholinergic (e.g. tiotropium)

LABA = Long acting beta agonist (e.g. salmeterol; formoterol)

SABA = Short-acting beta agonist (e.g. salbutamol; terbutaline)

ICS/LABA = inhaled corticosteroid/LABA (e.g. fluticasone/salmeterol; budesonide/formoteral)

**CHRONIC DISEASE MANAGEMENT (CDM) INCENTIVE FEE BILLING RULES**

1. The CDM Incentive fee can be claimed by family physicians only.
2. 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. 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.
3. The family physician is expected to act as case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations, including for investigations, follow-up visits and/or referrals.
4. Patients must be seen a minimum of two times per year by a licensed health care provider (includes physicians) in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.
5. Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.
6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year by March 31 of that year.
7. The qualifying chronic diseases eligible for the CDM incentive payment are:
   - **Type 1 and Type 2 Diabetes** defined as: FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L; and/or,
   - **Ischaemic Heart Disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram (includes post-MI <=5 yr); and/or,
   - **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator $FEV_1$ < 80% predicted and $FEV_1/FVC$ < 0.70.

8. For patients managed for COPD, a COPD Action Plan must be developed and then reviewed and completed annually, with a copy given to the patient and a copy available in the patient's clinical record.
9. The CDM incentive can be claimed once per fiscal year (April 1 to March 31 inclusive) if the following conditions are met:
   - the patient is 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 (see front of flow sheet) and documented in the clinical record or optional flow sheet at or before the time of billing.

# COPD ACTION PLAN

**(Review annually with your doctor)**

Patient Name: _____ Date: _____

HCN: _____ Date of Birth: _____

You have been diagnosed with Chronic Obstructive Pulmonary Disease (COPD). As someone with COPD, you are either in your stable, everyday state or having a flare up. This Plan will help you to quickly recognize and treat flare ups to manage your COPD and improve your health.

**COPD** (*Chronic Obstructive Pulmonary Disease*) can be stable or you could have a flare-up:

**When you are stable:**

1. Breathing with your usual shortness of breath
2. Able to do your usual daily activities
3. Mucous is easy to cough up

## How to tell if you are having a flare-up

A flare up may occur after you get a cold, get run down or are exposed to air pollution, pollen or very hot or cold weather. There are 3 things that define a flare-up:

1. Increased shortness of breath from your usual level
2. Increased amount of sputum from your usual level
3. Sputum changes from its usual colour to yellow, green or rust colour

Some people may feel a change in mood, fatigue or low energy prior to a flare-up.

## If any 2 or all of these symptoms persist for 48 or more hours do the following:

- □ Take your rescue inhaler 2-4 puffs as needed (up to 4-6 times per day) for shortness of breath.
- □ Take your prescribed antibiotic for a COPD flare-up (see over).
- □ Take your prescribed prednisone for a COPD flare-up (see over).
- □ Contact your doctor if you feel worse or do not feel better after 48 hours of treatment.
- □ Call 811 if you have questions
- □ Other _____

**IF YOU ARE EXTREMELY BREATHLESS, ANXIOUS, FEARFUL, DROWSY, CONFUSED OR HAVING CHEST PAIN, CALL 911 FOR AN AMBULANCE TO TAKE YOU TO THE EMERGENCY ROOM.**

Physician Signature_____

Patient/Caregiver Signature_____

## COPD MAINTENANCE MEDICATION RECORD

Patient Name: _____ Date: _____

HCN: _____ Date of Birth: _____

**Patients**: Take the following maintenance medications **everyday** to help maintain control of your COPD symptoms.

**Physicians**: Please fill in prescribed maintenance medications.

| Medication Prescribed | How Much to Take | When To Take |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## COPD FLARE-UP MEDICATION RECORD

**Patients**: Please fill in date when you start and finish your flare-up medications.

**Physicians**: Please fill in prescribed flare-up (antibiotics & prednisone) medications.

| Medication Prescribed | Start Date / Finish | Start Date / Finish | Start Date / Finish |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Make sure you take your prescribed medications until finished.**

---

**Please review this plan with your doctor at least annually.**

# PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

March 28, 2014 Volume L #2


Inside this issue




**CONTACT US:**

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**On-line documentation available at :**

http://www.medavie.bluecross.ca/msiprograms

## MEDICAL SERVICE UNIT/ANAESTHESIA UNIT CHANGE

Effective April 1, 2014, the Medical Service Unit (MSU) value will be increased from $2.37 to $2.42 and the Anaesthesia Unit (AU) value will be increased from $20.15 to $20.55.

## WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC

Effective April 1, 2014 the Workers' Compensation Board MSU Value will increase from $2.63 to $2.69 and the Workers' Compensation Board Anaesthetic Unit Value will increase from $22.39 to $22.83.

## PSYCHIATRY FEES

Effective April 1, 2014 the hourly Psychiatry rate for General Practitioners will increase to $110.55 while the hourly rate for Specialists increases to $149.90 as per the tariff agreement.

## SESSIONAL PAYMENTS

Effective April 1, 2014 the hourly Sessional rate for General Practitioners will increase to $145.20 while the hourly rate for Specialists increases to $169.40 as per the tariff agreement.

## FEE REVISIONS

The following health service codes have been terminated effective March 27, 2014:

| Category | Code | Description |
|---|---|---|
| MASG | 65.51C | Recurrent hernia – by laparoscopy |
| MASG | 65.59C | Recurrent hernia – by laparoscopy |

These fees have been replaced by HSC 65.51E – Recurrent ventral or incisional hernia repair, by laparoscopy, reducible or strangulated, with mesh, with or without enterolysis. Please refer to the January 31, 2014 MSI Physicians' Bulletin for more details on this service.

**CATARACT FEE REMINDER**

As announced previously in the March 28, 2013 MSI Physicians' Bulletin, the following reduction in cataract fees are effective April 1, 2014:

| | Cataract surgical fee reduction | | Cataract anaesthesia fee reduction | |
|---|---|---|---|---|
| Code | Current MSU | April 1st, 2014 | Current AU | April 1st, 2014 |
| 27.72 | 285 | 270 | 5+T | 4+T |
| 27.72B | 309 | 293 | 5+T | 4+T |
| 27.49A | 218.5 | 207 | 5+T | 4+T |
| 27.49B | 218.5 | 207 | 5+T | 4+T |
| 27.59A | 218.5 | 207 | 5+T | 4+T |
| 27.59B | 218.5 | 207 | 5+T | 4+T |

**FAMILY PHYSICIAN CHRONIC DISEASE MANAGEMENT INCENTIVE PROGRAM**
**Revised April 1, 2014**

The current *Physician Services Master Agreement, Schedule "K" 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 Master Agreement Steering Group (MASG) has recently approved changes to the existing Family Physician Chronic Disease Management (CDM) Incentive Program effective April 1, 2014 including:

- **Addition of chronic obstructive pulmonary disease (COPD) as an eligible chronic disease;**
- **Revisions to program requirements and documentation to incorporate COPD, reflect changes to clinical practice guidelines, and improve clarity; and,**
- **Increases to payment rates.**

The existing program strategy and general guidelines remain unchanged.

Qualifying Chronic Diseases
Effective April 1, 2014, the qualifying chronic diseases are:

- **Type 1 and Type 2 Diabetes** as evidenced by FPG $^{3}$7.0 mmol/L ***or*** Casual PG $^{3}$11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT $^{3}$11.1 mmol/L; and,
- **Ischaemic Heart Disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram.
- **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator $FEV_1$ < 80% predicted and $FEV_1$/FVC < 0.70

Required Indicators/Risk factors

Effective April 1, 2014, in order to claim a CDM incentive payment the following indicators/risk factors, as applicable, are required to be addressed as part of the annual cycle of care. The required indicators include all relevant common indicators plus the specific indicators for each disease. For example, if diabetes and COPD are present, the three common indicators for diabetes, IHD and COPD plus the three common indicators for diabetes and IHD plus the specific indicators for diabetes and the specific indicators for COPD would all need to be addressed in order to claim annual incentive payments for the two diseases.

*Common Indicators for Diabetes, IHD and COPD*

- Smoking cessation – discussed once per year if smoker (document smoker or nonsmoker)
- Immunizations discussed and/or given – once per year
- Exercise/activity – discussed, including possible referrals, once per year

*Common Indicators for Diabetes and IHD*

- Blood pressure – 2 times per year
- Weight/nutrition counseling – once per year
- Lipids – once per year

*PLUS THE FOLLOWING REQUIRED INDICATORS, DEPENDING ON THE APPLICABLE CHRONIC DISEASE:*

*Indicators for Diabetes only*

- HbA1C – ordered 2 times per year
- Renal function – ACR or eGFR ordered once per year
- Foot exam with 10-g monofilament – referred or completed once per year
- Eye exam – discussed and/or referred once per year for routine dilated eye exam

*Indicators for IHD only*

- Anti-platelet therapy – considered/reviewed once per year
- Beta-blocker – considered/reviewed once per year
- ACEI/ARB – considered/reviewed once per year
- Discuss Nitroglycerin – considered/reviewed once per year
- Consider further cardiac investigations – considered/reviewed once per year

***Indicator for COPD only***

- **COPD Action Plan required – Develop and then review and complete once per year**

CDM Incentive Payments

Effective April 1, 2014 eligible GPs are paid as follows:

- $100 base incentive payment once per fiscal year for managing an annual cycle of care and addressing the required indicators/risk factors for each patient with one qualifying chronic disease.
- $75 additional payment per fiscal year if the same patient is managed for a second qualifying chronic disease (total payment of $175)

- $50 additional payment per fiscal year if the patient is managed for three qualifying chronic diseases (total payment of $225).

**NOTE: Completion of the COPD Action Plan, if applicable, is included in these payments.**

The CDM incentive is claimed through a fee code. APP contract physicians are also eligible for the incentive and are paid by cheque twice a year based on their aggregate shadow billings.

CDM Incentive Billing Rules

1. The CDM Incentive fee can be claimed by family physicians only.

2. 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. 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 diseases (s) for each qualifying disease.

3. The family physician is expected to act as case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations, including for investigations, follow-up visits and/or referrals.

4. Patients must be seen a minimum of two times per year by a licensed health care provider (includes physicians) in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.

5. Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.

6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year by March 31 of that year.

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

   - **Type 1 and Type 2 Diabetes** defined as: FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L; and/or,

   - **Ischaemic Heart Disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram (includes post-MI <=5 yr); and/or,

   - **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator $FEV_1$ < 80% predicted and $FEV_1$/FVC < 0.70.

8. For patients managed for COPD, a COPD Action Plan must be developed and then reviewed and completed annually, with a copy given to the patient and a copy available in the patient's clinical record.

9. The CDM incentive can be claimed once per fiscal year (April 1 to March 31 inclusive) if the following conditions are met:

   - the patient is 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.

CDM Flow Sheet

The Family Physician Chronic Disease Management Flow Sheet (attached) is revised effective April 1, 2014. Use of the Flow Sheet continues to be optional.

**COPD Action Plan**

**A required indicator for COPD is the development and annual review and completion of a COPD Action Plan using the program COPD Action Plan template (attached).**

Please Note: The system update for this revision is scheduled for May 23rd, 2014. At present time, please submit claims for managing up to two chronic diseases in the usual manner. Please hold all claims for the new 3rd chronic disease management incentive amount. A new modifier will be added during the May 23rd, 2014 migration to account for this additional incentive. Once the update is complete, effective claims with a service date from April 1, 2014 to May 22, 2014 will be identified and reconciliation will occur in the Fall of 2014.

## BILLING REMINDERS

Critical Care Codes-Heath Service Code 03.05

As per Preamble section 7.9, Critical Care codes may be claimed for patients admitted to areas of the hospital that have been designated as Intensive Care Units by the Department of Health and Wellness by physicians who have been assigned to cover the ICU by the hospital because of their training or expertise.

It has come to MSI's attention that physicians other than those designated to cover the ICU are attempting to claim critical care codes. Critical care codes may be claimed only once per 24 hours by only one physician who is designated to cover the ICU that day. Non-designated physicians may not claim these codes.

While two (or more) physicians may share coverage of the ICU over a 24 hour period, Preamble rules do not permit both physicians to claim either the same ICU code or additional visits per patient (critical care or otherwise).

Supervision of Anticoagulant Therapy by Telephone, Fax or E-Mail- Health Service Code 13.99C

As per Preamble section 7.7.2, this health service code may be claimed once per month if the patient's treatment is managed by telephone, fax or e-mail. It may not be claimed within one month of hospitalization. As there will be months when a physician does not provide the monitoring necessary to claim this code, such as months during which the patient does not have an INR drawn or when they are hospitalized, physicians are discouraged from setting up automatic monthly billing systems for this health service code.

**EXPLANATORY CODES**

The following new explanatory codes have been added to the system:

MJ043 Service encounter has been disallowed as the provider number is not valid for this service.

MA058 Service encounter has been refused as you have previously billed HSC 82.42.

MA059 Service encounter has been refused as you have previously billed HSC 83.61.

AD048 Service encounter has been refused as you have previously billed HSC 66.3E or 66.3F.

MA060 Service encounter has been refused as you have previously billed HSC 66.82A.

**UPDATED FILES – AVAILABILITY**

Updated files reflecting changes are available for download on Friday, March 28th, 2014. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanatory codes (EXPLAIN.DAT).

# Family Physician Chronic Disease Management (CDM) Flow Sheet

Patient Name: _____ Diabetes: Type 1 ☐ Type 2 ☐ IHD ☐ COPD ☐

Date of birth: _____ (dd/mm/yy) Date(s) of Diagnosis: DM _____ (mm/yy) IHD _____ (mm/yy) COPD _____ (mm/yy)

Co morbidities: ☐ HTN ☐ Dyslipidemia ☐ PAD ☐ Renal Disease ☐ A Fib
☐ TIA/Stroke ☐ Mental Health Diagnosis ☐ CHF
Other: _____

Interventions/Investigations: PCI/Stent _____ ☐ Bare metal ☐ Drug-eluting ☐ Spirometry/PFT
CABG _____ Cardiac Cath. _____
Current Medication: _____
_____

| | | | | | |
|---|---|---|---|---|---|
| REQUIRED COMMON INDICATORS FOR DIABETES, IHD AND COPD | | Date / / | Date / / | Date / / | Date / / |
| ANNUALLY | Smoker ☐ Yes ☐ No If yes, discuss smoking cessation | | | | |
| ANNUALLY | Immunizations Discussed and/or given | | | | |
| ANNUALLY | Exercise/Activity | | | | |
| REQUIRED COMMON INDICATORS FOR DIABETES and IHD | | Date / / | Date / / | Date / / | Date / / |
| 2/YR | Blood pressure | | | | |
| ANNUALLY | Weight/Nutrition Counselling | | | | |
| ANNUALLY | Lipids Discuss statins LDL-C (mmol/L) TC/HDL-C | | | | |
| REQUIRED INDICATORS FOR DIABETES ONLY | | | | | |
| 2/YR | HbA1C | | | | |
| ANNUALLY | Renal Function ACR and eGFR | | | | |
| ANNUALLY | Foot Exam Use 10-g monofilament | | | | |
| ANNUALLY | Eye Exam Discuss and/or refer | | | | |
| REQUIRED INDICATORS FOR IHD ONLY | | | | | |
| ANNUALLY | Anti-platelet Therapy Review | | | | |
| ANNUALLY | Beta-blocker Review | | | | |
| ANNUALLY | ACEI/ARB Review | | | | |
| ANNUALLY | Discuss Nitroglycerin | | | | |
| ANNUALLY | Consider further cardiac investigations | | | | |
| REQUIRED INDICATORS FOR COPD ONLY | | | | | |
| 1/YR | COPD Action Plan Develop. Review and complete annually | | | | |
| *RECOMMENDED ITEMS (Optional for CDM Incentive payment)* | | | | | |

Self Management Referrals: ☐ Diabetes Centre ☐ Cardiac Rehab ☐ Your Way to Wellness ☐ Pulmonary Rehabilitation
Screen for: ☐ Depression/Anxiety ☐ Erectile Dysfunction
Lifestyle: ☐ Alcohol Use ☐ Psychsocial Issues
Economics: ☐ Pharmacare ☐ Third Party Insurance ☐ No Insurance ☐ Financial Issues
End of Life: ☐ Care Discussion

**Date CDM Incentive Code Billed:** _____

## SELECTED CHRONIC DISEASE MANAGEMENT GUIDELINE INDICATORS

| Common Indicators: DM, IHD & COPD | Target | Comments |
|---|---|---|
| Smoking Cessation | Non-smoker | |
| Immunizations | Influenza annually. Pneumococcal once, then for DM & IHD repeat at 65 yr.; for COPD repeat every 5-10 years.. | |
| Exercise/Activity | Discuss appropriate exercise/activity and possible referrals | For DM & IHD: 30 mins/day 5x/wk plus resistance exercise 3 x/wk.<br>For COPD: pulmonary rehab program |
| **Common Indicators: DM & IHD** | **Target** | **Comments** |
| Blood Pressure | IHD without DM or CKD: <140/90<br>DM: <140/80*<br>DM and CKD: <130/80**<br>In children: <95th %ile for age, gender and height | *In DM with no end organ damage<br>** Where this can be achieved safely without undue burden |
| Lipids | For IHD or IHD plus DM LDL-C: < 2.0 >50% reduction<br>For DM only LDL-C: < 2.6 | Test every 1-3 years OR as clinically indicated |
| Weight/Waist circumference/<br>Nutrition counseling | BMI: <25 kg/$m^2$ or<br>In children: <85th %ile for age<br>Waist circumference: M: <102 cm, F: <88 cm | |

| Diabetes Indicators | Target | Comments |
|---|---|---|
| HbA1C | < 7% | -q 6 mo. In stable DM<br>-q 3 mo. For all others<br>Individualize HbA1C based on age, DM duration & co-morbidity |
| Renal Function | ACR: <2.0 for males; <2.8 for females<br>eGFR: >60 mL/min | In presence of CKD, at least every 6 months.<br>Referral to nephrologist/internist if eGFR <30 mL/min |
| Routine foot examination | Annually | Q3-6 mo. In moderate to high risk foot. Assess skin, neuropathy (10 –g monofilament) and perfusion. |
| Routine dilated eye examination | At diagnosis, then every 1-2 years based on degree of retinopathy. | By optometrist or ophthalmologist |

| IHD Indicators | Duration | Comments |
|---|---|---|
| Beta-blocker | STEMI: Indefinitely<br>Non-STEMI: Indefinitely unless low risk | |
| ACEI/ARB | Indefinitely unless low risk | ACEI: Titrate to target dose.<br>Consider ARB if contraindication or intolerance to ACEI |
| Antiplatelet Therapy<br>**ASA** 81 to 325 mg OD<br><br>**Clopidogrel** 75 mg OD<br><br><br><br><br><br>**Ticagrelor** 90 mg BID | **ASA** indefinitely –STEMI, Non-STEMI and Stable Coronary Artery Disease<br><br>**Clopidogrel: STEMI** - Only if had PCI<br>Minimum 1 mo. post bare metal stent<br>Min. 12 mo. post drug-eluting stent<br><br>**Clopidogrel: Non-STEMI**<br>No PCI: Low risk - 3 mo; Inc. risk - 12 mo.; Very high risk - >12 mo.<br>PCI: Low risk & bare metal stent - 3 mo.; Increased risk regardless of stent or ≥1 drug-eluting stent - 12 mo.; very high risk regardless of stent or ≥3 drug-eluting stents or complex PCI - >12 mo<br><br>**Ticagrelor**<br>Prescribed to high risk Acute Coronary Syndrome patients, 12 months of therapy recommended. | **ASA** maximum dose 75-100 mg if on Ticagrelor<br>**Clopidogrel: STEMI**<br>Dependent on type of stent and risk profile<br><br>**Clopidogrel Non-STEMI**<br>Depends on risk of recurrent event & stent type<br><br>**Ticagrelor**: Reduce ASA to 75-100 mg. Transient dyspnea can be early side effect. Usually mild and resolves with continued therapy. |
| Discuss Nitroglycerin | | |
| Consider further cardiac investigations | | |

| COPD Indicators | Target | Comments |
|---|---|---|
| COPD Action Plan | Include medications and emergency instructions for patient. | Copy given to patient. |

**PHARMACOTHERAPY IN COPD**

**INCREASING DISABILITY AND LUNG FUNCTION IMPAIRMENT**

| MILD | MODERATE | VERY SEVERE |
|---|---|---|
| ↓ | | |
| **SABD prn**<br>↓ Persistent dyspnea | **Infrequent AECOPD (average of <1 per year)**<br>**LAAC *or* LABA + SABA prn**<br>↓ Persistent dyspnea | **Frequent AECOPD (≥1 per year)**<br>**LAAC + ICS/LABA +SABA prn**<br>↓ Persistent dyspnea |
| **LAAC + SABA prn**<br>or<br>**LABA + SABD prn** | **LAAC + LABA + SABA prn**<br>↓ Persistent dyspnea<br>**LAAC + ICS/LABA* + SABA prn** | **LAAC + ICS/LABA + SABA prn**<br>±<br>**Theophylline** |

*refers to lower dose ICS/LABA

SABD = Short-acting bronchodilator (e.g. ipatropium or SABA)

LAAC = Long acting anticholinergic (e.g. tiotropium)

LABA = Long acting beta agonist (e.g. salmeterol; formoterol)

SABA = Short-acting beta agonist (e.g. salbutamol; terbutaline)

ICS/LABA = inhaled corticosteroid/LABA (e.g. fluticasone/salmeterol; budesonide/formoteral)

**CHRONIC DISEASE MANAGEMENT (CDM) INCENTIVE FEE BILLING RULES**

1. The CDM Incentive fee can be claimed by family physicians only.
2. 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. 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.
3. The family physician is expected to act as case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations, including for investigations, follow-up visits and/or referrals.
4. Patients must be seen a minimum of two times per year by a licensed health care provider (includes physicians) in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.
5. Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.
6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year by March 31 of that year.
7. The qualifying chronic diseases eligible for the CDM incentive payment are:
   - **Type 1 and Type 2 Diabetes** defined as: FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L; and/or,
   - **Ischaemic Heart Disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram (includes post-MI <=5 yr); and/or,
   - **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator $FEV_1$ < 80% predicted and $FEV_1/FVC$ < 0.70.

8. For patients managed for COPD, a COPD Action Plan must be developed and then reviewed and completed annually, with a copy given to the patient and a copy available in the patient's clinical record.
9. The CDM incentive can be claimed once per fiscal year (April 1 to March 31 inclusive) if the following conditions are met:
   - the patient is 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 (see front of flow sheet) and documented in the clinical record or optional flow sheet at or before the time of billing.

# COPD ACTION PLAN

**(Review annually with your doctor)**

Patient Name: _____ Date: _____

HCN: _____ Date of Birth: _____

You have been diagnosed with Chronic Obstructive Pulmonary Disease (COPD). As someone with COPD, you are either in your stable, everyday state or having a flare up. This Plan will help you to quickly recognize and treat flare ups to manage your COPD and improve your health.

**COPD** (*Chronic Obstructive Pulmonary Disease*) can be stable or you could have a flare-up:

**When you are stable:**

1. Breathing with your usual shortness of breath
2. Able to do your usual daily activities
3. Mucous is easy to cough up

## How to tell if you are having a flare-up

A flare up may occur after you get a cold, get run down or are exposed to air pollution, pollen or very hot or cold weather. There are 3 things that define a flare-up:

1. Increased shortness of breath from your usual level
2. Increased amount of sputum from your usual level
3. Sputum changes from its usual colour to yellow, green or rust colour

Some people may feel a change in mood, fatigue or low energy prior to a flare-up.

## If any 2 or all of these symptoms persist for 48 or more hours do the following:

- □ Take your rescue inhaler 2-4 puffs as needed (up to 4-6 times per day) for shortness of breath.
- □ Take your prescribed antibiotic for a COPD flare-up (see over).
- □ Take your prescribed prednisone for a COPD flare-up (see over).
- □ Contact your doctor if you feel worse or do not feel better after 48 hours of treatment.
- □ Call 811 if you have questions
- □ Other _____

**IF YOU ARE EXTREMELY BREATHLESS, ANXIOUS, FEARFUL, DROWSY, CONFUSED OR HAVING CHEST PAIN, CALL 911 FOR AN AMBULANCE TO TAKE YOU TO THE EMERGENCY ROOM.**

Physician Signature_____

Patient/Caregiver Signature_____

## COPD MAINTENANCE MEDICATION RECORD

Patient Name: _____ Date: _____

HCN: _____ Date of Birth: _____

**Patients**: Take the following maintenance medications **everyday** to help maintain control of your COPD symptoms.

**Physicians**: Please fill in prescribed maintenance medications.

| Medication Prescribed | How Much to Take | When To Take |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## COPD FLARE-UP MEDICATION RECORD

**Patients**: Please fill in date when you start and finish your flare-up medications.

**Physicians**: Please fill in prescribed flare-up (antibiotics & prednisone) medications.

| Medication Prescribed | Start Date / Finish | Start Date / Finish | Start Date / Finish |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Make sure you take your prescribed medications until finished.**

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**Please review this plan with your doctor at least annually.**

# PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

January 31, 2014 Volume L #1

Inside this issue



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**On-line documentation available at :**

http://www.medavie.bluecross.ca/msiprograms

## *Electronic Bulletin now available*

Please note, that effective January 1, 2014, the MSI Physicians' Bulletin is only available on the MSI website at http://www.medavie.bluecross.ca/msiprograms. To be automatically notified of upcoming bulletins, follow the "Subscribe" link located on the home page. Bulletins can be easily saved and printed directly from the new MSI website

Subscribing to electronic access to physicians' bulletins is not only important, but strongly encouraged as it is the responsibility of all physicians to be aware of changes, updates, new billing codes and practices communicated in the bulletins. If for some reason you are unable to access the website please contact MSI at 496-7011 or 1-866-553-0585.

### NEW FEES

*Note: Physicians holding eligible services must submit their claims from January 1, 2014 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

Effective January 1, 2014 the following new health service codes are available for billing:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 57.6C | **Laparoscopic Total Colectomy**<br><br>Laparoscopic resection of colon with the creation of an ileorectal anastomosis or end ileostomy. Includes mobilization of entire colon, identification of both ureters, dissection of mesocolic vessels, division of colon, delivery of colon through the extraction site, with intra- or extra-corporeal anastomosis of bowel or creation of an end ileostomy, and closure of the extraction site. | 500 8+T |

Billing Guidelines:
Not to be billed with any other fees for resection of bowel or formation of colostomy or ileostomy on the same patient same day.

Specialty Restriction:
GNSG

Location:
HOSP

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 60.4B | **Laparoscopic Assisted Abdominoperineal Resection** | 630 8+T |

Laparoscopic resection of distal sigmoid colon, rectum, and anus with creation of end sigmoid colostomy and perineal dissection to remove the appropriate segment of bowel along with the anal sphincter. Includes mobilization of colon, identification of ureter, dissection of mesocolic vessels, division of colon, total mesorectal excision of rectum and delivery of sigmoid colon, rectum, and anus through perineal incision.

Billing Guidelines:
Not to be billed with any other fees for resection of bowel or formation of colostomy or ileostomy on the same patient same day.

Specialty Restriction:
GNSG with a fellowship in colorectal surgery and/or fellowship in minimally invasive surgery.

Location:
HOSP

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 65.51D | **Initial ventral or incisional hernia repair by laparoscopy, reducible or strangulated, with mesh, with or without enterolysis** | 220 6+T |

This fee is for the initial repair of a ventral or incisional hernia using a laparoscopic approach. This fee includes the use of mesh or prosthesis and any lysis of adhesions required to perform the procedure.

Billing Guidelines:
1. May not be billed with:
   66.4A Intestinal Obstruction - without resection
   66.3 Excision or destruction of lesion or tissue or peritoneum
2. May be billed with:
   57.42B Enterectomy with anastomosis if required providing this is documented in the operative report.

3. If the surgical time (skin to skin) exceeds 3 hours for this procedure, it shall be paid EC at a rate of 110 MSU per hour.

Specialty Restriction:
GNSG

Location:
HOSP

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 65.51E | **Recurrent ventral or incisional hernia repair, by laparoscopy, reducible or strangulated, with mesh, with or without enterolysis** | 325 6+T |

This fee is for the repair of a recurrent ventral or incisional hernia using a laparoscopic approach. This fee includes the use of mesh or prosthesis and any lysis of adhesions required to perform the procedure. Previous attempt at surgical repair of ventral/incisional hernia must be documented on the health record.

Billing Guidelines:
1. May not be billed with:
   66.4A Intestinal Obstruction - without resection
   66.3 Excision or destruction of lesion or tissue or peritoneum
2. May be billed with:
   57.42B Enterectomy with anastomosis if required providing this is documented in the operative report.
3. If the surgical time (skin to skin) exceeds 3.5 hours for this procedure, it shall be paid EC at a rate of 130 MSU per hour.

Specialty Restriction:
GNSG

Location:
HOSP

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 97.6E | **Post Mastectomy Breast Reconstruction with tissue expander or implant, immediate or delayed.** | 140 4+T |

This is a comprehensive fee for breast reconstruction, post mastectomy (immediate or delayed), with a tissue expander or implant to include any or all pectoralis major muscle elevation, serratus anterior muscle transposition, and any tissue shifts required to close the mastectomy wound.

Billing Guidelines:
Comprehensive fee, not to be billed with :
MASG 97.95 - Insertion of breast tissue expander(s) (regions required)

MASG 97.43 - Unilateral augmentation mammoplasty by implant or graft
MASG 97.44- Bilateral augmentation mammoplasty
Local tissue shifts

On the same patient, same side, same day.

Specialty Restriction:
PLAS

Location:
HOSP

Region:
Right, Left, Bilateral

**FEE REVISIONS**

Effective November 1, 2013, health service code **60.55** – Hartmann Resection has been revised and updated with the following information:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 60.55 | **Hartmann Resection** | 325 8+T |

This is a comprehensive fee for a Hartmann resection (partial sigmoid colectomy, formation of end colostomy, and closure of the distal segment).

Billing Guidelines:
Not to be billed with:
MASG 58.11 Colostomy unqualified
MASG 57.59 Other partial excision of large intestine

Specialty Restriction:
GNSG and VASG

Location:
HOSP

NOTE: The MSI system has now been updated. Claims for this code with a service date from November 1, 2013 to January 30, 2014 will be identified and a reconciliation will occur in the spring of 2014. The reconciliation will be calculated after the 90 day waiting period for submission of claims.

**HEALTH SERVICE CODE CLARIFICATION**

**Geriatrician's Initial Comprehensive Geriatric Consultation to Include CGA (Comprehensive Geriatric Assessment) HSC VIST 03.04D -** Please refer to the September 13, 2013 MSI Physicians Bulletin for complete details on this new health service code.

Billing Guidelines:
Time based fee requiring a minimum of 90 minutes. At least 80% of time must be spent in direct patient contact. No other fee codes may be billed for that patient in the same time period.

**Please note:**
Time spent with family/care givers to obtain pertinent information that cannot be obtained from the patient will constitute time spent in direct contact with the patient for the purposes of billing this code.

## BILLING REMINDERS

### Second Surgical Assistants

A surgical assistant is defined as a physician who assists the operating surgeon throughout a substantial portion of the operation. As per Preamble section 9.5.1 (d), when a second assistant is necessary, his or her claim is 50% of the stated service encounter for the first assistant with a minimum of 10.5 units. The need for a second assistant is to be supported by a letter from the surgeon explaining necessity. Please direct the supporting letter from the surgeon explaining the necessity to the MSI Medical Consultant for approval. When approval has been granted the physician may then submit the claim for adjudication.

Claims for second surgical assistants are to be submitted using exceptional circumstances (HSC EC). The text should indicate the health service code (HSC) of the procedure performed, the duration of the service, as well as indicating there is an approval letter on file for this second surgical assist claim.

### Paediatric Care of Over-age Patients Age 16 up to and Including 18 Years of Age

As per section 8.4.5 of the preamble, visits, excluding paediatric consultations, outside hospital for over-age patients are not to be paid at paediatric rates except for:

(i) Behavioural management.
(ii) Follow-up visits in a paediatrician's office for approved over-age patients with complex multi-system medical problems. **Application must be made in writing to the MSI Medical Consultant and prior approval obtained for each patient.**

**Please note: Application for approval must clearly state the diagnosis and provide sufficient clinical information to support complex multi-system medical problems.**

### Family Physician Chronic Disease Management Incentive (CDM1)

This program is intended to recognize the additional work of General Practitioners, beyond office visits, of providing guidelines-based care to patients with chronic diseases. Providing all eligibility requirements are met, the CDM incentive can be billed once per patient per Fiscal year. Please refer to the July 3, 2009 MSI Physicians' Bulletin for details on eligibility requirements.

**In order to receive payment for services provided in Fiscal 2013/14, all claims must be submitted to MSI by March 31, 2014.**

## EXPLANATORY CODES

The following new explanatory codes have been added to the system:

GN063 Multiple SRAS have claimed for this patient on same day. If second surgical assist for same surgery claim EC. If claiming as surgical assist on a different surgery (same patient/same day) resubmit with text indicating subsequent surgery

MA050 Service encounter has been refused as you have previously billed HSC 58.11 or 57.59.

MA051 Service encounter has been refused as you have previously billed HSC 60.55.

MA052 Service encounter has been refused as you have previously billed HSC 66.4A or 66.3.

MA053 Service encounter has been refused as you have previously billed HSC 65.51D or 65.51E.

MA054 Service encounter has been refused as you have previously billed HSC 97.95, 97.43, 97.44.

MA055 Service encounter has been refused as you have previously billed HSC 97.6E.

MA056 Service encounter has been refused as you have previously billed for a resection of bowel or formation of colostomy or ileostomy.

MA057 Service encounter has been refused as you have previously billed for a laparoscopic total colectomy or laparoscopic assisted Abdominoperineal.

VA056 Service encounter has been refused as the diagnostic code provided is not valid for this service.

**UPDATED FILES – AVAILABILITY**

Updated files reflecting changes are available for download on Friday, January 31, 2014. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanatory codes (EXPLAIN.DAT).

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

December 27, 2013 Volume XLIX #8

Inside this issue:



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http://www.medavie.bluecross.ca/msiprograms

## Re-immunization of Dr. Vitale's Patients

Recently the Nova Scotia College of Physicians & Surgeons suspended the license of Dr. William Vitale, a pediatrician in Halifax, for his practice of improperly mixing vaccines. As a result all patients who received two, four, six, twelve and 18-month vaccinations from Dr. Vitale between 1992-1994 or 2003-2013 may need to be re-immunized to ensure proper protection against vaccine preventable disease.

The following vaccines can be re-administered to former patients of Dr. William Vitale, as per the NS Public Health directions:

- Meningococcal C (Menjuncate)
- Pneumococcal conjugate (Prevnar)
- Varicella
- MMR
- PENTA (DTaP-IPV-Hib)
- MMRV (Priorix-Tetra)
- Adacel-Polio (Tdap-IPV)
- Boostrix
- Td (tetanus-diphtheria)
- IPV (Polio)

Physicians performing these re-immunizations are instructed to submit each immunization claim as EC with the following text included: "Re-immunization for patient of Dr. Vitale". Please indicate which immunization was provided in the claim text, and submit the service with diagnostic code VT069. Each vaccine must be billed as a separate EC claim.

As an exception to Preamble rule 7.2.3 (j), physicians shall also be permitted to bill a visit fee when the visit was made solely for one of the above re-immunizations. Please submit these visits with the applicable health service code and include diagnostic code VT069.

**Note that all other visit and immunization rules still apply.

# PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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Inside this issue




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**On-line documentation available at :**

http://www.medavie.bluecross.ca/msiprograms


## *New MSI Website and Electronic Bulletin Launched on September 16, 2013*

The Department of Health and Wellness, in collaboration with Medavie Blue Cross and Doctors Nova Scotia is very pleased to announce the launch of the new MSI website. The website can be found at www.medavie.bluecross.ca/msiprograms.

The new website includes simplified electronic access to important documents such as the MSI Physician's Manual; the Billing Instructions Manual and the MSI Physicians' Bulletins. The website also contains a "frequently asked questions" section along with a searchable archive of bulletins. The new website marks an important and progressive step into the ever advancing age of technology and away from paper based communication and information.

One of the key features of the new website is the ability for physicians and billing staff to be able to subscribe to electronic notification of upcoming MSI Physicians' Bulletins. The MSI Physicians' Bulletins contains important information for physicians, as it includes MSI billing updates, policy changes and other key topics related to insured services.

**Please note, that effective January 1, 2014, bulletins will only be available on the MSI website. To be automatically notified of upcoming bulletins, follow the "Subscribe" link located on the home page. Physicians will continue to receive paper copies of bulletins until December 31, 2013. Bulletins can be easily saved and printed directly from the new MSI website**

**Subscribing to electronic access to physicians' bulletins is not only important, but strongly encouraged as it is the responsibility of all physicians to be aware of changes, updates, new billing codes and practices, communicated in the bulletins.** If for some reason you are unable to access the website please contact MSI at 496-7011 or 1-866-553-0585.

**NEW FEES**

*Note: Physicians holding eligible services must submit their claims from October 1, 2013 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

Effective October 1, 2013 the following new health service codes are available for billing:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| CONS | 03.09H | **Antenatal Palliative Care Consultation (Limited)** | 42 |

For the limited consultation by the paediatric palliative care specialist to the mother of the fetus diagnosed with a potentially lethal anomaly or condition. The consultation covers the physical, emotional, social, spiritual issues related to the birth of a newborn diagnosed with a potentially lethal condition.

Billing Guidelines:
To be billed by PEDI using the MSI number of the mother for services rendered during the antenatal period. Consultation may only be billed once per mother per pregnancy. A list of qualified specialists is to be kept on file at MSI. Fetal diagnosis must be recorded in text and on the mother's health record.

Specialty Restriction:
PEDI with additional training in Paediatric Palliative Care.

Location:
HOSP, OFFC

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VIST | 03.03H | **Antenatal Palliative Care follow up visit** | 13 |

For the limited consultation by the paediatric palliative care specialist to the mother of the fetus diagnosed with a potentially lethal anomaly or condition. The consultation covers the physical, emotional, social, spiritual issues related to the birth of a newborn diagnosed with a potentially lethal condition.

Billing Guidelines:
To be billed by PEDI using the MSI number of the mother for services rendered during the antenatal period. Consultation may only be billed once per mother per pregnancy. A list of qualified specialists is to be kept on file at MSI. Fetal diagnosis must be recorded in text and on the mother's health record.

Specialty Restriction:
PEDI with additional training in Paediatric Palliative Care.

Location:
HOSP, OFFC

| Category | Code | Description | Unit Value |
|---|---|---|---|
| CONS | 03.09G | **Medical Management of Ectopic Pregnancy** | 56 |

This comprehensive fee includes the consultation, assessment, and counseling of a patient with a confirmed ectopic pregnancy who meets the criteria for medical management of her condition. Administration of cytotoxic medication(s) is included as are all verbal or electronic communications with the patient to relay results of follow up blood work as appropriate.

Billing Guidelines:
1. May not be billed with any other consultative or visit service same patient same day.
2. If surgery is required within 48 hrs of the delivery of cytotoxic medication, the service fee will be reduced to a regular consultation fee.
3. Once per patient per pregnancy

Specialty Restriction:
OBGY

Location:
HOSP, OFFC

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 78.1A | **Salpingectomy for morbidity, not for sterilization** | 130 6+T |

This fee is for the partial or complete removal of the fallopian tube for purposes other than sterilization, open or laparoscopic approach. Includes salpingectomy for cancer prophylaxis, Underlying diagnosis must be documented on the health record.

This fee will replace:
78.1 Total Salpingectomy-unilateral
78.22 Removal of Remaining Fallopian Tube
78.59 Other Partial Salpingectomy
78.21 Removal of Both Tubes

Billing Guidelines:
Not to be billed with oophorectomy same patient same side

Specialty Restriction:
OBGY, GNSG

Location:
HOSP

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 86.3A | **Surgical Removal of Extrauterine (Ectopic) Pregnancy-by any means**<br><br>This comprehensive fee is for the surgical treatment of an extrauterine (ectopic) pregnancy; tubal, ovarian, cervical, abdominal, or interstitial, requiring evacuation, salpingostomy, salpingectomy and/or oophorectomy, open or laparoscopic approach.<br><br>This fee will replace:<br>78.52 Salpingectomy (partial) with removal of ectopic pregnancy<br>78.63 Salpingo-salpingostomy<br>81.21 Removal of intraligamentous pregnancy<br><br>Billing Guidelines:<br>Not to be billed with salpingectomy, salpingostomy or oophorectomy.<br><br>Specialty Restriction:<br>OBGY, GNSG<br><br>Location:<br>HOSP | 130 6+T |

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 78.39A | **Interruption or removal of fallopian tubes for purposes of sterilization: abdominal, vaginal, laparoscopic-not hysteroscopic (unilateral or bilateral)**<br><br>This fee is for the interruption or removal of all or part of one or both fallopian tubes for purposes of sterilization: includes fulgarisation, occlusion by device, and transection: open (abdominal or vaginal) or laparoscopic approach. Not to be used for hysteroscopic occlusion.<br><br>This fee will replace:<br>78.31 Endoscopic Ligation and crushing of Fallopian Tubes uni or bilateral.<br>78.39 Endoscopic destruction or occlusion of fallopian tubes, uni or bilateral.<br>78.53A Suture Ligation of Fallopian Tubes<br><br>Billing Guidelines:<br>Not to be used for hysteroscopic sterilization, not to be billed with 66.83 Laparoscopy ME=ELEC Unilateral or bilateral, no additional billing for bilateral.<br><br>Specialty Restriction:<br>OBGY, GNSG<br><br>Location:<br>HOSP | 105 6+T |

**FEE REVISION**

Effective October 1, 2013, health service code **03.09C** - Palliative Care Consult has been revised and updated with the following information:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| CONS | 03.09C | **Palliative Care Consult**<br><br>Preamble 7.10.1<br>The Palliative Care Consultation can only be claimed by designated physicians (general practitioners or specialists) with recognized expertise in palliative care. The service provided must fulfill the normal requirements for a consultation as specified in the Preamble. The consultation includes a psychosocial assessment, comprehensive review of pharmacotherapy, appropriate counseling, and consideration of appropriate community resources where indicated. A prolonged consultation cannot be claimed. Specialists can claim the palliative care consultation fee or the consultation fee appropriate to their specialty. It is payable once per patient per physician. Physicians billing the Palliative Care consult must forward a letter to MSI indicating his/her credentials.<br><br>Physicians providing palliative care must have completed a minimum of six days of intensive didactic or small group training in palliative care, and a one-week clinical practicum in palliative care with a qualified physician supervisor.<br><br>Billing Guidelines:<br>Once per patient per physician.<br>Maximum multiples 8, (total of 3 hours)<br>Start and stop times must be recorded when billing multiples.<br><br>Specialty Restriction:<br>Physicians with recognized expertise in Palliative Care<br>List to be kept on file with MSI.<br><br>Location:<br>HOSP, OFFC, HOME | 62 + MU |

NOTE: Effective Claims for this code with a service date from October 1, 2013 to November 22, 2013 will be identified and a reconciliation will occur in the winter of 2013. The reconciliation will be calculated after the 90 day waiting period for submission of claims.

Effective November 1, 2013, health service code **60.55** – Hartmann Resection will be revised and updated with the following information:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 60.55 | **Hartmann Resection** | 325 8+T |

This is a comprehensive fee for a Hartmann resection (partial sigmoid colectomy, formation of end colostomy, and closure of the distal segment).

Billing Guidelines:
Not to be billed with:
MASG 58.11 Colostomy unqualified
MASG 57.59 Other partial excision of large intestine

Specialty Restriction:
GNSG and VASG

Location:
HOSP

NOTE: Please continue to submit claims for these services in the usual manner. Once MSI updates the system it will be published in the MSI Physicians' Bulletin. Claims for this code with a service date from November 1, 2013 will be identified and a reconciliation will occur in the winter of 2013. The reconciliation will be calculated after the 90 day waiting period for submission of claims.

**DISCONTINUED HEALTH SERVICE CODES**

Effective November 22, 2013 the following health service codes are no longer active:

| Category | Code | Description |
|---|---|---|
| MASG | 80.2C | **Laparoscopic supracervical hysterectomy** |
| MASG | 80.4B | **Laparoscopic assisted vaginal hysterectomy** |

(These 2 codes have been made redundant by the implementation on October 1, 2011 of: HSC 80.4C Laparoscopic hysterectomy - total, subtotal or laparoscopically assisted 300 MSU 6+T.)

| | | |
|---|---|---|
| MASG | 78.1 | **Total Salpingectomy-unilateral** |
| MASG | 78.22 | **Removal of Remaining Fallopian Tube** |
| MASG | 78.59 | **Other Partial Salpingectomy** |
| MASG | 78.21 | **Removal of Both Tubes** |
| MASG | 78.52 | **Salpingectomy (partial) with removal of ectopic pregnancy** |
| MASG | 78.63 | **Salpingo-salpingostomy** |
| MASG | 81.21 | **Removal of intraligamentous pregnancy** |
| MASG | 78.31 | **Endoscopic Ligation and crushing of Fallopian Tubes uni or bilateral.** |
| MASG | 78.39 | **Endoscopic destruction or occlusion of fallopian tubes, uni or bilateral.** |

| | | |
|---|---|---|
| MASG | 78.53A | **Suture Ligation of Fallopian Tubes**<br><br>(These 10 codes have been made redundant by the implementation of HSC 78.1A, 86,3A, and 86.3A, detailed previously in this bulletin.) |

**Changes VADT 28.73F and VADT 02.02A**

Effective November 12, 2013, physicians may claim **VADT 28.73F** code for patients with wet age-related macular degeneration (AMD), diabetic macular edema (DME) or retinal vein occlusion (RVO) when treating with ranibizumab or bevacizumab.

**Physicians must specify the patient diagnosis on the claim:**

One of the following specific diagnoses will be required when submitting the claim:

362.52 Exudative senile macular degeneration
362.01 Diabetic macular edema
362.35 Central retinal vein occlusion
362.36 Venous tributary (branch) occlusion

Effective November 12, 2013, VADT 02.02A will be available to all ophthalmologists treating patients with ranibizumab or bevacizumab for the AMD, DME or RVO.

The documentation requirements and guidelines (including maximum of six claims per patient per year) will remain the same.

**BILLING REMINDERS**

**Exceptional Clinical Circumstances versus Independent Consideration**

Exceptional Clinical Circumstances may warrant a fee other than that listed. In the event a practitioner performs a service he or she believes should be insured, but is unable to find an appropriate service code or finds an appropriate service code but feels the listed tariff does not adequately compensate the service, a request for an exceptional fee may be submitted. The request must be accompanied by complete details, including the duration of the service, adequate to explain and justify the number of units requested. ***An example where EC would apply is when a procedure was performed that does not yet have a fee code.***

**Independent Consideration**

Independent consideration is applied to certain services that are assigned a health service code but where a wide variation in case to case complexity and time exists and no unit value is listed. Independent consideration services must be accompanied by complete details, including duration of service, adequate to explain and justify the number of units requested. ***An example where IC would apply is HSC 98.11-Debridement of wound or infected tissue ME=COMP.***

**EXPLANATORY CODES**

The following new explanatory codes have been added to the system:

MA039 Service encounter has been refused as you have previously billed for a laparoscopy at the same encounter.

MA040 Service encounter has been refused as you have previously billed HSC 78.39A at the same encounter.

MA041 Service encounter has been refused as you have previously claimed an oophorectomy for this patient (same side) at the same encounter.

MA042 Service encounter has been refused as you have previously claimed HSC 78.1A for this patient (same side) at the same encounter.

MA043 Service encounter has been refused as you have previously claimed a salpingectomy, salpingostomy, or oophorectomy for this patient at the same encounter.

MA044 Service encounter has been refused as you have previously claimed for a removal of extrauterine pregnancy (HSC 86.3A) at the same encounter.

MA045 Service encounter has been refused as you have previously billed HSC 80.81, 81.09, 81.09A, 81.69A, 80.19B, or 03.26 at the same encounter.

MA046 Service encounter has been refused as you have previously billed HSC 80.19A – endometrial ablation at the same encounter.

PC033 Service encounter has been refused as psychotherapy or counselling are not payable at the same service encounter.

VT116 Service encounter has been refused as you have previously billed a visit or consultation on this day for this patient.

VT117 Service encounter has been refused as you have previously claimed HSC 03.09G on this day for this patient.

VT118 Service encounter has been disallowed as HSC 03.09G has previously been approved for this patient.

VT119 Service encounter has been refused as a consult and psychotherapy or counselling are not payable at the same service encounter.

VT120 Service encounter has been disallowed as HSC 03.09H has previously been approved for this patient.

VT121 Service encounter has been disallowed as the provider number is not valid for this service.

VT122 When claiming this service the fetal diagnosis must be recorded in the text field.

VT123 Service encounter has been disallowed as you do not have approval to bill for this service.

**UPDATED FILES – AVAILABILITY**

Updated files reflecting changes are available for download on Friday, November 22nd, 2013. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanatory codes (EXPLAIN.DAT).

## HOLIDAY DATES FOR 2014

Please make a note in your schedule of the following dates MSI will accept as “Holidays.”

| | |
|---|---|
| NEW YEAR’S DAY | WEDNESDAY, JANUARY 1, 2014 |
| GOOD FRIDAY | FRIDAY, APRIL 18, 2014 |
| EASTER MONDAY | MONDAY, APRIL 21, 2014 |
| VICTORIA DAY | MONDAY, MAY 19, 2014 |
| CANADA DAY | TUESDAY, JULY 1, 2014 |
| CIVIC HOLIDAY | MONDAY, AUGUST 4. 2014 |
| LABOUR DAY | MONDAY, SEPTEMBER 1, 2014 |
| THANKSGIVING DAY | MONDAY, OCTOBER 13, 2014 |
| REMEMBRANCE DAY | TUESDAY, NOVEMBER 11, 2014 |
| CHRISTMAS DAY | THURSDAY, DECEMBER 25, 2014 |
| BOXING DAY | FRIDAY, DECEMBER 26, 2014 |
| NEW YEAR’S DAY | THURSDAY, JANUARY 1, 2015 |

MSI Assessment Department (902) 496-7011
Fax Number (902) 490-2275
Toll Free Number 1-866-553-0585

# 2014 CUT-OFF DATES
# FOR RECEIPT OF
# PAPER & ELECTRONIC CLAIMS

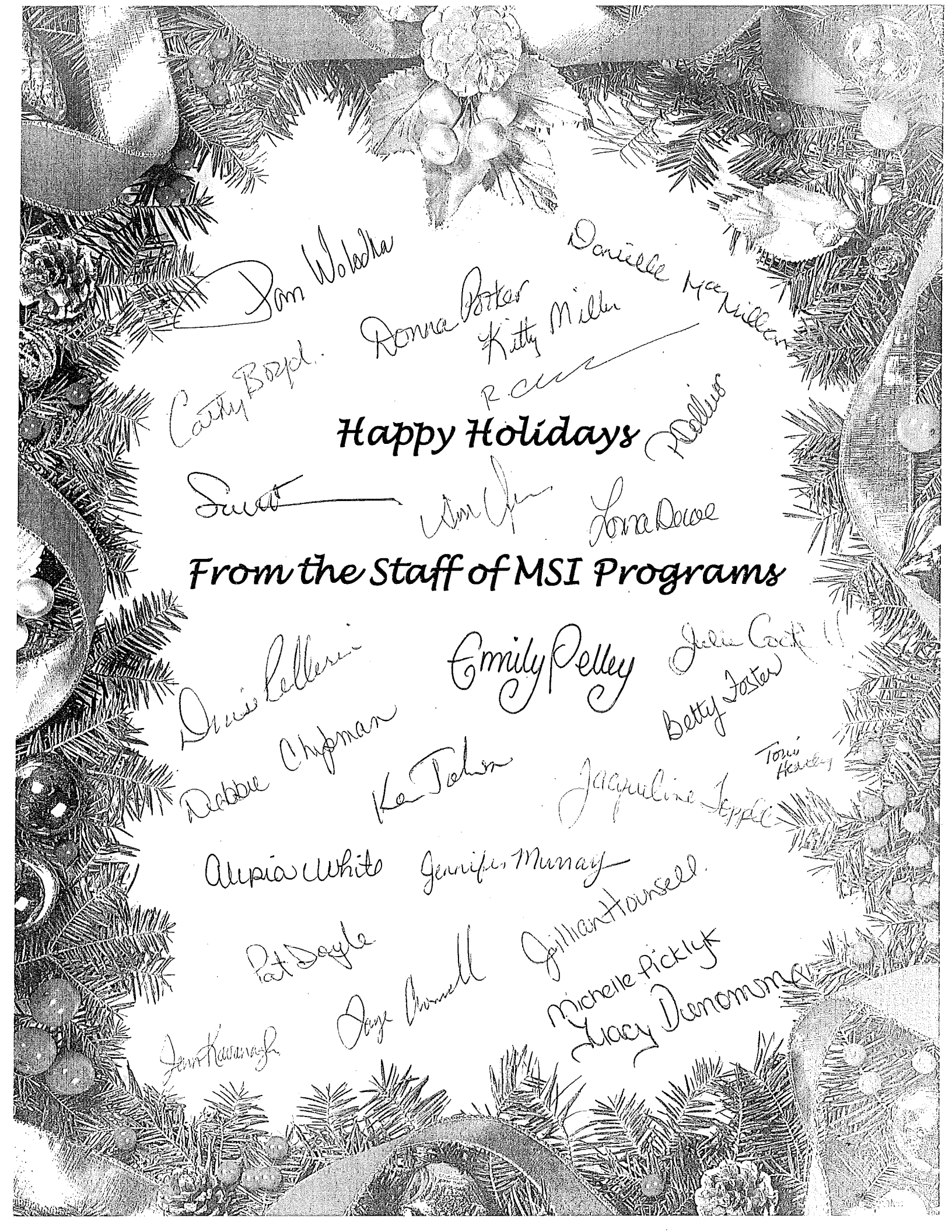
| PAPER CLAIMS | ELECTRONIC CLAIMS | PAYMENT DATE |
|---|---|---|
| December 27, 2013** | January 2, 2014 | January 8, 2014 |
| January 13, 2014 | January 16, 2014 | January 22, 2014 |
| January 27, 2014 | January 30, 2014 | February 5, 2014 |
| February 10, 2014 | February 13, 2014 | February 19, 2014 |
| February 24, 2014 | February 27, 2014 | March 5, 2014 |
| March 10, 2014 | March 13, 2014 | March 19, 2014 |
| March 24, 2014 | March 27, 2014 | April 2, 2014 |
| April 7, 2014 | April 10, 2014 | April 16, 2014 |
| April 21, 2014 | April 24, 2014 | April 30, 2014 |
| May 5, 2014 | May 8, 2014 | May 14, 2014 |
| May 16, 2014** | May 22, 2014 | May 28, 2014 |
| June 2, 2014 | June 5, 2014 | June 11, 2014 |
| June 16, 2014 | June 19, 2014 | June 25, 2014 |
| June 27, 2014** | July 3, 2014 | July 9, 2014 |
| July 14, 2014 | July 17, 2014 | July 23, 2014 |
| July 25, 2014** | July 30, 2014** | August 6, 2014 |
| August 11, 2014 | August 14, 2014 | August 20, 2014 |
| August 22, 2014** | August 27, 2014** | September 3, 2014 |
| September 8, 2014 | September 11, 2014 | September 17, 2014 |
| September 22, 2014 | September 25, 2014 | October 1, 2014 |
| October 3, 2014** | October 8, 2014** | October 15, 2014 |
| October 20, 2014 | October 23, 2014 | October 29, 2014 |
| October 31, 2014** | November 5, 2014** | November 12, 2014 |
| November 17, 2014 | November 20, 2014 | November 26, 2014 |
| December 1, 2014 | December 4, 2014 | December 10, 2014 |
| December 15, 2014 | December 18, 2014 | December 24, 2014 |
| December 23, 2014** | December 31, 2014** | January 07, 2015 |
| 11:00 AM CUT OFF | 11:59 PM CUT OFF | |

NOTE:
Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Radiology, Pathology, Internal Medicine Monthly Statistical Reports and Sessional Payments. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut off date to ensure processing for that payment period.

PLEASE NOTE, THE ** INDICATES A DATE VARIATION


Happy Holidays
From the Staff of MSI Programs

# PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

October 31, 2013 Volume XLIX #6

Inside this issue



**CONTACT US:**

**MSI_Assessment@medavie.bluecross.ca**

**On-line documentation available at :**

http://www.medavie.bluecross.ca/msiprograms

## *New MSI Website and Electronic Bulletin Launched on September 16, 2013*

The Department of Health and Wellness, in collaboration with Medavie Blue Cross and Doctors Nova Scotia is very pleased to announce the launch of the new MSI website. The website can be found at www.medavie.bluecross.ca/msiprograms.

The new website includes simplified electronic access to important documents such as the MSI Physician's Manual; the Billing Instructions Manual and the MSI Physicians' Bulletins. The website also contains a "frequently asked questions" section along with a searchable archive of bulletins. The new website marks an important and progressive step into the ever advancing age of technology and away from paper based communication and information.

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**Subscribing to electronic access to physicians' bulletins is not only important, but strongly encouraged as it is the responsibility of all physicians to be aware of changes, updates, new billing codes and practices, communicated in the bulletins.** If for some reason you are unable to access the website please contact MSI at 496-7011 or 1-866-553-0585.

**UPCOMING FEES**

*NOTE: Please hold all eligible service encounters to allow MSI the required time to update the system. Once a new Health Service Code has been assigned, it will be published in the MSI Physicians' Bulletin.*

The following fees have been approved for inclusion into the Fee Schedule, effective October 1, 2013:

| Category | Description | Unit Value |
|---|---|---|
| CONS | **Antenatal Palliative Care Consultation (Limited)** | 42 |

For the limited consultation by the paediatric palliative care specialist to the mother of the fetus diagnosed with a potentially lethal anomaly or condition. The consultation covers the physical, emotional, social, spiritual issues related to the birth of a newborn diagnosed with a potentially lethal condition.

Billing Guidelines:
To be billed by PEDI using the MSI number of the mother for services rendered during the antenatal period. Consultation may only be billed once per mother per pregnancy. A list of qualified specialists is to be kept on file at MSI. Fetal diagnosis must be recorded in text and on the mother's health record.

Specialty Restriction:
PEDI with additional training in Paediatric Palliative Care.

Location:
HOSP, OFFC

| Category | Description | Unit Value |
|---|---|---|
| VIST | **Antenatal Palliative Care follow up visit** | 13 MSU as per follow up visit |

For the limited consultation by the paediatric palliative care specialist to the mother of the fetus diagnosed with a potentially lethal anomaly or condition. The consultation covers the physical, emotional, social, spiritual issues related to the birth of a newborn diagnosed with a potentially lethal condition.

Billing Guidelines:
To be billed by PEDI using the MSI number of the mother for services rendered during the antenatal period. Consultation may only be billed once per mother per pregnancy. A list of qualified specialists is to be kept on file at MSI. Fetal diagnosis must be recorded in text and on the mother's health record.

Specialty Restriction:
PEDI with additional training in Paediatric Palliative Care.

Location:
HOSP, OFFC

| Category | Description | Unit Value |
|---|---|---|
| CONS | **Medical Management of Ectopic Pregnancy** | 56 |

This comprehensive fee includes the consultation, assessment, and counseling of a patient with a confirmed ectopic pregnancy who meets the criteria for medical management of her condition. Administration of cytotoxic medication(s) is included as are all verbal or electronic communications with the patient to relay results of follow up blood work as appropriate.

Billing Guidelines:
1. May not be billed with any other consultative or visit service same patient same day.
2. If surgery is required within 48 hrs of the delivery of cytotoxic medication, the service fee will be reduced to a regular consultation fee.
3. Once per patient per pregnancy

Specialty Restriction:
OBGY

Location:
HOSP, OFFC

| Category | Description | Unit Value | |
|---|---|---|---|
| MASG | **Salpingectomy for morbidity, not for sterilization** | 130 | 6+T |

This fee is for the partial or complete removal of the fallopian tube for purposes other than sterilization, open or laparoscopic approach. Underlying diagnosis must be documented on the health record.

This fee will replace:
78.1 Total Salpingectomy-unilateral
78.22 Removal of Remaining Fallopian Tube
78.59 Other Partial Salpingectomy
78.21 Removal of Both Tubes

Billing Guidelines:
Not to be billed with oophorectomy same patient same side

Specialty Restriction:
OBGY, GNSG

Location:
HOSP

| Category | Description | Unit Value |
|---|---|---|
| MASG | **Surgical Removal of Extrauterine (Ectopic) Pregnancy-by any means**<br><br>This comprehensive fee is for the surgical treatment of an extrauterine (ectopic) pregnancy; tubal, ovarian, cervical, abdominal, or interstitial, requiring evacuation, salpingostomy, salpingectomy and/or oophorectomy, open or laparoscopic approach.<br><br>This fee will replace:<br>78.52 Salpingectomy (partial) with removal of ectopic pregnancy<br>78.63 Salpingo-salpingostomy<br>81.21 Removal of intraligamentous pregnancy<br><br>Billing Guidelines:<br>Not to be billed with salpingectomy, salpingostomy or oophorectomy.<br><br>Specialty Restriction:<br>OBGY, GNSG<br><br>Location:<br>HOSP | 130 6+T |

| Category | Description | Unit Value |
|---|---|---|
| MASG | **Interruption or removal of fallopian tubes for purposes of sterilization: abdominal, vaginal, laparoscopic-not hysteroscopic (unilateral or bilateral)**<br><br>This fee is for the interruption or removal of all or part of one or both fallopian tubes for purposes of sterilization: includes fulgarisation, occlusion by device, and transection: open (abdominal or vaginal) or laparoscopic approach. Not to be used for hysteroscopic occlusion.<br><br>This fee will replace:<br>78.31 Endoscopic Ligation and crushing of Fallopian Tubes uni or bilateral.<br>78.39 Endoscopic destruction or occlusion of fallopian tubes, uni or bilateral.<br>78.53A Suture Ligation of Fallopian Tubes<br><br>Billing Guidelines:<br>Not to be used for hysteroscopic sterilization, not to be billed with 66.83 Laparoscopy ME=ELEC Unilateral or bilateral, no additional billing for bilateral.<br><br>Specialty Restriction:<br>OBGY, GNSG<br><br>Location:<br>HOSP | 105 6+T |

**FEE REVISIONS**

Effective October 1, 2013, health service code **03.09C** - Palliative Care Consult will be revised and updated with the following information:

| Category | Description | Unit Value |
|---|---|---|
| CONS | **Palliative Care Consult** | 62 + MU |

Preamble 7.10.1
The Palliative Care Consultation can only be claimed by designated physicians (general practitioners or specialists) with recognized expertise in palliative care. The service provided must fulfill the normal requirements for a consultation as specified in the Preamble. The consultation includes a psychosocial assessment, comprehensive review of pharmacotherapy, appropriate counseling, and consideration of appropriate community resources where indicated. A prolonged consultation cannot be claimed. Specialists can claim the palliative care consultation fee or the consultation fee appropriate to their specialty. It is payable once per patient per physician. Physicians billing the Palliative Care consult must forward a letter to MSI indicating his/her credentials.

Physicians providing palliative care must have completed a minimum of six days of intensive didactic or small group training in palliative care, and a one-week clinical practicum in palliative care with a qualified physician supervisor.

Billing Guidelines:
Once per patient per physician.
Maximum of 8 additional multiples, (total of 3 hours)
Start and stop times must be recorded when billing multiples.

Specialty Restriction:
Physicians with recognized expertise in Palliative Care
List to be kept on file with MSI.

Location:
HOSP, OFFC, HOME

NOTE: Please continue to submit claims for these services in the usual manner. Once MSI updates the system it will be published in the MSI Physicians' Bulletin. Claims for these codes with a service date from October 1, 2013 to November 22, 2013 will be identified and a reconciliation will occur in the winter of 2013. The reconciliation will be calculated after the 90 day waiting period for submission of claims.

**DISCONTINUED HEALTH SERVICE CODES**

Effective November 22, 2013 the following health service codes will no longer be active:

| Category | Code | Modifiers | Description | Value |
|---|---|---|---|---|
| MASG | 80.2C | | **Laparoscopic supracervical hysterectomy** | 235 6+T |
| MASG | 80.4B | | **Laparoscopic assisted vaginal hysterectomy** | 220 6+T |
| | | | These 2 codes have been made redundant by the implementation on October 1, 2011 of: HSC 80.4C Laparoscopic hysterectomy - total, subtotal or laparoscopically assisted 300 MSU 6+T. | |

**PREAMBLE REVISIONS**

7.5.5 A Prolonged Consultation may be applied to cases where the consultation extends beyond one hour for comprehensive consultations and a half-hour for repeat consultations, or a half hour for OBGY consultations– specifically for preconceptual consultation (Maternal fetal medicine), consultation for issues of sexual dysfunction, reproductive endocrinology, gynaecologic oncology, and urogynaecology**.** A prolonged consultation cannot be claimed with a limited consultation. Prolonged consultations are paid in 15-minute time blocks or portion thereof. Prolonged consultations are not to be confused with active treatment associated with detention.

A prolonged consultation may be claimed only by the following specialties:
(a) Anaesthesia
(b) Internal Medicine
(c) Neurology
(d) Physical Medicine
(e) Paediatrics
(f) Psychiatry
(g) Obstetrics and Gynaecology
***(h) Palliative Care***

**BILLING REMINDERS**

**Functional Endoscopic Sinus Surgery (FESS)**

The Department of Health and Wellness and Doctors Nova Scotia have reviewed the billing practice for FESS. Based on this review, existing codes can be billed for FESS effective July 1st, 2013. The deadline for submission of claims for FESS procedures is January 1, 2014 for all FESS claims with date of service between March 1st and October 1st 2013. For FESS procedures performed after October 1st 2013, the regular 90-day time limit will be in effect for submitting claims.

Please note that the above direction to proceed with using existing codes does not constitute approval of all current billing for FESS. Regular monitoring and audit processes, including pre-payment assessment, will apply to FESS claims as needed.

**GENERAL PRACTITIONER COLLABORATIVE PRACTICE INCENTIVE PROGRAM**

**Revisions to the eligibility criteria for the Collaborative Practice Incentive Program (CPIP) – 2013/2014**

The Master Agreement Steering Group (MASG) has approved the following revisions to the Collaborative Practice Incentive Program (CPIP) collaborative practice incentive component eligibility criteria, **effective April 1, 2013.**

Additional CPIP Incentive Component Eligibility Criteria

Starting in 2013/14, in order for an individual Family Physician to qualify for an annual CPIP incentive component payment, **two of the following five criteria must be met in addition to the existing program criteria approved in 2012:**

**Evening and/or week-end appointments:**

- Physicians are required to provide regular evening and/or weekend appointments, a minimum of once per week. **Accountability measure:** Appropriate billings for the GP Evening and Weekend Office Visit Incentive program (eligible office visits submitted with the modifier GPEW).

**Same day/next day appointments:**

- The collaborative practice is required to be structured to accommodate same day/next day appointments within the daily practice schedule on a regular on-going basis– patients are not to be just squeezed in. **Accountability Measure:** This needs to be reflected through ensuring there is normally always availability for patients to see one of the practice team members when patients contact the practice for an appointment

**Roles and Responsibilities:**

- Specific roles and responsibilities for all members of the practice team are documented, reviewed annually and updated as required. **Accountability measure:** Documented evidence available upon request.

**Team attendance at educational events:**

- Physicians and their teams are required to attend and/or participate together in educational events, relevant to their work, at least once per year. This could include team building activities internal to the practice. **Accountability measure:** Documented evidence of organized team building activity and the participants available upon request.

**Lead and/or participate in a quality improvement initiative:**

- Physicians are required to lead or participate with their team in at least one quality improvement initiative per year that is directly related to either patient care and/or practice improvement. **Accountability measure:** Documentation of quality improvement initiative(s) available upon request.

**Other Licensed Health Care Providers**

**Effective April 1, 2013,** for the purposes of the CPIP, the list of eligible "other licensed health care providers" is limited as follows to those appropriate and likely to work with family physicians as part of a community-based primary care collaborative practice team:

1. Licensed Practical Nurses
2. Chiropractor
3. Dentists
4. Dietician/Nutritionists
5. Occupational Therapists

6. Optometrists
7. Pharmacists
8. Psychologists
9. Physiotherapists
10. Registered Nurses (including Nurse Practitioners)
11. Midwives
12. Respiratory Therapists
13. Paramedics
14. Social Workers (Department of Community Services Legislation)

**Nova Scotia Provincial Locum Program**

The Provincial Locum Program is intended to facilitate the medical care to patients of eligible physicians, through the provision of funded coverage when the physician is away from their respective practice, due to illness, vacation and/or continuing medical education. It is generally accepted that a physician, while being replaced by a locum, is not providing billable services elsewhere.

Effective October 1st,2013, the Master Agreement Steering Group approved changes to the Nova Scotia Provincial Locum program. The following revised guidelines, payment rates and claim forms are in effect as of October 1, 2013. All forms can be found online on the MSI website (www.medavie.bluecross.ca/msiprograms). Please note: all claims must be calculated prior to submission. The available forms are functional and will calculate the values for you when completed electronically. Please be sure to include your signature on each submission.

**Revised GP Locum Guidelines Effective October 1, 2013**

Locum Physician Eligibility

- Locum physicians are required to be licensed by the College of Physicians and Surgeons of Nova Scotia.

Locum Coverage Eligibility for Family Practitioners: the following are the criteria for which the Provincial Locum Program will fund locum coverage for a Family Practitioner:

- Scheduled leave of physician for vacation, CME, maternity OR unplanned leave due to illness
- Physician located in any community outside Capital District Health Authority; and, the following communities within Capital District Health Authority: Musquoduboit Harbour, Middle Musquoduboit, Upper Musquoduboit, Jeddore, Ship Harbour, Sheet Harbour, Brooklyn, Falmouth, Kempt Shore, Newport Corner, Smiths Corner, Summerville, Three Mile Plains, Windsor, and Windsor Forks.
- Maximum 30 days coverage funded per fiscal year for each physician
- Current practices (non-CEC) located in Porters Lake and Mineville, will continue to be eligible for Locum funding until March 31, 2015, .As of April 1, 2015, these practices will no longer be eligible to receive Locum funding, unless changes to the program are approved through the MASG.
- Maximum 30 days coverage funded per fiscal year for each full time physician. Eligible coverage days will be pro-rated for part time physicians
- Locum day is defined as providing a minimum of 7.5 hours of clinical coverage. A half locum day is defined as providing a minimum of 3.75 hours of clinical coverage.

Services to be provided by locum physicians:
General Practitioners

- Family practice coverage (may include inpatient and nursing home, if part of GP normal practice)
- On-call or emergency department coverage where indicated, as requested on application form

Payment Rates
The following rates will be paid to physicians for providing locum coverage under the Provincial Locum Program:

- Minimum daily income guarantee: $800
    - *note: physician may request payment by FFS rather than income guarantee, in which case they will*

*receive only per diem and mileage through the Provincial Locum Program, in addition to their FFS billings*

- Top up in addition to minimum daily income guarantee will paid based on volume of services provided, as indicated by shadow billings, if a reconciliation is requested by the locum physician.
- Per diem to cover locum physician expenses, eg food and accommodation: $175 per day
    - Where the Locum physician commutes to the host practice from home on a daily basis, partial per diem will be provided (40%)
    - Where /when the DHA provides accommodation, the locum physician will only be eligible to claim 40% of the per-diem rate
    - Locum physicians who travel two hours or more (one way) between their residence and the locum site are eligible to claim one additional per diem day for each locum provided. Physicians who travel four or more hours (one way) between their residence and the locum site are eligible to claim two additional per diem days for each locum provided. The additional per diem payments are for travel to and from the locum site.
- Overhead: $210 per day payable to host practice to cover office overhead expenses;
    - *Note: where the locum physician is eligible to receive a 'top up' payment, the locum physician will receive 70% of the top up payment amount, and the host practice will receive 30% as overhead*.
- Mileage paid within Nova Scotia at current Nova Scotia Government rate
- Out of province locum physicians from New Brunswick and PEI may claim $175 for each trip to Nova Scotia to offset expenses. Other out of province locum physicians may claim $500 for each trip. Verification of travel may be requested.
- Bridge/road tolls within Nova Scotia will be reimbursed as required

Program Administration

- An application form will be completed and signed by the locum physician and the host physician/practice and submitted to MSI. All program related forms can be found at www.medavie.bluecross.ca/msiprograms. Completed forms can be faxed to MSI at 496-3060 (toll free: 1-855-350-3060) or emailed to Locumprogram@medavie.ca. Contact MSI at (902) 496-7104 with any enquiries.
- Approval/decline of locum application by MSI within 2 working days with notification of locum physician and host physician/practice (approval by MSI is conditional on granting of license by College of Physicians and Surgeons of Nova Scotia)
- If approved, submit a completed MSI Provider Business Arrangement Form and void cheque to the MSI Provider Coordinators, if your banking information is not on file with MSI.
- If the locum physician chooses the guaranteed daily rate as the preferred payment option, the locum physician will receive a locum shadow billing business arrangement (BA) number from MSI if a locum shadow billing BA number has not already been assigned. The shadow billing BA number is to be used to submit shadow billings. Payment through the Provincial Locum Program can only be provided where the locum physician has obtained a locum shadow billing arrangement number.
- The locum physician will prepare shadow billings for all services provided; the host physician/practice will provide administrative support for shadow billing.
- At the end of the locum, or on a weekly basis, the locum physician will submit a completed Claim Form to MSI for payment.
- MSI will verify the Claim form and make the payment(s).
- At the end of the locum, if the locum physician or host physician believes services provided exceed the value of the guaranteed daily rate over the course of the locum, they can apply for a 'top up' payment by contacting MSI and requesting a 'reconciliation' of payment.

Shadow billing:

- The provision of shadow billings is critical to the budget of the Provincial Locum Program, as the total amount of shadow billings is charged to the FFS cost centre. The locum program is only charged for the difference between the shadow billings and the guaranteed daily rate.

  **For General Practice locums, the office of the host physician is expected to provide administrative support to the locum physician for shadow billing. Payment for the minimum daily guarantee for locum services will be subject to receipt of shadow billings.**

**Revised Specialist Locum Guidelines Effective October 1, 2013**

Locum Physician Eligibility

- Locum physicians are required to be licensed by the College of Physicians and Surgeons of Nova Scotia.

Locum Coverage Eligibility for Specialists: the following are the criteria for which the Provincial Locum Program will fund coverage for Specialists.

- Scheduled leave of physicians for vacation, CME, maternity OR unplanned leave due to illness; OR,
- coverage for a position that has been vacated within the previous six months where an ongoing core service is being provided, OR, weekend coverage.
- Coverage for DHAs 1-8
- Core specialty services covered: general internal medicine, general surgery, anesthesiology, orthopedic surgery, obstetrics/gynecology, psychiatry, pediatrics, radiology, pathology and urology.
- Coverage provided for services in a Regional hospital for physician groups that have an approved facility on-call call rotation of 5 or fewer physicians
- Locum day is defined as providing a minimum of 7.5 hours of clinical coverage. A half locum day is defined as providing a minimum of 3.75 hours of clinical coverage
- Maximum 30 days funded coverage for each full time core service physician or vacant position per fiscal year; except 45 days coverage for physicians where they are the solo practitioner in a core service

Note: Specialists with an active clinical practice will not be funded through the locum program to cover services within their own DHAs.

Services to be provided by locum physicians:
Specialists

- Specialist hospital coverage including on-call
- Office coverage where indicated, as requested on application form

Payment Rates
The following rates will be paid to physicians for providing locum coverage under the Provincial Locum Program:

- Minimum daily income guarantee: $1200
    - *note: physician may request payment by FFS rather than income guarantee, in which case they will receive only per diem and mileage through the Provincial Locum Program, in addition to their FFS billings*
- Top up in addition to minimum daily income guarantee will be paid based on volume of services provided, as indicated by shadow billings, if requested by the locum physician
- Per diem to cover locum physician expenses, eg food and accommodation: $175 per day
    - Where the Locum physician commutes to the host practice from home on a daily basis, partial per diem will be provided (40%)
    - Where /when the DHA provides accommodation, the locum physician will only be eligible to claim 40% of the per-diem rate
    - Locum physicians who travel two hours or more (one way) between their residence and the locum site are eligible to claim one additional per diem day for each locum provided. Physicians who travel four or more hours (one way) between their residence and the locum site are eligible to claim two additional per diem days for each locum provided. The additional per diem payments are for travel to and from the locum site.
- Overhead: $210/day payable to host practice where office coverage is required
- Mileage paid within Nova Scotia at current Nova Scotia Government rate
- On-call fee to be funded by DHW and administered by the DHA.
- Out of province locum physicians from New Brunswick and PEI may claim $175 for each trip to Nova Scotia to offset expenses. Other out of province locum physicians may claim $500 for each trip. Verification of travel may be requested.

- Bridge/road tolls within Nova Scotia will be reimbursed as required.

Program Administration

- An application form will be completed and signed by the locum physician and the Chief of Staff of the host DHA, and submitted to MSI. All program related forms can be found at www.medavie.bluecross.ca/msiprograms. Completed forms can be faxed to MSI at 496-3060 (toll free: 1-855-350-3060) or emailed to Locumprogram@medavie.ca. Contact MSI at (902) 496-7104 with any enquiries.
- Approval/decline of locum application by MSI within 2 working days with notification of locum physician and Chief of Staff of host DHA (approval by MSI is conditional on granting of license by College of Physicians and Surgeons of Nova Scotia)
- If approved, submit a completed MSI Provider Business Arrangement Form and void cheque to the MSI Provider Coordinators, if your banking information is not on file with MSI.
- If the locum physician chooses the guaranteed daily rate as the preferred payment option, the locum physician will receive a locum shadow billing business arrangement (BA) number from MSI if a locum shadow billing BA number has not already been assigned. The shadow billing BA number is to be used to submit shadow billings. Payment through the Provincial Locum Program can only be provided where the locum physician has obtained a locum shadow billing arrangement number.
- The locum physician will prepare shadow billings for all services provided; the host DHA will provide administrative support for shadow billing.
- At the end of the locum, or on a weekly basis, the locum physician will submit a completed Claim Form to MSI for payment
- MSI will verify the Claim Form for payment
- At the end of the locum, if the locum physician believes services provided exceed the value of the guaranteed daily rate over the course of the locum, they can apply for a 'top up' payment by contacting MSI and requesting a 'reconciliation' of payment.

Shadow billing:

- The provision of shadow billings is critical to the budget of the Provincial Locum Program, as the total amount of shadow billings is charged to the FFS cost centre. The locum program is only charged for the difference between the shadow billings and the guaranteed daily rate.

  **For Specialist locums, the host DHA is expected to provide administrative support to the locum physician for shadow billing. Payment for locum services will be subject to receipt of shadow billings.**

## Psychiatry Locum Guidelines Effective October 1, 2013

Locum Physician Eligibility

- Locum physicians are required to be licensed by the College of Physicians and Surgeons of Nova Scotia.

Locum Coverage Eligibility for Psychiatry: the following are the criteria for which the Provincial Locum Program will fund locum coverage for Psychiatry:

- Scheduled leave of physicians for vacation, CME, maternity OR unplanned leave due to illness; OR, coverage for a position that has been vacated within the previous six months where an ongoing core service is being provided, OR, weekend coverage.
- Coverage for DHAs 1-8
- Coverage provided for services in a Regional hospital for physician groups that have an approved facility on-call rotation of 5 or fewer physicians
- Maximum 30 days funded coverage for each full time physician or vacant position per fiscal year; except 45

days coverage for physicians where they are the solo practitioner. The number of eligible coverage days will be pro-rated for part time physicians.
- Note: Psychiatrists with an active clinical practice will not be funded through the locum program to cover services within their own DHAs.

Payment Rates

The following rates will be paid to physicians for providing locum coverage under the Provincial Locum Program:

- An hourly rate will be paid through the District Psychiatry Program in keeping with the guidelines for that program. Program guidelines provide different rates for certified and non-certified psychiatrists. Arrangements for payment of this rate will be made by the District Health Authority in which the locum is provided, through MSI.
- Per diem to cover locum physician expenses, eg food and accommodation: $175 per day
    - Where the Locum physician commutes to the host practice from home on a daily basis, partial per diem will be provided (40%)
    - Where /when the DHA provides accommodation, the locum physician will only be eligible to claim 40% of the per-diem rate
    - Locum physicians who travel two hours or more (one way) between their residence and the locum site are eligible to claim one additional per diem day for each locum provided. Physicians who travel four or more hours (one way) between their residence and the locum site are eligible to claim two additional per diem days for each locum provided. The additional per diem payments are for travel to and from the locum site.
- Mileage paid within Nova Scotia at current Nova Scotia Government rate
- Out of province locum physicians from New Brunswick and PEI may claim $175 for each trip to Nova Scotia to offset expenses. Other out of province locum physicians may claim $500 for each trip. Verification of travel may be requested.
- Bridge/road tolls within Nova Scotia will be reimbursed as required

Program Administration

- An application form will be completed and signed by the locum physician and the Chief of Staff of the host DHA, and submitted to MSI. All program related forms can be found at www.medavie.bluecross.ca/msiprograms. Completed forms can be faxed to MSI at 496-3060 (toll free: 1-855-350-3060) or emailed to Locumprogram@medavie.ca. Contact MSI at (902) 496-7104 with any enquiries.
- Approval/decline of locum application by MSI within 2 working days with notification of locum physician and Chief of Staff of host DHA (approval by MSI is conditional on granting of license by College of Physicians and Surgeons of Nova Scotia)
- If approved, submit a completed MSI Provider Business Arrangement Form and void cheque to the MSI Provider Coordinators, if your banking information is not on file with MSI.
- At the end of the locum, or on a weekly basis, the locum physician will submit a completed Claim Form to MSI for payment.
- MSI will verify the Claim Form for payment of per diem and mileage.

**WCB REVISIONS**

Effective October 1, 2013 the following new Workers' Compensation Board fee was available for billing:

| Category | Code | | Value |
|---|---|---|---|
| WCB | WCB21 | **Follow-up visit report** | $37.50 |

Description:
To be claimed for completion of a follow up visit report.

Billing Guidelines:
This fee can only be claimed after a follow up office visit code (03.03 RP=SUBS. 03.03A RP=SUBS* and 03.04 RP=SUBS) is billed by the same physician on the same day for the patient.

Cannot be billed with an inpatient hospital visit.

A report is only required and can only be billed for a Long Terms Benefits client where there is a change in treatment or medical status.

Specialty Restriction:
All Specialists (excluding GENP, EMMD, COMD)

Location:
Office

*Please note, for 03.03A RP=SUBS, please hold all eligible service encounters from October 1, 2013 through to November 22, 2013 to allow MSI the required time to update the system.

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

September 13, 2013 Volume XLIX - #5

Inside this issue



**CONTACT US:**

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**On-line documentation available at :**

http://www.medavie.bluecross.ca/msiprograms

## ELECTRONIC BULLETIN LAUNCH ON SEPTEMBER 16, 2013

The Department of Health and Wellness, in collaboration with Medavie Blue Cross and Doctors Nova Scotia is very pleased to announce the launch of the new MSI website, effective Monday, September 16, 2013. The website can be found at www.medavie.bluecross.ca/msiprograms.

The new website will include simplified electronic access to important documents such as the MSI Physician's Manual; the Billing Instructions Manual and the MSI Physicians' Bulletins. The website will also contain a "frequently asked questions" section along with a searchable archive of bulletins. The new website marks an important and progressive step into the ever advancing age of technology and away from paper based communication and information.

One of the key features of the new website is the ability for physicians and billing staff to be able to subscribe to electronic notification of upcoming MSI Physicians' Bulletins. The MSI Physicians' Bulletins contains important information for physicians, as it includes MSI billing updates, policy changes and other key topics related to insured services.

**Please note, that effective January 1, 2014, bulletins will only be available on the MSI website. To be automatically notified of upcoming bulletins, follow the "Subscribe" link located on the home page. Physicians will continue to receive paper copies of bulletins until December 31, 2013. Bulletins can be easily saved and printed directly from the new MSI website**

**Subscribing to electronic access to physicians' bulletins is not only important, but strongly encouraged as it is the responsibility of all physicians to be aware of changes, updates, new billing codes and practices, communicated in the bulletins.**

If for some reason you are unable to access the website please contact MSI at 496-7011 or 1-866-553-0585.

**NEW FEES**

*Note: Physicians holding eligible services must submit their claims from August 1, 2013 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

Effective August 1, 2013 the following new health service codes are available for billing:

| Category | Code | | Unit Value | |
|---|---|---|---|---|
| VEDT | 50.37D | **EVAR – endovascular abdominal aortic aneurysm repair with stent graft** | | |
| | | **RO=FPHN** Vascular surgeon or Interventional radiologist only | 380 | 15+T |
| | | **RO=SPHN** Vascular surgeon or Interventional radiologist only | 228 | |

Endovascular abdominal aortic aneurysm repair using stent grafting.

Billing Guidelines:
This is a comprehensive fee to include preoperative planning and measurements, arteriotomy(ies) as required, the insertion of all catheters including initial access, intra-operative angiography, interpretation of any images taken at the time of the procedure, balloon angioplasties within the treatment zone, iliac endarterectomy, angioplasty, and/or repair as required, and removal of access catheters with any necessary closure of vessels.

Preamble rules 9.3.3(g) apply.

Second physician specialty restriction is the same as for first physician.

Not to be billed with:
MASG 50.37A Aortic graft plus bilateral femoral artery repair
Any additional angioplasties to be billed at LV 50 to a maximum of four, stents billed as ADON 51.59Q to a maximum of four.

Specialty Restriction:
Vascular surgery
Interventional radiology

Location:
Hospital

| Category | Code | | Unit Value |
|---|---|---|---|
| VIST | 03.04D | **Geriatrician's Initial Comprehensive Geriatric Consultation to Include CGA (Comprehensive Geriatric Assessment)** | 150 |

Description:
For the comprehensive assessment of the frail patient 65 years or older (frailty as characterized by low functional reserve, decreased muscle strength, and high susceptibility to disease). To be billed only when the entire assessment is performed by a physician with a Geriatric Medicine Subspecialty or Internal Medicine plus completion of a minimum 8 weeks training (PGY4 or greater) in geriatric assessment. The Comprehensive Geriatric Assessment will include all of the following elements and be documented in the heath record in addition to Start and Stop times. Assessment required a minimum of 90 minutes of patient to physician contact.

A) Assessment of cognition – usually using the Mini-Mental State Examination. If cognitive impairment is present, whether it meets the criteria for dementia, delirium or depression.
B) Other aspects of the mental state. Such as the presence of depression or other mood disorder. The presence of perceptual disturbances. Motivation. Health attitude.
C) Evaluation of special senses – functional ability in speech, hearing and vision is recorded.
D) Neuromascular examination to assess strength and specifically to evaluate deconditioning.
E) A functional assessment of mobility and balance to include detailed recording of the hierarchal assessment of balance and mobility (MacKnight C., Rockwood K., A hierarchical assessment of balance and mobility, Age and Ageing, 1995;24:126-130) is carried out.
F) Bowel and bladder function is recorded.
G) A brief nutritional screen focusing on weight and appetite is completed.
H) Functional capacity in personal instrumental and basic activities of daily living is recorded.
I) Sleep disruptions are recorded as is the presence of daytime somnolence.
J) Social Assessment. To include information about the extent of
social engagement, the presence of a caregiver, the marital state and living arrangements of the individual, condition of the house and whether or not they need to be able to navigate stairs in order to be safe at home. The presence of supports is recorded as well as some information about the caregiver, including their coping ability, their own health and their outlook.
K) Documentation of advanced care directives.

CGA procedure: Note 1: For people being assessed during an acute illness, items D through H are recorded both for the baseline state (2 weeks

previously) and currently.
CGA procedure Note 2: All this information is in addition to the general medical information recorded in the general medicine consult.

Billing Guidelines:
Time based fee requiring a minimum of 90 minutes.
Greater than 80% of time must be spent in direct patient contact.
No other fee codes may be billed for that patient in the same time period.

This Initial Assessment may be billed only once per patient per lifetime.

Specialty Restriction:
Geriatric Medicine
Internal Medicine with a minimum of 8 weeks recognized Geriatric subspecialty training (PGY4 level or greater)

Location:
Hospital/Clinic/Office

| Category | Code | | Unit Value |
|---|---|---|---|
| VIST | 03.04E | **Initial Geriatric Inpatient Medical Assessment** | 38.1 |

Description:
This fee is for the complete initial assessment of the geriatric hospital inpatient, age greater than or equal to 65 years, by the family physician most responsible for the patient's ongoing inpatient hospital care. Billed only once per patient per admission. May not be billed again for 6 months for the same patient.
This complete assessment is to include all of the following elements and be documented in the health record – include all positive and pertinent negative finds (based on *Guidelines for Medical Record-keeping 2008,* CPSNS):

1. Complete history: Extended history of the Chief Complaint, review of systems related to the problem, complete past medical and social history, pertinent family history.
2. Comprehensive Physical Examination: Extensive examination of the affected body area(s) and related system(s) plus extensive multisystem examination (3 or more systems in total).
3. Review of patient's hospital documents relating to current and prior visits.
4. Obtaining collateral history and information from caregivers.
5. Performance of a complete medication review to include collateral information from pharmacy and long term care facility as appropriate.
6. Obtaining advanced care directives (code status).
7. Reviewing and documenting relevant laboratory, imaging, and other test results pertaining to the present visit.

8. Formulating diagnoses and identifying important issues affecting the present admission.
9. Initiating an appropriate and timely management plan including a treatment plan, further investigations, advanced care planning and specialist or interdisciplinary consultation.

Billing Guidelines:
Not to be billed for transfers within the same hospital.

Recognized Systems:
- Eyes
- Ears, nose, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

Specialty Restriction:
GENP

Location:
Hospital only

| Category | Code | | Unit Value | |
|---|---|---|---|---|
| MASG | 61.69G | **Comprehensive Anal Sphincteroplasty for the Treatment of Anal Incontinence** | 220 | 4+T |

Description:
Comprehensive fee for the layered repair of the anal sphincter complex for the treatment of anal incontinence. Includes repair of internal and external anal sphincter, approximation of transverse perineal muscles, reattachment of bulbocavernosus muscles and perineal body reconstruction.

Billing Guidelines:
Not to be billed for acute anal sphincter trauma (use HSC 61.69E for acute non-obstetrical trauma, and HSC 87.82A or B, as appropriate, for acute obstetrical trauma). Not to be billed with MASG 83.61 (suture of vulva and perineum).

Specialty Restriction:
GNSG, OBGY

Location:
Hospital Only

| Category | Code | | Unit Value |
|---|---|---|---|
| MASG | 54.47A | **Esophagectomy with immediate reconstruction by Interposition of Hollow Viscus (Stomach, colon, or small bowel)** | 1000 |
| | | **AP=ABDO** | 7+T |
| | | **AP=CERV** | 6+T |
| | | **AP=THOR** | 13+T |

Description:
This is a comprehensive fee for the total, or near total (greater than 2/3) removal of the esophagus with immediate reconstruction using the interposition of a hollow viscus stomach, colon, or small bowel), includes esophagogastrostomy, vagotomy, proximal gastrectomy, pyloromyotomy, bowel mobilization and preparation, and feeding tube placement where required.

Billing Guidelines:
Not to be billed with:
MASG 54.33A Resection of esophagus one stage
MASG 54.42 Esophagogastrostomy (intrathoracic)
MASG 54.43 Esohageal anastomosis with interposition of small bowel
MASG 54.44A Esophageal bypass with colon/jejunum
MASG 54.45 Esophageal anastomosis with interposition of colon intrathoracic

MASG 54.47 Esophageal anastomosis with other interposition (intrathoracic)
MASG 46.2 Medistinal tissue destruction
MASG 55.1 Percutaneous gastrostomy
MASG 55.3 Pyloromotomy
MASG 55.5 Partial gastrectomy with anastomosis to esophagus
MASG 58.39A Percutaneous jejunostomy

Specialty Restriction:
GNSG, THSG

Location:
Hospital Only

## MULTIPLE BIRTHS BY CAESARIAN SECTION

The new fee for **Multiple births by Caesarian Section** previously announced in the July 19th, 2013 bulletin will not receive a new health service code. Instead, effective August 1, 2013 it has been included as the second multiple for the following Caesarean Section fees:

| Category | Code | | Unit Value | |
|---|---|---|---|---|
| MASG | 86.1 | **Cervical Caesarean Section** | | |
| | | SP=OBGY | 260 | 7+T |
| | | Multiple births – *plus multiple, if applicable* | 35 | |
| MASG | 86.1A | **Caesarean Section with tubal ligation** | | |
| | | SP=OBGY | 280 | 7+T |
| | | Multiple births – *plus multiple, if applicable* | 35 | |

*To claim for additional multiple births on either of these services provided from August 1, 2013 to September 12, 2013, please submit a delete for the original Caesarian Section service followed by a new claim with the 2nd multiple indicated.*

## PATHOLOGY FEE INCREASES

Effective July 1, 2013 the following pathology fee increases are now in effect (Relative calculations are based on Preamble Section 7.4.2)

| Code | Description | Old Fee Value | New Fee Value |
|---|---|---|---|
| P2325 | Surgicals, gross and microscopic | 19.08 | 23.85 |
| P3325 | Surgicals, gross and microscopic (premium 35%) | 28.08 | 32.85 |
| P5325 | Surgicals, gross and microscopic (premium 50%) | 28.62 | 35.78 |
| P2328 | Interpretation - fine needle aspiration biopsy | 15 | 18.75 |
| P3328 | Interpretation - fine needle aspiration biopsy (premium 35%) | 24 | 27.75 |
| P5328 | Interpretation - fine needle aspiration biopsy (premium 50%) | 24 | 28.13 |
| P2332 | Interpretation and report - NON GYN cytology slides | 5.61 | 7.01 |
| P3332 | Interpretation and report - NON GYN cytology slides (premium 35%) | 14.61 | 16.01 |
| P5332 | Interpretation and report - NON GYN cytology slides (premium 50%) | 14.61 | 16.01 |
| P2345 | Surgicals, gross and microscopic - three or more separate surgical specimens | 29.62 | 37.03 |
| P3345 | Surgicals, gross and microscopic - three or more separate surgical specimens (premium 35%) | 39.99 | 49.99 |
| P5345 | Surgicals, gross and microscopic - three or more separate surgical specimens (premium 50%) | 44.43 | 55.55 |
| P2346 | Surgicals, gross and microscopic - single large complex CA specimen including lymph nodes | 29.62 | 37.03 |
| P3346 | Surgicals, gross and microscopic - single large complex CA | 39.99 | 49.99 |

| Code | Description | Old Fee Value | New Fee Value |
|---|---|---|---|
| | specimen including lymph nodes (premium 35%) | | |
| P5346 | Surgicals, gross and microscopic - single large complex CA specimen including lymph nodes (premium 50%) | 44.43 | 55.55 |

*NOTE: Claims for these codes with a service date from July 1, 2013 to September 12, 2013 will be identified and a reconcilliation will occur in January 2014. The reconciliation will be calculated after the 90 day waiting period for submission of claims.*

**BILLING REMINDERS**

Nursing Home Visits

MSI staff have recently received a number of inquiries for billing for individuals who reside in residential care facilities (RCF) or are in an RCF unit or bed within a nursing home. Services for these individuals cannot be claimed using nursing home health service codes. The correct visit code for these individuals is a home visit. Preamble requirements for home visits are outlined in Preamble section 7.2.6 (c)

A list of locations eligible for nursing home fees can be found at the following location:
http://novascotia.ca/health/ccs/pubs/approved_facilities/Dir_approved_facilities_NH.pdf

Residential care facilities (claimed using home visits) are listed in the following document:
http://novascotia.ca/health/ccs/pubs/approved_facilities/Dir_approved_facilities_RCF.pdf

Unattached Patient Bonus

It has come to MSI's attention that some physicians are claiming this code when there has been no inpatient or medically necessary emergency department visit. Physicians must insure that this requirement has been met before claiming the incentive. Any changes to this requirement will be communicated via an MSI Bulletin.

This incentive is available for all eligible General Practitioners (GPs) who take on a patient who does not have a family physician and meets the supplied criteria, into their community-based family practice. The program is intended to address the specific issue of hospitalized patients or patients treated in the emergency department for medical problems who require follow-up in the community and who do not have a family physician. It is not intended to cover every patient who does not have a family doctor; i.e. situations such as practice closures or patient transfers.

Billing Guidelines

- The GP has had an established community-based family practice for at least one year prior to taking the Unattached Patient into his/her practice.
- The GP agrees to take the Unattached Patient into his/her practice following an inpatient or medically necessary emergency department hospital encounter where the patient has been identified as an Unattached Patient. The hospital encounter may have been directly with the GP or the GP may agree to take on the patient through a referral from the hospital.
- The GP keeps the Unattached Patient in his/her practice and maintains an open chart for the patient for a minimum of one year.

The GP must confirm and document at the initial visit with the Unattached Patient that the patient is unattached (i.e., does not already have a regular family physician). **Information about the hospital encounter that resulted in the GP taking the Unattached Patient into his/her practice must also be recorded in the patient's record.** This can be a referral form from the hospital emergency department, an inpatient hospital report or other documentation. **(Other documentation may include a note by the**

**physician, documenting their discussion with the patient, confirming the hospital encounter.)**

**NOTE:** Physicians are advised not to send patients to the emergency department to be referred in an effort to claim this fee. Upon audit, MSI will be verifying that an eligible hospital-based encounter did occur and that there was a medical necessity for the hospital encounter.

Date of Death and Organ Procurement

"Effective immediately, claims related to organ procurement can be submitted up to 5 days after the date of death in cases when a patient is pronounced "deceased" but is maintained on life support for the purpose of organ donation. There should be no further issues when submitting claims which meet these criteria."

MSI Documentation Reminder

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribe, and start and stop times if applicable.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptions, or emotional problems, the physician “deliberately established a professional relationship with the patient for the purposes of removing, modifying or alleviating existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development.” There should be evidence of the discussions that took place between the physician and the patient, the patient’s response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional well being of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by “long discussion,” “long talk,” “counselled,” “supportive psychotherapy,” etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service on that date, then the service is not paid for or a lesser benefit is given. **When the clinical record does not support the service claimed, there will be a recovery to MSI at the time of audit.** Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

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

**WCB REVISIONS**

Effective September 30, 2013 the following WCB codes will be terminated:

| Category | Code | | Unit Value |
|---|---|---|---|
| WCB | WCB18 | **Special assessment service requiring WCB approval prior to use** | $61.70 |
| WCB | WCB19 | **Special reporting service requiring WCB approval prior to use** | $61.70 |

Effective October 1, 2013 the following WCB code will only be billable by General Practitioners and Emergency Medicine:

| Category | Code | | Unit Value |
|---|---|---|---|
| WCB | WCB11 | **Physician assessment service**<br>Combined office visit and completion of Form 8/10 | $123.40 |

Also effective October 1, 2013 WCB codes **WCB13**, **WCB14**, and **WCB20** cannot be billed in combination with any other type of service encounter nor can they be billed together for the same patient on the same day.

**Community Services – New - Request for Essential Medical Treatment**

Effective October 1, 2013, the Employment Support and Income Assistance (ESIA) program will allow some medical treatments to be funded that currently are not covered. Examples of the health-related special needs services that **may** be considered, as a result of this change include massage therapy; chiropractic treatments; and acupuncture. As part of the eligibility criteria, the essential medical treatment must be prescribed by a physician, dentist or nurse practitioner and provided by a medical professional licensed or registered to practice in Nova Scotia.

A new form called "*Request for Essential Medical Treatments"* has been devised to cover applications for these special needs services only. This form **must** be completed and approved prior to treatment.

Once completed for a patient on behalf of Community Services, the *Request for Essential Medical Treatment" form* will be delivered to the assigned caseworker by the patient. The service encounter is submitted electronically to MSI. The appropriate health service code is C9999, Payment responsibility COM with a diagnostic code Z99 (i.e. community services). The HSC is claimed at 25 units, however; in this case the payment rate is remunerated at one dollar ($1.00) per unit for a total of $25.00. Any patient over 65 years of age does not qualify for this service.

If this form is completed for a patient who is registered, but not yet eligible, under MSI the physician can still submit to MSI in the above manner. However, if the individual has not registered and maintains an out of province health card number, the physician must submit directly to Community Services for payment.

**EXPLANATORY CODES**

The following new explanatory codes have been added to the system:

DE015 Service encounter has been refused as the previously claimed 03.04D also includes the fee for a comprehensive geriatric assessment.

MA035 Service encounter has been refused as you have previously billed HSC 83.61 at the same encounter.

MA036 Service encounter has been refused as you have previously billed HSC 61.69G at the same encounter.

MA037 Service encounter has been refused as you have already billed a portion of this comprehensive fee (HSC 54.33A, 54.42, 54.43, 54.44A, 54.45, 54.47, 46.2, 55.1, 55.3, 55.5, or 58.39A).

MA038 Service encounter has been refused as you have previously billed the comprehensive fee for esophagectomy with immediate reconstruction by interposition of hollow viscous (HSC 54.47A).

VA053 Service encounter has been refused as you have previously billed HSC 50.37D at the same encounter.

VA054 Service encounter has been refused as you have previously billed HSC 50.37A at the same encounter.

VA055 Service encounter for surgical assist has been refused as the role of second physician was previously billed for this service.

VT111 Service encounter has been refused as the patient is less than 65 years old.

VT112 Service encounter has been refused as the initial geriatric inpatient medical assessment has already been claimed for this hospital admission.

VT113 Service encounter has been refused as the initial geriatric inpatient medical assessment has already been claimed for this patient within the past 6 months.

VT114 Service encounter has been refused as the geriatrician's initial comprehensive geriatric consultation has previously been claimed for this patient.

VT115 Service encounter has been refused as you have previously billed another service for this patient during the same time period.

WB027 Service encounter has been refused as this WCB code cannot be claimed if you have already claimed another fee for the same patient on the same date.

WB028 Service encounter has been refused as you have previously claimed WCB13, WCB14, or WCB20 for this patient on this date.

WB029 Service encounter has been refused as you are not authorized to bill for a WCB12 or WCB16.

**UPDATED FILES – AVAILABILITY**

Updated files reflecting changes are available for download on Friday, September 13th, 2013. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanatory codes (EXPLAIN.DAT).

PROGRAMS OF THE NOVA SCOTIA DEPT. OF HEALTH
PO BOX 500 HALIFAX NOVA SCOTIA B3J 2S1
TELEPHONE (902) 468-9700

**NOVA SCOTIA MEDICAL SERVICES INSURANCE**

## PATHOLOGY STATISTICAL BILLING REPORT

| | |
|---|---|
| Provider Name or Group Name: | |
| Provider Number or Group Number: | |
| Institution Name and Number: | |
| Business Arrangement Number: | |
| Billing Period From: | |
| Billing Period To: | |
| Contact Name / Phone Number: | |

| CODE | EXAMINATION DESCRIPTION | UNITS | In Patient | Out Patient | Number of Exams | TOTAL UNITS |
|---|---|---|---|---|---|---|
| P2320 | Autopsy, gross (all ages) | 123.50 | | | | |
| P2321 | Autopsy, gross, negative cranium | 95.42 | | | | |
| P2322 | Autopsy, gross, limited | 28.07 | | | | |
| P2323 | Autopsy Tissues (Maximum 25 per autopsy) | 4.49 | | | | |
| P2324 | Surgicals, gross | 7.30 | | | | |
| P2325 | Surgicals, gross and microscopic | 23.85 | | | | |
| P2326 | Frozen Sections | 31.99 | | | | |
| P2328 | Interpretation–fine needle aspiration biopsy | 18.75 | | | | |
| P2329 | Cell Block | 14.60 | | | | |
| P2330 | Cytology (with a screener) | 1.00 | | | | |
| P2331 | Interpretation & Report–GYN cytology slides | 5.00 | | | | |
| P2332 | Interpretation & Report–NON GYN cytology slides | 7.01 | | | | |
| P2333 | Sex Chromatin Analysis | 5.61 | | | | |
| P2334 | Karyotype Test A–5 cells & 2 karyotypes | 16.84 | | | | |
| P2335 | Karyotype Test B–30 cells & 4 karyotypes | 22.46 | | | | |
| P2336 | Electron Microscopy Anatomical Pathology only | 52.90 | | | | |
| P2337 | * Immunohistochemistry–Head and Neck | 10.00 | | | | |
| P2338 | * Immunohistochemistry–Anterior Torso | 10.00 | | | | |
| P2339 | * Immunohistochemistry–Posterior Torso | 10.00 | | | | |
| P2340 | * Immunohistochemistry–Right arm | 10.00 | | | | |
| P2341 | * Immunohistochemistry–Left arm | 10.00 | | | | |
| P2342 | * Immunohistochemistry–Right leg | 10.00 | | | | |
| P2343 | * Immunohistochemistry–Left leg | 10.00 | | | | |
| P2344 | Liquid based preparation (thin prep) non gynaecological cytology (per slide) | 15.00 | | | | |
| P2345 | Surgicals, gross and microscopic 3 or more separate surgical specimens | 37.03 | | | | |
| P2346 | Surgicals, gross and microscopic, single large complex CA specimen including lymph notes | 37.03 | | | | |
| * Immunohistochemistry Staining and Interpretation of Surgical (Anatomic) Pathology Specimens | | | | **TOTAL UNITS CLAIMED:** | | |

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PO BOX 500 HALIFAX NOVA SCOTIA B3J 2S1
TELEPHONE (902) 468-9700

## NOVA SCOTIA MEDICAL SERVICES INSURANCE

# PATHOLOGY STATISTICAL BILLING REPORT - PREMIUM FEES

| | |
|---|---|
| Provider Name or Group Name: | |
| Provider Number or Group Number: | |
| Institution Name and Number: | |
| Business Arrangement Number: | |
| Billing Period From: | |
| Billing Period To: | |
| Contact Name / Phone Number: | |

| CODE | EXAMINATION DESCRIPTION-PREMIUM TIME | Premium value | Unit value | In patient | Out patient | No. of exams | TOTAL UNITS |
|---|---|---|---|---|---|---|---|
| P3320 | Autopsy, gross (all ages) | 35% | 166.73 | | | | |
| P5320 | Autopsy, gross (all ages) | 50% | 185.25 | | | | |
| P3321 | Autopsy, gross, negative cranium | 35% | 128.82 | | | | |
| P5321 | Autopsy, gross, negative cranium | 50% | 143.13 | | | | |
| P3322 | Autopsy, gross, limited | 35% | 37.89 | | | | |
| P5322 | Autopsy, gross, limited | 50% | 42.11 | | | | |
| P3323 | Autopsy Tissues (Maximum 25 per autopsy) | 35% | 13.49 | | | | |
| P5323 | Autopsy Tissues (Maximum 25 per autopsy) | 50% | 13.49 | | | | |
| P3324 | Surgicals, gross | 35% | 16.30 | | | | |
| P5324 | Surgicals, gross | 50% | 16.30 | | | | |
| P3325 | Surgicals, gross and microscopic | 35% | 32.85 | | | | |
| P5325 | Surgicals, gross and microscopic | 50% | 35.78 | | | | |
| P3326 | Frozen Sections | 35% | 43.19 | | | | |
| P5326 | Frozen Sections | 50% | 47.99 | | | | |
| P3328 | Interpretation - fine needle aspiration biopsy | 35% | 27.75 | | | | |
| P5328 | Interpretation - fine needle aspiration biopsy | 50% | 28.13 | | | | |
| P3329 | Cell Block | 35% | 23.60 | | | | |
| P5329 | Cell Block | 50% | 23.60 | | | | |
| P3330 | Cytology (with a screener) | 35% | 10.00 | | | | |
| P5330 | Cytology (with a screener) | 50% | 10.00 | | | | |
| P3331 | Interpretation & Report - GYN cytology slides | 35% | 14.00 | | | | |
| P5331 | Interpretation & Report - GYN cytology slides | 50% | 14.00 | | | | |
| P3332 | Interpretation & Report - NON GYN cytology slides | 35% | 16.01 | | | | |
| P5332 | Interpretation & Report - NON GYN cytology slides | 50% | 16.01 | | | | |
| P3333 | Sex Chromatin Analysis | 35% | 14.61 | | | | |
| P5333 | Sex Chromatin Analysis | 50% | 14.61 | | | | |
| P3334 | Karyotype Test A - 5 cells & 2 karyotypes | 35% | 25.84 | | | | |
| P5334 | Karyotype Test A - 5 cells & 2 karyotypes | 50% | 25.84 | | | | |
| P3335 | Karyotype Test B - 30 cells & 4 karyotypes | 35% | 31.46 | | | | |
| P5335 | Karyotype Test B - 30 cells & 4 karyotypes | 50% | 33.69 | | | | |
| P3336 | Electron Microscopy Anatomical Pathology only | 35% | 71.42 | | | | |
| P5336 | Electron Microscopy Anatomical Pathology only | 50% | 79.35 | | | | |
| P3345 | Surgicals, gross and microscopic 3 or more separate surgical specimens | 35% | 49.99 | | | | |
| P5345 | Surgicals, gross and microscopic 3 or more separate surgical specimens | 50% | 55.55 | | | | |
| P3346 | Surgicals, gross and microscopic, single large complex CA specimens including lymph notes | 35% | 49.99 | | | | |
| P5346 | Surgicals, gross and microscopic, single large complex CA specimens including lymph notes | 50% | 55.55 | | | | |
| | | | | | | **TOTAL UNITS CLAIMED:** | |

# PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

July 19, 2013 Volume XLIX - #4


Inside this issue



**CONTACT US:**

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**On-line documentation available at :**

**www.gov.ns.ca/health/physicians_bulletin**

## UPCOMING FEES

*NOTE: Please hold all eligible service encounters to allow MSI the required time to time to update the system. Once a new Health Service Code has been assigned, it will be published in the MSI Physicians' Bulletin.*

The following fees have been approved for inclusion into the Fee Schedule, effective August 1, 2013:

| Category | Description | Unit Value | |
|---|---|---|---|
| VEDT | **EVAR – endovascular abdominal aortic aneurysm repair with stent graft** | | |
| | **RO=FPHN Vascular surgeon or Interventional radiologist only** | 380 | 15+T |
| | **RO=SPHN Vascular surgeon or Interventional radiologist only** | 228 | |

Endovascular abdominal aortic aneurysm repair using stent grafting.

Billing Guidelines:
This is a comprehensive fee to include preoperative planning and measurements, arteriotomy(ies) as required, the insertion of all catheters including initial access, intra-operative angiography, interpretation of any images taken at the time of the procedure, balloon angioplasties within the treatment zone, iliac endarterectomy, angioplasty, and/or repair as required, and removal of access catheters with any necessary closure of vessels.

Preamble rules 9.3.3(g) apply.

Second physician specialty restriction is the same as for first physician.

**Coming in September!**

A new MSI website to better serve you.

New features include:

- A frequently asked questions section
- A searchable PDF of past copies of the MSI bulletin
- Electronic subscription functionality

**Watch for it!**

Not to be billed with:
MASG 50.37A Aortic graft plus bilateral femoral artery repair
Any additional angioplasties to be billed at LV 50 to a maximum of four, stents billed as ADON 51.59Q to a maximum of four.

Specialty Restriction:
Vascular surgery
Interventional radiology

Location:
Hospital

| Category | | Unit Value |
|---|---|---|
| VIST | **Initial Geriatric Inpatient Medical Assessment** | 38.1 |

Description:
This fee is for the complete initial assessment of the geriatric hospital inpatient, age greater than or equal to 65 years, by the family physician most responsible for the patient's ongoing inpatient hospital care.
Billed only once per patient per admission. May not be billed again for 6 months for the same patient.
This complete assessment is to include all of the following elements and be documented in the health record – include all positive and pertinent negative finds (based on *Guidelines for Medical Record-keeping 2008,* CPSNS):

1. Complete history: Extended history of the Chief Complaint, review of systems related to the problem, complete past medical and social history, pertinent family history.

2. Comprehensive Physical Examination: Extensive examination of the affected body area(s) and related system(s) plus extensive multisystem examination (3 or more systems in total).

3. Review of patient's hospital documents relating to current and prior visits.

4. Obtaining collateral history and information from caregivers.

5. Performance of a complete medication review to include collateral information from pharmacy and long term care facility as appropriate.

6. Obtaining advanced care directives (code status).

7. Reviewing and documenting relevant laboratory, imaging, and other test results pertaining to the present visit.

8. Formulating diagnoses and identifying important issues affecting the present admission.

9. Initiating an appropriate and timely management plan including a treatment plan, further investigations, advanced care planning and specialist or interdisciplinary consultation.

Billing Guidelines:
Not to be billed for transfers within the same hospital.

Recognized Systems:
- Eyes
- Ears, nose, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

Specialty Restriction:
GENP

Location:
Hospital only

| Category | | Unit Value |
|---|---|---|
| VIST | **Geriatrician's Initial Comprehensive Geriatric Consultation to Include CGA (Comprehensive Geriatric Assessment)** | 150 |

Description:
For the comprehensive assessment of the frail patient 65 years or older (frailty as characterized by low functional reserve, decreased muscle strength, and high susceptibility to disease). To be billed only when the entire assessment is performed by a physician with a Geriatric Medicine Subspecialty or Internal Medicine plus completion of a minimum 8 weeks training (PGY4 or greater) in geriatric assessment. The Comprehensive Geriatric Assessment will include all of the following elements and be documented in the heath record in addition to Start and Stop times. Assessment required a minimum of 90 minutes of patient to physician contact.

A) Assessment of cognition – usually using the Mini-Mental State Examination. If cognitive impairment is present, whether it meets the criteria for dementia, delirium or depression.
B) Other aspects of the mental state. Such as the presence of depression or other mood disorder. The presence of perceptual disturbances. Motivation. Health attitude.
C) Evaluation of special senses – functional ability in speech, hearing and vision is recorded.
D) Neuromascular examination to assess strength and specifically to evaluate deconditioning.
E) A functional assessment of mobility and balance to include detailed recording of the hierarchal assessment of balance and mobility (MacKnight C., Rockwood K., A hierarchical assessment of balance and mobility, Age and Ageing, 1995;24:126-130) is carried out.
F) Bowel and bladder function is recorded.
G) A brief nutritional screen focusing on weight and appetite is completed.
H) Functional capacity in personal instrumental and basic activities of daily living is recorded.

I) Sleep disruptions are recorded as is the presence of daytime somnolence.

J) Social Assessment. To include information about the extent of social engagement, the presence of a caregiver, the marital state and living arrangements of the individual, condition of the house and whether or not they need to be able to navigate stairs in order to be safe at home. The presence of supports is recorded as well as some information about the caregiver, including their coping ability, their own health and their outlook.

K) Documentation of advanced care directives.

CGA procedure: Note 1: For people being assessed during an acute illness, items D through H are recorded both for the baseline state (2 weeks previously) and currently.

CGA procedure Note 2: All this information is in addition to the general medical information recorded in the general medicine consult.

Billing Guidelines:
Time based fee requiring a minimum of 90 minutes.
Greater than 80% of time must be spent in direct patient contact.
No other fee codes may be billed for that patient in the same time period.

This Initial Assessment may be billed only once per patient per lifetime.

Specialty Restriction:
Geriatric Medicine
Internal Medicine with a minimum of 8 weeks recognized Geriatric subspecialty training (PGY4 level or greater)

Location:
Hospital/Clinic/Office

| Category | | Unit Value |
|---|---|---|
| MASG | **Esophagectomy with immediate reconstruction by Interposition of Hollow Viscus (Stomach, colon, or small bowel)** | 1000 |
| | **AP=ABDO** | 7+T |
| | **AP=CERV** | 6+T |
| | **AP=THOR** | 13+T |

Description:
This is a comprehensive fee for the total, or near total (greater than 2/3) removal of the esophagus with immediate reconstruction using the interposition of a hollow viscus stomach, colon, or small bowel), includes esophagogastrostomy, vagotomy, proximal gastrectomy, pyloromyotomy, bowel mobilization and preparation, and feeding tube placement where required.

Billing Guidelines:
Not to be billed with:
MASG 54.33A Resection of esophagus one stage
MASG 54.42 Esophagogastrostomy (intrathoracic)
MASG 54.43 Esohageal anastomosis with interposition of small bowel
MASG 54.44A Esophageal bypass with colon/jejunum
MASG 54.45 Esophageal anastomosis with interposition of colon intrathoracic

MASG 54.47 Esophageal anastomosis with other interposition (intrathoracic)
MASG 46.2 Medistinal tissue destruction
MASG 55.1 Percutaneous gastrostomy
MASG 55.3 Pyloromotomy
MASG 55.5 Partial gastrectomy with anastomosis to esophagus
MASG 58.39A Percutaneous jejunostomy

Specialty Restriction:
GNSG, THSG

Location:
Hospital Only

| Category | | Unit Value | |
|---|---|---|---|
| MASG | **Comprehensive Anal Sphincteroplasty for the Treatment of Anal Incontinence** | 220 | 4+T |

Description:
Comprehensive fee for the layered repair of the anal sphincter complex for the treatment of anal incontinence. Includes repair of internal and external anal sphincter, approximation of transverse perineal muscles, reattachment of bulbocavernosus muscles and perineal body reconstruction.

Billing Guidelines:
Not to be billed for acute anal sphincter trauma (use HSC 61.69E for acute non-obstetrical trauma, and HSC 87.82A or B, as appropriate, for acute obstetrical trauma). Not to be billed with MASG 83.61 (suture of vulva and perineum).

Specialty Restriction:
GNSG, OBGY

Location:
Hospital Only

| Category | | Unit Value | |
|---|---|---|---|
| ADON | **Multiple births by Caesarian Section** | 35 | Time only |

Description:
This fee is an add on to HSC 86.1 Cervical Caesarian Section, or 86.1A Caesarian Section with tubal ligation when greater than one delivery is performed. This compensates for the additional complexity of multiple births.

Billing Guidelines:
May be billed by the primary surgeon only, once per patient for multiple births by caesarian section. No matter how many births, this fee may only be billed once. Not to be added to the GP delivery fee.

Specialty Restriction:
OBGY

Location:
Hospital Only

**NEW FEES**

*Note: Physicians holding eligible services must submit their claims from May 1, 2013 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

Effective May 1, 2013 the following new health service code is available for billing:

| Category | Code | | Unit Value |
|---|---|---|---|
| VIST | 03.03G | **Examination of a victim of an alleged sexual assault and evidence collection**<br><br>Description:<br>This all-inclusive fee includes all aspects of the medical history, the medical, psychological and forensic examination, including collection of evidence according to the protocol prescribed by the Department of Justice for the investigation of an alleged sexual assault and the initial medical treatment of the victim by the physician.<br><br>Billing Guidelines:<br>Not to be billed with any other fees during the same time period.<br>To be eligible for this fee, the evidence must be collected and the documentation submitted according to the Dept of Justice protocol.<br><br>Specialty Restriction:<br>GENP, EMMD, COMD<br><br>Location:<br>Regional Hospitals only<br><br>*Physician Testimony – Sexual Assault Prosecution*<br>In the event that a charge of sexual assault is laid and a prosecution results, a physician may be subpoenaed by the Crown to testify in court. All costs associated with preparation for that court appearance and testifying in court should be submitted in an invoice to the Nova Scotia Public Prosecution Service by the physician. | 245 MSU + 15 units per 15 mins after 3 hours (maximum 6 x 15 min time intervals) |

Effective June 1, 2013 the following new health service codes are available for billing:

*Note: Physicians holding eligible services must submit their claims from June 1, 2013 onward within 90 days of the date of this bulletin. (Please include text referring to this bulletin for any service over the 90 day time frame).*

| Category | Code | Modifiers | | Unit Value |
|---|---|---|---|---|
| MASG | 94.13E | RG=LEFT<br>RG=RIGT<br>RG=BOTH | **Release of a single digit including the interphalangeal joint(s) for Dupuytren's disease** | 120 4+T |

Description:
Release of Dupuytren's contracture of a single digit including PIP and/or DIP joint to be used when palmar disease is not present. Dupuytren's involvement of digit must include the PIP and/or DIP joint.

To include any necessary joint or tendon releases; local tissue shifts, Z plasty, harvesting and placement of skin graft as required for wound closure.

Billing Guidelines:
Not to be billed with 98.51 C, 98.51 D Local Tissue shifts - Z plasty and flaps, 95.01 incision of tendon sheath,
92.63 A Excision (capsulectomy, synovectomy, debridement) of metacarpophalangeal joint,
92.63 B Excision (capsulectomy, synovectomy, debridement) of interphalangeal joint.
93.79 B, C, or E Arthroplasty or reconstruction of interphalangeal and/or metacarpophalangeal joint(s)

ADON 94.13D may be added if multiple digits are involved without palmar surgery.

Specialty Restriction:
PLAS, ORTH (With proof of Hand Fellowship)

Location:
Regional Hospitals only

| Category | Code | Modifiers | | Unit Value |
|---|---|---|---|---|
| CRCR | 03.05 | IN=CP01<br>IN=CP10<br>IN=CP11<br><br>ME=ECMO | **Comprehensive care for patient requiring Extracorporeal Membrane Oxygenation (ECMO)**<br><br>Description:<br>For the comprehensive care of the patient in the ICU/Critical care unit requiring ECMO<br><br>Billing Guidelines:<br>This replaces other critical care daily fees when the physician is responsible for critical care, ventilatory support, and manages extracorporeal membrane oxygenation for the patient in a designated intensive care area. Preamble rules as per Critical care/intensive care apply.<br><br>Location:<br>IWK and QEII Critical Care Units | First Day 205.08<br>Day 2-10 inclusive 102.9<br>Eleventh Day Onward 51.45 |

Effective July 1, 2013 the following new Workers' Compensation Board fee is available for billing:

*Note: Physicians holding eligible services must submit their claims from July 1, 2013 onward within 90 days of the date of this bulletin. (Please include text referring to this bulletin for any service over the 90 day time frame).*

| Category | Code | Modifiers | | Value |
|---|---|---|---|---|
| WCB | WCB20 | | **Carpal Tunnel Syndrome (CTS) Form Payment**<br><br>Description:<br>To be claimed for completion of the carpal tunnel syndrome form located on the WCB website (http://www.wcb.ns.ca).<br><br>Billing Guidelines:<br>This fee includes a visit as well as completion of the form.<br>This form is only to be used upon request from the WCB case worker.<br><br>Specialty Restriction:<br>GENP | $123.40 |

Effective September 1, 2013 the following new health service code will be available for billing:

| Category | Code | Modifiers | | Unit Value |
|---|---|---|---|---|
| ADON | 13.59L | RO=MENQ | **Meningococcal Quadrivalent vaccine**<br><br>Description:<br>For high risk individuals with the following conditions: (one dose) splenic disorders; complement, properdin, factor D or primary antibody deficiencies; post exposure prophylaxis for Meningococcal A, C, Y, W-135 serotypes and (three doses) for hematopoietic stem cell transplant. | 6 |

**PATHOLOGY FEE INCREASE**

Effective July 1, 2013 the following pathology fees will be increased by 25% (Relative calculations are based on Preamble Section 7.4.2):

| Code | Description | Old Fee Value | New Fee Value |
|---|---|---|---|
| P2325 | Surgicals, gross and microscopic | 19.08 | 23.85 |
| P3325 | Surgicals, gross and microscopic (premium 35%) | 28.08 | 32.85 |
| P5325 | Surgicals, gross and microscopic (premium 50%) | 28.62 | 35.78 |
| P2328 | Interpretation - fine needle aspiration biopsy | 15 | 18.75 |
| P3328 | Interpretation - fine needle aspiration biopsy (premium 35%) | 24 | 27.75 |
| P5328 | Interpretation - fine needle aspiration biopsy (premium 50%) | 24 | 28.13 |
| P2332 | Interpretation and report - NON GYN cytology slides | 5.61 | 7.01 |
| P3332 | Interpretation and report - NON GYN cytology slides (premium 35%) | 14.61 | 16.01 |
| P5332 | Interpretation and report - NON GYN cytology slides (premium 50%) | 14.61 | 16.01 |
| P2345 | Surgicals, gross and microscopic - three or more separate surgical specimens | 29.62 | 37.03 |
| P3345 | Surgicals, gross and microscopic - three or more separate surgical specimens (premium 35%) | 39.99 | 49.99 |
| P5345 | Surgicals, gross and microscopic - three or more separate surgical specimens (premium 50%) | 44.43 | 55.55 |
| P2346 | Surgicals, gross and microscopic - single large complex CA specimen including lymph nodes | 29.62 | 37.03 |
| P3346 | Surgicals, gross and microscopic - single large complex CA specimen including lymph nodes (premium 35%) | 39.99 | 49.99 |
| P5346 | Surgicals, gross and microscopic - single large complex CA specimen including lymph nodes (premium 50%) | 44.43 | 55.55 |

*NOTE: Please continue to submit claims for these services in the usual manner. Once MSI updates the system it will be published in the MSI Physicians' Bulletin. Claims for these codes with a service date from July 1, 2013 to fall 2013 will be identified and a reconcilliation will occur in the winter of 2013. The reconciliation will be calculated after the 90 day waiting period for submission of claims.*

**PREAMBLE REVISIONS**

8.3.3 Obstetrical Delivery
(b) Multiple Deliveries

(i) Multiple vaginal births are paid additional fees.
(ii) In the case of multiple births, when both a vaginal delivery and a Caesarean Section must be performed, the C-section is claimed at full fee and the vaginal delivery at 65%.
(ii) **When multiple babies are delivered by Caesarean Section, one service encounter may be made with the addition of the fee for multiple births by caesarian section where appropriate.**

**BILLING REMINDERS**

**Endometrial Ablation (HSC 80.19A) - Unbundling of Procedural Code**

Preamble section 9.3.3 prohibits the unbundling of procedural codes into constituent parts and billing MSI separately for them as well as claiming for the means used to access the surgical site. Therefore, when claiming HSC 80.19 A Endometrial ablation including D&C it is not appropriate to also claim for HSC 80.81 Hysteroscopy, 81.09 D&C, 81.09A Endocervical Curettage, 81.69A Endometrial Biopsy, 80.19B Endometrial Polypectomy or 03.26 Gynaecologic Examination as these are part of the endometrial ablation.

**Billing for Institutional Visits**

MSI staff have recently had a number of inquiries regarding billing for institutional visits. Institutional visits may be claimed for services provided in licensed and approved chronic care hospitals, residential centres, nursing homes and homes for special care. These visits may not be claimed for seniors' apartments or unlicensed boarding homes. The latter should be claimed using the appropriate home visit codes. For both institutional and home visits, there must be a specific request for the physician to visit the patient for a specific medical problem. It is not permitted to claim for regular "rounds" or visits either in institutions or a patient's home in the absence of such a patient-specific request.

**ANNOUNCEMENTS**

**Nova Scotia Locum Program – Important Update**

Please be advised that effective **Monday July 22, 2013**, the administration of the Provincial Locum Program will be managed through Medavie Blue Cross.

**As of July 22, 2013, all completed application forms, payment claim forms and queries are to be sent to Locumprogram@medavie.ca or via local fax at (902) 496-3060. Toll free fax is 1-855-350-3060.**

Completed application forms and payment claim forms can also be sent to the following mailing address:

MSI – Locum Program
PO Box 500
Halifax, NS B3J 2S1

**If you have any questions regarding the Locum program, please contact Jillian Hounsell at (902) 496-7104 or via email at Locumprogram@medavie.ca**

Please take note that only the administration of the Locum program has changed. All criteria, payment rates and approved Locum guidelines remain the same. Current Locum program application and payment claim forms, including approved Locum program guidelines can be found on the following website: Physicians.NovaScotia.ca

**New Medical Consultant**

We are pleased to announce that Dr. Scott Farrell has joined the MSI Program's team at Medavie Blue Cross as the new part-time Medical Consultant. Dr. Scott Farrell and Dr. Andrew Watson will be working as part-time Medical Consultants. If you have any MSI Assessment related questions for the Medical Consultants they can be reached at 496-7145 or by e-mail at MSI_MedicalConsultant@medavie.bluecross.ca.

## EXPLANATORY CODES

The following new explanatory codes have been added to the system:

AN003 Service encounter has been refused as this service can only be claimed by Anaesthesiologists.

GN062 Service encounter has been refused as you have not supplied the start and end times in the electronic text field.

MA033 Service encounter has been refused as you have previously claimed health service code 26.62 or 26.62B at the same encounter.

MA034 Service encounter has been refused as you have previously claimed a composite cataract fee at the same encounter.

MJ041 Service encounter has been refused as you have already billed a service that is included in this fee.

MJ042 Service encounter has been refused as you have already billed HSC 94.13E at the same encounter.

PP026 The remainder of your claims have been forwarded to MSI Pharmacare for review.

VT109 Service encounter has been refused as no other fees are payable during the same time period as 03.03G.

VT110 Service encounter has been refused as HSC 03.03G is not payable when other fees are billed during the same time period.

## UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, July 19th, 2013. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), modifier values (MODVALS.DAT), and explanatory codes (EXPLAIN.DAT).

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

June 14, 2013 Volume XLIX - #3

Inside this issue



**CONTACT US:**

**MSI_Assessment@medavie.bluecross.ca**

**On-line documentation available at :**

**www.gov.ns.ca/health/physicians_bulletin**

## UPCOMING FEES

*NOTE: Please hold all eligible service encounters to allow MSI the required time to update the system. Once a new Health Service Code has been assigned, it will be published in the MSI Physicians' Bulletin*

The following fee has been approved for inclusion into the Fee Schedule, effective May 1, 2013.

| Category | | Unit Value |
|---|---|---|
| VIST | **Examination of a victim of an alleged sexual assault and evidence collection**<br><br>Description:<br>This all-inclusive fee includes all aspects of the medical history, the medical, psychological and forensic examination, including collection of evidence according to the protocol prescribed by the Department of Justice for the investigation of an alleged sexual assault and the initial medical treatment of the victim by the physician.<br><br>Billing Guidelines:<br>Not to be billed with any other fees during the same time period.<br><br>To be eligible for this fee, the evidence must be collected and the documentation submitted according to the Department of Justice protocol. | 245 MSU + 15 units per 15 mins after 3 hours (maximum 6 x 15 min time intervals) |

Specialty Restriction:
GENP

Location:
Regional Hospitals only

. *Physician Testimony – Sexual Assault Prosecution*
In the event that a charge of sexual assault is laid and a prosecution results, a physician may be subpoenaed by the Crown to testify in court. All costs associated with preparation for that court appearance and testifying in court should be submitted in an invoice to the Nova Scotia Public Prosecution Service by the physician.

The following fee has been approved for inclusion into the Fee Schedule, effective June 1, 2013.

| Category | | Unit Value |
|---|---|---|
| MASG | **Release of a single digit including the interphalangeal joint(s) for Dupuytren's disease**<br><br>Description:<br>Release of Dupuytren's contracture of a single digit including PIP and/or DIP joint to be used when palmar disease is not present. Dupuytren's involvement of digit must include the PIP and/or DIP joint.<br><br>To include any necessary joint or tendon releases; local tissue shifts, Z plasty, harvesting and placement of skin graft as required for wound closure.<br><br>Billing Guidelines:<br>Not to be billed with 98.51 C, 98.51 D Local Tissue shifts - Z plasty and flaps, 95.01 incision of tendon sheath, 92.63 A Excision (capsulectomy, synovectomy, debridement) of metacarpophalangeal joint, 92.63 B Excision (capsulectomy, synovectomy, debridement) of interphalangeal joint. 93.79 B, C, or E Arthroplasty or reconstruction of interphalangeal and/or metacarpophalangeal joint(s)<br><br>In addition, the description of 94.13D has been amended to "Release of each additional digit including proximal interphalangeal joint release (Add on to complex palmar fasciectomy *or release of a single digit*) – plus multiples, if applicable. | 120 4+T |

ADON 94.13D may be added if multiple digits are involved without palmar surgery.

Specialty Restriction:
PLAS, ORTH (With proof of Hand Fellowship)

Location:
Hospitals only

The following fee has been approved by the Master Agreement Steering Group (MASG) for inclusion into the Fee Schedule, effective June 1, 2013

| Category | | Unit Value |
|---|---|---|
| CRCR | **Comprehensive care for patient requiring Extracorporeal Membrane Oxygenation (ECMO)** | First Day 205.08<br>Day 2-10 inclusive 102.9<br>Eleventh Day Onward 51.45 |

Description:
For the comprehensive care of the patient in the ICU/Critical care unit requiring ECMO

Billing Guidelines:
This replaces other critical care daily fees when the physician is responsible for critical care, ventilatory support, and manages extracorporeal membrane oxygenation for the patient in a designated intensive care area. Preamble rules as per Critical care/intensive care apply.

Location:
IWK and QEII Critical Care Units

**WCB - New form and fee for Carpal Tunnel Syndrome report**

Hand and Wrist symptoms caused by repetitive work are becoming more prevalent in NS workplaces, particularly in the form of Carpal Tunnel Syndrome. These symptoms can manifest over a period of time and it is difficult to causally relate Carpal Tunnel Syndrome to the workplace. In an effort to support injured workers and physicians and adjudicate claims in a timely manner, the Workers' Compensation Board of NS is launching a new form for Physicians related to Carpal Tunnel Syndrome. This new Hand/Wrist Report will provide the WCB with the medical information required to assess hand/wrist symptoms. This form will also streamline the current process for physicians by alleviating the need to provide the WCB with chart notes for Carpal Tunnel Syndrome injuries. This new form will be available for use on the WCB website at: http://www.wcb.ns.ca, starting July 1, 2013. Physicians will be paid the same amount for this form as the WCB's Physician's Report (Form 8/10). This fee includes the visit and completion of the form.

*NOTE: Please hold all eligible service encounters to allow MSI the required time to update the system. Once a new Health Service Code has been assigned, it will be published in the MSI Physicians' Bulletin*

**PREAMBLE REVISIONS**

**4.20 Sexual Assault Examination**

4.20.1 This is an assessment of a patient in which the physician follows the protocol prescribed by the Department of Justice for the investigation of alleged sexual assault.

4.20.2 The forensic examination portion of the treatment of a sexual assault victim is not insured under MSI, but payment is included in the Health Services Code ***Examination of a victim of an alleged sexual assault and evidence collection***. MSI will recover this portion of the fee from the Department of Justice. The police agency requesting the forensic examination must be indicated. (See Billing Instructions Manual re: fees)

**7.9.3 Critical Care Codes**

(d) Extracorporeal membrane Oxygenation (ECMO)-When one physician provides critical care, ventilator support services, and manages extracorporeal membrane oxygenation for the patient in a designated intensive care area, a service encounter claim should be submitted for Comprehensive care for patient requiring Extracorporeal Membrane Oxygenation.

**BILLING REMINDERS**

**Billing for services with no listed service code**

6.3.3 Exceptional Clinical Circumstances may warrant a fee other than that listed. In the event a practitioner performs a service he or she believes should be insured, but is unable to find an appropriate service code or finds an appropriate service code but feels the listed tariff does not adequately compensate the service, a request for an exceptional fee may be submitted. The request must be accompanied by complete details, including the duration of the service, adequate to explain and justify the number of units requested.

Note: The exceptional fee process is not intended for use on a routine basis when a physician disagrees with the listed tariff for a service.

**Functional Endoscopic Sinus Surgery (FESS)**

It has come to the attention of MSI Assessment that Functional Endoscopic Sinus Surgery is being billed using a variety of health service codes. As there is not an appropriate health service code for FESS, effective July 1/2013, it should be billed as EC as per 6.3.3. stated above. Please ensure that the text field indicates FESS was performed and include the duration of the procedure.

**Billing for I&D abscesses, removal foreign bodies, and wound packing**

Please note HSC 62.0A Drainage of abscess/cyst, HSC 62.0B Removal of foreign body and HSC 62.0C Incision and packing of wound are specific to hepatic surgery only. These major surgery codes are explicitly for liver-related surgeries and not to be used for other organs. Please refer to the Physicians Manual to ensure the proper Health Service Codes are used for non-liver related abscesses, foreign bodies and wound packing.

**Cosmetic surgery**

Physicians are reminded that cosmetic surgery is uninsured.

4.9.1 Cosmetic Surgery is defined as a service done solely for the purpose of altering the appearance of the patient and not medically necessary.

4.9.2 When there is doubt as to whether the proposed surgery is medically required or cosmetic, the operating surgeon should obtain prior approval from MSI. Anaesthetic and other fees associated with non-insured services are non-insured as well. MSI will pay for a visit or consultation to determine if a treatment method is insured, even though the proposed procedure is non-insured.

**Correct service date on claim**

Physicians are reminded that they must submit accurate claims information, including the date of service. When claims are audited, MSI staff look for the record of service on the date indicated on the claim. In some instances, physicians are submitting a date of service other than the date the patient received the service.

When a review of the documentation is required prior to payment, MSI staff are able access the Horizon Patient Folder (HPF) but only for the date of service noted on the claim. If a service is claimed on an incorrect date, the physician will be required to produce the record prior to processing the claim.

## GENERAL INFORMATION

**Health Card Processing**

The turnaround time for processing a request for a new health card is 10 business days following receipt of a complete application. The timeline for processing a health card renewal is 20 business days. These turnaround times are consistent with other jurisdictions across Canada.

It has come to MSI's attention that some office staff are faxing in renewal forms as urgent or noting the name of a specific MSI Customer Service Representative on the completed form in an attempt to have the renewal form processed more quickly. These special requests cannot be accommodated. In general, renewals will be processed in the order received.

**RCMP - Basic health care coverage**

Effective April 1, 2013, eligible Nova Scotian RCMP members receive coverage of their basic health care through MSI. By now, all eligible RCMP members should have received a Nova Scotia MSI health card which they must present for basic medical and hospital services. MSI-insured medical services provided to RCMP members should be billed at the regular MSI rates. Billing for services rendered due to duty-related illness should continue to be submitted to the RCMP member's divisional Occupational Health and Safety Services office.

**Outdated Claims Policy**

All original claims must be submitted to MSI within 90 days of the date of service. Claims that are outside of the specified time limitations will only be considered if extenuating circumstances can be demonstrated for a late submission and are within a reasonable time frame past the 90 day limit. Request for an extension must be made to MSI in writing and will be approved on a case by case basis.

The time frame for submitting the request to MSI for late submission should be within one month following the 90 day limit. Examples of extenuating circumstances may include physical damage to office such as fire or flood and or a serious technical issue.

Circumstances relating to staffing issues/shortages and mislaid, misfiled, or lost claims cannot be accepted by MSI as valid explanations for a late submission.

Claims for registered hospital in-patients must also be submitted within the 90-day time limitation regardless if the patient has been discharged or continues on an in-patient basis. It is incumbent on the physician to obtain the required billing information for these patients and submit claims within the prescribed time limitations. Explanations relating to late discharge summaries, or facilities not consolidating the required information for the physician, cannot be accepted as a valid explanation for a late submission.

Service Encounters submitted over the 90-day time limitation will be adjudicated to pay "zero" with the following exceptions:

a. Reciprocal billing claims (out of province) must be submitted within 12 months of the date of service.

b. Resubmission of refused claims or incorrect billings. These claims must be resubmitted to MSI within 185 days of the date of service. Each resubmission must contain an annotation in the text field of the Service

Encounter submission referencing the previous Service Encounter Number.

**Please note: Failure to annotate the text field with the previous Service Encounter Number will result in an adjudication paid at "zero**."

Important Information Physicians Need to Tell MSI

- Are you changing your bank account? (form required)
- Are you relocating your office practice?
- Is your MSI business mail properly addressed?
- Are you changing your billing software or service bureau?

For any of the above reasons or other related issues, please contact the Provider Coordinators at msiproviders@medavie.ca or send a detailed fax to 469-4674/ Toll-free 1-877-910-4674. If you would like to speak to one of the Provider Coordinators, please call 496-7107.

# PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

March 28, 2013 Volume XLIX - #2


Inside this issue



**CONTACT US:**

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**On-line documentation available at :**

**www.gov.ns.ca/health/physicians_bulletin**

## MEDICAL SERVICE UNIT/ANAESTHESIA UNIT CHANGE

Effective April 1, 2013, the Medical Service Unit (MSU) value will be increased from $2.32 to $2.37 and the Anaesthesia Unit (AU) value will be increased from $19.75 to $20.15.

## WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC

Effective April 1, 2013 the Workers' Compensation Board MSU Value will increase from $2.58 to $2.63 and the Workers' Compensation Board Anaesthetic Unit Value will increase from $21.94 to $22.39

## SESSIONAL PAYMENTS

Effective April 1, 2013 the Sessional payment rates for General Practitioners will increase to 59 MSUs while the rate for Specialists increases to 69 MSUs as per the tariff agreement.

## PSYCHIATRY FEES

Effective April 1, 2013 the hourly Psychiatry rate for General Practitioners will increase to $108.38 while the hourly rate for Specialists increases to $146.96 as per the tariff agreement.

**NEW FEES – PILOT PROJECT**

The Department of Health and Wellness and Doctors Nova Scotia recognize the need to explore the feasibility of introducing fees that support care being provided closer to home. With this in mind, effective April 01, 2013 the following fee codes are being piloted with a small group of physicians:

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| CONS | 03.09E | RF=REFD<br>SP=GAST | **1)Remote Specialist Telephone Advice – Consultant Physician –** ***Providing advice*** | 25 |
| CONS | 03.09F | | **2)Remote Specialist Telephone Advice – Referring Physician –** ***Seeking advice*** | 11.5 |

**Description:**
Payable for a verbal communication, initiated by the referring specialist or family physician, and taking place within these time frames:

1. Urgent-within 2 hours
2. Emergent-by end of day, or
3. Elective-within the week (5 days)

Payable for a two-way telephone (or electronic verbal communication) regarding the assessment and management of the patient but without the consulting physician seeing the patient. Not payable for written communication- i.e. letter, fax, e-mail, text.

The referring physician is seeking an expert opinion from the consulting physician due to the complexity and severity of the case – with the intent of continuing to provide the patient's care- i.e.not to arrange transfer, telemedicine consultation or diagnostic tests. Not solely for the discussion of diagnostic test results.
Is payable in addition to a visit same day for the referring physician.

Includes review of relevant date: family history, history of present complaint, laboratory and diagnostic tests.

**Billing Guidelines:**
Once per patient per day for referring and consulting physician.

The following must be documented in the health record:
Pt name and HCN, start and stop times, physician names, reason for consultation, opinions of consultant physician.
Time and date of original call and time and date of response call.
*Discussion time will be recorded for the pilot project without limitation to the minimum or maximum times*
Must reference other physician's billing number on the claim.

Not payable for situations where the purpose of the call is to:

a) book an appointment
b) arrange for transfer of care that occurs within 24 hours
c) arrange for an expedited consultation or procedure within 24 hours
d) arrange for laboratory or diagnostic investigations
e) inform the referring physician of results of diagnostic investigations
f) arrange a hospital bed for the patient

Restricted to CDHA Division of Gastroenterology for the specialist code.

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| VIST | 03.03F | SP=GAST | **Scheduled Specialist Telephone Patient Management/Follow-up** | 11.5 |

**Description:**
Payable for a scheduled telephone communication between the specialist physician and the patient who has been seen previously by the same physician in consultation, no sooner than 7 days following the initial consultation. This communication is intended to take the place of an office follow up visit that would have otherwise been scheduled where a physical examination may not be required.

**Billing Guidelines:**

1. Payable for a two-way telephone (or electronic verbal communication) between the specialist physician and the patient or patient's representative (care giver). Not payable for written communication- i.e. letter, fax, e-mail, text.
2. The fee is payable for scheduled telephone appointments only.
3. The specialist physician must have seen or had a documented encounter with the patient within the preceding 6 months.
4. May be billed up to 4 times per physician per patient per year.
5. Not payable in addition to any other service for the same patient by the same physician on the same day.

Start and stop times must be recorded in the health record as well as documentation of the encounter with a letter to the referring physician or family physician.
*Discussion time will be recorded for the pilot project without limitation to the minimum or maximum times.*

Not payable for situations where the purpose of the call is to:
a) Book an appointment
b) Relay test results only without resultant change in management plan
c) When the telephone communication is held with a proxy for the physician, for example: Nurse, or resident physician.

Restricted to CDHA Division of Gastroenterology for the specialist code.

**CATARACT FEE REVISIONS**

Effective April 1, 2013, a reduction will be applied to the cataract surgical and cataract anaesthesia fees. The reduction will continue to be phased-in over the subsequent 36 months, on April 1st of each year. The following fees will be reduced:

| Category | Code | Description |
|---|---|---|
| MASG | 27.72 | **Insertion of intraocular lens prosthesis with cataract extraction, one stage** |
| MASG | 27.72B | **Insertion of intraocular lens prosthesis with cataract extraction, high risk patients, monocular patients, or patients who require cataract surgery in association with glaucoma, vitreoretinal surgery, corneal transplantation or serious complications of previous cataract surgery** |
| MASG | 27.49A | **Excision – crystalline lens – senile or others** |
| MASG | 27.49B | **Excision – crystalline lens – senile or others, high risk patients, monocular patients, or patients who require cataract surgery in association with glaucoma, vitreoretinal surgery, corneal transplantation or serious complications of previous cataract surgery** |
| MASG | 27.59A | **Excision – crystalline lens – senile or others** |
| MASG | 27.59B | **Excision – crystalline lens – senile or others, high risk patients, monocular patients, or patients who require cataract surgery in association with glaucoma, vitreoretinal surgery, corneal transplantation or serious complications of previous cataract surgery** |

The fee changes are reflected in the table below:

| **Cataract surgical fee reduction** | | | | | | **Cataract anaesthesia fee reduction** | | |
|---|---|---|---|---|---|---|---|---|
| Code | Current MSU | April 1, 2013 | April 1, 2014 | April 1, 2015 | April 1, 2016 | Current AU | April 1, 2013 | April 1, 2014 |
| 27.72 | 300 | 285 | 270 | 255 | 225 | 6+T | 5+T | 4+T |
| 27.72B | 325 | 309 | 293 | 276 | 244 | 6+T | 5+T | 4+T |
| 27.49A | 230 | 218.5 | 207 | 195.5 | 172.5 | 6+T | 5+T | 4+T |
| 27.49B | 230 | 218.5 | 207 | 195.5 | 172.5 | 6+T | 5+T | 4+T |
| 27.59A | 230 | 218.5 | 207 | 195.5 | 172.5 | 6+T | 5+T | 4+T |
| 27.59B | 230 | 218.5 | 207 | 195.5 | 172.5 | 6+T | 5+T | 4+T |

## BILLING REMINDERS

Instillation of Bladder Chemotherapy (Health Service Code 10.56A) and Injection of Prophylactic Substance (Health Service Code 13.59)

These codes may not be claimed by a physician when it has been conducted by a nurse who is a DHW/IWK employee and the bladder catheterization/instillation or injection is part of the nurse's usual duties. As outlined in Preamble section 4.16 services provided by nurses are not insured in Nova Scotia and may not be billed to MSI. These services are paid through the salary of the nurse and it is not appropriate for physicians to also claim for them.

Infusion of Chemotherapy (Health Service Code 13.55)

This code may only be used for injection of antineoplastic agents. It may not be used for injection of other agents such as Remicade.

Claiming for Procedures or Consultations with 35% or 50% Premium

As outlined in Preamble section 7.4 premium fees may be claimed for certain services provided on an emergency basis during designated time periods. An emergency basis is defined as a service that must be performed without delay because of the medical condition of the patient. As outlined in Preamble 1.8.4 where a differential fee is claimed based upon time, location, etc., the information on the patient record must substantiate the claim. The physician claiming the premium is responsible for ensuring that the clinical record indicates the time the physician was asked to see the patient and the time the patient was seen. As per Preamble 7.2.3 (f) visits (including consultations) requested in one time period and performed in another time period must always be claimed using the lesser of the two rates.

Time-Based Codes

Physicians are reminded that they must document the start and stop times of their encounter with the patient directly on the clinical record for all time based codes. Since December 2012, MSI has also required that these times be included in the text field when the claim is submitted. Payment for timed codes is based upon the time spent directly with the patient. **Physicians may not claim for administrative time such as completing chart notes**. Examples of time-based codes include psychotherapy, counselling, complex care, and prolonged consultations, among others.

## EXPLANATORY CODES

The following new explanatory codes have been added to the system:

CN021 Service encounter has been refused as you have already billed remote specialist telephone advice for this patient on this date.

GN060 Service encounter has been reduced to reflect maximum daily time allowed.

GN061 Service encounter has been refused based on the preamble ruling for payment of detention time. See Preamble 7.3.

MA032 Service encounter has been refused as a surgical assist cannot be performed in the office.

VT105 Service encounter has been disallowed as a previously approved surgery includes post operative care for up to 14 days after the date of service (Preamble 9.3.1).

VT106 Service encounter has been disallowed as a consultation has been billed in the previous 7 days for this patient by this provider.

VT107 Service encounter has been refused as four of these services have previously been approved in the past 365 days.

VT108 Service encounter has been refused as this code is not payable in addition to any other service for the same patient by the same physician on the same day.

The following explanatory code has been revised:

MA023 Service encounter has been disallowed as you have previously billed another major surgery for this patient on the same day.

**UPDATED FILES – AVAILABILITY**

Updated files reflecting changes are available for download on Thursday, March 28th, 2013. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanation code (EXPLAIN.DAT).

# PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

February 15, 2013 Volume XLIX - #1


Inside this issue



**CONTACT US:**


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**On-line documentation available at:**

**www.gov.ns.ca/health/physicians_bulletin**

## MEDICAL SERVICE UNIT/ANAESTHESIA UNIT CHANGE

Effective April 1, 2013, the Medical Service Unit (MSU) value will be increased from $2.32 to $2.37 and the Anaesthesia Unit (AU) value will be increased from $19.75 to $20.15.

## WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC

Effective April 1, 2013 the Workers' Compensation Board MSU value will increase from $2.58 to $2.63 and the Workers' Compensation Board Anaesthetic Unit value will increase from $21.94 to $22.39.

## SESSIONAL PAYMENTS

Effective April 1, 2013 the Sessional payment rates for General Practitioners will increase to 59 MSUs while the rate for Specialists increase to 69 MSUs as per the tariff.

## PSYCHIATRY FEES

Effective April 1, 2013 the hourly Psychiatry rate for General Practitioners will increase to $108.38 while the hourly rate for Specialists increases to $146.96 as per the tariff agreement.

**NEW FEES**

Effective January 1, 2013 the following new health service codes are available for billing:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VADT | 01.14H | **Esophagogastroscopy plus endoscopic placement of esophageal stent with or without the use imaging**<br><br>This is a comprehensive fee for the placement of an esophangeal stent. It includes esophagogastroscopy, esophageal dilation where required, and placement of the esophageal stent with or without the use of radiologic guidance.<br><br>Billing Guidelines:<br>Not to be billed with:<br>• 01.14C Oesophago-gastroscopy<br>• 54.71 Insertion of permanent tube into esophagus<br>• 54.92E Dilation of esophagus with esophagoscopy | 90 4+T |
| VADT | 49.98I | **Complex Cardiac Ablation for Atrial Fibrillation and complex cardiac arrhythmias (see description)**<br><br>This is a composite fee for the intracardiac catheter ablation of arrythmogenic focus or foci, for the treatment of complex cardiac arrhythmias (not atrioventricular nodal reentry or atrioventricular reentry), atrial fibrillation, ventricular tachycardia, and cases of arrhythmia in patients with complex congenital heart malformations. This fee includes percutaneous right heart catheterization, transeptal left heart catheterization, all diagnostic imaging (including angiography), electrocardiograms, electrophysiologic mapping, ablation, and electric counter shock of heart as required. This fee does not apply to the treatment of *reentrant* supraventricular tachycardia *(atrioventricular nodal reentry or atrioventricular reentry).*<br><br>**Billing Guidelines:**<br>Not billable with:<br>• 49.95, A, B<br>• 49.96, A through H<br>• 49.97, A through G<br>• 49.98, A through H<br>• ADON 50.83, 50.91, 50.98A, 13.72 | 796 9+T |

## DISCONTINUED HEALTH SERVICE CODES

Effective February 15, 2013 the following health service codes will no longer be active:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 54.71A | Introduction of Mousseau-Bardin tube | 150 |
| MASG | 54.71B | Insertion of Celestin tube | 200 |

Please note that these have been replaced with the new patient specific health service code **01.14H - Esophagogastroscopy plus endoscopic placement of esophageal stent with or without the use imaging.**

## INCORRECT DIAGNOSTIC CODES FOR URGENT CARE VISIT SERVICES

Please note the following diagnostic codes are not valid when claiming for urgent care visits or callbacks: 3804, 5210, 7062, V681, 9190, 7030, V221, 700, 30510, 37300, 2724, 6910, 7063, 7964, 9194, V2501, 1112, 2720, 2722, 37515, 38801, 4720, 5282, 7575, 78050, 78053, 7834, 78836, 79093, 9114, 9124, 9164, 9174, V1272, V201, V241, V2509, V259, V411, V413, V6549, V658, V720, V723, V725, V729, V762.

## REQUESTS FOR AN OPERATIVE REPORT

When a claim has been paid at zero with error code NR072 asking for an OR report, the original claim itself also has to be resubmitted with an action code of "R" for reassessment. If the OR report is received and no reassessment (R) is sent in for the original service encounter, the claim will not be paid. Please ensure that upon submitting the required OR report that a reassessment is sent in with text referencing the OR report.

## BILLING REMINDERS

Billing for Services Provided by Medical Trainees

Preamble section 8.1.2 outlines billing rules for payment of physicians who are supervising the clinical activities of medical students or residents. Physicians are reminded that they must personally be present at the time the medical trainee is providing the service or immediately available to render assistance. An attending physician may claim for only the resident's services, or his/her own but not both. Visits on a teaching unit may only be claimed by the attending physician when he/she is physically present on the clinical teaching unit that day. If multiple services/procedures are being supervised, the attending physician may not claim a total number of services in excess of those he/she might have claimed in the absence of other members of the team.

Physicians are reminded that they may not bill for procedures or visits carried out by nurses or nurse practitioners except for a very limited number of procedures carried out by nurses/nurse practitioners who are directly employed by a fee for service family physician.

Lifestyle Counselling – 08.49C

Physicians are reminded that as per Preamble Section 8.9, "Lifestyle Counselling is a prolonged discussion where the physician attempts to direct the patient in the proper management of health related concern; e.g. lipid or dietary counselling, AIDS advice, smoking cessation, health heart advice, etc." This is only billable by the general practitioner providing on-going primary care to the patient.

Independent Consideration

Preamble section 6.3.1 - Independent consideration is applied to certain services recognized to have wide variation in case to case complexity and time. (Refer to Billing Instructions Manual) Independent consideration services must be accompanied by complete details, including duration of service, adequate to explain and justify the number of units requested.

Exceptional Clinical Circumstances

Preamble section 6.3.3 - Exceptional Clinical Circumstances may warrant a fee other than that listed. In the event a practitioner performs a service he or she believes should be insured, but is unable to find an appropriate service code or finds an appropriate service code but feels the listed tariff does not adequately compensate the service, a request for an exceptional fee may be submitted. The request must be accompanied by complete details, including the duration of the service, adequate to explain and justify the number of units requested.

**Note:** The exceptional fee process is not intended for use on a routine basis when a physician disagrees with the listed tariff for a service.

## EXPLANATORY CODES

The following new explanatory codes have been added to the system:

AD047 Service encounter has been refused as HSC 98.49C must be submitted prior to the add-on 98.49D.

CR011 Service encounter has been refused as this service has already been billed for this date.

CR012 Service encounter has been refused as a fee for intensive care has already been claimed for this patient on this date. Critical or comprehensive care cannot be claimed on the same day as intensive care.

CR013 Service encounter has been refused. When a physician provides both critical and ventilator care to a patient they should claim comprehensive care. Please delete the previously paid ventilatory care and submit a claim for comprehensive care.

CR014 Service encounter has been refused. When a physician provides both critical and ventilator care to a patient they should claim comprehensive care. Please delete the previously paid critical care and submit a claim for comprehensive care.

CR015 Service encounter has been refused as a fee for comprehensive care has previously been claimed for this patient on this day (preamble 7.9.2).

CR016 Service encounter has been refused as a fee for critical or ventilatory care has previously been claimed for this patient on this day (preamble 7.9.2).

CR017 Service encounter has been refused as a fee for intensive care has previously been claimed for this patient on this date.

CR018 Service encounter has been refused as a fee for comprehensive or critical care has previously been claimed for this patient on this date.

GN059 A consult has previously been approved for your specialty during this hospitalization.

MA026 Service encounter has been refused as you have previously billed a portion of this composite service at the same encounter (bronchoscopy, decortication, or mediastinal lymph node dissection).

MA027 Service encounter has been refused as you have previously billed a VATS lung lobectomy at the same encounter.

MA028 Service encounter has been refused as you have previously billed health service code 77.3 or 78.21 at the same encounter.

MA029 Service encounter has been refused as you have previously billed health service code 77.19A at the same encounter.

MA030 Service encounter has been refused as you have previously billed health service code 77.52 at the same encounter.

MA031 Service encounter has been refused as you have previously billed health service code 78.21 at the same encounter.

VA049 Service encounter has been refused as a 01.14C, 54.71, or 54.92E has been billed at this same encounter.

VA050 Service encounter has been refused as a 01.14H has been billed at the same encounter.

VA051 Service encounter has been refused as a 49.95A, 49.95B, 49.96A,B,C,D,E,F,G,H, 49.97A,B,C,D,E,F,G, 49.98A,B,C,D,E,F,G,H, 50.83, 50.91, 50.98A, or 13.72 has been billed at this same encounter.

VA052 Service encounter has been refused as a 49.98I has been billed at this same encounter.

VT101 Service encounter has been refused as a diagnostic code used is not valid for urgent services.

VT102 Service encounter has been disallowed. Please submit a copy of the clinical record before requesting a reassessment for this claim.

VT103 A comprehensive or initial limited visit may not be claimed within 30 days of a comprehensive consultation on the same patient for the same condition. See preamble 7.2.3 (c).

VT104 A comprehensive visit may not be claimed within 30 days of a previous limited or comprehensive visit. See preamble 7.2.3 (d).

The following explanatory codes have been revised:

GN052 Service encounter has been disallowed. Please submit a reassess (action code R) along with a copy of the time sheet for the surgery performed to aid in the adjudication of your claim.

VA045 Service encounter has been disallowed as HSC 50.99A and 69.94 require text indicating the intravenous/catheter insertion was performed by the physician.

**UPDATED FILES – AVAILABILITY**

Updated files reflecting changes are available for download on Friday, February 15th, 2013. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanation code (EXPLAIN.DAT).

# PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

December 7, 2012 Volume XLVIII - #4


Inside this issue



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**On-line documentation available at:**

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## NEW FEES

Effective October 1, 2012 the following new health service codes are available for billing:

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| MASG | 44.4A | RG=LEFT<br>RG=RIGT | **VATS Lung Lobectomy**<br><br>Video-assisted thoracoscopic surgery (VATS) to remove an entire lobe of the lung.<br><br>Billing Guidelines:<br>This is a comprehensive fee for the video-assisted thoracoscopic removal of a lung lobe to include the procedures required to visualize the operative area, mobilize the lobe and determine the extent of resection required, namely; bronchoscopy, decortication, and mediastinal lymph node dissection, where necessary. When diagnostic procedures such as bronchoscopy, lung biopsy, wedge resection with frozen section, or mediastinal lymph node sampling, are performed during the same operative session, in the same anatomical location (same lung, same lobe), and the surgeon uses these results to determine the extent of the necessary surgical resection, only the most extensive procedure performed will be remunerated. | 480 13+T |

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VADT | 43.1B | **Bedside percutaneous tracheostomy**<br><br>The planned, percutaneous insertion of a tracheostomy tube for a ventilated patient in the intensive care unit.<br><br>Billing Guidelines:<br>This is a comprehensive fee to include any and all procedures required to insert the tracheostomy tube including, but not limited to, any means of visualization required to assess the anatomy of the airway and confirm tube placement.<br><br>Not to be billed with:<br>Any other bronchoscopy same patient same day unless the indications for a full diagnostic bronchoscopy are recorded in the medical record.<br><br>May be billed in addition to daily CRCR fees. | 100 6+T |

Effective January 1, 2013 the following new health service code is available for billing:

| | | | |
|---|---|---|---|
| MASG | 71.4B<br>SP=OBGY<br>SP=UROL<br>(Interim Fee) | **Urethral sling using prosthetic material such as TVT, TOT etc, by any method**<br><br>Billing Guidelines:<br>• Cystoscopy cannot be billed in addition. | 150 4+T |

*Note: Physicians holding eligible services must submit their claims from October 1, 2012 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

**FEE REVISIONS**

Case Management Fee

Effective December 7, 2012 the following fee has been corrected to the proper amount:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VIST | 03.03D | Case Management Conference | • 14.5 units per 15 minutes for GPs<br>• 17.0 units per 15 minutes for Specialists |

Effective April 1, 2013 the following fee revision will be in effect:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VIST | 03.03D | Case Management Conference | • 14.75 units per 15 minutes for GPs<br>• 17.25 units per 15 minutes for Specialists |

Effective April 1, 2014 the following fee revision will be in effect:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VIST | 03.03D | Case Management Conference | • 15.0 units per 15 minutes for GPs<br>• 17.5 units per 15 minutes for Specialists |

Decortication of Lung

Effective October 1, 2012, health service code 46.41 – Decortication of lung has been revised and updated with the following information:

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| MASG | 46.61A | RG=LEFT<br>RG=RIGT | **Decortication of Lung – Primary Procedure**<br><br>Major decortication of lung as primary procedure for indications such as empyemectomy, treatment of fibrothorax, or clotted hemothorax.<br><br>Billing Guidelines:<br>May be billed only when decortication is the primary procedure. | 280 15+T |

**BILLING REMINDERS**

Catheter Insertion

Physicians may only claim for insertion of a catheter when they have personally performed the service. Preamble Rule 5.3.1 states "All insured services claimed must reflect services rendered personally by the physician in an appropriate clinical setting." Therefore these health service codes may not be claimed when they are carried out by another health care provider such as a nurse, nurse practitioner or X-Ray technologist as part of their usual duties. Effective December 7, 2012 text will be required on all claims explaining why the physician has claimed for the catheter insertion.

Time Based Services

As per Preamble section 1.8.1 (H) “An appropriate medical record must be maintained for all insured services claimed. The minimum record must contain, for MSI purposes, the following: (H) Time and duration of visit in the case of time-based fees”. Effective December 7, 2012 any claims for time based services must have the start and end times documented in the electronic text field. Anaesthesia services are exempt from the electronic text requirement.

HSC 09.13A and 09.13B

Regions are not required for billing HSC 09.13A and 09.13B. In addition, HSC 09.13B is only billable once per 365 days per patient.

HSC 98.12U and 98.99F - Cryotherapy of Warts

Effective December 7, 2012, health service codes 98.12U - Cryotherapy of warts and 98.99F - Cryotherapy of planter warts or molluscum contagiosum have a maximum of two multiples (ie 10 warts) claimable per service encounter.

Unbundling of Claims

Section 9.3.3 (a) of the Preamble in the Physician's Manual restricts the unbundling of a procedure fee into its constituent parts and billing for the parts individually or in combination with the procedural fee. For example, a laparoscopic assisted vaginal hysterectomy should be billed as 80.4B and not vaginal hysterectomy plus laparoscopy (80.4 + 66.83).

Effective July 1, 2010 MSI began an initiative to assess claims submitted where more than one procedure is claimed for the same patient on the same day. Please be advised that as the manual assessment of these claims continues, operative reports may be requested and there may be an increase in turnaround time.

Laparoscopy

As per Preamble 9.3.3 (d), "When one physician performs a definitive procedure on an organ or within a body cavity, only that service should be claimed. The procedure used to provide surgical exposure should not be claimed." Therefore health service code 66.83 (Laparoscopy) cannot be billed with health service codes 77.19C (Laparoscopic ovarian cystectomy), 57.59A (Laparoscopic assisted colectomy) or 80.4C (Laparoscopic hysterectomy).

Diagnostic Codes for Premium Services

Please note the following diagnostic codes are not valid when claiming for premium consults and procedures:

- V220 – Supervis Normal First Pregnancy
- V221 – Supervis Other Normal Pregnancy
- V222 – Pregnancy State Incidental
- V720 – Routine Examination of Eyes and Vision
- V7281 – Pre-OP Cardiovascular Exam
- V7284 – Unspecified Pre-OP Examination
- 36250 – Macular Degeneration Unspecified
- 64630 – Habitual Aborter/Unspecified

Billing for Services Not Provided

If a service has not been provided, it can not be claimed by a physician. Similarly, cancelled visits or procedures can not be claimed. It has come to MSI's attention that some physicians are billing for cancelled procedures. Physicians are reminded that they may not bill for such circumstances.

Cerumen (Ear Wax) Removal

Preamble 7.2.3 (a) stipulates that if the sole purpose of a visit is to provide a procedure then only the procedure may be billed. However, removal of cerumen has been an uninsured service in Nova Scotia for many years except in the case of a febrile child. Physicians may not bill either a visit or a procedural code when the sole purpose of the encounter is cerumen removal in other clinical situations.

Service Encounters with Uninsured Services

As per Preamble 5.3.3, "As part of the provision of an insured service, patients may be charged directly for the provision of consumable items not covered by MSI. These charges must be explained and agreed to by the patient before the insured service is provided."

When billing non-insured services, physicians should be familiar with Preamble Section 5.4:

"5.4 Billing for insured and non-insured services at the same visit.

5.4.1 A physician must exercise caution whenever billing MSI and the patient or a third party during the same visit. In principle, under no circumstances should any service, or any component of a service, be claimed for twice.

5.4.2 Whenever possible, the attending physician must acquaint the patient, or person responsible for the patient, with the financial obligation involved in the patient's care.

5.4.3 If the insured service is the primary reason for the visit, any additional charges for non-insured services must be explained to, and accepted by, the patient before provision of these services. Charges for non-insured services will reflect only those services over and above those provided on an insured basis. It is not appropriate to bill both MSI and WCB for the same service.

5.4.4 At no time should provision of insured services be contingent upon the patient agreeing to accept additional non-insured services.

5.4.5 When physicians are providing non-insured services, they are required to advise the patient of insured alternatives, if any exist.

5.4.6 Incidental findings

(a) If an inconsequential health matter or finding is discovered or discussed during the provision of a non-insured service, it is not appropriate to claim for an insured service.
(b) If a significant health matter or finding becomes evident, necessitating additional insured examination(s) or treatment(s), then these subsequent medically necessary services may be claimed to MSI.

5.4.7 When a non-insured service is the primary reason for the visit, any service encounter for insured services provided as a medical necessity will reflect only services over and above those provided on a non-insured basis."

Long-Term Care Clinical Geriatric Assessment (CGA)

Audits of this health service code CGA1, which was introduced in early 2011, have begun and deficiencies in completion of the documentation are being noted. Physicians are reminded that they must satisfy all requirements outlined prior to billing the CGA1 code.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| DEFT | CGA1 | Long Term Care Clinical Geriatric Assessment | 26.32 |

Description:

The Long-Term Care Clinical Geriatric Assessment (CGA) is an evidence-based clinical process that allows for interdisciplinary input to best assess the complexity of the nursing home resident. The CGA process and form, once completed, gives a point in time assessment of medical, functional and psychosocial needs of the resident which serves as a benchmark to treat to when the clinical condition changes. The physician is directly responsible for completing the medication list, diagnostic categories, cognition, emotional, behaviors, and provides the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessments. The frailty level has been determined to be a predictor of the clinical trajectory of the resident, which is helpful in determining what course of care is reasonable, and a reference to use when discussing a resident's care plan with the resident, families and/or staff. The physician has the option to fill out the other fields on the CGA form as well. However the CGA process is best served when all disciplines involved with the resident complete their sections so as to provide accuracy and encourage dialogue among the clinical team. The other providers who may provide input for the CGA include: nursing, social work, physiotherapy, occupational therapy, pharmacy and/or other health care disciplines consistent with their scope of practice.

The CGA form should be near the front of every nursing home chart and will serve as the lead clinical document that will travel with the resident when a transfer (ER, other facility etc) occurs. In this way accurate clinical information is provided to other caregivers the resident may need to be treated by. This will help ensure accurate communication of the resident's care directives, and all relevant baseline clinical information so any care outside the facility or by any on-call physician can be provided with this vital clinical information that will enhance the quality of care given.

Billing Guidelines:

- Family physicians will be remunerated for the completion of a Long-Term Care Clinical Geriatric Assessment (CGA) for residents of licensed Nursing Homes and Residential Care Facilities (RCF's) funded by the Department of Health only.
- The CGA may be billed twice per fiscal year (April 1 – March 31), per resident. The initial CGA is recommended to be completed as soon as possible following Nursing Home or RCF admission, once the physician and clinical team have had time to become familiar with the resident/patient.
- The CGA is normally completed through a collaborative team process involving the family physician and other licensed long-term care healthcare providers. The physician claiming the CGA fee is responsible for the diagnostic section (Cognitive Status, Emotional and Behaviors), the medication section, and providing the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessment. Other sections of the CGA may be completed by the physician or by other licensed healthcare providers.
  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.
- Prior to claiming the CGA fee, the physician must review, complete and sign the CGA form in the long-term care facility on the date of the final CGA service encounter and place a note in the resident's clinical record (progress notes) corroborating that the CGA has been completed.
- The date of service is the date when the final CGA service encounter occurs and the CGA form is completed and signed by the physician.
- The CGA fee is billable by eligible fee-for service physicians and by eligible APP contract physicians, based on shadow billings.

It is recommended that the CGA form is attached to any applicable transfer forms, including inter facility transfers whenever possible.

Eligible APP Physicians will be required to shadow bill the new fee code in order to receive payment. Eligible claims will be reviewed and paid twice per year in the form of a cheque from MSI. Estimated payment dates for this new fee are June and December of each year.

## GENERAL PRACTICE COMPREHENSIVE CARE INCENTIVE PROGRAM – ADDITIONAL SERVICE CATEGORY

Pap Smears for women ages 40 – 75 years on the date of service have been added to the General Practice Comprehensive Care Incentive Program (CCIP) as an additional CCIP-eligible service

category for 2012/13. Calculation of the number of CCIP-eligible Pap Smear services will be based on claims for HSC 03.26A Pap Smear provided for women ages 40-75 years during the period July 1 to June 30 prior to the calculation of the annual CCIP payment. Other CCIP-eligible service categories include: nursing home visits; inpatient hospital care; obstetrical deliveries; maternity/newborn visits; home visits; all office visits for children under two years; and, selected GP procedures.

The CCIP provides incentives and recognition to family physicians for providing a comprehensive breadth and depth of services for their patients. To qualify for a 2012/13 CCIP payment, family physicians must have minimum total fee-for-service and/or shadow billings of $100,000, including

minimum office billings of $25,000, and reach the first activity threshold for at least two CCIP-eligible service categories during the 12-month CCIP calculation period. Payments to individual physicians are determined each year by: the total amount of CCIP funding available; total CCIP-eligible services provided; the number of physicians who qualify for a payment; and the number of service categories and activity levels per service provided by the individual physician.

**EXPLANATORY CODES**

The following new explanatory codes have been added to the system:

VA045 Service encounter has been disallowed as HSC 50.99A and 69.94 require text stating the reason for the intravenous/catheter insertion.

VA046 Service encounter has been refused as only one 09.13B can be paid in a 365 day period.

VA047 Service encounter has been refused. HSC 03.26C is included in the complete care code 81.8 which was previously billed for this patient on this day.

VA048 Service encounter has been refused as cystoscopy cannot be billed in addition to HSC 71.4B.

VT096 Service encounter has been refused as the maximum number of subsequent limited visits has already been claimed for this patient this week.

VT097 Service encounter has been refused as you have already been approved for a supportive care claim within the past three days (Preamble 7.6.1).

VT098 Service encounter has been refused as you have already been approved for two supportive care claims within the past seven days (Preamble 7.6.1).

VT099 Service encounter has been refused as you can only claim subsequent weekly visits after 56 days from hospital admission. Prior to that you may claim subsequent daily visits.

VT100 Service encounter has been refused as HSC 03.26C has previously been billed for this patient on the same day.

GN055 Service encounter has been refused as you have already claimed the surgeon fee for this service.

GN056 Service encounter has been refused as you have already claimed the surgical assist fee for this service.

GN057 Service encounter has been disallowed as the diagnostic code submitted does not warrant a premium fee.

GN058 When claiming multiples for a time based service the start and end times must be included in the text field.

MA020 Service encounter has been refused as you have already billed HSC 28.41/28.41A/28.42/ 28.42A/ 28.44A, or 28.72 on that date.

MA021 Service encounter has been refused as you have already billed HSC 28.73E or 28.49A on that date.

MA022 Service encounter has been refused as you have already billed HSC 28.41/28.41A/28.42/ 28.42A or 28.44A on that date.

MA023 Service encounter has been refused as you have previously billed another major surgery for this patient on the same day.

MA024 Service encounter has been refused as HSC 77.19C, 57.59A, or 80.4C has been billed at this encounter.

MA025 Service encounter has been refused as HSC 66.83 has been billed at this same encounter.

MJ040 Service encounter has been refused as a 01.34A has previously been billed for this patient on this day.

**UPDATED FILES – AVAILABILITY**

Updated files reflecting changes are available for download on Friday, December 7, 2012. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanation code (EXPLAIN.DAT).

**CAREER OPPORTUNITY**

| | |
|---|---|
| Job Title: | Medical Consultant |
| Internal/External: | Internal/External |
| Department: | MSI Monitoring |
| Competition: | 2012-668 |
| Employment Type: | Part Time - Contract Position |
| Location(s): | Dartmouth, Nova Scotia |
| Reports to: | Team Leader |

"To help improve the health and well-being of people and their communities."

Recognized as one of Canada's 10 Most Admired Corporate Cultures, Medavie Blue Cross understands each one of its 1,900 employees plays a key role in building a strong and successful organization. Throughout the six provinces in which we operate, we know our people make a difference in our customers' lives each day. We encourage our employees to be involved and to support activities that allow for personal and professional growth and development. As a not-for-profit organization, we also place a high priority on giving back to the communities in which we live.

If you are looking for an opportunity in a challenging, fast-paced and team-oriented work environment with a leading local organization, the career you've been looking for may be waiting for you at Medavie Blue Cross.

Role Summary:

We are currently recruiting for a Medical Consultant to join the MSI Monitoring Team. Under the supervision of the Team Leader, the incumbent will support the MSI post-payment monitoring function. The Medical Consultant will provide the medical link between the paying agency and providers. In collaboration with the MSI Monitoring Team, they also will advise key stakeholders of Medavie Blue Cross and the Department of Health and Wellness of Nova Scotia on MSI Monitoring related matters including the development of policies and procedures.

As a MSI Monitoring Medical Consultant your key responsibilities will include:

- Conduct fee for service and shadow billing audits in collaboration with the Medicare Auditors.
- Provide medical expertise and support to Pharmacare Auditors.
- Support the evaluation of select alternative funding contracts; includes interviews with providers, associations and other parties.
- Assist in the development of the annual audit plan, procedures to enhance monitoring operations, and the development of risk analysis strategies to utilize departmental resources efficiently.
- Communicate with providers, Nova Scotia residents, Department of Health and Wellness, Doctors Nova Scotia, law enforcement, other government agencies in relation to MSI audit, including Medicare and Pharmacare.
- Participate on various Department of Health and Wellness and professional committees as required.

- Resolve issues and maintain productive, professional relationships with medical provider community and Department of Health and Wellness; inform providers through bulletin articles of changing audit policies, administrative procedures and billing issues.
- Liaise with staff from other MSI departments including the provision of claims assessment support as required.
- Maintain confidentiality, respecting both patients and provider matters.

As the ideal candidate, you possess the following qualifications:

- Education: University degree with a Doctorate in Medicine.
- Work Experience: Minimum of 15 years experience as a physician in a range of practice settings. Specialist training and administrative experience would be an asset.
- Computer Skills: Computer skills in MS Office suite (Word, Excel, etc.)
- Other Qualifications: Ability to travel throughout the province of Nova Scotia.

If you are interested in working with a team of professionals in a challenging role and you possess the necessary qualifications, please email your cover letter and resume/CV directly to: Stephanie Edge, Human Resources Coordinator, Medavie Blue Cross (Stephanie.Edge@medavie.bluecross.ca).

We would like to thank all candidates for expressing interest. Please note only those selected for interviews will be contacted.

Citizenship - Useful Information

Please indicate in your application the reason you are entitled to work in Canada: Canadian citizenship, permanent resident status or work permit.

Reliability screening will be required.

Medavie Blue Cross is an equal opportunity employer.

# 2013 CUT-OFF DATES
# FOR RECEIPT OF
# PAPER & ELECTRONIC CLAIMS

| PAPER CLAIMS | ELECTRONIC CLAIMS | PAYMENT DATE |
|---|---|---|
| December 28, 2012** | January 3, 2013 | January 9, 2013 |
| January 14, 2013 | January 17, 2013 | January 23, 2013 |
| January 28, 2013 | January 31, 2013 | February 6, 2013 |
| February 11, 2013 | February 14, 2013 | February 20, 2013 |
| February 25, 2013 | February 28, 2013 | March 6, 2013 |
| March 11, 2013 | March 14, 2013 | March 20, 2013 |
| March 22, 2013** | March 27, 2013** | April 3, 2013 |
| April 8, 2013 | April 11, 2013 | April 17, 2013 |
| April 22, 2013 | April 25, 2013 | May 1, 2013 |
| May 6, 2013 | May 9, 2013 | May 15, 2013 |
| May 17, 2013** | May 23, 2013 | May 29, 2013 |
| June 3, 2013 | June 6, 2013 | June 12, 2013 |
| June 17, 2013 | June 20, 2013 | June 26, 2013 |
| June 28, 2013** | July 4, 2013 | July 10, 2013 |
| July 15, 2013 | July 18, 2013 | July 24, 2013 |
| July 26, 2013** | July 31, 2013** | August 7, 2013 |
| August 12, 2013 | August 15, 2013 | August 21, 2013 |
| August 23, 2013** | August 28, 2013** | September 4, 2013 |
| September 9, 2013 | September 12, 2013 | September 18, 2013 |
| September 23, 2013 | September 26, 2013 | October 2, 2013 |
| October 4, 2013 | October 9, 2013** | October 16, 2013 |
| October 21, 2013 | October 24, 2013 | October 30, 2013 |
| November 1, 2013** | November 6, 2013** | November 13, 2013 |
| November 18, 2013 | November 21, 2013 | November 27, 2013 |
| December 2, 2013 | December 5, 2013 | December 11, 2013 |
| December 13, 2013** | December 18, 2013** | December 24, 2013** |
| December 27, 2013** | January 2, 2014 | January 8 , 2014 |
| 11:00 AM CUT OFF | 11:59 PM CUT OFF | |

NOTE:
Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Radiology, Pathology, Internal Medicine Monthly Statistical Reports and Sessional Payments. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut off date to ensure processing for that payment period.

PLEASE NOTE, THE ** INDICATES A DATE VARIATION

# HOLIDAY DATES FOR 2013

Please make a note in your schedule of the following dates MSI will accept as "Holidays."

| | |
|---|---|
| NEW YEAR'S DAY | TUESDAY, JANUARY 1, 2013 |
| GOOD FRIDAY | FRIDAY, MARCH 29, 2013 |
| EASTER MONDAY | MONDAY, APRIL 1, 2013 |
| VICTORIA DAY | MONDAY, MAY 20, 2013 |
| CANADA DAY | MONDAY, JULY 1, 2013 |
| CIVIC HOLIDAY | *IF APPLICABLE* |
| LABOUR DAY | MONDAY, SEPTEMBER 2, 2013 |
| THANKSGIVING DAY | MONDAY, OCTOBER 14, 2013 |
| REMEMBRANCE DAY | MONDAY, NOVEMBER 11, 2013 |
| CHRISTMAS DAY | WEDNESDAY, DECEMBER 25, 2013 |
| BOXING DAY | THURSDAY, DECEMBER 26, 2013 |
| NEW YEAR'S DAY | WEDNESDAY, JANUARY 1, 2014 |

MSI Assessment Department (902) 496-7011
Fax Number (902) 490-2275
Toll Free Number 1-866-553-0585

# PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

August 31, 2012 Volume XLVIII - #3


Inside this issue



**CONTACT US:**

**MSI_Assessment@medavie.bluecross.ca**

**On-line documentation available at:**

**www.gov.ns.ca/health/physicians_bulletin**

## NEW FEES

Effective April 1, 2012 the following new health service codes are available for billing:

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| MASG | 17.5B | RP=REPT<br>RG=LEFT<br>RG=RIGT<br>RG=BOTH | **Repeat Ulnar Nerve Release at the elbow (cubital tunnel)**<br><br>This is a composite fee for the surgical release of the ulnar nerve at the elbow for relief of ulnar nerve entrapment syndrome by any or all means, specifically; simple release, subcutaneous release, or primary submuscular release. Includes neuroplasty, exploration and transposition with or without neurolysis.<br><br>Billing Guidelines:<br>Not to be billed with:<br>• HSC 17.05D Explore peripheral nerve transplant or transposition with/without neurolysis, or<br>• HSC 17.5A Exploration of peripheral nerve transplant or nerve transposition with or without neurolysis.<br><br>Specialty Restrictions:<br>• PLAS<br>• ORTH<br>• GNSG<br>• NUSG | 200 4+T |

| Category | Code | Description | Unit Value |
|---|---|---|---|
| ADON | 46.04L | **Intraoperative Placement of Interpleural Catheter for Paravertebral Block**<br><br>The placement of an interpleural catheter under direct vision for the purpose of initiating and maintaining a paravertebral block for postoperative pain relief when the placement of the catheter necessitates surgical entry into a separate body cavity from the one in which the primary procedure was performed.<br><br>Billable with flank incisions only (see list under Billing Guidelines).<br><br>Billing Guidelines:<br>May be billed with the following MASG procedures that require a flank incision:<br><br>• 52.4A Retro-peritoneal lymph node dissection<br>• 67.3 Partial nephrectomy (regions required)<br>• 67.41E Radical nephrectomy lumbar of thoraco-abdominal (regions required)<br>• 67.79A Pyeloureteroplasty (regions required)<br><br>Specialty Restrictions:<br>• UROL<br><br>Not to be billed with:<br>• PMNO 16.91M – Acute pain management (non-obstetrical) consultation unrelated to delivery of anaesthesia, insertion of epidural/spinal catheter and care day 1<br>• PMNO 46.04G – Acute pain management (non-obstetrical) consultation unrelated to delivery of anaesthesia, insertion of CPNB (Continuous peripheral nerve block) catheter and care on day 1<br>• PMNO 46.04I – Acute pain management (nonobstetrical) insertion of CPNB catheter in conjunction with anaesthesia SP=ANAE<br><br>May only be billed by one physician for the same patient, same day. | 50 |

*Note: Physicians holding eligible services must submit their claims from April 1, 2012 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

**REMINDER - UNBUNDLING OF CLAIMS**

Section 9.3.3 (a) of the Preamble in the Physician's Manual does not permit the unbundling of a procedure into its constituent parts and billing for the parts individually or in combination with the procedure. For example, a laparoscopic assisted vaginal hysterectomy should be billed as 80.4B and not vaginal hysterectomy plus laparoscopy (80.4 + 66.83).

Effective July 01, 2010 MSI began an initiative to assess claims submitted where more than one procedure is claimed for the same patient on the same day.

Please be advised that as the manual assessment of these claims continues it may increase turnaround time, as well as generate a request for operative reports. Please also see the note below regarding order of claims submissions for multiple procedures.

**ORDER OF CLAIMS SUBMISSIONS - IMMUNIZATION TRAY FEES, ADD-ON PROCEDURES AND SURGICAL PROCEDURES**

For some services, the order in which the claims are submitted is important in ensuring payment. In general, the primary service should be submitted followed by any secondary claims. For example:

- When billing for an immunization please ensure that you claim the immunization first followed by the ADON tray fee. If the tray fee is billed first it will be rejected by the computer and not be paid.
- When billing multiple surgical procedures during a single encounter, bill the primary health service code first, followed by any secondary or add-on procedures.

**MULTIPLE LONG BONE FRACTURES**

This is a reminder that the new LV=LV85 modifier only applies to certain open reduction fractures. The following is a list of applicable codes:

| HSC | DESCRIPTION |
|---|---|
| 91.30A | Fractured humerus neck without dislocation of head - open reduction |
| 91.30B | Fractured humerus shaft - open reduction |
| 91.30C | Fractured humerus - epicondyle - medial - open reduction |
| 91.30D | Fractured humerus - epicondyle - lateral - open reduction |
| 91.30E | Fractured humerus tuberosity - open reduction |
| 91.30F | Fractured humerus neck with dislocation of head - open reduction |
| 91.30G | Fractured humerus - supra or transcondylar - open reduction |
| 91.31 | Open reduction of fracture with internal fixation, radius and ulna |
| 91.31A | Open reduction - fractured olecranon |
| 91.31B | Open reduction - radius - head or neck |
| 91.31C | Open reduction fractured radius or ulna - shaft |
| 91.31D | Colles' or Smith's fracture - open reduction |
| 91.31E | Monteggia's or Galleazzi's fracture - open reduction |
| 91.31G | Distal comminuted intra-articular fracture of radius (to include distal ulna) due to high energy trauma. To include open reduction, internal/external fixation as required when performed in conjunction with remote donor site bone graft. |
| 91.34A | Fracture femur neck - open reduction with internal fixation |
| 91.34B | Fractured femur - pertrochanteric - open reduction |
| 91.34C | Fractured femur - shaft or transcondylar - open reduction |
| 91.34D | Fracture femur neck - prosthetic replacement |
| 91.35A | Fracture - tibia with or without fibula - shaft - open reduction |
| 91.35B | Fractured tibial plafond, with or without fibula, open reduction and internal fixation - including removal of pre-existing internal or external fixation devices. |
| 91.35C | Fractured tibia with or without fibula - plateau - open reduction |
| 91.35D | Fractured ankle - single malleolus - open reduction |
| 91.35E | Fracture fibula - open reduction |
| 91.35F | Fractured ankle - bi or trimalleolar - open reduction |
| 91.38A | Fractured - clavicle - open reduction |
| 91.95C | External fixation of tibial plafond fracture |
| 91.95D | External fixation of tibial plafond fracture, with open reduction and internal fixation of fibular fracture. |

## REQUESTS FOR AN OPERATIVE REPORT

When a claim has been paid at zero with error code NR072 asking for an OR report, the original claim itself also has to be resubmitted with an action code of "R" for reassessment. If the OR report is received and no reassessment (R) is sent in for the original service encounter, the claim will not be paid. Please ensure that upon submitting the claim with a required OR report, that a reassessment is sent in with electronic text referencing the OR report.

## BILLING REMINDERS

### The "Meet and Greet"

Physicians are reminded that Preamble rules stipulate that all services billed to MSI must be medically necessary i.e. there must be a specific health related concern/complaint that has led the patient to seek medical attention. It is not appropriate to bill MSI for a "meet and greet" visit with a new patient unless a health related concern/complaint has been addressed at the visit. Similarly, it is not appropriate to bill a comprehensive visit or counselling for such encounters unless the visit is medically necessary and Preamble requirements for these codes have been satisfied.

### Breast MRI Code

Several years ago a patient specific health service code for breast MRI interpretation (02.76A) was introduced. Radiologists are reminded that they must use this code rather than bulk billed MRI codes when claiming for breast MRI services.

### ICU Care

Preamble section 7.9.1 defines Intensive Care Unit (ICU) services as services rendered in intensive care units (ICUs) approved by the Department of Health and Wellness by physicians who have been assigned by a hospital to the ICU staff by reason of special training or experience. Physicians billing ICU services are reminded that these codes may only be claimed in Intensive Care Units designated by the Department of Health and Wellness and not in other locations such as step-down units or emergency departments.

### Intravenous Insertion

Physicians may only claim for insertion of an intravenous when they have personally performed the service. These health service codes may not be claimed when they are carried out by another health care provider such as a nurse, nurse practitioner or X-Ray technologist as part of their usual duties. Effective September 1, 2012 text will be required explaining why the physician has claimed for the intravenous insertion.

### Phototherapy Services for Dermatologic Conditions

If a physician is claiming a visit at the time a patient attends for phototherapy for a dermatologic condition, a visit may only be claimed if Preamble requirements for a visit are met. This means that the physician must personally render the visit (Preamble section 1.4) and document history and physical findings in the clinical record (Preamble section 7.)

### Repair of Retinal Detachment

As with all procedural codes, codes for repair of a retinal detachment are composite and intended to reimburse the physician for all components of the service (see item above re unbundling of codes.) When claiming for repair of a retinal detachment, physicians may only bill for one therapeutic modality i.e. either diathermy (Health Service Codes 28.41 and 28.41A), or cryotherapy (Health Service Codes 28.42 and 28.42A), or photocoagulation (Health Service Codes 28.44A, 28.44B and 28.44C). It is not permitted to bill more than one of these codes for the same repair.

Trigger Point Injections

Physicians are reminded that the correct health service code when claiming for injection of trigger points is 17.72J (myoneural blockade injections). Health service codes 93.92A (injection into joint or ligament) and 95.94A (injection into soft tissue) are not to be used when carrying out trigger point injections.

## MSI DOCUMENTATION REMINDER

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribed.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptions, or emotional problems, the physician “deliberately established a professional relationship with the patient for the purposes of removing, modifying or alleviating existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development.” There should be evidence of the discussions that took place between the physician and the patient, the patient’s response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional well being of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by “long discussion,” “long talk,” “counselled,” “supportive psychotherapy,” etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service on that date, then the service is not paid for or a lesser benefit is given. **When the clinical record does not support the service claimed, there will be a recovery to MSI at the time of audit.**

Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

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

## INFLUENZA IMMUNIZATION

For the 2012-2013 Season, the influenza immunization is not restricted to certain age groups or risk categories. Please refer to the attached schedule of provincial immunizations for the diagnostic codes to be used when billing for the influenza immunization.

**REMINDERS: BILLING GUIDELINES FOR PROVINCIAL IMMUNIZATIONS**

Please see the attached Schedule of Provincial Immunizations for billing purposes.

1. If one vaccine is administered but no associated office visit is billed **(i.e. the sole purpose for the visit is the immunization), claim the immunization at a full fee of 6.0 MSUs.**

2. If two vaccines are administered at the same visit but no associated office visit is billed **(i.e. the sole purpose for the visit is the immunization), claim for each immunization at a full fee of 6.0 MSUs each.**

3. If one vaccine is administered in conjunction with a billed office visit, **claim both the office visit and the immunization at full fee.**

4. If two vaccines are administered in conjunction with a billed office visit, **the office visit and the first injection can be claimed at full fee. All subsequent injections will be paid at 50 percent.**

5. For children under 12 months of age, if a vaccine is administered in conjunction with a well baby care visit, **claim the well baby care visit and the immunization.**

**EXPLANATORY CODES**

The following new explanatory codes have been added to the system:

AD045 Service encounter has been refused as this patient has previously received a dosage of Quadracel vaccine.

AD046 Service encounter has been refused as an immunization injection must be claimed prior to the tray fee.

DE014 Service encounter has been refused as invalid or omitted location.

GN053 Service encounter has been refused as it is not appropriate to claim diagnostic code V650, V651, V681, V709, OR V729 for this service.

GN054 Service encounter has been refused as the diagnostic code submitted is not valid for patients over 18 months of age.

VT095 Service encounter has been refused as an initial hospital visit has already been claimed for this patient on the same admission date.

**UPDATED FILES – AVAILABILITY**

Updated files reflecting changes are available for download on Friday, August 31st, 2012. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanation code (EXPLAIN.DAT).

## SCHEDULE OF PROVINCIAL IMMUNIZATIONS

Refer to the following fee schedule when claiming for individual immunization(s) not billed in conjunction with an office visit or a single immunization billed in conjunction with an office visit:

| IMMUNIZATION | HEALTH SERVICE CODE | MODIFIER | MSUs | DIAGNOSTIC CODE |
|---|---|---|---|---|
| PENTA (DaPTP, Hib) | 13.59L | RO=PENT | 6.0 | V069 |
| MMR | 13.59L | RO=MMAR | 6.0 | V069 |
| Adacel-Polio (Tdap-IPV) | 13.59L | RO=ADPO | 6.0 | V069 |
| Td | 13.59L | RO=TEDI | 6.0 | V069 |
| Influenza - Pregnant | 13.59L | RO=INFL | 6.0 | V221 |
| Influenza - Males and non-pregnant females | 13.59L | RO=INFL | 6.0 | V048 |
| Varicella | 13.59L | RO=VARI | 6.0 | V069 |
| Adacel | 13.59L | RO=ADAC | 6.0 | V069 |
| Menjugate | 13.59L | RO=MENC | 6.0 | V069 |
| Pneumococcal Polysaccharide | 13.59L | RO=PNEU | 6.0 | V069 |
| Pneumococcal Polysaccharide In addition to Influenza | 13.59L | RO=PNEU | 6.0 | V066 |
| Boostrix® | 13.59L | RO=BOTR | 6.0 | V069 |
| Pneumococcal Conjugate | 13.59L | RO=PNEC | 6.0 | V069 |
| Combined MMR and Varicella | 13.59L | RO=MMRV | 6.0 | V069 |

When claiming immunization with a visit, the visit will be paid in full at 100%. The first inoculation will be in full at 6.0 MSU and all subsequent inoculations will be paid at 3.0 MSU or 50%. If the purpose of the visit is for immunization only, then the first two inoculations will be paid at 100% and all subsequent inoculations at 50% of the specified MSU.

Refer to the following table when claiming for a provincial immunization tray fee:

| HEALTH SERVICE CODE | DESCRIPTION | MSUs |
|---|---|---|
| 13.59M | Provincial Immunization Tray Fee | 1.5 per multiple (Max 4) |

Refer to the following diagnostic code table, when claiming for pneumococcal and varicella immunizations:

| **PATIENT'S CONDITION** | **DIAGNOSTIC CODE** |
|---|---|
| At risk irrespective of age | Diagnostic code applicable to condition,<br>e.g. 25000 diabetes mellitus |
| Close contact of at risk individual | V018 |
| Well Senior | V069 |

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

June 18, 2012 Volume XLVIII - #2

Inside this issue



## CONTACT US:

**MSI_Assessment@medavie.bluecross.ca**

**On-line documentation available at:**
**www.gov.ns.ca/health/physicians_bulletin**

## ANAESTHESIA MODIFIER CLARIFICATION

Clarification on the intended use of Controlled Hypotension CO=CHYO:

There have been discussions involving the intended use for this technique and it is currently under review by MSI. The use of controlled hypotension is intended for longer cases with excessive bleeding to minimize blood loss and reduce the need for transfusions provided there are no contraindications for this technique. Also it is intended for specific cases in order to optimize surgical view. Therefore MSI now requires explanatory text when claiming for controlled hypotension.

## MSI HEALTH CARD RENEWAL

The Nova Scotia Health Card is the unique patient identifier that links all systems together to ensure seamless care for all residents of Nova Scotia. It is the most important piece of health identification.
A valid health card must be submitted each and every time a patient visits their physician or accesses any provincial health care program. Please ensure that patient claims are submitted with current and accurate information.
It is the patients responsibility to ensure their health card is up to date, however should your office be presented with an expired health card please have them complete the attached renewal form. This can be faxed to MSI at (902) 481-3160. Please note these renewal forms are available online at:
**http://www.gov.ns.ca/health/msi/MSI_Health_Card_Renewal_Form_Nov05.pdf**

## NEW FEES

Effective April 1, 2012 the following new health service codes are available for billing:

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| MASG | 14.49J | | **Posterior Fossa Craniotomy**<br><br>Posterior Fossa Craniotomy for the excision of intracranial, infratentorial lesions, such as cysts, tumors or intracerebral hematoma.<br><br>Billing Guidelines:<br>May be billed with ADON 15.12B Duraplasty | 975<br>14+T |

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| MASG | 17.39B | RG=LEFT<br>RG=RIGT<br>RG=BOTH | **Neuroplasty of Major Peripheral Nerve of the Upper extremity (excluding median nerve at the carpal tunnel, and ulnar nerve at the elbow). Specifically; Guyon's Canal (ulnar nerve release at wrist), Anterior Interosseous Nerve(median nerve in forearm), Posterior Interosseous nerve (radial nerve in forearm)**<br><br>Neuroplasty or release of major upper extremity peripheral nerves to include the surgical decompression of an intact nerve from scar tissue, including neurolysis and or transposition to repair or restore the nerve. | 125 4+T |
| MASG | 17.39C | | **Neuroplasty of Major Peripheral Nerve of the Lower extremity. Specifically; Peroneal Nerve release, Tarsal Tunnel (posterior tibial nerve)**<br><br>Neuroplasty or release of major lower extremity peripheral nerves to include the surgical decompression of an intact nerve from scar tissue, including neurolysis and or transposition to repair or restore the nerve. | 125 4+T |
| MASG | 17.5B | RG=LEFT<br>RG=RIGT<br>RG=BOTH | **Ulnar Nerve Release at the elbow (cubital tunnel)**<br><br>This is a composite fee for the surgical release of the ulnar nerve at the elbow for relief of ulnar nerve entrapment syndrome by any or all means, specifically; simple release, subcutaneous release, or primary submuscular release. Includes neuroplasty, exploration and transposition with or without neurolysis.<br><br><u>Billing Guidelines:</u><br>Not to be billed with:<br>• HSC 17.05D Explore peripheral nerve transplant or transposition with/without neurolysis, or<br>• HSC 17.5A Exploration of peripheral nerve transplant or nerve transposition with or without neurolysis. | 125 4+T |
| ADON | 13.59L | RO=ADPO | Injection for Adacel-Polio (Tdap-IPV)<br><br>**NOTE: Effective June 22, 2012 the 13.59L with RO=QUAD will no longer be used. After this date please use the new modifier of RO=ADPO when giving either the Quadracel or Adacel-Polio vaccines.** | 6 |

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| VADT | 03.26C | | **Female Pelvic Examination with Speculum**<br><br>For the performance of a comprehensive pelvic examination in either a ***symptomatic***, female patient or screening for sexually transmitted infections. The following elements are to be documented in the health record:<br>1. Visual inspection of the vulva and perineum<br>2. Insertion of the speculum into the vagina to inspect the vault and cervix<br>3. Bimanual examination of the pelvis<br>4. Conduction of a pelvi-rectal examination where indicated.<br><br>Billing Guidelines:<br>• Not billable with Pap smear VADT 03.26A, or ADON 03.26B | 10.5 |
| VIST | 03.03E | AG=ADUT | **03.03 Adults with Developmental Disabilities Visit** | 19.5 |
| | 03.04C | AG=ADUT | **03.04 Adults with Developmental Disabilities Complete Examination**<br><br>This fee is to apply to the care of adults with developmental disabilities by family physicians in the office, hospital, at home, or in residential care facilities.<br><br>Billing Guidelines:<br>***For the following ICD diagnostic codes only*:**<br>• 29900 Autism<br>• 29980 Retts Disorder, Pervasive Developmental Disorder, Asperger's Disorder<br>• 3155 Mixed Developmental Disorder<br>• 3430 Cerebral Palsy(paraplegic, congenital)<br>• 3431 Cerebral Palsy (hemiplegic, congenital)<br>• 7580 Chromosomal Abnormalities<br>• 7580 Down's Syndrome<br>• 7583 Cri du Chat syndrome<br>• 7583 Velo-cardiofacial syndrome<br>• 7595 Tuberous sclerosis<br>• 75989 Noonan Syndrome<br>• 75981 Prader Willi<br>• 75983 Fragile X<br>• 75989 Angelman's Syndrome<br>• 76071 Fetal Alcohol Syndrome | 36 |

To Include those not specifically coded:
Under 758:

- Williams Syndrome
- Deletion 22q11.2
- Smith-Magenis Syndrome(17p deletion)
- Charge (Hall Hittner) Syndrome

Under 3155:
May include conditions that are frequently but not always associated with developmental or cognitive disability, such as:

- Cerebral Palsy, Neurofibromatosis
- Deletion 22q11.2
- Chronic Brain injury (traumatic or hypoxic).

In these cases the physician may be expected to record the ICD code, if one is available, and add "with Developmental Disability" or "with DD".

Not to be billed with:
VIST 03.03 Supportive Care

*Note: Physicians holding eligible services must submit their claims from April, 2012 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

**FEE REVISIONS**

Effective October 1, 2011 the following fee revision is now in effect:

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| VEDT | 16.91R | AN=LABR | Continuous Conduction Anaesthesia for relief of pain in labour<br><br>Provision of neuraxial anaesthesia for relief of pain in labour and delivery.<br>To include the entire epidural insertion, all top-ups, maintenance, normal vaginal delivery and removal of epidural catheter.<br><br>To be billed only by the physician who initiates the epidural. Once per patient per labour. | 166 MSU effective Oct 1, 2011 |

*NOTE: Claims for these codes with a service date from October 1, 2011 to June 21, 2012 will be identified and a reconcilliation will occur in the fall of 2012. The reconciliation will be calculated after the 90 day waiting period for submission of claims.*

## DISCOUNTINUED HEALTH SERVICE CODES

Effective June 22, 2012 the following health service code will no longer be active:

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| ADON | 13.59L | RO=QUAD | Injection for diphtheria, pertussis and poliomyelitis | 6 |

Please note that this has been replaced by health service code 13.59L RO=ADPO

## BILLING FOR SERVICES PROVIDED BY OTHER HEALTH CARE PROVIDERS

Preamble Rule 5.3.1 states "All insured services claimed must reflect services rendered personally by the physician in an appropriate clinical setting. The physician may claim for visits conducted partially by the nurse only if the physician has personally participated in the visit and this is reflected in the clinical note. A signature or electronic sign off of the chart is not considered sufficient documentation of direct participation in the visit.

## ELIGIBILITY CRITERIA FOR BTO ESCORTS

The Department of Health and Wellness eligibility criteria for client escorts reads:

The program covers costs for client escorts who are considered “essential”. The need for an essential escort is determined at the time of BTO registration. Categories include:

- Visually impaired/disabled (mentally or physically)
- Very frail patient who cannot be on their own or cannot transport themselves to treatments
- Patient requiring feeding tube
- Bone Marrow Transplant donor or recipient (these patients are medically required to have someone with them at all times)
- Parents of child with cancer

## EXPLANATORY CODES

The following new explanatory codes have been added to the system:

AD041 Service encounter has been refused as you have already made a claim for HSC 16.91M, 46.04G or 46.04I at the same service encounter.

AD042 Service encounter has been refused as a claim was already made for this service on the same date.

AD043 Service encounter has been refused as a claim was previously made for HSC 46.04L: Intraoperative placement of interpleural catheter for paravertebral block, for this patient on the same day.

AD044 Service encounter has been refused as you have previously billed the maximum of two claims for HSC 13.59L RO=MMRV for this patient.

MA013 Service encounter has been refused as you have already made a claim for health service code 17.05D or 17.5A at the same encounter

MA014 Service encounter has been refused as you have already made a claim for health service code 17.5B at the same encounter.

MA015 Service encounter has been refused as you have already billed a blepharoptosis code for the same eye on that date.

MA016 Service encounter has been refused as you have already billed a blepharoplasty code for the same eye on that date.

MA017 Service encounter has been refused as you have already billed a blepharoplasty or blepharoptosis code for the same eye on that date.

MA018 Service encounter has been refused as you have already billed a removal of periorbital fat code for the same eye on that date.

MA019 Service encounter has been refused. When a blepharoplasty is performed for a diagnosis of bleparochalasis or dermatochalasis, code 22.5C should be used, not a lid ptosis code.

VA042 Service encounter has been refused as you have previously claimed a pap smear or tray fee for this patient on the same day.

VA043 Service encounter has been refused as you have previously claimed a pelvic examination for this patient on the same day.

VA044 Service encounter has been refused as you cannot claim a tray fee with a pelvic examination (HSC 03.26C).

VT092 Service encounter has been refused as 03.03 supportive care has been claimed this day.

VT093 Service encounter has been refused as 03.03E or 03.04C has been claimed this day.

VT094 Service encounter has been refused as you have not used a qualifying diagnostic code.

**UPDATED FILES – AVAILABILITY**

Updated files reflecting changes are available for download on Friday, June 22nd, 2012. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), modifier values (MODVALS.DAT) and explanation code (EXPLAIN.DAT).

## SCHEDULE OF PROVINCIAL IMMUNIZATIONS

Refer to the following fee schedule when claiming for individual immunization(s) not billed in conjunction with an office visit or a single immunization billed in conjunction with an office visit:

| IMMUNIZATION | HEALTH SERVICE CODE | MODIFIER | MSUs | DIAGNOSTIC CODE |
|---|---|---|---|---|
| PENTA (DaPTP, Hib) | 13.59L | RO=PENT | 6.0 | V069 |
| MMR | 13.59L | RO=MMAR | 6.0 | V069 |
| Adacel-Polio (Tdap-IPV) | 13.59L | RO=ADPO | 6.0 | V069 |
| Td | 13.59L | RO=TEDI | 6.0 | V069 |
| Influenza - Pregnant | 13.59L | RO=INFL | 6.0 | V221 |
| Influenza - Males and non-pregnant females | 13.59L | RO=INFL | 6.0 | V048 |
| Varicella | 13.59L | RO=VARI | 6.0 | V069 |
| Adacel | 13.59L | RO=ADAC | 6.0 | V069 |
| Menjugate | 13.59L | RO=MENC | 6.0 | V069 |
| Pneumococcal Polysaccharide | 13.59L | RO=PNEU | 6.0 | V069 |
| Pneumococcal Polysaccharide In addition to Influenza | 13.59L | RO=PNEU | 6.0 | V066 |
| Boostrix® | 13.59L | RO=BOTR | 6.0 | V069 |
| Pneumococcal Conjugate | 13.59L | RO=PNEC | 6.0 | V069 |
| Combined MMR and Varicella | 13.59L | RO=MMRV | 6.0 | V069 |

When claiming immunization with a visit, the visit will be paid in full at 100%. The first inoculation will be in full at 6.0 MSU and all subsequent inoculations will be paid at 3.0 MSU or 50%. If the purpose of the visit is for immunization only, then the first two inoculations will be paid at 100% and all subsequent inoculations at 50% of the specified MSU.

Refer to the following table when claiming for a provincial immunization tray fee:

| HEALTH SERVICE CODE | DESCRIPTION | MSUs |
|---|---|---|
| 13.59M | Provincial Immunization Tray Fee | 1.5 per multiple (Max 4) |

Refer to the following diagnostic code table, when claiming for pneumococcal and varicella immunizations:

| **PATIENT'S CONDITION** | **DIAGNOSTIC CODE** |
|---|---|
| At risk irrespective of age | Diagnostic code applicable to condition,<br>e.g. 25000 diabetes mellitus |
| Close contact of at risk individual | V018 |
| Well Senior | V069 |

# HEALTH CARD RENEWAL

**FULL NAME:** _____ **HEALTH CARD #:** _____
{Given Name(s) & Surname}

**MAILING ADDRESS (**including Postal Code**):**

Street/PO Box/RR# _____ **GENDER (**M/F**):** _____

City/Town/Village/Postal Code_____ **DATE OF BIRTH:**_____
**(**Day/Month/Year**)**

**HOME ADDRESS (** if different from above**):**

Street/Apt#_____ **HOME PHONE #**_____

Community Name _____ **WORK PHONE #** _____

**PLEASE NOTE: IF THE BIRTHDATE ON YOUR HEALTH CARD IS WRONG, YOU MUST PROVIDE A COPY OF YOUR BIRTH CERTIFICATE.** ALSO**,** IF YOUR ADDRESS HAS CHANGED, PLEASE SPECIFY IF IT **IS NOT** A COMPLETE FAMILY MOVE.

**I CERTIFY THAT I AM A PERMANENT RESIDENT OF NOVA SCOTIA.** (A PERMANENT RESIDENT IS A PERSON WHO MAKES HIS/HER HOME AND IS ORDINARILY PRESENT IN NOVA SCOTIA.)
**I AUTHORIZE ANY HEALTH SERVICE PROVIDER PAID BY MEDICAL SERVICES INSURANCE (MSI) TO RELEASE ANY INFORMATION REQUESTED BY MSI FOR CLAIMS PAYMENT AND AUDIT.**

_____

**SIGNATURE** (A Parent/Guardian must sign for dependants under the age of 16) **DATE**

**YOUR ORGAN AND/OR TISSUE DONOR DECISION MUST ALSO BE RENEWED.**

## ORGAN and TISSUE DONATION – GIVING LIFE

You now have the opportunity to offer someone a second chance at life by becoming an organ and/or tissue donor.
Please consider this option and if you are interested**, complete and sign the form below.**
Identification as a Donor will appear on your new Health Card (and must be reconfirmed during the renewal process).
The information below will be stored in a computerized donor registry.
For donor program information, please call: (902) 473-5523 or toll-free 1-877-841-3929.

**Please specify which organ(s) and/or tissue(s) you wish to donate:**

☐ **ALL** organ(s) and tissue(s) needed for transplant, **OR** ☐ **ONLY** the following organ(s) and/or tissue(s) needed for transplant

**ORGANS**: □ Lungs □ Heart □ Liver □ Kidneys □ Pancreas □ Small Bowel
**TISSUES:** □ Skin □ Vein □ Corneas (eyes) □ Bone & Related Structures □ Heart Valves/Pericardium

**Your signature is required for organ and/or tissue donation. A parent/guardian must sign for dependants under the age of 16. Consent to organ and/or tissue donation is voluntary and is not required for Health Card eligibility.**

DATE:: _____ Signature: _____

For Health Card information, call MSI at: (902) 496-7008 – or toll-free (in NS) at: 1-800-563-8880.

**PLEASE FAX TO MSI REGISTRATION AND ENQUIRY AT (902) 481-3160**
NOVA SCOTIA MSI, PO BOX 500, HALIFAX, NS B3J 2S1
PHONE (902) 496-7008 (1-800-563-8880)

(RE-013) June 2012

# PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

March 26, 2012 Volume XLVIII - #1


Inside this issue



**CONTACT US:**

**MSI_Assessment@medavie.bluecross.ca**

**On-line documentation available at:**

**www.gov.ns.ca/health/physicians_bulletin**

## MEDICAL SERVICE UNIT/ANAESTHESIA UNIT CHANGE

Effective April 1, 2012, the Medical Service Unit (MSU) value will be increased from $2.30 to $2.32 and the Anaesthesia Unit (AU) value will be increased from $19.55 to $19.75.

## WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC

Effective April 1, 2012 the Workers' Compensation Board MSU Value will increase from $2.56 to $2.58 and the Workers' Compensation Board Anaesthetic Unit Value will increase from $18.30 to $21.94

## PSYCHIATRY FEES

Effective April 1, 2012 the hourly Psychiatry rate for General Practitioners will increase to $106.26 while the hourly rate for Specialists increases to $144.08 as per the tariff agreement.

## REGIONAL EMERGENCY DEPARTMENTS HOURLY RATE

Effective April 1, 2012 the hourly rate for Regional Emergency Departments will increase to $192.00.

## NEW FEES

The following fees have been approved by the Master Agreement Steering Group (MASG) for inclusion into the Fee Schedule, effective October 1, 2011.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 93.96A | **Cervical Total Disc Arthroplasty (artificial disc)**<br><br>Total disc Arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteotomy for | 750 8+T |

nerve root or spinal cord decompression and microdissection), single interspace, cervical.

For the surgical treatment of cervical myelopathy and myeloradiculopathy in patients with an otherwise biomechanically normal spine amenable to the anterior approach.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 16.09J | **Cervical Laminoplasty**<br><br>2 Level cervical Laminoplasty to include osteotomies, and insertion of hardware for fixation of lamina, with duraplasty and lysis of adhesions as required.<br><br>For the treatment of cervical myelopathy and myeloradiculopathy<br>Not to be billed with laminectomy codes:<br>16.09A through D<br>16.1A and B<br>16.2A and B<br>16.3A through C<br>16.49A<br>16.5A and B<br>16.93D | 500 8+T |
| MASG | 90.40B | **Repair of Sternal Non-union**<br><br>Repair of Sternal non-union/dehiscence – open reduction and internal fixation using plates and screws, to include harvest and placement of bone graft as required. Includes removal of existing hardware (wire), debridement and irrigation of the wound, and tissue shifts required for skin closure. At least one week post cardiac surgery.<br><br>Not to be billed with:<br>90.4A Reclosure of sternal wound….150<br>98.79A Reclosure of sternal wound….150 (regions required)<br>90.69B Removal of internal fixation-metal plate, band, screw or nail….71 (regions required)<br>89.3A Sternal Split 200 MSU<br><br>Not to be billed with BOGR codes.<br>For example:<br>BOGR 90.00A Bone graft – clavicle….175<br>BOGR 90.04A Bone graft – femur – neck or shaft….175 | 750 20+T |

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 57.59A | **Laparoscopic Assisted Colectomy; right, left, or segmental**<br><br>Laparoscopic resection of the appropriate segment of colon. Includes mobilization of colon, identification of the ureter, dissection of mesocolic vessels, division of colon, delivery of colon through the extraction site, with intra- or extra-corporeal anastomosis of bowel, and closure of the extraction site. This is intended to be a comprehensive fee for the entire procedure.<br>Not to be billed with HSC 66.19 Other Laparotomy, or HSC 66.83 Laparoscopy.<br><br>RG=ASCE – Ascending<br>RG=DESC – Descending<br>RG=DTSE – Other Segments | 350 8+T |
| MASG | 60.52B | **Laparoscopic Assisted Anterior Resection**<br><br>Laparoscopic resection of the appropriate segment of colon with coloproctostomy (low pelvic anastomosis). Includes mobilization of colon, identification of the ureter, dissection of mesocolic vessels, division of colon, delivery of colon through the extraction site, with intra- or extra-corporeal anastomosis of bowel (including EEA stapling), to include all stapling, and closure of the extraction site.<br><br>This is intended to be a comprehensive fee for the entire procedure.<br>Not to be billed with HSC 66.19 Other Laparotomy, HSC 66.83 Laparoscopy, or HSC 60.52A Lower anterior Resection where EEA stapler is used. | 420 8+T |
| MASG | 80.4C | **Laparoscopic Hysterectomy –Total, Subtotal, or Laparoscopically assisted**<br><br>Removal of the uterus and cervix using the laparoscopic approach with delivery of the uterus through the vagina or through an abdominal port using morcellation, bivalving, or coring as required. The uterine body (corpus) must be laparoscopically detached from at least the upper surrounding supportive and vascular structures in order to bill for this procedure.<br><br>This is intended to be a comprehensive fee for the entire procedure. This fee is not to be billed when laparoscopy is performed as a diagnostic procedure at the time of surgery. | 300 6+T |

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 94.13C | **Complex Palmar Fasciectomy for Dupuytren's Disease**<br><br>To be used for open, complex fasciectomy for excision of Dupuytren's disease involving the palmar fascia.<br>To include local tissue shifts, Z plasty, harvesting and placement of skin graft as required for wound closure.<br><br>Not to be billed with 98.51C, 98.51D Local Tissue shifts – Z plasty and flaps, skin grafts.<br><br>**Clinical example:**<br>Complex palmar disease, with or without MCP joint involvement limiting extension (grade 2) or web space involvement | 180 4+T |
| ADON | 94.13D | **Release of each additional digit including proximal interphalangeal joint release (Add on to Complex Palmar Fasciectomy)**<br><br>An add on code to complex palmar fasciectomy to be used for release of each additional digit to a maximum of four.<br>Involvement of digit must include the PIP joint.<br>To include any necessary joint or tendon releases; local tissue shifts, Z plasty, harvesting and placement of skin graft as required for wound closure.<br><br>Not to be billed with:<br>98.51C, 98.51D Local Tissue shifts – Z plasty and flaps,<br>95.01 incision of tendon sheath,<br>92.63A Excision (capsulectomy, synovectomy, debridement) of metacarpophalangeal joint.<br>93.79B, C, or E Arthroplasty or reconstruction of interphalangeal and/or metacarpophalangeal joint(s).<br><br>**Clinical example:**<br>Complex palmar disease, with involvement of multiple digits (grade 3) to the level of the PIP joint or beyond | 70 |

| Category | Code | Description | Unit Value |
|---|---|---|---|
| ADON (Interim fee) | 02.25A | **Unilateral Breast Tomosynthesis**<br><br>Tomosynthesis of one breast for diagnostic purposes. | 5 |

| | | | |
|---|---|---|---|
| | | Patient specific add on to R485 Mammo "Mammography unilateral", or R490 Mammo "Mammography Diagnostic Bilateral" when breast tomosynthesis is performed, on one breast, in addition to full field digital mammography for diagnostic, not screening, purposes.<br><br>*This is a two year term fee and will require reassessment at the end of the term date. | |
| ADON (Interim fee) | 02.25B | **Bilateral Breast Tomosynthesis**<br><br>Tomosynthesis of both breasts for diagnostic purposes<br><br>Patient specific add on to R490 Mammo "Mammography Diagnostic Bilateral" when breast tomosynthesis is performed, on one breast, in addition to full field digital mammography for diagnostic, not screening, purposes.<br><br>*This is a two year term fee and will require reassessment at the end of the term date. | 10 |

*NOTE: Physicians holding eligible services must submit their claims from October 1, 2011 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

The following fee has been approved for inclusion into the Fee Schedule, effective April 1, 2012:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VADT | 13.59L<br>RO=MMRV | Combined MMR and Varicella vaccine | 6 |

**INTERIM FEES**

The following interim fees have been established for inclusion into the Fee Schedule, effective January 1, 2012.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VADT | 09.13A | Real time (eye) ultrasound | 38.70 |
| VADT | 09.13B | Axial length measurement by ultrasound | 25.44 |

*NOTE: Physicians holding eligible services must submit their claims from January 1, 2012 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

**UPCOMING FEES**

The follwing fees have been approved by the Master Agreement Steering Group (MASG) for inclusion into the Fee Schedule, effective April 1, 2012

| Category | Description | Unit Value |
|---|---|---|
| VIST | **03.03 Adults with Developmental Disabilities Visit** | 19.5 |
| | **03.04 Adults with Developmental Disabilities Complete Examination** | 36 |

This fee is to apply to the care of adults with developmental disabilities by family physicians in the office, hospital, at home, or in residential care facilities.

Billing Guidelines
*For the following ICD diagnostic codes only*:
299.00 Autism
299.80 Retts Disorder, Pervasive Developmental Disorder, Aspberger's Disorder
315.5 Mixed Developmental Disorder
343.0 Cerebral Palsy(paraplegic, congenital)
343.1 Cerebral Palsy (hemiplegic, congenital)
758 Chromosomal Abnormalities
758.0 Down's Syndrome
758.31 Cri du Chat syndrome
758.32 Velo-cardiofacial syndrome
759.5 Tuberous sclerosis
759.89 Noonan Syndrome
759.81 Prader Willi
759.83 Fragile X
759.89 Angelman's Syndrome
760.71 Fetal Alcohol Syndrome
To Include those not specifically coded:
Under 758:
William's Syndrome, Deletion 22q11.2, Smith-Magenis Syndrome(17p deletion), Charge (Hall Hittner) Syndrome
Under 315.5:

> May include conditions that are frequently but not always associated with developmental or cognitive disability, such as Cerebral Palsy, Neurofibromatosis, Deletion 22q11.2 or Chronic Brain injury (traumatic or hypoxic). In these cases the physician may be expected to record the ICD code, if one is available, and add "with Developmental Disability" or "with DD".

Not to be billed with:
VIST 03.03 Supportive Care

| Category | Description | Unit Value |
|---|---|---|
| VADT | **Female Pelvic Examination with Speculum**<br><br>For the performance of a comprehensive pelvic examination in either a ***symptomatic***, female patient or screening for sexually transmitted infections. The following elements are to be documented in the health record:<br>1. Visual inspection of the vulva and perineum<br>2. Insertion of the speculum into the vagina to inspect the vault and cervix<br>3. Bimanual examination of the pelvis<br>4. Conduction of a pelvi-rectal examination where indicated.<br><br>Billing Guidelines<br>Not billable with Pap smear VADT 03.26A, or ADON 03.26B | 10.5 |
| ADON | **Intraoperative Placement of Interpleural Catheter for Paravertebral Block**<br><br>The placement of an interpleural catheter under direct vision for the purpose of initiating and maintaining a paravertebral block for postoperative pain relief when the placement of the catheter necessitates surgical entry into a separate body cavity from the one in which the primary procedure was performed.<br><br>Billable with flank incisions only (see list under Billing Guidelines).<br><br>Billing Guidelines<br>May be billed with the following MASG procedures that require a flank incision:<br><br>52.4A Retro-peritoneal lymph node dissection<br><br>67.3 Partial nephrectomy (regions required)<br><br>67.41E Radical nephrectomy lumbar of thoraco-abdominal (regions required)<br><br>67.41G Nephro-ureterectomy with resection of ureterovesical junction (regions required)<br><br>67.79A Pyeloureteroplasty (regions required)<br><br><u>Not to be billed with:</u><br><br>PMNO 16.91M – Acute pain management (non-obstetrical) consultation unrelated to delivery of | 50 |

anaesthesia, insertion of epidural/spinal catheter and care day 1

PMNO 46.04G – Acute pain management (non-obstetrical) consultation unrelated to delivery of anaesthesia, insertion of CPNB (Continuous peripheral nerve block) catheter and care on day 1

PMNO 46.04I – Acute pain management (non-obstetrical) insertion of CPNB catheter in conjunction with anaesthesia SP=ANAE

May only be billed by one physician for the same patient, same day.

| Category | Description | Unit Value |
|---|---|---|
| MASG | **Neuroplasty of Major Peripheral Nerve of the Upper extremity (excluding median nerve at the carpal tunnel, and ulnar nerve at the elbow). Specifically; Guyon's Canal (ulnar nerve release at wrist), Anterior Interosseous Nerve(median nerve in forearm), Posterior Interosseous nerve (radial nerve in forearm wrist)**<br><br>Neuroplasty or release of major upper extremity peripheral nerves to include the surgical decompression of an intact nerve from scar tissue, including neurolysis and or transposition to repair or restore the nerve. | 125 4+T |
| MASG | **Neuroplasty of Major Peripheral Nerve of the Lower extremity. Specifically; Peroneal Nerve release, Tarsal Tunnel (posterior tibial nerve)**<br><br>Neuroplasty or release of major lower extremity peripheral nerves to include the surgical decompression of an intact nerve from scar tissue, including neurolysis and or transposition to repair or restore the nerve. | 125 4+T |
| MASG | **Posterior Fossa Craniotomy**<br><br>Posterior Fossa Craniotomy for the excision of intracranial, infratentorial lesions, such as cysts, tumors or intracerebral hematoma.<br><br>Billing Guidelines:<br>May be billed with ADON 15.12B Duraplasty | 975 14+T |

| Category | Description | Unit Value |
|---|---|---|
| MASG | **Ulnar Nerve Release at the elbow (cubital tunnel)**<br><br>This is a composite fee for the surgical release of the ulnar nerve at the elbow for relief of ulnar nerve entrapment syndrome by any or all means, specifically; simple release, subcutaneous release, or primary submuscular release. Includes neuroplasty, exploration and transposition with or without neurolysis.<br><br>Billing Guidelines:<br>Not to be billed with:<br><br>HSC 17.05D Explore peripheral nerve transplant or transposition with/without neurolysis, or<br><br>HSC 17.5A Exploration of peripheral nerve transplant or nerve transposition with or without neurolysis. | 125 4+T |
| MASG<br>RP=REPT | **Repeat Ulnar Nerve Release at the elbow (cubital tunnel)**<br><br>This is a composite fee for the repeat surgical release of the ulnar nerve at the elbow for relief of recurrent ulnar nerve entrapment syndrome by any or all means, specifically; simple release, subcutaneous release, or primary submuscular release. Includes neuroplasty, exploration and transposition with or without neurolysis.<br><br>**Billing Guidelines**<br>Not to be billed with:<br><br>HSC 17.05D Explore peripheral nerve transplant or transposition with/without neurolysis, or<br><br>HSC 17.5A Exploration of peripheral nerve transplant or nerve transposition with or without neurolysis. | 200 4+T |

**FEE REVISIONS**

The following fee adjustments have been approved by the Master Agreement Steering Group (MASG) for inclusion into the Fee Schedule, effective October 1, 2011.

| Category | Code | Description | Unit Value | |
|---|---|---|---|---|
| MASG | 80.2A | **Subtotal Abdominal Hysterectomy**<br><br>Abdominal approach to the removal of the uterus without the cervix.<br><br>This procedure should be reserved for difficult hysterectomies when the removal of the cervix is judged to put the patient at additional risk of surgical complications.<br>Adnexal surgery may be billed at LV50 as is the case with other routes of hysterectomy. | 240 | 6+T |
| MASG | 80.2B | **Subtotal Abdominal Hysterectomy with rectocele and/or cystocele repair**<br><br>Abdominal approach to the removal of the uterus without the cervix, with repair of rectocele and/or cystocele.<br><br>This procedure should be reserved for difficult hysterectomies when the removal of the cervix is judged to put the patient at additional risk of surgical complications.<br><br>Not to be billed with HSC 82.41 Repair of cystocele – paravaginal repair, 82.42 Repair of rectocele – paravaginal repair, 82.43 Repair of cystocele and rectocele – paravaginal repair. | 287 | 6+T |
| MASG | 80.3 | **Total Abdominal Hysterectomy**<br><br>Removal of the uterus and cervix using the abdominal approach.<br><br>This is intended to be a comprehensive fee for the entire procedure. | 240 | 6+T |
| MASG | 80.3A | **Total Abdominal Hysterectomy with rectocele and/or cystocele repair**<br><br>Abdominal approach to the removal of the uterus and cervix, with repair of rectocele and/or cystocele. | 287 | 6+T |

| | | | |
|---|---|---|---|
| | | This is intended to be a comprehensive fee for the entire procedure.<br><br>Not to be billed with HSC 82.41 Repair of cystocele – paravaginal repair, 82.42 Repair of rectocele – paravaginal repair, 82.43 Repair of cystocele and rectocele – paravaginal repair. | |
| **Category** | **Code** | **Description** | **Unit Value** |
| MASG | 80.3B | **Total Abdominal Hysterectomy with retropubic incontinence repair**<br><br>Abdominal approach to the removal of the uterus and cervix, with retropubic incontinence repair such as urethropexy.<br><br>This is intended to be a comprehensive fee for the entire procedure.<br><br>Not to be billed with HSC 71.5A Urethrovesical Suspension for Stress Incontinence. | 287 6+T |
| MASG | 80.4 | **Vaginal Hysterectomy**<br><br>Removal of the uterus and cervix using the vaginal approach.<br><br>This is intended to be a comprehensive fee for the entire procedure. | 240 6+T |
| MASG | 80.4A | **Total Vaginal Hysterectomy with rectocele and/or cystocele repair**<br><br>Vaginal approach to the removal of the uterus and cervix, with repair of rectocele and/or cystocele.<br><br>This is intended to be a comprehensive fee for the entire procedure.<br><br>Not to be billed with HSC 82.41 Repair of cystocele – paravaginal repair, 82.42 Repair of rectocele – paravaginal repair, 82.43 Repair of cystocele and rectocele – paravaginal repair | 287 6+T |
| **Category** | **Code** | **Description** | **Unit Value** |
| VEDT | 16.91R | Continuous Conduction Anaesthesia for relief of pain in labour<br><br>Provision of neuraxial anaesthesia for relief of pain in labour and delivery. | 166 MSU effective Oct 1, 2011 |

| | |
|---|---|
| | To include the entire epidural insertion, all top-ups, maintenance, normal vaginal delivery and removal of epidural catheter.<br><br>To be billed only by the physician who initiates the epidural. Once per patient per labour.<br>AN=LABR |

*NOTE: Claims for these codes with a service date from October 1, 2011 to March 29, 2012 will be identified and reconcilliation will occur in the summer of 2012. The reconciliation will be calculated after the 90 day waiting period for submission of claims.*

**DISCONTINUED HEALTH SERVICE CODES**

Effective December 31, 2011 the following Radiology Bulk Billing codes will no longer be active:

| Code | Description | Unit Value |
|---|---|---|
| R1270 | Ultrasound – Real Time (Eye) | 38.70 |
| R1271 | Ultrasound – Axial Length Measurement | 25.44 |

Please note that these have been replaced with the new patient specific Health Service codes **09.13A – Real time (eye) ultrasound** and **09.13B – Axial length measurements by ultrasound**.

Effective March 30, 2011 the following health service code will no longer be active:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 94.13A | Dupuytren's Contracture with Dissection of Palmar Fascia (Complex) | 144 4+T |

Please note that these have been replaced with the new patient specific Health Service codes **94.13C – Complex Palmar Fasciectomy for Dupuytren's Diesease**.

**PREMIUM FEES** – Reminder

Premium fees may be claimed for certain services provided on an emergency basis during designated time periods. An emergency basis is defined as services, which must be performed without delay because of the medical condition of the patient.

Premium Fees May Be Claimed For:

(a) Consultations, except where a consult is part of the composite fee
(b) Surgical procedures except those performed under local or no anaesthetic
(c) Fractures regardless of whether an anaesthetic is administered
(d) Obstetrical deliveries
(e) Newborn Resuscitation
(f) Selected Diagnostic Imaging Services
(g) Pathology Services

The designated times where premium fees may be claimed and the payment rates are:

**Time Period Time Payment Rate**
Monday to Friday 17:00 - 23:59 US=PREM (35%)
Tuesday to Saturday 00:00 - 07:59 US=PR50 (50%)
Saturday 08:00 - 16:59 US=PREM (35%)
Saturday to Monday 17:00 - 07:59 US=PR50 (50%)
Recognized Holidays 08:00 - 23:59 US=PR50 (50%)

Premium fees also apply to emergency anaesthesia for a surgical procedure (not a diagnostic or therapeutic) provided by a non-certified anaesthetist at the interruption of his or her regularly scheduled office hours.

Premium fees are paid at 35% or 50% of the appropriate service code but at not less than 18 units for patient-specific services and at not less than 9 units for non-patient-specific diagnostic imaging and pathology services paid through the hospital by special arrangement with MSI.

If a service requires use of an anaesthetic, the anaesthetic start time determines if a premium fee may be claimed.

Premium fees may not be claimed with:

(a) Detention
(b) Critical Care/Intensive Care
(c) Diagnostic and Therapeutic Procedures other than Selected Diagnostic Imaging Services
(d) Surgeons and assistants fees for liver transplants

Physicians are reminded that the above criteria must be satisfied in order for a premium to be billed. It is not appropriate to bill a premium for all services performed during premium times. If elective procedures are done during premium times or when the physician does not attend the patient for an emergency condition, premium fees may not be billed.

It is incumbent upon the physician to ensure that the clinical record reflects that the requirements for billing a premium have been satisfied.

**PREAMBLE REVISIONS**

The Master Agreement Steering Group (MASG) has approved the following preamble amendments, effective October 1, 2011.

**Time Premiums for select endoscopic procedures**
**Change to:**

9.2.1 No premium fees may be claimed for Diagnostic and Therapeutic procedures other than selected Diagnostic Imaging Services **and selected endoscopic procedures. (See Section 7.4.1)**

7.4.1 Premium Fees May Be Claimed For:
(a) Consultations, except where a consult is part of the composite fee
(b) Surgical procedures except those performed under local or no anaesthetic
(c) Fractures regardless of whether an anaesthetic is administered
(d) Obstetrical deliveries
(e) Newborn Resuscitation
(f) Selected Diagnostic Imaging Services

(g) Pathology Services
(h) Selected Endoscopic Procedures

**Endoscopic Procedures eligible for premium:**

| | | | |
|---|---|---|---|
| **Fiberoptic bronchoscopy** | | | |
| VADT 01.08A | Transbronchial lung biopsy with fiberscope | 110 | 6+T |
| **Other nonoperative bronchoscopy** | | | |
| VADT 01.09 | Other nonoperative bronchoscopy | 60 | 6+T |
| VADT 01.09A | Bronchoscopy with biopsy | 65 | 6+T |
| VADT 01.09B | Bronchoscopy - with foreign body removal | 85 | 6+T |
| **Other nonoperative esophagoscopy** | | | |
| VADT 01.12 | Other nonoperative esophagoscopy | 60 | 4+T |
| VADT 01.12A | Oesophagobronchoscopy | 85 | 6+T |
| VADT 01.12B | Oesophagoscopy with biopsy | 65 | 4+T |
| VADT 01.12C | Oesophagoscopy - with removal of foreign body | 85 | 4+T |
| **Gastroscopy** | | | |
| VADT 01.14A | Injection of ulcer through the scope for G.I. bleed or application of crazy glue into fundal region of stomach (scope included) | 120 | 4+T |
| VADT 01.14C | Esophagogastroscopy | 70 | 4+T |
| VADT 01.14D | Esophagogastroscopy with biopsy | 75 | 4+T |
| VADT 01.14E | Esophagogastroscopy-with removal of foreign body | 85 | 4+T |
| ADON 01.14F | Insertion of intragastric balloon in addition to gastroscopic | 50 | |
| ADON 01.14G | Removal of polyps in addition to the appropriate fee esophagogastroscopy - plus multiples, if applicable | 10 | |
| **Colonoscopy** | | | |
| VADT 01.22C | Colonoscopy of descending colon | 40 | 4+T |
| ADON 01.22F | Balloon dilation of colonic stricture (In addition to colonoscopy) | 30 | |
| **Endoscopic excision or destruction of lesion or tissue of esophagus** | | | |
| ADON 54.21A | Electrocautery of GI bleeding lesions - add on to endoscopic fees | 10 | |
| **Pancreatic Sphincterotomy** | | | |
| VADT 63.82A | Esophagogastroduodenoscopy - with papillotomy | 230 | 4+T |
| **Endoscopic Retrograde Cholangiography (ERC)** | | | |
| VADT 63.95A | Esophagogastroduodenoscopy - with basket extraction of stones | 173.4 | 4+T |
| VADT 63.95B | Esophagogastroduodenoscopy - with indwelling naso biliary catheter | 170 | 4+T |
| VADT 63.95C | Esophagogastroduodenoscopy - with biliary stents | 170 | 4+T |
| VADT 64.91A | Esophagogastroduodenoscopy - with cannulation of pancreatic duct | 120 | 4+T |
| ADON 64.91B | Choledochoscopy with associated procedure | 25 | |

**Post-Fracture Care**

9.4.1 Surgical Rules apply to treatment of fractures except:

(a) A fracture procedure (not dislocation) includes necessary after care up to ***14 days.*** The application and removal of casts or traction devices is included in the fee, even if removal takes place after the ***14 day*** period.

**Multiple Fractures**

9.4.12 (a) Where multiple fractures are treated by the same surgeon the greater procedure is claimed at 100% and 50% is claimed for each additional fracture.

***(b) When multiple major fractures involve different long bones (where long bones are specified as clavicle, humerus, radius, contralateral ulna, femur, tibia and contralateral fibula), occur at the same time and are managed under the same anaesthetic, the greater procedure is claimed 100% and 85% is claimed for each additional long bone fracture, unless specified otherwise. [This does not apply to fractures of the ulna when the radius on the same side is fractured or fractures of the fibula when the tibia on the same side is fractured].***

*NOTE: Physicians holding eligible services must submit their claims from October 1, 2011 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

**2011/12 GENERAL PRACTITIONER COLLABORATIVE PRACTICE INCENTIVE PROGRAM**

A new Collaborative Practice Incentive Program (CPIP) for family physicians, funded through the Master Agreement, was implemented in 2010/11. Incentive payments under this program are intended to support current collaborative practice models, that meet the program criteria, as well as to encourage other physicians to move towards new models of collaborative care. For the purpose of the CPIP, Collaborative Practice is defined as an inter-professional process of communication and decision making that enables the separate and shared knowledge and skills of different healthcare providers to synergistically influence the client/patient care provided. It occurs when healthcare providers work with people from within their own profession, with people outside of their profession and with patients/clients and their families.

The CPIP guidelines have undergone revision for 2011/12 to better reflect the overall intent of the program and to improve the application process. Major changes include:

- a reduction in the required minimum number of family physicians participating in the collaborative practice from three to two;
- reductions in the required minimum levels of annual office billings by the physician and weekly hours worked by other health care providers;
- de-linking of the eligibility of an individual physician, based on billings, from other physicians in the practice; and,
- a new requirement that physicians apply for the collaborative practice incentive as a practice group rather than as individuals (payments will still be made to individual physicians).

Physicians should also be aware that the 2011/12 CPIP guidelines have been approved by the Master Agreement Steering Group for one year only. Research is continuing on best practices on how to establish optimal collaborative care models and the funding

models to support them. As a result, this incentive program is expected to evolve and may change in the next year.

**2011/12 CPIP: Collaborative Practice Incentive Component**

Fee-for-service (FFS), alternative payment plan (APP) contract and academic funding plan (AFP) contract physicians may apply for the 2011/12 CPIP Collaborative Practice Incentive Component payment of $5,000 per eligible physician.

Eligibility Criteria:

In order to receive a CPIP incentive payment, all of the following eligibility criteria must be met:

1. The physician must have minimum total insured billings/payments of $100,000, including $25,000 of office billings, during the period from January 1, 2011 to December 31, 2011. The physician's eligibility is not dependent on the billing levels of other physicians. The minimum billing criteria are waived for physicians who have practiced in Nova Scotia for less than the 12-month billing period used to determine program eligibility for the annual payment; e.g., new graduates and physicians who have re-located to Nova Scotia from elsewhere.

2. The physician must be participating as a member of an eligible collaborative practice at the time of application for the 2011/12 Collaborative Practice Incentive Component payment.

3. The collaborative practice must consist of a minimum of two (2) family physicians and one (1) "collaborating other licensed health care provider". This includes all other legislated licensed healthcare providers except specialist physicians:
    - Licensed Practical Nurses
    - Chiropractor
    - Dentists
    - Dental Assistant
    - Dental Technicians
    - Denturists
    - Dental Hygienists
    - Dietician/Nutritionists
    - Physicians
    - Occupational Therapists
    - Optometrists
    - Dispensing Opticians
    - Pharmacists
    - Psychologists
    - Physiotherapists
    - Registered Nurses (including Nurse Practitioners)
    - Medical Laboratory Technologists
    - Medical Radiation Technologists
    - Midwives
    - Respiratory Therapists
    - Paramedics
    - Social Workers (Department of Community Services Legislation)

4. For the purpose of the CPIP, one "collaborating other licensed health care provider" is defined as working a minimum of 20 hours per week.

5. One "collaborating other licensed health care provider" position could be filled by 1-3 people in an effort to encourage flexible collaboration and respond to patient needs.

6. The required ratio of eligible GP's to "collaborating other licensed healthcare providers" is as follows (minimum of two GP's required)

| Number of eligible GPs | Required number of "collaborating other licensed healthcare providers" |
|---|---|
| 2-5 GP's | 1 |
| 6-10 GP's | 2 |
| 11-15 GP's | 3 |
| 16-20 GP's | 4 |

7. GP's must engage in **Meaningful Team Collaboration** with each other and the "collaborating other licensed healthcare provider(s)". All required characteristics must be present.

**Meaningful Team Collaboration ***

| Characteristic | Accountability Measure |
|---|---|
| Team members provide care to a common group of patients | ➢ Common patient population |
| Team members develop common goals for patient outcomes and work towards those goals | ➢ Chart verification of interaction among team members in patient care as appropriate |
| Appropriate roles and functions are assigned to each member of the team | ➢ All providers practicing to full scope of practice |
| The team possesses a mechanism for sharing information about the patient | ➢ Common patient record and/or shared EMR |
| The team possesses a mechanism to oversee the carrying out of plans and to make adjustments as necessary | ➢ Set time for formal team collaboration (i.e., case conferences, team meetings) |

*** All characteristics must be present**

8. Formal team collaboration must occur at least once per week and include the "collaborating other licensed health care provider(s)".

Not Eligible:

The following practice situations and/or activities are not eligible for the 2011/12 CPIP Collaborative Practice Incentive Component payment:

- Participation in a community on-call rotation as the primary collaborative activity.
- A physician who collaborates with other physicians and health care providers at occasional clinics (e.g., well women's clinic) but not as part of his/her core community family practice.
- A solo physician who practices with another health care provider such as a nurse.

- Co-located physicians with separate practices and separate patient populations who may occasionally cover each other's practice; e.g., when the other physician is on vacation.
- Talking to or consulting with other health care providers, such as pharmacists, who do not work as an on-going integral part of the collaborative practice team.
- Locum physicians.
- Walk-in clinics. Only comprehensive care practices that provide on-going longitudinal care to a defined patient population are eligible.
- Hospital-focused collaborative practice groups; e.g., family physicians covering in-patients. The incentive applies to community family physician office-based practices only.

Application Process, Verification and Funding:

The application and detailed information about the application process and timeline for the CPIP Collaborative Practice Incentive Component payment will be sent out to all family physicians through Doctors Nova Scotia at the end of March 2012. **Although the application will again be sent to individuals, this year physicians who are part of an eligible community-based collaborative practice must submit one completed application, listing the names of all participating family physicians, as a practice group. Applications from individual physicians will not be accepted.** All applications received will be subject to a verification process, facilitated by the Manager of the Physician Master Agreement, to ensure all the eligibility criteria have been met.

Eligible family physicians will receive a CPIP Collaborative Practice Incentive Component payment of $5,000 per physician for fiscal year 2011/12. Payments will be made to each qualifying individual physician, not to the practice. Payments are expected to be made during the first quarter of 2012/13.

**2011/12 CPIP: One–Time Education Funding to Off-Set Income Loss Component**

The One–Time Education Funding to Off-Set Income Loss Component of the CPIP continues for 2011/12. Fee-for-service (FFS) physicians, who attend the Building Better Tomorrow Together (BBTT) education sessions, can receive a flat rate payment of $1,000 per completed module as an off-set for any income loss they may incur as a result of the time required to attend the session. Payments will be made on a quarterly basis to all eligible physicians, based on the number of modules completed. The District Health Authorities will track the names of all physicians who attend sessions and provide this list to the Manager of the Physician Master Agreement for processing and payment. **APP and AFP physicians are not eligible for these payments.**

All family physicians (FFS, APP and AFP), who do not meet all eligibility criteria for the CPIP Collaborative Practice Incentive Component payment, can participate in the education modules. However, only fee-for-service physicians are eligible to receive the $1,000 income loss off-set payments.

For more information about the Collaborative Practice Incentive Program, contact:

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**EXPLANATORY CODES**

The following new explanatory codes have been added to the system:

AD040 Service encounter has been refused as you have previously billed HSC 98.51C, 98.51D, 95.01, 92.63A, 92.63B, 93.79B, 93.79C or 93.79E for this patient on the same day.

MA009 Service encounter has been refused as you have already made a claim for health service code 90.4A, 98.79A, 90.69B, 89.3A or a BOGR category code at the same encounter.

MA010 Service encounter has been refused as you have already made a claim for health service code 90.40B at the same encounter.

MF005 Service encounter has been reduced. When multiple procedures for fractures involving different long bones are performed at the same time, only one is approved at 100%.

MJ030 Service encounter has been refused as you have previously billed HSC 82.41, 82.42 or 82.43 for this patient on the same day.

MJ031 Service encounter has been refused as you have previously billed HSC 80.2B, 80.3A or 80.4A for this patient on the same day.

MJ032 Service encounter has been refused as you have previously billed HSC 71.5A for this patient on the same day.

MJ033 Service encounter has been refused as you have previously billed HSC 80.3B for this patient on the same day.

MJ034 Service encounter has been refused as you have previously billed a local tissue shift (HSC 98.51C or 98.51D) for this patient on the same day.

MJ035 Service encounter has been refused as you have previously billed a complex palmar fasciectomy (HSC 94.13C) for this patient on the same day.

MJ036 Service encounter has been refused as you have previously billed HSC 66.19 or 66.83 for this patient on the same day.

MJ037 Service encounter has been refused as you have previously billed HSC 57.59A or 60.52B for this patient on the same day.

MJ038 Service encounter has been refused as you cannot bill a 60.52A and a 60.52B for this patient on the same day.

MJ039 Service encounter has been refused as you have previously billed health service code 94.13D.

**WCB EXPLANATORY CODES**

WBPUJ Not in WCB NS Jurisdiction

WBPUF Firm / Employer not registered with WCB

WBPUH No WCB claim with that health card number

WBPUI WCB claim inactive / closed

WBPUM WCB claim disallowed

WBPUW Not work related / no action

**UPDATED FILES – AVAILABILITY**

Updated files reflecting changes are available for download on Friday, March 30th, 2012. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), modifier values (MODVALS.DAT) and explanation code (EXPLAIN.DAT).

**ANNOUNCEMENT**

We are pleased to announce that Dr. Allen Bishop has joined the MSI Assessment Team at Medavie Blue Cross as the new Medical Consultant effective January 30, 2012. If you have any MSI Assessment related questions, please contact Dr. Bishop at 902-496-7145.

# Immunization Update

## Recently Asked Questions are Answered

1. ***What vaccines are being given by Public Health in the schools?***
   The following vaccines are being given to Grade 7 students this year:
   - Hepatitis B
   - Meningococcal C Conjugate
   - Tetanus, Diphtheria and Acellular Pertussis (Tdap)
   - Human Papillomavirus (HPV) – for girls only

   It is expected that these Grade 7 vaccines will be given by Public Health Nurses at the school clinics. Exceptions for giving these vaccines in a physician's office will be made only under special circumstances.

2. ***My daughter started school in September. When should she receive her immunizations due at 4 to 6 years of age?***
   It is recommended that children this age receive their final childhood immunizations (MMR, Tdap) prior to starting grade primary to provide full protection to the child as they enter the school system.

3. ***Will multiple injections overwhelm my baby's immune system?***
   Because of progressive vaccine science, we are giving fewer antigens now than we did 20 years ago. Today at the two month visit there are a total of 34 antigens. In 1980 the DPTP vaccine alone had 3017 antigens. It is recommended to give all vaccines the baby is eligible for at every visit. This means fewer office visits and fewer periods of discomfort. It increases the probability that children will be fully immunized and protected at the appropriate age.

4. ***Do I give Pneumococcal vaccine with the flu vaccine?***
   Pneumococcal vaccine should be given to all people 65 years and older, residents in long term care facilities, and people with some chronic diseases. It is not a seasonal vaccine – some physicians give it to their patients when they turn 65 to ensure that they get it. A booster dose is not recommended for those who have been vaccinated with polysaccharide vaccine. However a booster dose should be considered for those of any age at highest risk of invasive infection (see Canadian Immunization Guide – page 273).

5. ***Do I need to submit reciprocal forms to Public Health?***
   Reciprocal forms are to be completed and returned to Public Health for all publicly funded vaccines (except influenza) provided to all vaccine providers including physicians (influenza stats are collected through the MSI system). If you use the Nightingale System, you can print the patient's immunization report from their visit and submit that report to Public Health instead of a reciprocal. Information required includes: patient name / address / MSI number, date vaccine given, vaccine name, lot number, site and route of administration, and vaccine provider's name. All immunization data is entered in the Public Health electronic data base to monitor immunization rates, to provide immunization information to individuals as requested and to track vaccine lot numbers in case of recalls.

6. ***When do I complete an "Adverse Event Following Immunization" form?***
   All moderate to severe adverse events following immunization must be reported to Public Health by next business day (see "It's the Law" poster). All adverse events are investigated by Public Health and recommendations made. You will receive a response from Public Health for all AEFI forms submitted.

7. ***Is Rotavirus vaccine now available?***
   The two dose oral vaccine is available in Capital Health only until November 2012 (part of an evaluation project). You can order this vaccine from Public Health along with all your other vaccines. (see attached information about the vaccine)

**Public Health staff are here to support your immunization practice**

Do you have a new staff member responsible for vaccine management at your office? Do you / your staff have questions about how to order or how to store / manage your vaccine supply? Do you have a plan to protect your vaccine in case of a power outage? A member of the Public Health Immunization Team can come to your office to answer any questions or provide an education session for your staff. Just phone 481-4956 to make arrangements.

**Immunization Information Lines at Public Health**

- Children ages 0 to 5 years 481-5914
- School aged children 481-4956
- Adults 481-5824
- To place your vaccine order 481-5867 / fax orders to 481-5923
- To order immunization resources 481-5813
- Records Request Line 481-5890

**Immunization resources available:**

- Immunization Tool Kit for Family Practice Offices – get a copy from Public Health or check this website http://www.cdha.nshealth.ca/public-health/immunization/immunization-toolkit-family-practice
- Canadian Immunization Guide – http://www.phac-aspc.gc.ca/publicat/cig-gci/index-eng.php
- Nova Scotia Immunization Schedules – http://www.gov.ns.ca/hpp/cdpc/immunization.asp
- Nova Scotia Immunization Manual – http://www.gov.ns.ca/hpp/publications/13067_ns_immunizationmanual.pdf
- Guide to Report Adverse Events Following Immunization – http://www.phac-aspc.gc.ca/im/aefi_guide/index-eng.php
- National Advisory Committee on Immunization (NACI) – http://www.phac-aspc.gc.ca/naci-ccni/index-eng.php

## SCHEDULE OF PROVINCIAL IMMUNIZATIONS

Refer to the following fee schedule when claiming for individual immunization(s) not billed in conjunction with an office visit or a single immunization billed in conjunction with an office visit:

| IMMUNIZATION | HEALTH SERVICE CODE | MODIFIER | MSUs | DIAGNOSTIC CODE |
|---|---|---|---|---|
| PENTA (DaPTP, Hib) | 13.59L | RO=PENT | 6.0 | V069 |
| MMR | 13.59L | RO=MMAR | 6.0 | V069 |
| QUAD (DaPTP) | 13.59L | RO=QUAD | 6.0 | V069 |
| Td | 13.59L | RO=TEDI | 6.0 | V069 |
| Influenza - Pregnant | 13.59L | RO=INFL | 6.0 | V221 |
| Influenza - Males and non-pregnant females | 13.59L | RO=INFL | 6.0 | V048 |
| Varicella | 13.59L | RO=VARI | 6.0 | V069 |
| Adacel | 13.59L | RO=ADAC | 6.0 | V069 |
| Menjugate | 13.59L | RO=MENC | 6.0 | V069 |
| Pneumococcal Polysaccharide | 13.59L | RO=PNEU | 6.0 | V069 |
| Pneumococcal Polysaccharide In addition to Influenza | 13.59L | RO=PNEU | 6.0 | V066 |
| Boostrix® | 13.59L | RO=BOTR | 6.0 | V069 |
| Pneumococcal Conjugate | 13.59L | RO=PNEC | 6.0 | V069 |
| Combined MMR and Varicella | 13.59L | RO=MMRV | 6.0 | V069 |

When claiming immunization with a visit, the visit will be paid in full at 100%. The first inoculation will be in full at 6.0 MSU and all subsequent inoculations will be paid at 3.0 MSU or 50%. If the purpose of the visit is for immunization only, then the first two inoculations will be paid at 100% and all subsequent inoculations at 50% of the specified MSU.

Refer to the following table when claiming for a provincial immunization tray fee:

| HEALTH SERVICE CODE | DESCRIPTION | MSUs |
|---|---|---|
| 13.59M | Provincial Immunization Tray Fee | 1.5 per multiple (Max 4) |

Refer to the following diagnostic code table, when claiming for pneumococcal and varicella immunizations:

| **PATIENT'S CONDITION** | **DIAGNOSTIC CODE** |
|---|---|
| At risk irrespective of age | Diagnostic code applicable to condition,<br>e.g. 25000 diabetes mellitus |
| Close contact of at risk individual | V018 |
| Well Senior | V069 |

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

December 16, 2011 Volume XLVI - #5

Inside this issue



**CONTACT US:**
**MSI_Assessment@medavie.bluecross.ca**

**On-Line documentation available at:**
**www.gov.ns.ca/health/physicians_bulletin**

## ANAESTHESIA UNIT CHANGE

Effective October 1st, 2011, Anaesthesia Unit (AU) value will be Increased from $16.47 to $19.55.

*NOTE: Please continue to submit claims in the normal manner. Ninety days after the system has been updated, a retroactive payment will be processed.*

## NEW FEES

Effective January 01, 2011 the following new Health Service Code is available for billing:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VADT | 28.73F | **Intravitreal Injection of a pharmacologic agent for the treatment of wet macular degeneration**<br><br>For a patient diagnosed with wet macular degeneration, this fee includes the counselling of the patient, preparation of the eye, administration of subconjunctival anaesthesia and topical antibiotic as required and injection of the pharmacologic agent. Regions required. | 25 |

*Physicians holding eligible services must submit their claims from January 1st onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

Effective September 01, 2011 the following new Health Service Codes are available for billing:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 93.79F | **Thumb CMC Joint Tendon Interpositional Arthoplasty**<br><br>To include removal of the trapezium, dissection of tendon, protection of radial nerve and osteotomies as required. Regions required. | 190 4+T |
| MASG | 93.48A | **Total Ankle Arthroplasty with Prosthesis**<br><br>Procedure includes insertion of hardware, all associated bone preparation and soft tissue procedures such as alteration of tendon length, tendon transfer and repair, and synovectomy as required. Regions required. | 350 4+T |
| VEDT | 04.49C | **Peripheral Blood Film Review**<br><br>Review of peripheral blood film by the pathologist or hematopathologist in response to a perceived abnormality in the complete blood count as determined by local laboratory policies. Includes review of blood film, patient history, correlation with other laboratory tests, assessment or morphology of all cell lines with the provision of a report and recommendations.<br><br>For clinical diagnostic purposes only. Not for QA. | 10 |
| VEDT | 16.91R | **Continuous Conduction Anaesthesia for relief of pain in labour**<br><br>Provision of neuraxial anaesthesia for relief of pain in labour and delivery.<br>To include the entire epidural insertion, all top-ups, maintenance, normal vaginal delivery and removal of epidural catheter.<br><br>To be billed only by the physician who initiates the epidural. Once per patient per labour.<br>AN=LABR | 140 |
| VEDT | 04.49B | **HLA Identification and Crossmatch**<br><br>HLA of a donor's blood followed by screening of potential recipients based on existing HLA typing. Crossmatching of potential donor recipient pairs is then performed to assess transplant potential. | 52.90 |

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VEDT | 04.49A | **HLA Typing**<br><br>HLA typing for bone marrow and solid organ transplant patients.<br><br>Includes sequencing of DNA and comparison of all HLA loci as required to assess donor/recipient compatibility. | 52.90 |
| VEDT | 04.49D | **Flow Cytometry**<br><br>Flow Cytometry for the diagnosis and follow up of patients with hematologic malignancies and immune disorders.<br><br>To include interpretation of scout specimen and selection of all markers required to render a diagnosis. | 52.90 |
| VEDT | 53.81A | **Bone Marrow Interpretation**<br><br>Examination of all slides, confirmation of cell counts, interpretation of hematopoesis and iron stains, required to render a diagnosis based on WHO criteria. | 28.62 |
| VEDT | 02.75B | **Coronary CT Angiography**<br><br>Coronary CT Angiography performed under direct supervision of the radiologist. Fee includes the performance and interpretation of the scan with all necessary work station, plus the administration of medication to control heart rate and contrast material as required.<br>**Not to be used as a screening test in asymptomatic patients.**<br><br>Not billable with:<br>CT 1141 CT Thorax with contrast<br>CT 1180 3D Reconstruction<br><br>**Specialty restriction**<br>DIRD, RADI Diagnostic and Therapeutic Radiology Level 2 (150 training cases plus 8 weeks training in CT angiography) or greater certification for CT Angiography as described by the Canadian Association of Radiologists and Canadian Cardiovascular Society. Physicians wishing to use this code for billing must provide appropriate documentation of qualifications to MSI to be kept on file.<br><br>May not be performed on less than 64 slice CT scanner. | 120 |

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VADT | 98.98A | **Percutaneous expansion/inflation of a tissue expander**<br><br>Full fee for first expander, 50% for each additional expander (to a maximum of three expanders) per patient per day.<br><br>A maximum of four expansions per expander, following insertion of a medically necessary expander.<br><br>Not to be billed for cosmetic expanders. May only be billed after 98.98 or 97.95 have been billed. | 13 |
| ADON | 99.09A | **Morbid Obesity Surgical Add On**<br><br>Billable once per patient per physician in addition to the amount payable for the major procedure(s) where a morbidly obese patient undergoes surgery to the neck, hip, or trunk and:<br>a. has a BMI (body mass index) greater than 50 and this is recorded in the patient's health record.<br>b. the procedure is performed using an open technique through an incision for major neck and hip surgery and an open or laparoscopic technique for the trunk and is performed under general, or neuraxial anaesthesia.<br>c. the principle technique is neither aspiration, core or fine needle biopsy, dilation, endoscopy, cautery, ablation, nor catheterization.<br>d. not billable for bariatric surgery. | 32.9 MSU<br><br>4.6 AU |
| ADON | 49.99C | **Repeat Open Heart Surgery**<br><br>An add on code for repeat open heart surgery or revision of open cardiac surgery with pump, via a Sternotomy when the repeat surgery is 28 days or more after the previous open heart procedure.<br><br>Not billable unless a repeat Sternotomy is the method of approach. The fee would be applicable to repeat coronary artery bypass grafting, open valve replacement surgery, heart transplantation, and congenital heart surgery. | 120 |

| Category | Code | Description | Unit Value | |
|---|---|---|---|---|
| ADON | 48.2C | **Total Arterial Grafting**<br><br>Procedures Auxiliary to Open Heart Surgery: ADON to CABG when all grafts are non-LIMA arterial grafts. Used with HSC 48.12, 48.13 or 48.14<br><br>This ADON covers the harvest, preparation, and use of arterial grafts for coronary artery bypass graft surgery from sites other than the left internal mammary artery (LIMA) which is considered included in the base fee (HSC 48.12, 48.13 or 48.14). Not billable when any vein grafting is used for coronary artery bypass graft surgery. | 100 | |
| MAFR | 91.95C | **External Fixation of Tibial plafond fracture**<br><br>Closed reduction with external fixation of a tibial plafond fracture with or without minimal internal fixation.<br><br>Stage one of the treatment of a tibial plafond fracture, also known as a pilon fracture, or distal tibial explosion fracture. The purpose of this stage is to stabilise the fracture and allow for resolution of soft tissue swelling and wound management prior to open reduction and internal fixation of the same fracture.<br>May not be billed with 91.35B, or 91.35E same limb, same region. | 150 | 4+T |
| MAFR | 91.95D | **External Fixation of Tibial plafond fracture, with open reduction and internal fixation of fibular fracture**<br><br>Closed reduction with external fixation of a tibial plafond fracture with or without minimal internal fixation, with open reduction and internal fixation of distal fibular fracture.<br><br>Stage one of the treatment of a tibial plafond fracture, also known as a pilon fracture, or distal tibial explosion fracture, when there is a distal fibular fracture of the same limb. The purpose of this stage is to stabilise the fracture and allow for resolution of soft tissue swelling and wound management prior to open reduction and internal fixation of the same fracture.<br>May not be billed with 91.35B, or 91.35E same limb, same region. | 175 | 4+T |

*Physicians holding eligible services must submit their claims from September 1st onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

**FEE CORRECTION**

Please note the following corrections to the Angioplasty anaesthesia units.

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| VADT | 51.59J | | **Percutaneous Arterial Angioplasty – Central Vessels** | 137.7<br>**15+T** |
| | | RG=INRE | Aorta - infra renal | |
| | | | May be billed in addition to other adjacent vessel angioplasty if indicated. | |
| VADT | 51.59K | | **Percutaneous Arterial Angioplasty – Lower Limbs** | 183.6<br>**8+T** |
| | | RG=RANT | Anterior Tibial – right side | |
| | | RG=LANT | Anterior Tibial – left side | |
| | | RG=RPOT | Posterior Tibial – right side | |
| | | RG=LPOT | Posterior Tibial – left side | |
| | | RG=RPER | Peroneal – right side | |
| | | RG=LPER | Peroneal – left side | |
| | | | Code may be billed for a maximum of 2 vessels per side (Lt or Rt) | |
| VADT | 51.59O | | **Venous Angioplasty – Lower Limbs** | 137.7<br>**10+T** |
| | | RG=RCOI | Common iliac – right side | |
| | | RG=LCOI | Common iliac – left side | |
| | | RG=RINI | Internal iliac – right side | |
| | | RG=LINI | Internal iliac – left side | |
| | | RG=REXI | External iliac – right side | |
| | | RG=LEXI | External iliac – left side | |
| | | | Code may be billed for a maximum of 2 vessels per side (Lt or Rt) for the following indications: | |
| | | | May-Thurner Syndrome (compression of left iliac vein secondary to overlying iliac artery) | |

Post Thrombotic Stenoses

Neoplastic Compression or Invasion

Post Renal Transplant Venous stenosis

**FEE REVISIONS:**

Effective September 1, 2011 the following fee revision is now in effect:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MAFR | 91.35B | **Fractured tibial plafond, with or without fibula, open reduction and internal fixation – including removal of pre-existing internal or external fixation devices (regions required)**<br><br>Open reduction and internal fixation of tibial plafond facture, also known as a pilon fracture, or distal tibial explosion fracture. This is the second stage of a two stage procedure. The fee includes removal of any external and/or internal fixation previously inserted, for the same fracture.<br><br>May not bill with 90.69B for same region, same day.<br>Not to be billed with any fee code for removal of fixation device for the same fracture, same region, same day. | 200 4+T |

*Claims for this code with a service date from September 1, 2011 to January 5, 2012 will be identified and reconciliation will occur in the spring of 2012. The reconciliation will be calculated after the 90-day waiting period for submission of claims.*

Effective January 6, 2012 the following Health Service Code will no longer be active:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| ANAE | 16.91K | **Continuous conduction anaesthesia for relief of pain**<br><br>AN=LABR, RP=INTL<br>AN=LABR, RP=SUBS | 7+T<br>Time only |

Please note that this fee has been replaced with the new Health Service code 16.91R – **Continuous Conduction Anaesthesia for relief of pain in labour**.

Effective January 6, 2012 the following Pathology Bulk Billing Codes will no longer be active:

| Code | Description | Unit Value |
|---|---|---|
| P2327 | **Bone marrow interpretation** | 15.44 |
| P3327 | **Bone marrow interpretation (35% premium)** | 24.44 |
| P5327 | **Bone marrow interpretation (50% premium)** | 24.44 |

Please note that these have been replaced with the new patient specific Health Service code **53.81A – Bone Marrow Interpretation.**

## INTERIM FEE – ULTRASOUND EYE

Effective January 1st 2012 the following health service codes; R1270 and R1271 will be terminated and replaced with 2 new patient specific interim fee codes listed below:

| Category | Description | Unit Value |
|---|---|---|
| VADT | **Real Time (eye) Ultrasound** | 38.7 |
| VDAT | **Axial Length Measurement by Ultrasound** | 25.44 |

*Please hold all eligible service encounters to allow MSI the required time to update the system. Once a new health service code has been assigned, it will be published in the MSI Physicians' Bulletin. These interim fee are in affect for 18 months.*

## UPCOMING FEES

The following fees have been approved by the Master Agreement Steering Group (MASG) for inclusion into the Fee Schedule, effective October 1, 2011.

| Category | Description | Unit Value |
|---|---|---|
| MASG | **Cervical Total Disc Arthroplasty (artificial disc)** | 750 8+T |
| | Total disc Arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteotomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical.<br><br>For the surgical treatment of cervical myelopathy and myeloradiculopathy in patients with an otherwise biomechanically normal spine amenable to the anterior approach. | |

| | | |
|---|---|---|
| MASG | **Cervical Laminoplasty**<br><br>2 Level cervical Laminoplasty to include osteotomies, and insertion of hardware for fixation of lamina, with duraplasty and lysis of adhesions as required.<br><br>For the treatment of cervical myelopathy and myeloradiculopathy<br>Not to be billed with laminectomy codes:<br>16.09A through D<br>16.1A and B<br>16.2A and B<br>16.3A through C<br>16.49A<br>16.5A and B<br>16.93D | 500 8+T |

| **Category** | **Description** | **Unit Value** |
|---|---|---|
| MASG | **Repair of Sternal Non-union**<br><br>Repair of Sternal non-union/dehiscence – open reduction and internal fixation using plates and screws, to include harvest and placement of bone graft as required. Includes removal of existing hardware (wire), debridement and irrigation of the wound, and tissue shifts required for skin closure. At least one week post cardiac surgery.<br><br>Not to be billed with:<br>90.4A Reclosure of sternal wound….150<br>98.79A Reclosure of sternal wound….150 (regions required)<br>90.69B Removal of internal fixation-metal plate, band, screw or nail….71 (regions required)<br>89.3A Sternal Split 200 MSU<br><br>Not to be billed with BOGR codes.<br>For example:<br>BOGR 90.00A Bone graft – clavicle….175<br>BOGR 90.04A Bone graft – femur – neck or shaft….175 | 750 20+T |
| MASG | **Laparoscopic Assisted Colectomy; right, left, or segmental**<br><br>Laparoscopic resection of the appropriate segment of colon. Includes mobilisation of colon, identification of the ureter, dissection of mesocolic vessels, division of colon, delivery of colon through the extraction site, with intra- or extra-corporeal anastomosis of bowel, and closure of the extraction site.<br>This is intended to be a comprehensive fee for the entire procedure.<br>Not to be billed with HSC 66.19 Other Laparotomy, or HSC 66.83 Laparoscopy. | 350 8+T |

| | | |
|---|---|---|
| MASG | **Laparoscopic Assisted Anterior Resection** | 420 8+T |
| | Laparoscopic resection of the appropriate segment of colon with coloproctostomy (low pelvic anastomosis). Includes mobilisation of colon, identification of the ureter, dissection of mesocolic vessels, division of colon, delivery of colon through the extraction site, with intra- or extra-corporeal anastomosis of bowel (including EEA stapling), to include all stapling, and closure of the extraction site.<br><br>This is intended to be a comprehensive fee for the entire procedure.<br>Not to be billed with HSC 66.19 Other Laparotomy, HSC 66.83 Laparoscopy, or HSC 60.52A Lower anterior Resection where EEA stapler is used. | |

| **Category** | **Description** | **Unit Value** |
|---|---|---|
| MASG | **Laparoscopic Hysterectomy –Total, Subtotal, or Laparoscopically assisted** | 300 6+T |
| | Removal of the uterus and cervix using the laparoscopic approach with delivery of the uterus through the vagina or through an abdominal port using morcellation, bivalving, or coring as required. The uterine body (corpus) must be laparoscopically detached from at least the upper surrounding supportive and vascular structures in order to bill for this procedure.<br><br>This is intended to be a comprehensive fee for the entire procedure. This fee is not to be billed when laparoscopy is performed as a diagnostic procedure at the time of surgery. | |
| MASG | **Complex Palmar Fasciectomy for Dupuytren's Disease** | 180 4+T |
| | To be used for open, complex fasciectomy for excision of Dupuytren's disease involving the palmar fascia.<br>To include local tissue shifts, Z plasty, harvesting and placement of skin graft as required for wound closure.<br><br>Not to be billed with 98.51C, 98.51D Local Tissue shifts – Z plasty and flaps, skin grafts.<br><br>Clinical example: Complex palmar disease, with or without MCP joint involvement limiting extension (grade 2) or web space involvement. | |

| | | |
|---|---|---|
| ADON | **Release of each additional digit including proximal interphalangeal joint release (Add on to Complex Palmar Fasciectomy)**<br><br>An add on code to complex palmar fasciectomy to be used for release of each additional digit to a maximum of four. Involvement of digit must include the PIP joint.<br>To include any necessary joint or tendon releases; local tissue shifts, Z plasty, harvesting and placement of skin graft as required for wound closure.<br><br>Not to be billed with:<br>98.51C, 98.51D Local Tissue shifts – Z plasty and flaps,<br>95.01 incision of tendon sheath,<br>92.63A Excision (capsulectomy, synovectomy, debridement) of metacarpophalangeal joint.<br>93.79B, C, or E Arthroplasty or reconstruction of interphalangeal and/or metacarpophalangeal joint(s).<br><br>Clinical example: Complex palmar disease, with involvement of a multiple digits (grade 3) to the level of the PIP joint or beyond. | 70 4+T |

| **Category** | **Description** | **Unit Value** |
|---|---|---|
| ADON<br>(Interim fee) | **Unilateral Breast Tomosynthesis**<br><br>Tomosynthesis of one breast for diagnostic purposes.<br><br>Patient specific add on to 485 Mammo "Mammography unilateral", or 490 Mammo "Mammography Diagnostic Bilateral" when breast tomosynthesis is performed, on one breast, in addition to full field digital mammography for diagnostic, not screening, purposes.<br><br>*This is a two year term fee and will require reassessment at the end of the term date. | 5 |
| ADON<br>(Interim fee) | **Bilateral Breast Tomosynthesis**<br><br>Tomosynthesis of both breasts for diagnostic purposes<br><br>Patient specific add on to 490 Mammo "Mammography Diagnostic Bilateral" when breast tomosynthesis is performed, on one breast, in addition to full field digital mammography for diagnostic, not screening, purposes.<br><br>*This is a two year term fee and will require reassessment at the end of the term date. | 10 |

*NOTE: Please hold all eligible service encounters to allow MSI the required time to update the system. Once a new Health Service Code has been assigned, it wil be published in the MSI Physicians' Bulletin.*

## CODE CLARIFICATION

Effective October 1, 2011 the following fee has been amended with additional billing Information:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 94.13B<br>PO=PART | **Partial Excision fascia (open) – Palmar Dupuytren's Disease**<br><br>To be used for open, partial excision of palmar fascia for Dupuytren's disease involving the palmar fascia and first web space. To include local tissue shifts, Z plasty, harvesting and placement of skin graft as required for wound closure.<br><br>Not to be billed with Z plasty, flap or skin graft for same region.<br><br>Clinical example: Simple nodules or simple palmar band (grade 1), done under local or wrist block anaesthesia. | 100 4+T |

## UPCOMING FEE ADJUSTMENTS

The following fee adjustments have been approved by the Master Agreement Steering Group (MASG) for inclusion into the Fee Schedule, effective October 1, 2011.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 80.2A | **Subtotal Abdominal Hysterectomy**<br><br>Abdominal approach to the removal of the uterus without the cervix.<br><br>This procedure should be reserved for difficult hysterectomies when the removal of the cervix is judged to put the patient at additional risk of surgical complications.<br>Adnexal surgery may be billed at LV50 as is the case with other routes of hysterectomy. | 240 6+T |
| MASG | 80.2B | **Subtotal Abdominal Hysterectomy with rectocele and/or cystocele repair**<br><br>Abdominal approach to the removal of the uterus without the cervix, with repair of rectocele and/or cystocele. | 287 6+T |

| | | | | |
|---|---|---|---|---|
| | | This procedure should be reserved for difficult hysterectomies when the removal of the cervix is judged to put the patient at additional risk of surgical complications.<br>Not to be billed with HSC 82.41 Repair of cystocele – paravaginal repair, 82.42 Repair of rectocele – paravaginal repair, 82.43 Repair of cystocele and rectocele – paravaginal repair. | | |
| MASG | 80.3 | **Total Abdominal Hysterectomy**<br><br>Removal of the uterus and cervix using the abdominal approach.<br><br>This is intended to be a comprehensive fee for the entire procedure. | 240 | 6+T |
| MASG | 80.3A | **Total Abdominal Hysterectomy with rectocele and/or cystocele repair**<br><br>Abdominal approach to the removal of the uterus and cervix, with repair of rectocele and/or cystocele.<br><br>This is intended to be a comprehensive fee for the entire procedure.<br>Not to be billed with HSC 82.41 Repair of cystocele – paravaginal repair, 82.42 Repair of rectocele – paravaginal repair, 82.43 Repair of cystocele and rectocele – paravaginal repair. | 287 | 6+T |
| **Category** | **Code** | **Description** | **Unit Value** | |
| MASG | 80.3B | **Total Abdominal Hysterectomy with retropubic incontinence repair**<br><br>Abdominal approach to the removal of the uterus and cervix, with retropubic incontinence repair such as urethropexy.<br><br>This is intended to be a comprehensive fee for the entire procedure.<br>Not to be billed with HSC 71.5A Urethrovesical Suspension for Stress Incontinence. | 287 | 6+T |
| MASG | 80.4 | **Vaginal Hysterectomy**<br><br>Removal of the uterus and cervix using the vaginal approach.<br><br>This is intended to be a comprehensive fee for the entire procedure. | 240 | 6+T |
| MASG | 80.4A | **Total Vaginal Hysterectomy with rectocele and/or cystocele repair**<br><br>Vaginal approach to the removal of the uterus and cervix, with repair of rectocele and/or | 287 | 6+T |

cystocele.

This is intended to be a comprehensive fee for the entire procedure.
Not to be billed with HSC 82.41 Repair of cystocele – paravaginal repair, 82.42 Repair of rectocele – paravaginal repair, 82.43 Repair of cystocele and rectocele – paravaginal repair

*NOTE: Please continue to submit claims in the normal manner. Ninety days after the system has been updated, a retroactive payment will be processed.*

**PROCEDURES FOR TREATMENT OF SNORING**

Physicians are advised that procedures for the treatment of snoring are uninsured and therefore cannot be billed to MSI.

**LONG TERM CARE CLINICAL GERIATRIC ASSESSMENT FORM – REVISED**

The CGA form has been slightly revised based on feedback from physicians. Revisions include minor formatting as well as the removal of the shaded areas which made copying and faxing difficult.

Please begin using this revised version immediately.

Templates are available for download on the members side of the Doctors Nova Scotia website and all applicable LTC facilities will be provided with this revised document as well.

**PREAMBLE REVISIONS**

The Master Agreement Steering Group (MASG) has approved the following preamble amendments, effective September 1, 2011.

7.5.5 A Prolonged Consultation may be applied to cases where the consultation extends beyond one hour for comprehensive consultations and a half-hour for repeat consultations, ***or a half hour for OBGY consultations - specifically for preconceptual consultation(Maternal fetal medicine), consultation for issues of sexual dysfunction, reproductive endocrinology, gynecologic oncology, and urogynaecology.*** A prolonged consultation cannot be claimed with a limited consultation. Prolonged consultations are paid in 15-minute time blocks or portion thereof. Prolonged consultations are not to be confused with active treatment associated with detention.A prolonged consultation may be claimed only by the following specialties:
(a)Anaesthesia
(b)Internal Medicine
(c) Neurology
(d)Physical Medicine
(e)Pediatrics
(f)Psychiatry
***(g)Obstetrics and Gynaecology***

*Prolonged consultations for Obstetrics and Gynaecology with a service date from September 1, 2011 to January 5, 2012 that were held according to the October 2011 bulletin can be submitted now including multiples indicating the time spent with the patient. Claims will be identified and reconciliation will occur in the spring of 2012. The reconciliation will be calculated after the 90-dayswaiting period for submission of claims. This will ensure all services are caught when the reconciliation is completed.*

The Master Agreement Steering Group (MASG) has approved the following preamble amendments, effective October 1, 2011.

**Effective October 1st, 2011 Time Premiums may be claimed for select endoscopic procedures. For complete list of procedures please refer to the preamble.**

**Endoscopic Procedures eligible for premium:**

| | | |
|---|---|---|
| **Fiberoptic bronchoscopy** | | |
| VADT 01.08A Transbronchial lung biopsy with fiberscope | 110 | 6+T |
| **Other nonoperative bronchoscopy** | | |
| VADT 01.09 Other nonoperative bronchoscopy | 60 | 6+T |
| VADT 01.09A Bronchoscopy with biopsy | 65 | 6+T |
| VADT 01.09B Bronchoscopy - with foreign body removal | 85 | 6+T |
| **Other nonoperative esophagoscopy** | | |
| VADT 01.12 Other nonoperative esophagoscopy | 60 | 4+T |
| VADT 01.12A Oesophagobronchoscopy | 85 | 6+T |
| VADT 01.12B Oesophagoscopy with biopsy | 65 | 4+T |
| VADT 01.12C Oesophagoscopy - with removal of foreign body | 85 | 4+T |
| **Gastroscopy** | | |
| VADT 01.14A Injection of ulcer through the scope for G.I. bleed or application of crazy glue into fundal region of stomach (scope included) | 120 | 4+T |
| VADT 01.14C Esophagogastroscopy | 70 | 4+T |
| VADT 01.14D Esophagogastroscopy with biopsy | 75 | 4+T |
| VADT 01.14E Esophagogastroscopy-with removal of foreign body | 85 | 4+T |
| ADON 01.14F Insertion of intragastric balloon in addition to gastroscopic fee | 50 | |
| ADON 01.14G Removal of polyps in addition to the appropriate esophagogastroscopy - plus multiples, if applicable | 10 | |
| **Colonoscopy** | | |
| VADT 01.22C Colonoscopy of descending colon | 40 | 4+T |
| ADON 01.22F Balloon dilation of colonic stricture (In addition to colonoscopy) | 30 | |
| **Endoscopic excision or destruction of lesion or tissue of esophagus** | | |
| ADON 54.21A Electrocautery of GI bleeding lesions - add on to endoscopic fees | 10 | |
| **Pancreatic Sphincterotomy** | | |
| VADT 63.82A Esophagogastroduodenoscopy - with papillotomy | 230 | 4+T |
| **Endoscopic Retrograde Cholangiography (ERC)** | | |
| VADT 63.95A Esophagogastroduodenoscopy - with basket extraction of stones | 173.4 | 4+T |
| VADT 63.95B Esophagogastroduodenoscopy - with indwelling naso biliary catheter | 170 | 4+T |
| VADT 63.95C Esophagogastroduodenoscopy - with biliary stents | 170 | 4+T |

| | | |
|---|---|---|
| VADT 64.91A Esophagogastroduodenoscopy - with cannulation of pancreatic duct | 120 | 4+T |
| ADON 64.91B Choledochoscopy with associated procedure | 25 | |

*NOTE: Please hold all eligible service encounters to allow MSI the required time to update the system. Once the system has been updated, the changes will be published in an upcoming MSI Physicians' Bulletin.*

## EXPLANATORY CODES

The following new explanatory codes have been added to the system:

MF001 Service encounter has been refused as a removal of fixation device claim was previously made for the same region on that service date.

MF002 Service encounter has been refused as a removal of fixation device fee is included in previously billed 91.35B.

MF003 Service encounter has been refused as you have already made a claim for health service code 91.35B or 91.35E.

MF004 Service encounter has been refused as you have already made a claim for health service code 91.35C or 91.35D.

PP024 Services provided by a non-physician are not insured. (ex. chiropractor, physiotherapist, pac-physician's assistant, podiatrist, nurse practitioner).

VA041 Service encounter has been refused as you have already billed 2 vessels for this side.

VE007 Service encounter has been refused as the conduction of anaesthesia for relief of pain in labour has already been claimed for this patient.

## UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, January 6th, 2012. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanation code (EXPLAIN.DAT).

# Long-Term Care
# Clinical Geriatric Assessment (CGA)

PATIENT ID

WNL: Within Normal Limits ASST: Assisted
IND: Independent DEP: Dependent

Chief lifelong occupation: _____ Education: (yrs) _____

**Cr Cl/eGFR:** _____

**Infection Control**
MRSA _____ Pos _____ Neg
VRE _____ Pos _____ Neg
Flu shot given (d/m/y) _____
Pneumococcal vaccine given (d/m/y) _____
TB test done (d/m/y) _____
Tetanus (d/m/y) _____

**Cognitive Status*** 
❒ WNL
❒ Dementia
❒ Delirium
MMSE _____

**Emotional***
❒ WNL
❒ Depression
❒ Other
❒ Hallucinations/Delusions
❒ ⇩Mood
❒ Anxiety
Date (d/m/y): _____

**Behaviours***
❒ Verbal Non-aggressive
❒ Verbal Aggressive
❒ Physical Non-aggressive
❒ Physical Aggressive

**Communication:**

**Speech**
❒ WNL
❒ Impaired

**Hearing**
❒ WNL
❒ Impaired

**Vision**
❒ WNL
❒ Impaired

**Foot-care needed**
❒ Yes ❒ No

**Dental care needed**
❒ Yes ❒ No

**Skin Integrity Issues**
❒ Yes ❒ No

**Strength**
❒ WNL ❒ Weak
Upper: Proximal Distal R L
Lower: Proximal Distal R L

| | | |
|---|---|---|
| **Mobility** | Transfers | ❒ IND ❒ ASST ❒ DEP |
| | Walking Aid | ❒ IND Slow ❒ ASST ❒ DEP _____ |
| **Balance** | Balance | ❒ WNL ❒ Impaired |
| | Falls | ❒ No ❒ Yes Frequency |
| **Elimination** | Bowel | ❒ Constip ❒ Cont ❒ Incont |
| | Bladder | ❒ Catheter ❒ Cont ❒ Incont |
| **Nutrition** | Weight | ❒ STABLE ❒ LOSS ❒ GAIN |
| | Appetite | ❒ WNL ❒ FAIR ❒ POOR |
| **ADLs** | Feeding | ❒ IND ❒ ASST ❒ DEP |
| | Bathing | ❒ IND ❒ ASST ❒ DEP |
| | Dressing | ❒ IND ❒ ASST ❒ DEP |
| | Toileting | ❒ IND ❒ ASST ❒ DEP |

**Personal Directives** ❒ Yes ❒ No
**Substitute Decision Maker:** _____
**Tel #:** _____

**Code Status:**
❒ Do Not Attempt to Resuscitate
❒ Do Not Hospitalize
❒ Hospitalize
❒ Attempt to Resuscitate

**Marital Status**
❒ Married
❒ Divorced
❒ Widowed
❒ Single

**Family Stress**
❒ None
❒ Low
❒ Moderate
❒ High

| Problems/Past History/Diagnosis* | Medication Adjustment Required* | Associated Medication* |
|---|---|---|
| 1. | ❒ | |
| 2. | ❒ | |
| 3. | ❒ | |
| 4. | ❒ | |
| 5. | ❒ | |
| 6. | ❒ | |
| 7. | ❒ | |
| 8. | ❒ | |
| 9. | ❒ | |
| 10. | ❒ | |
| 11. | ❒ | |
| 12. | ❒ | |

**Current Frailty Score* (Scale description on next page)**

*** NOTE: The physician must complete all items marked with an asterisk (*) and meet all Master Agreement Long-Term Clinical Geriatric Assessment (CGA) program criteria in order to claim the CGA fee.**

| Scale ❒ 5. Mildly Frail | ❒ 6. Moderately Frail | ❒ 7. Severely Frail | ❒ 8. Very Severely ill | ❒ 9. Terminally Ill |
|---|---|---|---|---|

**Clinical Frailty Scale****

**5. Mildly Frail** – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

**6. Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and **need help with bathing** and might need minimal assistance (cuing, standby) with dressing.

**7. Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

**8. Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover from even a minor illness.

**9. Terminally Ill** – Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

**1. Canadian Study on Health & Aging, Revised 2008
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173; 489-495

Adapted from Clinical Frailty Scale ©2007 – 2009. Version 1.2 All rights reserved. Geriatric Medicine Research, Dalhousie University, Halifax, Canada

| CGA Associated Visits | |
|---|---|
| **Date** | **Comments** |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Physician Name (please print): _____ Physician Signature: _____

Signed on (d/m/y): _____ (Visit required on this date)

NOVA SCOTIA MEDICAL SERVICES INSURANCE

PROGRAMS OF THE NOVA SCOTIA DEPT. OF HEALTH

PO BOX 500 HALIFAX NOVA SCOTIA B3J 2S1

TELEPHONE (902) 468-9700

# RADIOLOGY STATISTICAL BILLING REPORT

| | |
|---|---|
| **PROVIDER or GROUP NAME** | |
| **PROVIDER or GROUP No** | **BUSINESS ARRANGEMENT No** |
| **INSTITUTION NAME** | **INSTITUTION No** |
| **CONTACT PERSON** | **PHONE NUMBER** |
| **BILLING PERIOD FROM** | **TO** |

| CODE | GROUP | DESCRIPTION | UNIT VALUE | IN PATIENT | OUT PATIENT | TOTAL EXAMS | TOTAL UNITS |
|---|---|---|---|---|---|---|---|
| 1 | Other | Interpretation of submitted films | 6.25 | | | | |
| 2 | Other | Fluoroscopy in O.R. | 3.13 | | | | |
| 3 | Other | Conventional Tomography | 9.38 | | | | |
| 5 | H&N | Skull—routine views | 4.40 | | | | |
| 6 | H&N | Temporomandibular joints | 4.34 | | | | |
| 7 | H&N | Internal auditory meati | 4.34 | | | | |
| 8 | H&N | Sella turcica | 4.34 | | | | |
| 9 | H&N | Optic foramina | 4.34 | | | | |
| 11 | H&N | Mastoids—added view | 4.34 | | | | |
| 12 | H&N | Eye for foreign body | 4.34 | | | | |
| 15 | H&N | Facial bones | 4.40 | | | | |
| 20 | H&N | Mandible | 3.31 | | | | |
| 25 | H&N | Nasal bones | 3.31 | | | | |
| 30 | H&N | Sinuses—paranasal | 3.88 | | | | |
| 35 | H&N | Salivary gland region | 3.31 | | | | |
| 45 | H&N | Panorex (Teeth—full set) | 4.97 | | | | |
| 50 | H&N | Arthrogram | 20.76 | | | | |
| 55 | H&N | Dacrocystogram | 5.53 | | | | |
| 60 | H&N | Sialogram | 9.38 | | | | |
| 70 | H&N | Speech study | 44.24 | | | | |
| 105 | Bone | Cervical spine | 5.19 | | | | |

| CODE | GROUP | DESCRIPTION | UNIT VALUE | IN PATIENT | OUT PATIENT | TOTAL EXAMS | TOTAL UNITS |
|---|---|---|---|---|---|---|---|
| 110 | Bone | Thoracic spine | 3.31 | | | | |
| 115 | Bone | Lumbar spine | 5.19 | | | | |
| 120 | Bone | Sacrum/coccyx | 3.31 | | | | |
| 125 | Bone | Scoliosis series | 8.85 | | | | |
| 126 | Bone | Scoliosis with stress | 11.07 | | | | |
| 129 | Bone | Metastatic series (5) | 9.12 | | | | |
| 130 | Bone | Metabolic bone survey | 9.12 | | | | |
| 131 | Bone | All long bones added to 129 | 2.28 | | | | |
| 140 | Mylo | Discogram | 11.07 | | | | |
| 150 | Mylo | Lumbar myelogram | 18.75 | | | | |
| 151 | Mylo | Complete myelogram | 28.14 | | | | |
| 152 | Mylo | Cervical injection myelogram | 18.75 | | | | |
| 185 | Other | Fetal Study | 3.31 | | | | |
| 205 | Bone | Shoulder | 3.41 | | | | |
| 210 | Bone | Scapula | 3.41 | | | | |
| 215 | Bone | A.C. joints with & without weights | 3.41 | | | | |
| 220 | Bone | Clavicle | 3.41 | | | | |
| 221 | Bone | Bone age determination | 4.53 | | | | |
| 223 | Bone | Scaphoid | 3.41 | | | | |
| 224 | Bone | Humerus | 3.41 | | | | |
| 225 | Bone | Elbow | 3.41 | | | | |
| 226 | Bone | Wrist | 3.41 | | | | |
| 227 | Bone | Forearm | 3.41 | | | | |
| 228 | Bone | Hand | 3.41 | | | | |
| 229 | Bone | Finger | 1.71 | | | | |
| 230 | Bone | Arthrogram shoulder | 20.76 | | | | |
| 305 | Bone | Hip | 3.41 | | | | |
| 310 | Bone | Pelvis | 3.31 | | | | |
| 315 | Bone | Pelvis and hips | 3.99 | | | | |
| 320 | Bone | Sacroiliac joints | 3.31 | | | | |
| 321 | Bone | Patella | 3.41 | | | | |
| 322 | Bone | Foot | 3.41 | | | | |
| 323 | Bone | Ankle | 3.41 | | | | |
| 324 | Bone | Knee | 3.41 | | | | |
| 325 | Bone | Calcaneus | 3.41 | | | | |
| 326 | Bone | Tibia & fibula | 3.41 | | | | |

| CODE | GROUP | DESCRIPTION | UNIT VALUE | IN PATIENT | OUT PATIENT | TOTAL EXAMS | TOTAL UNITS |
|---|---|---|---|---|---|---|---|
| 327 | Bone | Toe | 1.71 | | | | |
| 328 | Bone | Feet—weight bearing | 6.64 | | | | |
| 335 | Bone | Femur | 3.41 | | | | |
| 340 | Bone | Orthoroentgenogram (leg length measurement) | 2.58 | | | | |
| 350 | Bone | Arthrogram hip | 20.76 | | | | |
| 351 | Bone | Arthrogram knee | 20.76 | | | | |
| 403 | Other | Fluoroscopy 10 minutes | 12.50 | | | | |
| 404 | Chest | Single view | 3.13 | | | | |
| 405 | Chest | Multiple views | 5.13 | | | | |
| 425 | Chest | Ribs—each side | 2.90 | | | | |
| 435 | Chest | Sternum | 3.31 | | | | |
| 439 | Bone | Dual photon densitometry | 11.73 | | | | |
| 440 | Bone | Sternoclavicular joints | 3.41 | | | | |
| 445 | H&N | Neck—for soft tissue | 3.31 | | | | |
| 470 | Chest | Bronchogram unilateral | 11.07 | | | | |
| 484 | Mammo | Mammography screening bilateral | 5.09 | | | | |
| 485 | Mammo | Mammography unilateral | 7.19 | | | | |
| 486 | Mammo | Breast cystography | 6.63 | | | | |
| 490 | Mammo | Mammography diagnostic bilateral | 14.07 | | | | |
| 495 | Mammo | Needle localization | 34.39 | | | | |
| 500 | Mammo | Galactography | 6.63 | | | | |
| 505 | Mammo | Stereotactic localization | 19.29 | | | | |
| 510 | Mammo | Surgical specimen radiography | 3.82 | | | | |
| 605 | Abdomen | Survey film | 3.13 | | | | |
| 610 | Abdomen | Multiple films | 3.88 | | | | |
| 620 | G.I. | Esophagus | 14.62 | | | | |
| 625 | G.I. | Upper G.I. series | 18.69 | | | | |
| 630 | G.I. | Upper G.I. Paediatric | 28.05 | | | | |
| 635 | G.I. | Small bowel study | 9.67 | | | | |
| 640 | G.I. | Enteroclysis | 26.57 | | | | |
| 650 | G.I. | Colon—barium only | 14.91 | | | | |
| 655 | G.I. | Colon Paediatric—single | 22.37 | | | | |
| 660 | G.I. | Colon—double contrast | 19.92 | | | | |
| 666 | G.I. | Defaecography | 26.57 | | | | |
| 670 | G.I. | Cholecystogram | 4.97 | | | | |
| 690 | G.I. | T-tube Cholangiogram | 6.63 | | | | |

| 691 | G.I. | Operative Cholangiogram | 4.66 | | | | |
|---|---|---|---|---|---|---|---|
| 695 | G.I. | ERCP | 6.63 | | | | |
| **CODE** | **GROUP** | **DESCRIPTION** | **UNIT VALUE** | **IN PATIENT** | **OUT PATIENT** | **TOTAL EXAMS** | **TOTAL UNITS** |
| 709 | G.I. | Herniography | 9.38 | | | | |
| 710 | G.I. | Fistula/sinus with contrast | 4.40 | | | | |
| 745 | G.I. | Percutaneous Transhepatic Cholangiogram | 6.63 | | | | |
| 815 | G.I. | Intravenous urogram (IVP) | 14.53 | | | | |
| 823 | G.U. | Retrograde pyelogram | 4.53 | | | | |
| 830 | G.U. | Voiding cystourethrogram | 11.07 | | | | |
| 835 | G.U. | Cystogram Paediatric | 18.75 | | | | |
| 840 | G.U. | Loopogram | 4.40 | | | | |
| 845 | G.U. | Retrograde urethrogram | 4.53 | | | | |
| 846 | G.U. | Cavernosogram | 4.40 | | | | |
| 850 | G.U. | Antegrade (T-tube) Pyelogram | 4.53 | | | | |
| 865 | G.U. | Renal cystogram | 6.63 | | | | |
| 885 | G.U. | Vasogram | 4.40 | | | | |
| 895 | G.U. | Hysterosalpingogram | 5.53 | | | | |
| 910 | G.U. | Pelvimetry | 6.63 | | | | |
| 1001 | Vascular | Venous DSA—abnormal or renal | 35.52 | | | | |
| 1002 | Vascular | Venous DSA—Aortic arch | 39.58 | | | | |
| 1003 | Vascular | Pulmonary angiogram bilateral | 93.79 | | | | |
| 1004 | Vascular | Pulmonary angiogram unilateral | 62.53 | | | | |
| 1006 | Vascular | Unilateral peripheral arteriogram | 22.14 | | | | |
| 1007 | Vascular | Bilateral peripheral arteriogram | 33.21 | | | | |
| 1008 | Vascular | Aortography (abdominal) | 44.21 | | | | |
| 1009 | Vascular | Visceral selective arteriogram | 44.21 | | | | |
| 1010 | Vascular | Venogram extremity | 25.01 | | | | |
| 1011 | Vascular | Venocavogram selective | 22.14 | | | | |
| 1012 | Vascular | Visceral Venogram | 22.14 | | | | |
| 1013 | Vascular | Spinal artery selective | 22.14 | | | | |
| 1014 | Vascular | Bronchial artery selective | 44.21 | | | | |
| 1015 | Vascular | Lymphangiogram | 44.21 | | | | |
| 1016 | Vascular | Arch aortogram | 44.21 | | | | |
| 1017 | Vascular | Spleenoportogram | 53.90 | | | | |
| 1018 | Vascular | Intraoperative angiogram | 43.77 | | | | |
| 1021 | Vascular | Common carotid bilateral | 55.83 | | | | |
| 1022 | Vascular | Internal carotid bilateral | 55.83 | | | | |

| 1023 | Vascular | External carotid bilateral | 55.83 | | | | |
|---|---|---|---|---|---|---|---|
| 1024 | Vascular | Vertebral bilateral | 55.83 | | | | |
| 1026 | Vascular | Common carotid unilateral | 30.45 | | | | |
| **CODE** | **GROUP** | **DESCRIPTION** | **UNIT VALUE** | **IN PATIENT** | **OUT PATIENT** | **TOTAL EXAMS** | **TOTAL UNITS** |
| 1027 | Vascular | Internal carotid unilateral | 30.45 | | | | |
| 1028 | Vascular | External carotid unilateral | 30.45 | | | | |
| 1029 | Vascular | Vertebral unilateral | 30.45 | | | | |
| 1056 | Cardiac | Coronary Arteries | 50.75 | | | | |
| 1057 | Cardiac | Coronary Arteries with Ergot | 25.38 | | | | |
| 1058 | Cardiac | Coronary Artery Grafts | 50.75 | | | | |
| 1059 | Cardiac | P.T.C.A. | 50.75 | | | | |
| 1061 | Cardiac | Right Ventriculogram | 25.38 | | | | |
| 1062 | Cardiac | Left Ventriculogram | 25.38 | | | | |
| 1063 | Cardiac | Cardiac Panning <45 min. | 60.90 | | | | |
| 1064 | Cardiac | Cardiac Panning >45min. | 121.81 | | | | |
| 1071 | Cardiac | Aortic Root (cardiac) | 25.38 | | | | |
| 1105 | C.T. | CT head without contrast | 42.33 | | | | |
| 1111 | C.T. | CT head with contrast | 42.33 | | | | |
| 1115 | C.T. | CT head without + with contrast | 53.27 | | | | |
| 1121 | C.T. | CT neck without contrast | 42.33 | | | | |
| 1125 | C.T. | CT neck with contrast | 42.33 | | | | |
| 1130 | C.T. | CT neck without + with contrast | 53.27 | | | | |
| 1135 | C.T. | CT thorax without contrast | 42.33 | | | | |
| 1141 | C.T. | CT thorax with contrast | 42.33 | | | | |
| 1145 | C.T. | CT thorax without + with contrast | 53.27 | | | | |
| 1150 | C.T. | CT abdomen without contrast | 42.33 | | | | |
| 1155 | C.T. | CT abdomen with contrast | 42.33 | | | | |
| 1160 | C.T. | CT abdomen without + with contrast | 53.27 | | | | |
| 1162 | C.T. | CT extremities without contrast | 42.33 | | | | |
| 1163 | C.T. | CT extremities with contrast | 42.33 | | | | |
| 1164 | C.T. | CT extremities without and with contrast | 53.27 | | | | |
| 1165 | C.T. | CT pelvis without contrast | 42.33 | | | | |
| 1166 | C.T. | CT pelvis with contrast | 42.33 | | | | |
| 1167 | C.T. | CT pelvis without and with contrast | 53.27 | | | | |
| 1169 | C.T. | CT spine without contrast | 42.33 | | | | |
| 1170 | C.T. | CT spine with contrast | 42.33 | | | | |
| 1172 | C.T. | CT spine without + with contrast | 53.27 | | | | |

| 1173 | C.T. | Densitometry CT | 9.07 | | | | |
|---|---|---|---|---|---|---|---|
| 1180 | C.T. | 3D reconstruction | 12.16 | | | | |
| 1186 | C.T. | CT head special without contrast | 42.33 | | | | |
| 1187 | C.T. | CT head special with contrast | 42.33 | | | | |
| **CODE** | **GROUP** | **DESCRIPTION** | **UNIT VALUE** | **IN PATIENT** | **OUT PATIENT** | **TOTAL EXAMS** | **TOTAL UNITS** |
| 1188 | C.T. | CT head special without + with contrast | 53.27 | | | | |
| 1205 | Ultrasound | Abdomen general | 25.39 | | | | |
| 1206 | Ultrasound | Spine | 25.39 | | | | |
| 1211 | Ultrasound | Aorta | 12.50 | | | | |
| 1212 | Ultrasound | Appendix | 18.75 | | | | |
| 1214 | Ultrasound | Pylorus | 18.75 | | | | |
| 1213 | Ultrasound | Kidneys | 18.75 | | | | |
| 1220 | Ultrasound | Pelvis, male or female (GYN) | 18.75 | | | | |
| 1225 | Ultrasound | Endovaginal | 26.95 | | | | |
| 1226 | Ultrasound | Endovaginal with pelvic | 38.70 | | | | |
| 1231 | Ultrasound | Endorectal | 25.39 | | | | |
| 1245 | Ultrasound | Obstetrical | 27.51 | | | | |
| 1246 | Ultrasound | Obstetrical, recheck | 12.50 | | | | |
| 1250 | Ultrasound | Biophysical profile | 4.84 | | | | |
| 1255 | Ultrasound | Obs. Multiple – (add on) | 20.04 | | | | |
| 1256 | Ultrasound | Obs. Multiple – recheck (add on) | 6.25 | | | | |
| 1264 | Ultrasound | Cerebral | 33.49 | | | | |
| 1265 | Ultrasound | Thyroid/parathyroid (NECK) | 18.75 | | | | |
| 1275 | Ultrasound | Scrotum | 25.45 | | | | |
| 1280 | Ultrasound | Shoulder | 18.75 | | | | |
| 1285 | Ultrasound | Hip | 18.75 | | | | |
| 1295 | Ultrasound | Breast, single | 12.50 | | | | |
| 1296 | Ultrasound | Chest | 18.75 | | | | |
| 1297 | Ultrasound | Popliteal fossa | 12.50 | | | | |
| 1298 | Ultrasound | Subcutaneous mass | 12.50 | | | | |
| 1306 | Ultrasound | Intraoperative U/S | 47.56 | | | | |
| 1307 | Ultrasound | Portable – M.D. in attendance | 18.75 | | | | |
| 1309 | Ultrasound | Fetal echo | 78.16 | | | | |
| 1310 | Ultrasound | Two Dimensional cardiac | 47.56 | | | | |
| 1311 | Ultrasound | M-Mode cardiac | 25.44 | | | | |
| 1312 | Ultrasound | Doppler-Quantitative, cardiac | 30.45 | | | | |
| 1313 | Ultrasound | Doppler – Qualitative, cardiac | 15.23 | | | | |

| 1335 | Ultrasound | Doppler abdominal blood vessels | 33.49 | | | | |
|---|---|---|---|---|---|---|---|
| 1340 | Ultrasound | Carotid doppler | 33.49 | | | | |
| 1345 | Ultrasound | Doppler-extremities | 18.75 | | | | |
| **CODE** | **GROUP** | **DESCRIPTION** | **UNIT VALUE** | **IN PATIENT** | **OUT PATIENT** | **TOTAL EXAMS** | **TOTAL UNITS** |
| 1405 | M.R.I. | Cranial Multisection SE | 40.97 | | | | |
| 1406 | M.R.I. | Cranial Multisection IR | 25.76 | | | | |
| 1407 | M.R.I. | Cranial Repeat, sequence | 19.91 | | | | |
| 1409 | M.R.I. | ENT Multisection SE | 40.97 | | | | |
| 1411 | M.R.I. | ENT Multisection IR | 25.76 | | | | |
| 1412 | M.R.I. | ENT Repeat, sequence | 19.91 | | | | |
| 1415 | M.R.I. | Thorax Multisection SE | 46.83 | | | | |
| 1416 | M.R.I. | Thorax Multisection IR | 40.97 | | | | |
| 1417 | M.R.I. | Thorax Repeat, sequence | 23.42 | | | | |
| 1420 | M.R.I. | Abdomen Multisection SE | 46.83 | | | | |
| 1421 | M.R.I. | Abdomen Multisection IR | 40.97 | | | | |
| 1422 | M.R.I. | Abdomen Repeat, sequence | 23.42 | | | | |
| 1425 | M.R.I. | Pelvis Multisection SE | 46.83 | | | | |
| 1426 | M.R.I. | Pelvis Multisection IR | 40.97 | | | | |
| 1427 | M.R.I. | Pelvis Repeat sequence | 23.42 | | | | |
| 1430 | M.R.I. | Extremities Multisection SE | 40.97 | | | | |
| 1431 | M.R.I. | Extremities Multisection IR | 25.76 | | | | |
| 1432 | M.R.I. | Extremities Repeat, sequence | 19.91 | | | | |
| 1440 | M.R.I. | Spine (one seq.) Multisection SE | 37.47 | | | | |
| 1441 | M.R.I. | Spine (one seq.) Multisection IR | 24.58 | | | | |
| 1442 | M.R.I. | Spine (one seq. Repeat, sequence | 18.73 | | | | |
| 1445 | M.R.I. | Spine (two adjoining) Multisection SE | 44.50 | | | | |
| 1446 | M.R.I. | Spine (two adjoining) Multisection IR | 37.47 | | | | |
| 1447 | M.R.I. | Spine (two adjoining) Repeat sequence | 22.25 | | | | |
| 1450 | M.R.I. | Spine (two not add.) Multisection SE | 66.74 | | | | |
| 1451 | M.R.I. | Spine (two not add.) Multisection IR | 37.47 | | | | |
| 1452 | M.R.I. | Spine (two not add.) Repeat sequence | 32.78 | | | | |
| 1453 | M.R.I. | Add 30% for gating | 14.05 | | | | |
| 1776 | Nuc. Med. | Labelled WBC | 41.04 | | | | |
| 1777 | Nuc. Med. | Gallium (one area) | 28.14 | | | | |
| 1778 | Nuc. Med. | Gallium (multiple areas) | 35.08 | | | | |
| 1790 | Nuc. Med. | Vascular study (flow) add on | 11.73 | | | | |
| 1810 | Nuc. Med. | Brain scan | 11.73 | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1811 | Nuc. Med. | Brain Perfusion | 46.89 | | | | |
| 1812 | Nuc. Med. | CSF study (Cisternogram) | 35.18 | | | | |
| 1813 | Nuc. Med. | Shunt function study | 46.89 | | | | |
| 1814 | Nuc. Med. | Radionuclide Arthrogram | 35.18 | | | | |
| **CODE** | **GROUP** | **DESCRIPTION** | **UNIT VALUE** | **IN PATIENT** | **OUT PATIENT** | **TOTAL EXAMS** | **TOTAL UNITS** |
| 1816 | Nuc. Med. | Bone scan – one area | 23.45 | | | | |
| 1817 | Nuc. Med. | Bone scan – multiple areas | 28.14 | | | | |
| 1818 | Nuc. Med. | Bone marrow – one area | 23.45 | | | | |
| 1819 | Nuc. Med. | Marrow scan – multiple areas | 28.14 | | | | |
| 1820 | Nuc. Med. | Bone Density | 11.73 | | | | |
| 1830 | Nuc. Med. | Lung ventilation scan | 23.45 | | | | |
| 1835 | Nuc. Med. | Lung scan perfusion | 23.45 | | | | |
| 1840 | Nuc. Med. | Liver and spleen | 18.75 | | | | |
| 1843 | Nuc. Med. | Haemangioma (RBC) | 28.14 | | | | |
| 1845 | Nuc. Med. | Spleen scan (RBC) | 18.75 | | | | |
| 1850 | Nuc. Med. | Hepatobiliary | 23.45 | | | | |
| 1853 | Nuc. Med. | Bile salt study | 23.45 | | | | |
| 1855 | Nuc. Med. | Gastric emptying | 23.45 | | | | |
| 1860 | Nuc. Med. | Ectopic gastric mucosa | 23.45 | | | | |
| 1865 | Nuc. Med. | G.I bleed | 46.89 | | | | |
| 1870 | Nuc. Med. | G.E. reflux | 18.75 | | | | |
| 1871 | Nuc. Med. | Esophageal motility | 46.89 | | | | |
| 1872 | Nuc. Med. | Ciliary motion study | 31.27 | | | | |
| 1873 | Nuc. Med. | Peritoneal/venous shunt | 23.45 | | | | |
| 1875 | Nuc. Med. | Renal static imaging | 11.73 | | | | |
| 1880 | Nuc. Med. | Renal scan and renogram | 35.18 | | | | |
| 1881 | Nuc. Med. | A.C.E. renal scan | 46.89 | | | | |
| 1885 | Nuc. Med. | Diuretic stimulation (add on) | 11.73 | | | | |
| 1890 | Nuc. Med. | Testicual scan | 23.45 | | | | |
| 1899 | Nuc. Med. | Residual urine (add on) | 11.73 | | | | |
| 1904 | Nuc. Med. | Myocardial rest | 23.45 | | | | |
| 1905 | Nuc. Med. | Mycardial Stress and rest | 37.52 | | | | |
| 1906 | Nuc. Med. | Myocardial rest quantitative (add on) | 7.04 | | | | |
| 1907 | Nuc. Med. | Myocardial stress and rest quantitative – add on | 11.73 | | | | |
| 1910 | Nuc. Med. | MUGA with Quantitative | 23.45 | | | | |
| 1911 | Nuc. Med. | Exercise MUGA | 58.62 | | | | |
| 1912 | Nuc. Med. | Mycardial Infarction | 23.45 | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1913 | Nuc. Med. | Cardiac first pass | 28.14 | | | | |
| 1914 | Nuc. Med. | Cardiac shunt | 23.45 | | | | |
| 1915 | Nuc. Med. | Venoscintigram | 23.45 | | | | |
| 1920 | Nuc. Med. | Thyroid Uptake | 18.75 | | | | |
| 1921 | Nuc. Med. | Thyroid scan | 18.75 | | | | |
| **CODE** | **GROUP** | **DESCRIPTION** | **UNIT VALUE** | **IN PATIENT** | **OUT PATIENT** | **TOTAL EXAMS** | **TOTAL UNITS** |
| 1922 | Nuc. Med. | Thyroid uptake special | 23.45 | | | | |
| 1925 | Nuc. Med. | Adrenal scan | 70.34 | | | | |
| 1930 | Nuc. Med. | Parathryoid scan | 35.18 | | | | |
| 1935 | Nuc. Med. | Tumor imaging | 28.14 | | | | |
| 1940 | Nuc. Med. | Salivary gland scintigraphy | 23.45 | | | | |
| 1945 | Nuc. Med. | Dacroscintigraphy | 30.48 | | | | |
| 1946 | Nuc. Med. | Lymphoscintigram | 23.45 | | | | |
| 1947 | Nuc. Med. | Isolated limb perfusion | 11.73 | | | | |
| 1950 | Nuc. Med. | Tomography (add on) | 12.50 | | | | |
| 1951 | Nuc. Med. | Hepatobiliary with pharmacologic stimulation | 35.18 | | | | |
| 1955 | Nuc. Med. | Hyperthyroidism (Therapy) | 42.21 | | | | |
| 1960 | Nuc. Med. | Carcinoma of Thyroid (Therapy) | 58.62 | | | | |
| 1961 | Nuc. Med. | Metastatic Carcinoma (Therapy) | 42.21 | | | | |
| 1962 | Nuc. Med. | Ascites or Pleural effusion (Therapy) | 42.21 | | | | |
| 1963 | Nuc. Med. | Synovectomy (Therapy) | 42.21 | | | | |
| 1964 | Nuc. Med. | Polycythemia (Therapy) | 42.21 | | | | |
| 1970 | Nuc. Med. | Red cell volume | 11.73 | | | | |
| 1971 | Nuc. Med. | Plasma volume | 11.73 | | | | |
| 1972 | Nuc. Med. | Red cell survival | 23.45 | | | | |
| 1973 | Nuc. Med. | Sequestration study | 46.89 | | | | |
| 1974 | Nuc. Med. | Ferrokinetics | 23.45 | | | | |
| 1976 | Nuc. Med. | Stool for blood loss | 11.73 | | | | |
| 1977 | Nuc. Med. | I-131 Gastrointestinal protein loss study | 11.73 | | | | |
| 1978 | Nuc. Med. | C-14 Breath test | 11.73 | | | | |
| 1979 | Nuc. Med. | Glomerular Filtration Rate (with blood samples) | 11.73 | | | | |
| 1981 | Nuc. Med. | Schilling test with or without intrinsic factor | 11.73 | | | | |
| 1995 | Nuc. Med. | Retrograde Nuclide Cystogram | 18.75 | | | | |
| | | | TOTAL UNITS FOR THIS CLAIM: | | | | |

PROGRAMS OF THE NOVA SCOTIA DEPT. OF HEALTH
PO BOX 500 HALIFAX NOVA SCOTIA B3J 2S1
TELEPHONE (902) 468-9700

**NOVA SCOTIA MEDICAL SERVICES INSURANCE**

# PATHOLOGY STATISTICAL BILLING REPORT

| | |
|---|---|
| Provider Name or Group Name: | |
| Provider Number or Group Number: | |
| Institution Name and Number: | |
| Business Arrangement Number: | |
| Billing Period From: | |
| Billing Period To: | |
| Contact Name / Phone Number: | |

| CODE | EXAMINATION DESCRIPTION | UNITS | In Patient | Out Patient | Number of Exams | TOTAL UNITS |
|---|---|---|---|---|---|---|
| P2320 | Autopsy, gross (all ages) | 123.50 | | | | |
| P2321 | Autopsy, gross, negative cranium | 95.42 | | | | |
| P2322 | Autopsy, gross, limited | 28.07 | | | | |
| P2323 | Autopsy Tissues (Maximum 25 per autopsy) | 4.49 | | | | |
| P2324 | Surgicals, gross | 7.30 | | | | |
| P2325 | Surgicals, gross and microscopic | 19.08 | | | | |
| P2326 | Frozen Sections | 31.99 | | | | |
| P2328 | Interpretation–fine needle aspiration biopsy | 15.00 | | | | |
| P2329 | Cell Block | 14.60 | | | | |
| P2330 | Cytology (with a screener) | 1.00 | | | | |
| P2331 | Interpretation & Report–GYN cytology slides | 5.00 | | | | |
| P2332 | Interpretation & Report–NON GYN cytology slides | 5.61 | | | | |
| P2333 | Sex Chromatin Analysis | 5.61 | | | | |
| P2334 | Karyotype Test A–5 cells & 2 karyotypes | 16.84 | | | | |
| P2335 | Karyotype Test B–30 cells & 4 karyotypes | 22.46 | | | | |
| P2336 | Electron Microscopy Anatomical Pathology only | 52.90 | | | | |
| P2337 | * Immunohistochemistry–Head and Neck | 10.00 | | | | |
| P2338 | * Immunohistochemistry–Anterior Torso | 10.00 | | | | |
| P2339 | * Immunohistochemistry–Posterior Torso | 10.00 | | | | |
| P2340 | * Immunohistochemistry–Right arm | 10.00 | | | | |
| P2341 | * Immunohistochemistry–Left arm | 10.00 | | | | |
| P2342 | * Immunohistochemistry–Right leg | 10.00 | | | | |
| P2343 | * Immunohistochemistry–Left leg | 10.00 | | | | |
| P2344 | Liquid based preparation (thin prep) non gynaecological cytology (per slide) | 15.00 | | | | |
| P2345 | Surgicals, gross and microscopic 3 or more separate surgical specimens | 29.62 | | | | |
| P2346 | Surgicals, gross and microscopic, single large complex CA specimen including lymph notes | 29.62 | | | | |
| * Immunohistochemistry Staining and Interpretation of Surgical (Anatomic) Pathology Specimens | | **TOTAL UNITS CLAIMED:** | | | | |

PROGRAMS OF THE NOVA SCOTIA DEPT. OF HEALTH
PO BOX 500 HALIFAX NOVA SCOTIA B3J 2S1
TELEPHONE (902) 468-9700

**NOVA SCOTIA MEDICAL SERVICES INSURANCE**

# PATHOLOGY STATISTICAL BILLING REPORT - PREMIUM FEES

| | |
|---|---|
| Provider Name or Group Name: | |
| Provider Number or Group Number: | |
| Institution Name and Number: | |
| Business Arrangement Number: | |
| Billing Period From: | |
| Billing Period To: | |
| Contact Name / Phone Number: | |

| CODE | EXAMINATION DESCRIPTION-PREMIUM TIME | Premium value | Unit value | In patient | Out patient | No. of exams | TOTAL UNITS |
|---|---|---|---|---|---|---|---|
| P3320 | Autopsy, gross (all ages) | 35% | 166.73 | | | | |
| P5320 | Autopsy, gross (all ages) | 50% | 185.25 | | | | |
| P3321 | Autopsy, gross, negative cranium | 35% | 128.82 | | | | |
| P5321 | Autopsy, gross, negative cranium | 50% | 143.13 | | | | |
| P3322 | Autopsy, gross, limited | 35% | 37.89 | | | | |
| P5322 | Autopsy, gross, limited | 50% | 42.11 | | | | |
| P3323 | Autopsy Tissues (Maximum 25 per autopsy) | 35% | 13.49 | | | | |
| P5323 | Autopsy Tissues (Maximum 25 per autopsy) | 50% | 13.49 | | | | |
| P3324 | Surgicals, gross | 35% | 16.30 | | | | |
| P5324 | Surgicals, gross | 50% | 16.30 | | | | |
| P3325 | Surgicals, gross and microscopic | 35% | 28.08 | | | | |
| P5325 | Surgicals, gross and microscopic | 50% | 28.62 | | | | |
| P3326 | Frozen Sections | 35% | 43.19 | | | | |
| P5326 | Frozen Sections | 50% | 47.99 | | | | |
| P3328 | Interpretation - fine needle aspiration biopsy | 35% | 24.00 | | | | |
| P5328 | Interpretation - fine needle aspiration biopsy | 50% | 24.00 | | | | |
| P3329 | Cell Block | 35% | 23.60 | | | | |
| P5329 | Cell Block | 50% | 23.60 | | | | |
| P3330 | Cytology (with a screener) | 35% | 10.00 | | | | |
| P5330 | Cytology (with a screener) | 50% | 10.00 | | | | |
| P3331 | Interpretation & Report - GYN cytology slides | 35% | 14.00 | | | | |
| P5331 | Interpretation & Report - GYN cytology slides | 50% | 14.00 | | | | |
| P3332 | Interpretation & Report - NON GYN cytology slides | 35% | 14.61 | | | | |
| P5332 | Interpretation & Report - NON GYN cytology slides | 50% | 14.61 | | | | |
| P3333 | Sex Chromatin Analysis | 35% | 14.61 | | | | |
| P5333 | Sex Chromatin Analysis | 50% | 14.61 | | | | |
| P3334 | Karyotype Test A - 5 cells & 2 karyotypes | 35% | 25.84 | | | | |
| P5334 | Karyotype Test A - 5 cells & 2 karyotypes | 50% | 25.84 | | | | |
| P3335 | Karyotype Test B - 30 cells & 4 karyotypes | 35% | 31.46 | | | | |
| P5335 | Karyotype Test B - 30 cells & 4 karyotypes | 50% | 33.69 | | | | |
| P3336 | Electron Microscopy Anatomical Pathology only | 35% | 71.42 | | | | |
| P5336 | Electron Microscopy Anatomical Pathology only | 50% | 79.35 | | | | |
| P3345 | Surgicals, gross and microscopic 3 or more separate surgical specimens | 35% | 39.99 | | | | |
| P5345 | Surgicals, gross and microscopic 3 or more separate surgical specimens | 50% | 44.43 | | | | |
| P3346 | Surgicals, gross and microscopic, single large complex CA specimens including lymph notes | 35% | 39.99 | | | | |
| P5346 | Surgicals, gross and microscopic, single large complex CA specimens including lymph notes | 50% | 44.43 | | | | |
| | | | | | | **TOTAL UNITS CLAIMED:** | |

# 2012 CUT-OFF DATES
# FOR RECEIPT OF
# PAPER & ELECTRONIC CLAIMS

| PAPER CLAIMS | ELECTRONIC CLAIMS | PAYMENT DATE |
|---|---|---|
| December 30, 2011** | January 5, 2012 | January 11, 2012 |
| January 16, 2012 | January 19, 2012 | January 25, 2012 |
| January 30, 2012 | February 2, 2012 | February 8, 2012 |
| February 13, 2012 | February 16, 2012 | February 22, 2012 |
| February 27, 2012 | March 1, 2012 | March 7, 2012 |
| March 12, 2012 | March 15, 2012 | March 21, 2012 |
| March 26, 2012 | March 29, 2012 | April 4, 2012 |
| April 9, 2012 | April 12, 2012 | April 18, 2012 |
| April 23, 2012 | April 26, 2012 | May 2, 2012 |
| May 7, 2012 | May 10, 2012 | May 16, 2012 |
| May 18, 2012 ** | May 24, 2012 | May 30, 2012 |
| June 4, 2012 | June 7, 2012 | June 13, 2012 |
| June 18, 2012 | June 21, 2012 | June 27, 2012 |
| June 30, 2012 ** | July 5, 2012 | July 11, 2012 |
| July 16, 2012 | July 19, 2012 | July 25, 2012 |
| July 30, 2012 | August 1, 2012 ** | August 8, 2012 |
| August 13, 2012 | August 16, 2012 | August 22, 2012 |
| August 27, 2012 | August 29, 2012 ** | September 5, 2012 |
| September 10, 2012 | September 13, 2012 | September 19, 2012 |
| September 24, 2012 | September 27, 2012 | October 3, 2012 |
| October 5 ,2012 ** | October 11, 2012 | October 17, 2012 |
| October 22, 2012 | October 25, 2012 | October 31, 2012 |
| November 5, 2012 | November 7, 2012 ** | November 14, 2012 |
| November 19, 2012 | November 22, 2012 | November 28, 2012 |
| December 3, 2012 | December 6, 2012 | December 12, 2012 |
| December 13, 2012 ** | December 18, 2012 ** | December 24, 2012 ** |
| December 31, 2012 | January 3, 2013 | January 9, 2013 |
| 11:00 AM CUT OFF | 11:59 PM CUT OFF | |

NOTE:
Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Radiology, Pathology, Internal Medicine Monthly Statistical Reports and Sessional Payments. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut off date to ensure processing for that payment period.

PLEASE NOTE, THE ** INDICATES A DATE VARIATION

November 30, 2011

## HOLIDAY DATES FOR 2012

Please make a note in your schedule of the following dates MSI will accept as "Holidays."

| | |
|---|---|
| NEW YEAR'S DAY | MONDAY, JANUARY 2, 2012 |
| GOOD FRIDAY | FRIDAY, APRIL 6, 2012 |
| EASTER MONDAY | MONDAY, APRIL 9, 2012 |
| VICTORIA DAY | MONDAY, MAY 21, 2012 |
| CANADA DAY | MONDAY, JULY 2, 2012 |
| CIVIC HOLIDAY | *IF APPLICABLE* |
| LABOUR DAY | MONDAY, SEPTEMBER 3, 2012 |
| THANKSGIVING DAY | MONDAY, OCTOBER 8, 2012 |
| REMEMBRANCE DAY | MONDAY, NOVEMBER 12, 2012 |
| CHRISTMAS DAY | TUESDAY, DECEMBER 25, 2012 |
| BOXING DAY | WEDNESDAY, DECEMBER 26, 2012 |
| NEW YEAR'S DAY | TUESDAY, JANUARY 1, 2013 |

MSI Assessment Department (902) 496-7011
Fax Number (902) 490-2275
Toll Free Number 1-866-553-0585

# Happy Holidays!

*From the Staff of the MSI Programs*

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

October 21, 2011 Volume XLVI - #4

Inside this issue



## CONTACT US

***MSI_Assessment@medavie.bluecross.ca***

## ***ELECTRONIC CLAIMS CUT-OFF REVISION***

Please note that the previously communicated cut-off date for paper claims submission on December 19, 2011 has been revised due to the holiday season. Claims must now be submitted by 11:00 a.m. on December 16, 2011 to ensure processing for the payment date of December 28, 2011.

## UPCOMING FEES

The following fee has been approved by the Master Agreement Steering Group (MASG) for inclusion into the Fee Schedule, effective January 1, 2011.

| Category | Description | Unit Value |
|---|---|---|
| VADT | **Intravitreal Injection of a pharmacologic agent for the treatment of wet macular degeneration**<br><br>For a patient diagnosed with wet macular degeneration, this fee includes the counselling of the patient, preparation of the eye, administration of subconjunctival anaesthesia and topical antibiotic as required and injection of the pharmacologic agent. | 25 |

*NOTE: Physicians are advised to continue billing HSC 28.73D – Intravitreal Injection of Antibiotics – until MSI updates the system. Once a new Health Service Code has been assigned, it wil be published in the MSI Physicians' Bulletin.*

The following fees have been approved by the Master Agreement Steering Group (MASG) for inclusion into the Fee Schedule, effective September 1, 2011.

| Category | Description | Unit Value |
|---|---|---|
| MASG | **Thumb CMC Joint Tendon Interpositional Arthroplasty**<br><br>To include removal of the trapezium, dissection of tendon, protection of radial nerve and osteotomies as required. | 190 4+T |

| | | |
|---|---|---|
| MASG | **Total Ankle Arthroplasty with Prosthesis**<br><br>Procedure includes insertion of hardware, all associated bone preparation and soft tissue procedures such as alteration of tendon length, tendon transfer and repair, and synovectomy as required. | 350 4+T |

| **Category** | **Description** | **Unit Value** |
|---|---|---|
| VEDT | **Peripheral Blood Film Review**<br><br>Review of peripheral blood film by the pathologist or hematopathologist in response to a perceived abnormality in the complete blood count as determined by local laboratory policies. Includes review of blood film, patient history, correlation with other laboratory tests, assessment or morphology of all cell lines with the provision of a report and recommendations. | 10 |
| VEDT | **Continuous Conduction Anaesthesia for relief of pain in labour**<br><br>Provision of neuraxial anaesthesia for relief of pain in labour and delivery.<br>To include the entire epidural insertion, all top-ups, maintenance, normal vaginal delivery and removal of epidural catheter. | 140 |
| VEDT | **Flow Cytometry**<br><br>Flow Cytometry for the diagnosis and follow up of patients with hematologic malignancies and immune disorders. | 52.90 |
| VEDT | **HLA Identification and Crossmatch**<br><br>HLA of a donor's blood followed by screening of potential recipients based on existing HLA typing. Crossmatching of potential donor recipient pairs is then performed to assess transplant potential. | 52.90 |
| VEDT | **HLA Typing**<br><br>HLA typing for bone marrow and solid organ transplant patients. | 52.90 |
| VEDT | **Bone Marrow Interpretation**<br><br>Examination of all slides, confirmation of cell counts, interpretation of hematopoesis and iron stains, required to render a diagnosis based on WHO criteria. | 28.62 |

| | | |
|---|---|---|
| VEDT | **Coronary CT Angiography**<br><br>Coronary CT Angiography performed under direct supervision of the radiologist. Fee includes the performance and interpretation of the scan with all necessary work station, plus the administration of medication to control heart rate and contrast material as required.<br>**Not to be used as a screening test in asymptomatic patients.** | 120 |

| Category | Description | Unit Value | |
|---|---|---|---|
| VADT | **Percutaneous expansion/inflation of a tissue expander** | 13 | |
| ADON | **Morbid Obesity Surgical Add On**<br><br>Billable once per patient per physician in addition to the amount payable for the major procedure(s) where a morbidly obese patient undergoes surgery to the neck, hip, or trunk and:<br>a. has a BMI (body mass index) greater than 50 and this is recorded in the patient's health record.<br>b. the procedure is performed using an open technique through an incision for major neck and hip surgery and an open or laparoscopic technique for the trunk and is performed under general, or neuraxial anaesthesia.<br>c. the principle technique is neither aspiration, core or fine needle biopsy, dilation, endoscopy, cautery, ablation, nor catheterization.<br>d. not billable for bariatric surgery. | 32.9 | 4.6 |
| ADON | **Repeat Open Heart Surgery**<br><br>An add on code for repeat open heart surgery or revision of open cardiac surgery with pump, via a Sternotomy when the repeat surgery is 28 days or more after the previous open heart procedure. | 120 | |
| ADON | **Total Arterial Grafting**<br><br>Procedures Auxiliary to Open Heart Surgery:<br>ADON to CABG when all grafts are non-LIMA arterial grafts. Used with HSC 48.12, 48.13 or 48.14 | 100 | |
| MASG | **External Fixation of Tibial plafond fracture**<br><br>Closed reduction with external fixation of a tibial plafond fracture with or without minimal internal fixation.<br><br>Stage one of the treatment of a tibial plafond fracture, also known as a pilon fracture, or distal | 150 | 4+T |

tibial explosion fracture. The purpose of this stage is to stabilise the fracture and allow for resolution of soft tissue swelling and wound management prior to open reduction and internal fixation of the same fracture.

| Category | Description | Unit Value |
|---|---|---|
| MASG | **External Fixation of Tibial plafond fracture, with open reduction and internal fixation of fibular fracture**<br><br>Closed reduction with external fixation of a tibial plafond fracture with or without minimal internal fixation, with open reduction and internal fixation of distal fibular fracture.<br><br>Stage one of the treatment of a tibial plafond fracture, also known as a pilon fracture, or distal tibial explosion fracture, when there is a distal fibular fracture of the same limb. The purpose of this stage is to stabilise the fracture and allow for resolution of soft tissue swelling and wound management prior to open reduction and internal fixation of the same fracture. | 175 4+T |

*NOTE: Please hold all eligible service encounters to allow MSI the required time to update the system. Once a new Health Service Code has been assigned, it wil be published in the MSI Physicians' Bulletin.*

## FEE REVISION

The following fee revision has been approved by the Master Agreement Steering Group (MASG) for inclusion into the Fee Schedule, effective September 1, 2011.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 91.35B | **Fractured tibial plafond, with or without fibula, open reduction and internal fixation – including removal of preexisting internal or external fixation devices (regions required)**<br><br>Open reduction and internal fixation of tibial plafond facture, also known as a pilon fracture, or distal tibial explosion fracture. This is the second stage of a two stage procedure. The fee includes removal of any external and/or internal fixation previously inserted, for the same fracture. | 200 4+T |

*NOTE: Please continue to submit claims in the normal manner. Ninety days after the system has been updated, a retroactive payment will be processed.*

**PREAMBLE REVISIONS**

The Master Agreement Steering Group (MASG) has approved the following preamble amendments, effective September 1, 2011.

7.5.5 A Prolonged Consultation may be applied to cases where the consultation extends beyond one hour for comprehensive consultations and a half-hour for repeat consultations, ***or a half hour for OBGY consultations - specifically for preconceptual consultation(Maternal fetal medicine), consultation for issues of sexual dysfunction, reproductive endocrinology, gynaecologic oncology, and urogynaecology.*** A prolonged consultation cannot be claimed with a limited consultation. Prolonged consultations are paid in 15-minute time blocks or portion thereof. Prolonged consultations are not to be confused with active treatment associated with detention.

A prolonged consultation may be claimed only by the following specialties:
(a)Anaesthesia
(b)Internal Medicine
(c) Neurology
(d)Physical Medicine
(e)Paediatrics
(f)Psychiatry
(***g)Obstetrics and Gynaecology***

7.10.2 Pallative Care Support Visit
The Palliative Care Support Visit is a time-based all-inclusive visit for the purpose of providing pain and symptom management, emotional support and counseling to patients with terminal disease. The physician must spend at least 80% of the time claimed with the patient and cannot claim for any other visits with the patient on the same day.
***Can be claimed if the patient is registered with the district integrated palliative care service.***

7.10.3 Pallative Care Chart Review and/or Telephone Call
The Palliative Care Medical Chart Review and/or Telephone call, fax or e-mail advice eligible for payment are those initiated by health care professionals involved with the care of the palliative care patient. Telephone calls, fax or e-mails initiated by the palliative patient or his/her family members are not eligible. Physicians and health care professionals involved should keep a detailed record of telephone calls, fax or e-mails. Palliative care medical chart review and/or telephone calls, fax or e-mails ***can be claimed if the patient is registered with the district integrated palliative care service.***

8.3.2 Calculation of Anaesthetic Fees
A Basic Unit is listed for most procedures. It is the value assigned to each procedure to cover all anaesthetic services except the time actually spent either in administering the anaesthesia or in unusual detention with the patient. Additional procedures, not routine components of an anaesthetic procedure, will be billed either as additional anaesthesia procedures, or as replacements for, or additions to, the basic units. These procedures include the following items, for which the basic rate will be increased or replaced by a unit value specific to the factors listed below (See Billing Instructions Manual):

***viii) Morbid Obesity-when providing general, or neuraxial anaesthesia for a patient with a body mass index (BMI) greater than 50, the units will be increased.***

9.4.1 Surgical Rules apply to treatment of fractures except:

a) A fracture procedure (not dislocation) includes necessary after care up to ***14 days.*** The application and removal of casts or traction devices is included in the fee, even if removal takes place after the ***14 day*** period.

9.4.12 Multiple Fractures

a) Where multiple fractures are treated by the same surgeon the greater procedure is claimed at 100% and 50% is claimed for each additional fracture.

***b) When multiple major fractures involve different long bones (where long bones are specified as clavicle, humerus, radius, contralateral ulna, femur, tibia and contralateral fibula), occur at the same time and are managed under the same anaesthetic, the greater procedure is claimed at 100% and 85% is claimed for each additional long bone fracture, unless specified otherwise. [This does not apply to fractures of the ulna when the radius on the same side is fractured, or fractures of the fibula when the tibia on the same side is fractured].***

*NOTE: Please hold all eligible service encounters to allow MSI the required time to update the system. Once the applicable changes have been made, they wil be published in the MSI Physicians' Bulletin.*

## LIVER TRANSPLANT RECIPIENT TELEPHONE CALLS (VIST 03.03 RO=TALR)

This code is for the provision of telephone advice by a transplant hepatologist and is only payable when the call is initiated by the physician(s) in the patient's home community who is responsible for monitoring the patient between visits to the transplant hepatologist. Both physicians must keep a detailed record of the call. This health service code may not be used for other types of telephone calls.

## SLEEP STUDIES

Physicians are reminded that health service code 03.19C is to be used when a level 1 sleep study has been conducted; i.e., a sleep technician is in continuous attendance and the study takes place in a sleep centre of a hospital based sleep laboratory. It may not be used for portable at home testing which should be billed as 03.19F for Level II testing or 03.19G for Level III testing.

## PERIPHERAL NERVE BLOCKS

If at the time of performing temporary nerve blocks (Health Service Code 17.72C) additional injections are needed to secure adequate analgesia, either at the trunk level or more peripherally, this is included in the original nerve block code and not payable as a multiple. Additionally, physicians are advised that only one occipital nerve block per side may be claimed.

## PATHOLOGISTS – SECOND OPINION CONSULTS

Pathologists are reminded that they may not bill second opinion consults for cases that are part of a Quality Assurance program.

## GUIDELINES FOR FUNDING OUT OF PROVINCE ADDICTION TREATMENT

Funding for out of province treatment for addictions treatment will be considered where it can be demonstrated that the individual patient has a significant problem which has been

**unresponsive to all reasonable attempts** to treat it utilizing services available within Nova Scotia's publicly funded addictions services system.

1. **Certain conditions apply to consideration of such requests:**

    - The province will only consider payment for out of province treatment if **prior** approval is given to the specific patient/client to meet a need for treatment that cannot be met within the province.

    - Consideration will only be given to a limited number of established **accredited** programs outside Nova Scotia that offer specialized programs. Extraordinary circumstances may be considered on a case by case basis.

2. **Applications for out of province treatment for addiction treatment issues must be accompanied by:**

    - A detailed **history of previous experience with addiction treatment** and some indication of why these experiences have had limited impact on recovery.

    - An indication of **the facility/program selected**; why it was selected; the likelihood of a positive outcome from treatment there and an estimate of the related costs.

    - **If available**, an up to date psychiatric assessment conducted by a Nova Scotia registered psychiatrist. This should include a full assessment including details about the present problem; previous psychiatric history; family, personal and social history; medical history; mental state examination and medication currently prescribed.

3. **In addition to meeting the conditions for out province treatment for addiction treatment:**

    - The client must be **assessed by a clinical therapist** working at Addictions Services in the client's district of residence

    - The case is to be **reviewed by the Director of Addiction Services** to determine the availability and suitability of in-province treatment and to make a recommendation for out of province treatment to the relevant physician.

    - A **follow up treatment plan** with Addiction Services (e.g. Community Based Services) upon return from out of province treatment must be included in the request.

4. **Application Process:**

    - The physician is responsible to compile all documentation and submit a letter of request to MSI for out of province treatment funding.

    - Applications are directed to the MSI Medical Consultant.

    - MSI will send request to Executive Director, Mental Health, Children's Services and Addictions for approval.

**GUIDELINES FOR FUNDING OUT OF PROVINCE TREATMENT FOR MENTAL HEALTH**

Funding for out of province treatment for mental health treatment issues will be considered where it can be demonstrated that the individual patient has a significant problem which has been **unresponsive to all reasonable attempts** to treat it utilizing services available within Nova Scotia's publicly funded mental health system.

**1. Certain conditions apply to consideration of such requests:**

- The province will only consider payment for out of province treatment if **prior** approval is given to the specific patient/client to meet a need for treatment that cannot be met within the province.
- Consideration will only be given to a limited number of established **accredited** programs outside Nova Scotia that offer specialized programs. Extraordinary circumstances may be considered on a case by case basis.
- Residents of Nova Scotia requiring medical care not available in Nova Scotia must be referred for out-of – province treatment by a Nova Scotia specialist approved as such by the College of Physicians and Surgeons of Nova Scotia.

**2. Applications for out of province treatment for addiction treatment issues must be accompanied by:**

- A detailed **history of previous attempts at treatment with mental health** and some indication of why these experiences have had limited impact.
- An indication of **the facility/program selected**; why it was selected; the likelihood of a positive outcome from treatment there and an estimate of the related costs.
- An up to date psychiatric assessment conducted by a Nova Scotia registered psychiatrist. This should include a **full** assessment including details about the present problem; previous psychiatric history; family, personal and social history; medical history; mental state examination and medication currently prescribed.

**3. In addition to meeting the conditions for out province treatment for mental health treatment:**

- There must be a stated plan for follow-up and continued care of the patient on their return to the province.

**4. Application Process:**

- The physician is responsible to compile all documentation and submit a letter of request to MSI for out of province treatment funding.
- Applications are directed to the MSI Consultant.
- MSI will send request to Executive Director, Mental Health, Children's Services and Addictions for approval.

**MSI DOCUMENTATION REMINDER**

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribed.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptions, or emotional problems, the physician "deliberately established a professional relationship with the patient for the purposes of removing, modifying or retarding existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional well being of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy," etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service, then the service is not paid for or a lesser benefit is given.

Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

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

**INFLUENZA IMMUNIZATION**

For the 2011-2012 Season, the influenza immunization is not restricted to certain age groups or risk categories. Please refer to the attached schedule of provincial immunizations for the diagnostic codes to be used when billing for the influenza immunization.

**REMINDERS: BILLING GUIDELINES FOR PROVINCIAL IMMUNIZATIONS**

Please see the attached Schedule of Provincial Immunizations for billing purposes.

1. If one vaccine is administered but no associated office visit is billed **(i.e. the sole purpose for the visit is the immunization), claim the immunization at a full fee of 6.0 MSUs.**

2. If two vaccines are administered at the same visit but no associated office visit is billed **(i.e. the sole purpose for the visit is the immunization), claim for each immunization at a full fee of 6.0 MSUs each.**

3. If one vaccine is administered in conjunction with a billed office visit, **claim both the office visit and the immunization at full fee.**

4. If two vaccines are administered in conjunction with a billed office visit, **the office visit and the first injection can be claimed at full fee. All subsequent injections will be paid at 50 percent.**

5. For children under 12 months of age, if a vaccine is administered in conjunction with a well baby care visit, **claim the well baby care visit and the immunization.**

**REMINDER: SOFTWARE VENDORS**

Software developers must notify MSI three months in advance of any changes to the accredited software that might impact the claims submission process. MSI will determine if any additional testing is required to maintain accreditation status.

## SCHEDULE OF PROVINCIAL IMMUNIZATIONS

Refer to the following fee schedule when claiming for individual immunization(s) not billed in conjunction with an office visit or a single immunization billed in conjunction with an office visit:

| IMMUNIZATION | HEALTH SERVICE CODE | MODIFIER | MSUs | DIAGNOSTIC CODE |
|---|---|---|---|---|
| PENTA (DaPTP, Hib) | 13.59L | RO=PENT | 6.0 | V069 |
| MMR | 13.59L | RO=MMAR | 6.0 | V069 |
| QUAD (DaPTP) | 13.59L | RO=QUAD | 6.0 | V069 |
| Td | 13.59L | RO=TEDI | 6.0 | V069 |
| Influenza - Pregnant | 13.59L | RO=INFL | 6.0 | V221 |
| Influenza - Males and non-pregnant females | 13.59L | RO=INFL | 6.0 | V048 |
| Varicella | 13.59L | RO=VARI | 6.0 | V069 |
| Adacel | 13.59L | RO=ADAC | 6.0 | V069 |
| Menjugate | 13.59L | RO=MENC | 6.0 | V069 |
| Pneumococcal Polysaccharide | 13.59L | RO=PNEU | 6.0 | V069 |
| Pneumococcal Polysaccharide In addition to Influenza | 13.59L | RO=PNEU | 6.0 | V066 |
| Boostrix® | 13.59L | RO=BOTR | 6.0 | V069 |
| Pneumococcal Conjugate | 13.59L | RO=PNEC | 6.0 | V069 |

When claiming immunization with a visit, the visit will be paid in full at 100%. The first inoculation will be in full at 6.0 MSU and all subsequent inoculations will be paid at 3.0 MSU or 50%. If the purpose of the visit is for immunization only, then the first two inoculations will be paid at 100% and all subsequent inoculations at 50% of the specified MSU.

Refer to the following table when claiming for a provincial immunization tray fee:

| HEALTH SERVICE CODE | DESCRIPTION | MSUs |
|---|---|---|
| 13.59M | Provincial Immunization Tray Fee | 1.5 per multiple (Max 4) |

Refer to the following diagnostic code table, when claiming for pneumococcal and varicella immunizations:

| PATIENT'S CONDITION | DIAGNOSTIC CODE |
|---|---|
| At risk irrespective of age | Diagnostic code applicable to condition, e.g. 25000 diabetes mellitus |
| Close contact of at risk individual | V018 |
| Well Senior | V069 |

# PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

July 22, 2011 Volume XLVI - #3


Inside this issue



## CONTACT US

The MSI Assessment department now has an email address available for questions that physicians may have regarding:

- Electronic billing, adjudication, or payment
- Service encounter submission policies and procedures
- Forms and reference materials
- Bank deposit enquiries – EFT

**Please send any enquiries to:**

***MSI_Assessment@medavie.bluecross.ca***

## NEW FEES

Effective January 01, 2011 the following new Health Service Codes are available for billing:

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| VADT | 51.59I | | **Percutaneous Arterial Angioplasty – Upper Limbs** | |
| | | **RG=RRUA**<br>**RG=LRUA** | Radial or ulnar artery – right side<br>Radial or ulnar artery – left side<br><br>Code may be billed only once per side (Lt or Rt) | 183.6 8+T |
| VADT | 51.59J | | **Percutaneous Arterial Angioplasty – Central Vessels** | |
| | | **RG=INRE** | Aorta - infra renal<br><br>May be billed in addition to other adjacent vessel angioplasty if indicated. | 137.7 5+T |
| VADT | 51.59J | **RG=SURE** | Aorta – supra renal<br><br>May be billed in addition to other adjacent vessel angioplasty if indicated. | 200 15+T |

| | | | | |
|---|---|---|---|---|
| VADT | 51.59J | **RG=GVIB** | Great vessel – innominate/brachiocephalic | 183.6 15+T |
| | | **RG=GVCC** | Great vessel – left common carotid | |
| | | **RG=GVSA** | Great vessel – left subclavian artery | |
| | | | Code may be billed only once per named great vessel artery. | |
| VADT | 51.59J | **RG=VCEL** | Visceral – celiac | 183.6 8+T |
| | | **RG=VSMA** | Visceral - SMA | |
| | | **RG=VIMA** | Visceral - IMA | |
| | | **RG=VSPL** | Visceral - splenic | |
| | | **RG=VHEP** | Visceral - hepatic | |
| | | | Code may be billed only once per named visceral artery. | |

| **Category** | **Code** | **Modifiers** | **Description** | **Unit Value** |
|---|---|---|---|---|
| VADT | 51.59K | | **Percutaneous Arterial Angioplasty – Lower Limbs** | |
| | | **RG=RPOP** | Popliteal – right side | 137.7 8+T |
| | | **RG=LPOP** | Popliteal – left side | |
| | | | Code may be billed only once per side (Lt or Rt). Popliteal region is adductor hiatus tibial trifurcation. | |
| VADT | 51.59K | **RG=RANT** | Anterior Tibial – right side | 183.6 10+T |
| | | **RG=LANT** | Anterior Tibial – left side | |
| | | **RG=RPOT** | Posterior Tibial – right side | |
| | | **RG=LPOT** | Posterior Tibial – left side | |
| | | **RG=RPER** | Peroneal – right side | |
| | | **RG=LPER** | Peroneal – left side | |
| | | | Code may be billed for a maximum of 2 vessels per side (Lt or Rt) | |
| VADT | 51.59L | | **Venous Angioplasty - Head** | |
| | | **RG=RSIG** | Dural Sinus (Sigmoid sinus) – right side | 183.6 10+T |
| | | **RG=LSIG** | Dural Sinus (Sigmoid sinus) – left side | |
| | | **RG=RTRA** | Dural Sinus (Transverse sinus) – right side | |
| | | **RG=LTRA** | Dural Sinus (Transverse sinus) – left side | |
| | | **RG=SAGG** | Dural Sinus (Saggital sinus) | |

| | | | | | |
|---|---|---|---|---|---|
| | | | Code may be billed only once per sinus per side for the following indications:<br><br>Venous angioplasty to treat increased Intra-cranial pressure secondary to an identified cerebral venous stenosis or occlusion (compression by adjacent neoplasm or mass, isolated idiopathic stenosis, etc.) [cerebral venous sinuses and jugular vein outflow]. | | |
| **Category** | **Code** | **Modifiers** | **Description** | **Unit Value** | |
| VADT | 51.59M | | **Venous Angioplasty – Upper Limbs** | | |
| | | **RG=RRUA**<br>**RG=LRUA** | Radial or ulnar vein – right side<br>Radial or ulnar vein – left side<br><br>Code may be billed only once per side (Lt or Rt) for the following indications:<br><br>Dialysis AV Fistula or Graft Outflow vein stenosis or occlusion<br><br>Post Thrombotic Stenosis or occlusions | 137.7 | 8+T |
| VADT | 51.59M | **RG=RBAC**<br>**RG=LBAC** | Basilic or cephalic vein – right side<br>Basilic or cephalic vein – left side<br><br>Code may be billed only once per side (Lt or Rt) for the following indications:<br><br>Dialysis AV Fistula or Graft Outflow vein stenosis or occlusion<br><br>Post Thrombotic Stenosis or occlusions | 137.7 | 8+T |
| VADT | 51.59M | **RG=RAXI**<br>**RG=LAXI** | Axillary vein – right side<br>Axillary vein – left side<br><br>Code may be billed only once per side (Lt or RT) for the following indications:<br><br>Post Thrombotic Stenosis or occlusions | 137.7 | 8+T |

| | | | | | |
|---|---|---|---|---|---|
| | | | Thoracic outlet syndrome | | |
| VADT | 51.59N | | **Venous Angioplasty – Central Vessels** | | |
| | | **RG=VREN**<br>**RG=VSUM**<br>**RG=VSPL**<br>**RG=VHEP**<br>**RG=VPOR** | Visceral – renal<br>Visceral – superior mesenteric<br>Visceral – splenic<br>Visceral – hepatic<br>Visceral – portal<br><br>Code may be billed only once per named visceral vein (renal, superior mesenteric, splenic, hepatic, portal) for the following indications:<br><br>Stenosis or occlusion (Budd Chiari, post surgical, post transplant, etc.) | 183.6 | 10+T |
| **Category** | **Code** | **Modifiers** | **Description** | **Unit Value** | |
| VADT | 51.59N | **RG=IVCA** | Inferior Vena Cava (IVC)<br><br>Code may be billed only once for the following indications:<br><br>IVC Stenosis (post surgical), Neoplastic compression or invasion. | 137.7 | 10+T |
| VADT | 51.59N | **RG=SVCA** | Superior Vena Cava<br><br>Code may be billed only once for the following indications:<br><br>Stenosis or occlusion related to venous compression or invasion secondary to neoplastic disease, or,<br>Stenosis or occlusion related to organized fibrin sheath and/or organized thrombus from indwelling central venous catheters | 137.7 | 10+T |
| VADT | 51.59N | **RG=RBRC**<br>**RG=LBRC** | Brachiocephalic – right side<br>Brachiocephalic – left side<br><br>Code may be billed only once per side (Lt or Rt) per region for the following indications:<br><br>Stenosis or occlusion related to venous compression or invasion | 137.7 | 10+T |

| | | | | | |
|---|---|---|---|---|---|
| | | | secondary to neoplastic disease, or,<br>Stenosis or occlusion related to organized fibrin sheath and/or organized thrombus from indwelling central venous catheters | | |
| VADT | 51.59N | **RG=RSUB**<br>**RG=LSUB** | Subclavian vein – right side<br>Subclavian vein – left side<br><br>Code may be billed only once per side (Lt or Rt) per region for the following indications:<br><br>Stenosis or occlusion related to venous compression or invasion secondary to neoplastic disease, or,<br>Stenosis or occlusion related to organized fibrin sheath and/or organized thrombus from indwelling central venous catheters | 137.7 | 10+T |

| **Category** | **Code** | **Modifiers** | **Description** | **Unit Value** | |
|---|---|---|---|---|---|
| VADT | 51.59O | | **Venous Angioplasty – Lower Limbs** | | |
| | | **RG=RCSF**<br>**RG=LCSF** | Common femoral/Superficial femoral – right side<br>Common femoral/Superficial femoral – left side | 137.7 | 8+T |
| | | **RG=RPRF**<br>**RG=LPRF** | Profunda femoris – right side<br>Profunda femoris – left side<br><br>Code may be billed only once per side (Lt or Rt) per anatomic region for the following indications:<br><br>Post Thrombotic Stenoses or occlusions | | |
| VADT | 51.59O | **RG=RCOI**<br>**RG=LCOI** | Common iliac – right side<br>Common iliac – left side | 137.7 | 8+T |
| | | **RG=RINI**<br>**RG=LINI** | Internal iliac – right side<br>Internal iliac – left side | | |
| | | **RG=REXI**<br>**RG=LEXI** | External iliac – right side<br>External iliac – left side<br><br>Code may be billed for a | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | maximum of 2 vessels per side (Lt or Rt) for the following indications:<br><br>May-Thurner Syndrome (compression of left iliac vein secondary to overlying iliac artery)<br><br>Post Thrombotic Stenoses<br><br>Neoplastic Compression or Invasion<br><br>Post Renal Transplant Venous stenosis | | |
| VADT | 51.59O | **RG=RPOP**<br>**RG=LPOP** | Popliteal – right side<br>Popliteal – left side<br><br>Code may be billed only once per side (Lt or Rt)<br><br>Popliteal Region:<br>Adductor hiatus to tibial trifurcation<br><br>Indications:<br>Post Thrombotic Stenoses or occlusions | 137.7 | 8+T |

***Note:** Each angioplasty code is intended to include all angiography performed of the extremity or region at the time of the angioplasty procedure. Each code is intended to include all angioplasties necessary within the vessel or region regardless of the length of number of vascular occlusions. The maximum number of anatomic regions that may be billed at one service encounter is 4. A table of applicable anatomic regions is available on page 9 of this bulletin.

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| ADON<br>(Interim fee) | 51.59Q | | **Non-cardiac, endovascular stent placement**<br><br>This code is an ADON to arterial angioplasty codes when indicated.<br><br>Code may be billed a maximum of one per anatomic region. Please use multiples to indicate additional anatomic regions to a maximum of four per service encounter. A table of applicable anatomic regions is available on page 9 of this bulletin. | 50 |

| | | | | |
|---|---|---|---|---|
| ADON | 51.59R | | **Thrombolysis following non-cardiac angiography**<br><br>This code is an ADON to arterial angioplasty codes when indicated.<br><br>Code may be billed a maximum of one per patient per day. | 150 |

*Physicians holding eligible services must submit their claims from January 1st onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

Effective May 01, 2011 the following new interim Health Service Code is available for billing:

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| VADT<br>(Interim fee) | 02.02A | | **Optical Coherence Tomography for Macular Analysis in Wet AMD**<br><br>This fee is for interpretation of OCT images of the macula in cases of wet AMD treated with Lucentis or Avastin. A written report of the image interpretation must be available in the medical record. The fee is for interpretation of one or both eyes as necessary.<br><br>This fee is only available to retinal specialists providing intravitreal injections of Lucentis or Avastin for wet AMD. It may only be billed in association with intravitreal Lucentis and Avastin injections.<br>A maximum of 6 OCT fees may be claimed per wet AMD patient per year. Please include text on each claim specifying which drug was used during treatment. | 8 |

*Physicians holding eligible services must submit their claims from May 1st onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

**FEE REVISIONS:**

Effective July 22, 2011 the following Health Service Codes will no longer be active:

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| VADT | 51.59A | | **Angioplasty - Iliac** | 137.7 |

| | | | |
|---|---|---|---|
| VADT | 51.59B | **Angioplasty - Femoral** | 137.7 |
| VADT | 51.59C | **Angioplasty - Renal** | 183.6 |
| VADT | 51.59G | **Brachial Angioplasty** | 137.7 |
| VADT | 48.0J | **Subintimal Recanalisation of vascular occlusion as an add on to angioplasty or stent but not both** | 125 |

In their place the following Health Service Codes will be available for billing effective July 22, 2011 (Please note that the Anaesthesia fees for the following arterial angioplasty services are effective January 1, 2011 as they were unavailable for the previously terminated Health Service Codes):

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| VADT | 51.59I | | **Percutaneous Arterial Angioplasty – Upper Limbs** | |
| | | **RG=RBRA**<br>**RG=LBRA** | Brachial – right side<br>Brachial – left side | 137.7 8+T |
| | | | Code may be billed only once per side (Lt or Rt) | |
| VADT | 51.59J | | **Percutaneous Arterial Angioplasty – Central Vessels** | |
| | | **RG=RRMV**<br>**RG=LRMV** | Renal (main vessel) – right side<br>Renal (main vessel) – left side | 183.6 8+T |
| | | **RG=RRSV**<br>**RG=LRSV** | Renal (segmental vessel) – right side<br>Renal (segmental vessel) – left side | |
| | | | Code may be billed only once per main vessel (Lt or Rt) plus one segmental vessel per side if indicated. | |
| VADT | 51.59K | | **Percutaneous Arterial Angioplasty – Lower Limbs** | |
| | | **RG=RCOI**<br>**RG=LCOI** | Common iliac – right side<br>Common iliac – left side | 137.7 8+T |
| | | **RG=RINI**<br>**RG=LINI** | Internal iliac – right side<br>Internal iliac – left side | |
| | | **RG=REXI**<br>**RG=LEXI** | External iliac – right side<br>External iliac – left side | |

| | | | | | |
|---|---|---|---|---|---|
| | | | Code may be billed for a maximum of 2 vessels per side (Lt or Rt) | | |
| VADT | 51.59K | **RG=RCSF** | Common femoral/Superficial femoral – right side | 137.7 | 8+T |
| | | **RG=LCSF** | Common femoral/Superficial femoral – left side | | |
| | | **RG=RPRF** | Profunda femoris – right side | | |
| | | **RG=LPRF** | Profunda femoris – left side | | |
| | | | Code may be billed only once per side (Lt or Rt) per anatomic region. | | |

*Physicians holding eligible anaesthesia services must submit their claims from January 1st onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

***Note:** Each angioplasty code is intended to include all angiography performed of the extremity or region at the time of the angioplasty procedure. Each code is intended to include all angioplasties necessary within the vessel or region regardless of the length of number of vascular occlusions. The maximum number of anatomic regions that may be billed at one service encounter is 4. A table of applicable anatomic regions is available on page 9 of this bulletin.

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| ADON | 51.59P | | **Subintimal Recanalisation of vascular occlusion**<br><br>This code is an ADON to arterial angioplasty codes when indicated, for occlusions greater than 3cm in length.<br><br>Code may be billed a maximum of once per side (Lt or Rt) | 125 |

The following Health Service Code has had a description amendment to allow for remote interrogation:

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| VEDT | 03.52B | | **Review of Pacemaker Patient's Chart, following technologist clinic visit or remote interrogation**<br><br>(Includes review and interpretation of interrogation record and ECG, and written report to family physician or referring physician and applies to all permanently implanted single chamber, dual chamber and defibrillating pacemakers.) | 8 |

**NEW MODIFIERS**

The following table lists modifier values now used in Angioplasty codes and the anatomic regions they indicate:

| Modifier Value | Anatomic Region |
|---|---|
| RG=RANT | Anterior Tibial – right side |
| RG=LANT | Anterior Tibial – left side |
| RG=INRE | Aorta – Infra renal |
| RG=SURE | Aorta – Supra renal |
| RG=RAXI | Axillary – right side |
| RG=LAXI | Axillary – left side |
| RG=RBAC | Basilic or cephalic – right side |
| RG=LBAC | Basilic or cephalic – left side |
| RG=RBRA | Brachial – right side |
| RG=LBRA | Brachial – left side |
| RG=RBRC | Brachiocephalic – right side |
| RG=LBRC | Brachiocephalic – left side |
| RG=RCSF | Common femoral/Superficial femoral – right side |
| RG=LCSF | Common femoral/Superficial femoral – left side |
| RG=RCOI | Common iliac – right side |
| RG=LCOI | Common iliac – left side |
| RG=SAGG | Dural Sinus (Saggital sinus) |
| RG=RSIG | Dural Sinus (Sigmoid sinus) – right side |
| RG=LSIG | Dural Sinus (Sigmoid sinus) – left side |
| RG=RTRA | Dural Sinus (Transverse sinus) – right side |
| **Modifier Value** | **Anatomic Region** |
| RG=LTRA | Dural Sinus (Transverse sinus) – left side |
| RG=REXI | External iliac – right side |
| RG=LEXI | External iliac – left side |
| RG=GVIB | Great Vessel – innominate / brachiocephalic |
| RG=GVCC | Great Vessel – left common carotid |
| RG=GVSA | Great Vessel – left subclavian |
| RG=IVCA | Inferior Vena Cava (IVC) |
| RG=RINI | Internal iliac – right side |
| RG=LINI | Internal iliac – left side |
| RG=RPER | Peroneal – right side |
| RG=LPER | Peroneal – left side |
| RG=RPOP | Popliteal – right side |
| RG=LPOP | Popliteal – left side |
| RG=RPOT | Posterior Tibial – right side |
| RG=LPOT | Posterior Tibial – left side |
| RG=RPRF | Profunda femoris – right side |
| RG=LPRF | Profunda femoris – left side |
| RG=RRUA | Radial or ulnar – right side |
| RG=LRUA | Radial or ulnar – left side |
| RG=RRMV | Renal (main vessel) – right side |
| RG=LRMV | Renal (main vessel) – left side |
| RG=RRSV | Renal (segmental vessel) – right side |
| RG=LRSV | Renal (segmental vessel) – left side |
| RG=RSUB | Subclavian – right side |
| RG=LSUB | Subclavian – left side |
| RG=SVCA | Superior Vena Cava |
| RG=VCEL | Visceral – celiac |

| | |
|---|---|
| RG=VSMA | Visceral – SMA |
| RG=VIMA | Visceral – IMA |
| RG=VSPL | Visceral – splenic |
| RG=VHEP | Visceral - hepatic |
| RG=VREN | Visceral - renal |
| RG=VSUM | Visceral – superior mesenteric |
| RG=VPOR | Visceral - portal |

**MSI MEDICAL CONSULTANT**

Dr. Andrew Watson has agreed to take on the responsibilities of the Medical Consultant on an interim basis, replacing Dr. Gayle Higgins who has retired from this position.

**PHYSICIAN'S MANUAL ONLINE**

The Physician's manual and Billing Instructions manual can now be accessed online at the Department of Health and Wellness website:

http://www.gov.ns.ca/health/reports/

**EXPLANATORY CODES**

The following new explanatory codes have been added to the system:

AD039 Service encounter has been refused as a claim for Thrombolysis has already been made for this day

VA036 Service encounter has been refused as you have already billed the maximum or four angioplasties for the same encounter.

VA037 Service encounter has been disallowed as the injection used to treat wet AMD has not been specified. Please resubmit, indicating the injected substance.

VA038 Service encounter has been refused as the maximum of six OCT fees have already been claimed for this patient within the past year.

VA039 Service encounter has been refused as you have already claimed an angioplasty for the same extremity or region during this encounter.

VA040 Service encounter has been refused as an angioplasty can only be billed from a hospital location.

**UPDATED FILES – AVAILABILITY**

Updated files reflecting changes are available for download on Friday, July 22nd, 2011. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanation code (EXPLAIN.DAT), and modifier values (MODVALS.DAT).

**CAREER OPPORTUNITY**

| | |
|---|---|
| **Job Title:** | Medical Consultant |
| **Department:** | MSI Programs |
| **Competition:** | 0511-436 |
| **Employment Type:** | Consultant position on a 3 year contract |
| **Location(s):** | Dartmouth, NS |
| **Salary:** | Competitive Compensation |
| **Reports to:** | Manager |
| **Closing Date:** | August 12, 2011 |

**Helping to improve the health and well-being of people and their communities.**

Recognized as one of Canada's 10 Most Admired Corporate Cultures, Medavie Blue Cross is a leading provider of individual and group health benefits in the Atlantic Provinces and group health benefits in Ontario and Quebec. We also administer a number of federal and provincial government health programs and services.

We are currently accepting applications for a Medical Consultant. The successful candidate will work as a contractor onsite with the MSI team in our Dartmouth office and will be responsible for providing professional medical guidance in support of the MSI claims adjudication system. In this role, the successful candidate will be responsible for providing a professional link between physicians, government and patients.

If you are looking for an opportunity in a challenging, fast-paced and team-oriented work environment with a leading organization, the career you've been looking for may be waiting for you at Medavie Blue Cross.

**As a Medical Consultant, your key responsibilities will include to:**

- Provide direction and guidance to the Claims Assessment team regarding claims adjudication and payment;

- Review requests for pre-authorization of in-province physician services; out-of-province/country
physician services or hospitalization and retroactive payment of out-of-province/country physician services or hospitalization claims;

- Ensure all administrative processes are followed for out-of-province/country referrals for addiction and mental health services;

- Provide or assist in the first level of appeals for citizen/provider complaints regarding issues of medical insurability, medical necessity and treatment not normally insured as well as provider appeals regarding claims payment;

- Provide assistance to the Department of Health and Wellness Medical Consultant to support medical policy, medical tariff development and activities related to claims assessment; and

- Respond to enquiries from patients, physicians, Doctors NS, Nova Scotia College of Physicians and Surgeons, Medical Directors and the Department of Health and Wellness with respect to individual patient claims and the insurability of specific services for an individual according to Department of Health and Wellness policy.

**As the ideal candidate, you possess the following qualifications:**

Required: The successful candidate must be licensed as a physician in Nova Scotia

Work Experience: Ten to 15 years experience as a physician in a range of practice settings. Surgical and administrative experience would be an asset

Other Qualifications: Strong interpersonal skills and the ability to resolve conflicts and deal with stressful situations.

Computer Skills: General computer knowledge

Communication Skills: Excellent written and verbal communication skills are fundamental to the position.

**Reliability Screening/Canadian Citizenship requirements**

Because of the sensitive nature of our lines of business, all employees/contractors/consultants are required to complete Reliability Screening. Please indicate in your application the reason you are entitled to work in Canada: Canadian citizenship, permanent resident status or work permit.

If you are interested in this position, please apply online at www.medavie.bluecross.ca under the Careers Section.

We would like to thank all candidates for expressing interest. Please note only those selected for interviews will be contacted. No phone calls please.

# PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

April 1, 2011 Volume XLVI - #2


Inside this issue



## MEDICAL SERVICE UNIT / ANAESTHESIA UNIT

Effective April 1, 2011, the Medical Service Unit (MSU) value will be increased from $2.28 to $2.30 and the Anaesthesia Unit (AU) value will be increased from $16.31 to $16.47.

## WORKERS'S COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC

Effective April 1, 2011 the Workers' Compensation Board MSU Value will increase from $2.53 to $2.56 and the Workers' Compensation Board anaesthetic unit value will increase from $18.12 to $18.30.

## PSYCHIATRY FEES

Effective April 1, 2011 the hourly Psychiatry rate for General Practitioners will increase to $105.21 while the hourly rate for Specialists increases to $142.66 as per the tariff agreement.

## NEW FEES

Effective January 01, 2011 the following new Health Service Codes are available for billing:

| Category | Code | Modifiers | Description | Unit Value | |
|---|---|---|---|---|---|
| MASG | 49.71E | | **Insertion of CRT Pacemaker/Defibrillator Device – composite fee**<br><br>Development of device pocket, insertion of device and battery pack, insertion of RA, RV and LV leads as required.<br>The fee includes all procedures required to place the LV lead – coronary sinus cannulation, coronary sinus angiogram, fluoroscopy and EP mapping. Interrogation of device and threshold testing.<br><br>Not billable with electrophysiology studies or cardio version same patient same day. Not billable with ICD insertion team fee. | 360 | 9+T |

| Category | Code | Modifiers | Description | Unit Value | |
|---|---|---|---|---|---|
| MASG | 49.71F | RO=FPHN<br>RO=SPHN | **Insertion of CRT Pacemaker/Defibrillator Device – team fee**<br>RO=FPHN<br>Development of device pocket, insertion of device and battery pack, insertion of RA, RV leads as required.<br>RO=SPHN<br>May only be billed in conjunction with CRT device insertion RO=FPHN and not as a stand alone procedure. This fee includes all procedures required to place the LV lead – coronary sinus cannulation, coronary sinus angiogram, fluoroscopy and EP mapping. Interrogation of device and threshold testing.<br><br>Not billable with electrophysiology studies or cardio version same patient same day. | 200<br><br>160 | 9+T |
| ADON | 49.71G | | **Defibrillator Testing**<br><br>Testing of implantable cardiac defibrillator device at the time of insertion as required.<br><br>Not billable with electrophysiology studies or cardio version same patient same day. | 60 | 9+T |
| VADT | 03.45A | | **Remote Follow Up ICD Device**<br><br>The routine or emergency interrogation of an implantable cardiac defibrillator for the purpose of checking the device function or retrieving information regarding recent ICD therapy or device alerts.<br><br>Routine interrogation may be billed yearly. May also be billed for unscheduled monitoring for device alerts or after ICD therapy delivery – the reasons for interrogation must be documented in patient's medical record. | 15 | |

*Physicians holding eligible services must submit their claims from January 1st onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

**Upcoming Fees:**

The following venous angioplasty and arterial angioplasty fees have been approved by the Master Agreement Steering Committee (MASG) for inclusion into the fee schedule effective **January 1, 2011.**

| Category | Description | Unit Value | |
|---|---|---|---|
| VADT | Venous angioplasty - Axillary vein angioplasty | 137.7 | 8+T |
| VADT | Venous angioplasty - Dural sinus | 183.6 | 10+T |
| VADT | Venous angioplasty - femoral | 137.7 | 8+T |
| VADT | Venous angioplasty - iliac | 137.7 | 10+T |
| VADT | Venous angioplasty - Popliteal vein angioplasty | 137.7 | 8+T |
| VADT | Venous angioplasty - Basilic or cephalic vein angioplasty | 137.7 | 8+T |
| VADT | Venous angioplasty - Brachiocephalic vein angioplasty | 137.7 | 10+T |
| VADT | Venous angioplasty - Inferior Vena Cava (IVC) angioplasty | 137.7 | 10+T |
| VADT | Venous angioplasty - Radial or ulnar vein angioplasty | 137.7 | 8+T |
| VADT | Venous angioplasty - Subclavian vein angioplasty | 137.7 | 10+T |
| VADT | Venous angioplasty - Superior Vena Cava angioplasty | 137.7 | 10+T |
| VADT | Venous angioplasty - Visceral vein angioplasty (renal, superior mesenteric, splenic, hepatic, portal) | 183.6 | 10+T |
| VADT | Percutaneous aorta - infra renal angioplasty | 137.7 | 15+T |
| VADT | Percutaneous aorta - supra renal angioplasty | 200 | 15+T |
| VADT | Percutaneous Great vessel (innominate/braciocephalic, left common carotid or left Subclavian artery) angioplasty | 183.6 | 15+T |
| VADT | Percutaneous Radial or ulnar artery angioplasty | 183.6 | 8+T |
| VADT | Percutaneous Visceral Arterial angioplasty (celiac, SMA, IMA, splenic, hepatic) | 183.6 | 8+T |
| VADT | Percutaneous Anterior Tibial, Posterior Tibial or Peroneal Artery Angioplasty | 183.6 | 8+T |
| VADT | Percutaneous Popliteal Artery Angioplasty | 137.7 | 8+T |
| ADON (Interim Fee) | Non-cardiac, endovascular stent placement | 50 | 8+T |
| ADON | Thrombolysis following non cardiac angiography | 150 | |

****Note:** Please hold all eligible service encounters to allow MSI the required time to update the system. Once a new health service code has been assigned it will be published in the MSI Physicians Bulletin.

## VASCULAR SURGERY PROCEDURAL CODES

There are a number of instances in which incorrect vascular procedural codes are being submitted to MSI. Physicians billing these codes are reminded of the following:

A procedural code is intended to reimburse physicians for all components of the procedure. It is not permitted to unbundle procedural codes and bill MSI separately for them. For example:

Billing angiograms is not acceptable at the time of a definitive therapeutic vascular procedure. It is expected that diagnostic angiography would have been done prior to the therapeutic procedure. Contrast injections or fluoroscopy required at the time of the therapeutic procedure are included in the procedural fee.

Similarly, billing arteriotomy and/or arterioplasty codes in addition to angioplasty, peripheral vascular stenting procedures or aortic/iliac artery repairs is also not permitted as these are integral parts of the procedure.

## REGARDING MINIMALLY INVASIVE VASCULAR PROCEDURES:

If a minimally invasive procedure is performed and there is no specific minimally invasive code in the MSI Physician's Manual the closest open code may be used until such time as until a new fee request is made to the Fee Schedule Advisory Committee. However, if a minimally invasive code does exist, this code should be used. The surgeon cannot choose to bill the open code when in fact he or she performed the minimally invasive procedure.

## ENDOVASCULAR ABDOMINAL ANEURYSM REPAIR

The open abdominal aneurysm code may be used until such time as a fee code for endovascular repair has been established. However, it is not permitted to bill an additional code on occasions when the stent descends into the iliac vessels. An alternative would be to use the open aortic bifurcation graft. Angioplasty codes are not appropriate as an aneurysm look-alike and cardiac stent codes should not be added to open aneurysm or bifurcation graft codes.

## OPTHALMOLOGY – UPDATED REQUIREMENT

Please be advised that any claims for Health service code 28.73C – intraocular or intravitreal injection of air – now require text indicating the injected substance. Physicians are advised to use HSC 28.73D – intravitreal injection of antibiotics – when injecting a medication such as Lucentis or Avastin. This is an interim fee to be used while a new fee is being considered by the Fee Schedule Advisory Committee.

## LONG-TERM CARE CLINICAL GERIATRIC ASSESSMENT (CGA)

Additional new incentive funding is available through the Physicians Master Agreement in 2010/11 to support new programs and/or incentives for family physicians participation in Continuing Care.

Effective January 1, 2011 the following new fee code (billable by general practitioners only) has been approved by the MASG for inclusion in the fee schedule:

| Category | Code | Description | MSU |
|---|---|---|---|
| DEFT | CGA1 | Long-Term Care Clinical Geriatric Assessment | 26.32 |

**Description:**

Long-Term Care Clinical Geriatric Assessment (CGA) is an evidence-based clinical process that allows for interdisciplinary input to best assess the complexity of the nursing home resident. The CGA process and form, once completed, gives a point in time assessment of medical, functional and psychosocial needs of the resident which serves as a benchmark to treat to when the clinical condition changes. The physician is directly responsible for completing the medication list, diagnostic categories, cognition, emotional, behaviours and provides the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessments. The frailty level has been determined to be a predictor of the clinical trajectory of the resident, which is helpful in determining what course of care is reasonable, and a reference to use when discussing a resident's care plan with the resident, families and/or staff. The physician has the option to fill out the other fields on the CGA form as well. However the CGA process is best served when all disciplines involved with the resident complete their sections so as to provide accuracy and encourage dialogue among the clinical team.
The other providers who may provide input for the CGA include: nursing, social work, physiotherapy, occupational therapy, pharmacy and/or other health care disciplines consistent with their scope of practice.

The CGA form should be near the front of every nursing home chart and will serve as the lead clinical document that will travel with the resident when a transfer (ER, other facility etc) occurs. In this way accurate clinical information is provided to other caregivers the resident may need to be treated by. This will help ensure accurate communication of the resident's care directives, and all relevant baseline clinical information so any care outside the facility or by any on-call physician can be provided with this vital clinical information that will enhance the quality of the care given.

**Billing Guidelines:**

- Effective January 1, 2011, family physicians will be remunerated for the completion of the Long-Term Care Clinical Geriatric assessment (CGA) for residents of licensed Nursing Homes and Residential Care Facilities (RCF'S) funded by the Department of Health only.

- The CGA may be billed twice per fiscal year (April 1 – March 31) per resident. The initial CGA is recommended to be completed as soon as possible following Nursing Home or RCF admission, once the physician and clinical team have had time to become familiar with the resident/patient.

- The CGA is normally completed through a collaborative team process involving the family physician and other licensed long-term care healthcare providers. The physician claiming the CGA fee is responsible for the diagnostic section (Cognitive Status, Emotional and Behaviours), the medication section, and providing the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessment. Other sections of the CGA may be completed by the physician or by other licensed healthcare providers.

- 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 recorded on the CGA form.

- Prior to claiming the CGA fee, the physician must review, complete and sign the CGA form in the long-term care facility on the date of the final CGA service encounter and place a note in the resident's clinical record (progress notes) corroborating that the CGA has been completed.

- The date of the service is the date when the final CGA service encounter occurs and the CGA form is completed and signed by the physician.

- The CGA fee is billable by eligible fee-for service physicians and by eligible APP contract physicians, based on shadow billings.

It is recommended that the CGA form is attached to any applicable transfer forms, including inter facility transfers whenever possible.

**The CGA form is attached to this Bulletin and also on the Doctors Nova Scotia member's website.**

**Eligible APP Physicians will be required to shadow bill the new fee code in order to receive payment. Eligible claims will be reviewed and paid twice per year in the form of a cheque from MSI. Estimated payment dates for this new fee are June and December of each year, with the first payments beginning in June, 2011.**

*Physicians holding eligible service encounters can now submit their claims from January 1st onward. Claims must be submitted within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

**PREMIUM FEES** – Reminder

Premium fees may be claimed for certain services provided on an emergency basis during designated time periods. An emergency basis is defined as services, which must be performed without delay because of the medical condition of the patient.

Premium Fees May Be Claimed For:

(a) Consultations, except where a consult is part of the composite fee
(b) Surgical procedures except those performed under local or no anaesthetic
(c) Fractures regardless of whether an anaesthetic is administered
(d) Obstetrical deliveries
(e) Newborn Resuscitation
(f) Selected Diagnostic Imaging Services
(g) Pathology Services

The designated times where premium fees may be claimed and the payment rates are:

**Time Period Time Payment Rate**
Monday to Friday 17:00 - 23:59 US=PREM (35%)
Tuesday to Saturday 00:00 - 07:59 US=PR50 (50%)
Saturday 08:00 - 16:59 US=PREM (35%)
Saturday to Monday 17:00 - 07:59 US=PR50 (50%)
Recognized Holidays 08:00 - 23:59 US=PR50 (50%)

Premium fees also apply to emergency anaesthesia for a surgical procedure (not a diagnostic or therapeutic) provided by a non-certified anaesthetist at the interruption of his or her regularly scheduled office hours.

Premium fees are paid at 35% or 50% of the appropriate service code but at not less than 18 units for patient-specific services and at not less than 9 units for non-patient-specific diagnostic imaging and pathology services paid through the hospital by special arrangement with MSI.

If a service requires use of an anaesthetic, the anaesthetic start time determines if a premium fee may be claimed.

Premium fees may not be claimed with:

(a) Detention
(b) Critical Care/Intensive Care
(c) Diagnostic and Therapeutic Procedures other than Selected Diagnostic Imaging Services
(d) Surgeons and assistants fees for liver transplants

Physicians are reminded that the above criteria must be satisfied in order for a premium to be billed. It is not appropriate to bill a premium for all services claimed during premium times, for elective procedures or when the physician does not attend the patient without delay.

It is incumbent upon the physician to ensure that the clinical record reflects that the requirements for billing a premium have been satisfied.

## PRESCRIPTION RENEWALS and PROVISION OF REQUISITIONS

Physicians are reminded that if a prescription renewal or requisition for a diagnostic or therapeutic service is provided to a patient without an evaluation of the patient then a visit may not be claimed.

## VISITS CONDUCTED BY NON-PHYSICIAN HEALTH CARE PROFESSIONALS

In order to meet the requirements of a visit, the physician must personally participate in the visit.

## HSC 65.49B – STRANGULATED/INCARCERATED HERNIA WITH RESECTION

Surgeons are advised that this code is only to be billed when a segment of bowel has been resected.

## HPF WEB

Physicians whose clinical records are stored on the HPF Web are reminded of the importance of filing patient records on the day the service was provided to the patient and billed to MSI. If the physician's clinical note is filed on a date other than the day the service was provided and billed to MSI the discrepancy may result in an unfavourable audit result. Physicians should ensure that they have completed their clinical note before the record is filed to the HPF Web. MSI staff is not able to access HPF and records obtained from HPF for audit purposes are provided to MSI staff by health records personnel.

## EXPLANATORY CODES

The following new explanatory codes have been added to the system:

| | |
|---|---|
| DE013 | Service encounter has been refused as two Long-Term Care Clinical Geriatric Assessments have previously been paid this year. |
| MJ027 | Service encounter has been disallowed as the injected substance has not been indicated. |
| MJ028 | Service encounter has been refused as a claim for the ICD insertion team fee has already been made for this patient. |
| MJ029 | Service encounter has been refused as a claim for the ICD insertion composite fee has already been made for this patient. |
| NR083 | Service encounter has been refused as a substance other than air was injected. |
| VA035 | Service encounter has been refused as you cannot claim electrophysiology studies on the same day as the insertion of CRT pacemaker/defibrillator device. |
| VT091 | Service encounter has been disallowed as this service is included in the CGA1 service that has previously been approved. |

## UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, April 1st, 2011. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanation code (EXPLAIN.DAT).

**2010/11 GENERAL PRACTITIONER COLLABORATIVE PRACTICE INCENTIVE PROGRAM**

Effective April 1, 2010, funding is provided through the Master Agreement for a new General Practitioner Collaborative Practice Incentive Program (CPIP). The CPIP guidelines for fiscal year 2010/11 have been approved and the program implemented. It is anticipated that this program will be reviewed and evolve in future years.

CPIP incentive payments are intended to support family physicians who are currently participating in collaborative practice models that meet the CPIP program criteria, as well as to encourage other physicians to move towards new models of collaborative care. For the purpose of the CPIP, Collaborative Practice is defined as an inter-professional process of communication and decision making that enables the separate and shared knowledge and skills of different healthcare providers to synergistically influence the client/patient care provided. It occurs when healthcare providers work with people from within their own profession, with people outside of their profession and with patients/clients and their families.

The 2010/11 Collaborative Practice Incentive Program has two funding components:

- Part One: Collaborative Practice Incentive Component
- Part Two: One-Time Education Funding to Off-Set Income Loss Component

**CPIP Part One: Collaborative Practice Incentive Component**

A payment of $5,000 is available to fee-for-service, APP contract and AFP physicians who meet all of the 2010/11 Collaborative Practice Incentive Component program criteria and submit an application for funding.

2010/11 Eligibility Criteria

1. The physician must have minimum total insured billings/payments of $100,000, including $50,000 of office billings, in the period from February 1, 2010 to January 31, 2011.

2. The physician must participate as a member of a Collaborative Practice consisting of a minimum of three CPIP-eligible general practitioners (GPs) and one full-time equivalent (FTE) “other licensed health care provider”.

3. The physician must have participated in a qualifying Collaborative Practice for a minimum of 6 months between February 1, 2010 and January 31, 2011.

4. “Other licensed healthcare providers” for the CPIP (i.e. other than general practitioners) includes all legislated licensed healthcare providers except specialist physicians.

   **Legislated Licensed Healthcare Providers**
   Licensed Practical Nurses
   Chiropractor
   Dentists
   Dental Assistant
   Dental Technicians
   Denturists
   Dental Hygienists
   Dietician/Nutritionists
   Physicians
   Occupational Therapists
   Optometrists
   Dispensing Opticians

Pharmacists
Psychologists
Physiotherapists
Registered Nurses (including Nurse Practitioners)
Medical Laboratory Technologists
Medical Radiation Technologists
Midwives
Respiratory Therapists
Paramedics
Social Workers (Department of Community Services Legislation)

5. A 1.0 FTE "other licensed health care provider" works a minimum of 37.5 hours per week and could be filled by 1-3 people in an effort to encourage flexible collaboration and respond to patient needs.

6. The required ratio of eligible general practitioners (GPs) to "other licensed healthcare providers" is (minimum of three GPs required):

| Number of Eligible GPs | Required Number of "Other Licensed Healthcare Providers" (FTEs) |
|---|---|
| 3-5 GPs | 1 |
| 6-10 GPs | 2 |
| 11-15 GPs | 3 |
| 16-20 GPs | 4 |

7. Collaborative practice team collaboration must occur at least once per week.

8. Family physicians must engage in **meaningful collaboration** with each other as well as the "other licensed healthcare providers" in the Collaborative Practice. Meaningful collaboration is defined as follows (**all characteristics must be present**):

| Characteristic | Accountability Measure |
|---|---|
| Team members provide care to a common group of patients | ➢ Common patient population |
| Members develop common goals for patient outcomes and work towards those goals | ➢ Chart verification of interaction among team members in patient care as appropriate |
| Appropriate roles and functions are assigned to each member of the team | ➢ Job descriptions established and available for each member of the team |
| The team possesses a mechanism for sharing information about the patient | ➢ Common patient record and/or shared EMR |
| The team possesses a mechanism to oversee the carrying out of plans and to make adjustments as necessary | ➢ Set time for formal collaboration (i.e. case conferences, team meetings) |

<u>Application Process and Funding</u>

In order to receive a 2010/11 Collaborative Practice Incentive Component payment, eligible physicians are required to complete and submit an application for the funding. **The application, along with more information about the application process and timelines, is being sent out to family physicians through Doctors Nova Scotia on April 4, 2011 by email, if the physician has indicated to Doctors Nova Scotia this is his/her preferred method of communication, or by mail.**

All applications received will be subject to a verification process, facilitated by the Manager of the Physician Master Agreement and in consultation with the District Health Authorities, to ensure all eligibility criteria have been met.

It is expected that the Collaborative Practice Incentive Component payments, in the form of a cheque, will be mailed to qualifying physicians by MSI in June, 2011.

**CPIP Part Two: One-Time Education Funding to Off-Set Income Loss Component**

*Building a Better Tomorrow Together (BBTT)* is a series of facilitated continuing education modules for health care professionals and their support staff that enable articipants/teams to acquire new knowledge and develop skills in inter-professional collaboration. A certificate of completion/attendance is awarded at the completion of each three-hour module. The BBTT program is currently being implemented by every District Health Authority (DHA) across Nova Scotia. Family physicians interested in learning about and/or participating in a collaborative practice are encouraged to attend the education sessions offered and complete the BBTT modules. Information about the BBTT modules is attached to this Bulletin as Appendix A.

Through the CPIP, fee-for-service physicians who attend the BBTT education sessions can receive a flat rate payment of $1,000 for each module completed as an off-set for any income loss they may have incurred as a result of the time required to attend the session. The DHAs will track the names of physicians who attend sessions and send this list to the Manager, Physician Master Agreement for processing and payment. Payments will be made on a quarterly basis to all eligible physicians, based on the number of modules completed.

**APP and AFP contract physicians are not eligible for these payments.**

All family physicians (fee-for-service, APP and AFP), who do not meet the eligibility criteria for the Collaborative Practice Incentive Component payments, are welcome to participate in the BBTT education modules. However, only fee-for-service physicians will be eligible to receive the income loss off-set funding for each completed module.

More information about the Building a Better Tomorrow Together education program is available through the following DHA BBTT contacts:

| DHA | Lead | Telephone | Email |
|---|---|---|---|
| South Shore Health- 1 | Lisa Joudrey | 527-5214 | ljoudrey@ssdha.nshealth.ca |
| South West Nova – 2 | Rosanne d'Eon | 742-3542 Ext. 683 | rdeon@swndha.nshealth.ca |
| AVDHA - 3 | Geoff Piers | 365-1705 | gpiers@avdha.nshealth.ca |
| CEHHA – 4 | Carolyn Irving | 893-5554 Ext. 2581 | Carolyn.Irving@cehha.nshealth.ca |
| CHA – 5 | Sharon Griffin | 667-5400 Ext. 6493 | Sharon.Griffin@cha.nshealth.ca |
| PCHA - 6 | Kim Byrne | 752-7600 Ext 4848 | Kimberly.byrne@pcha.nshealth.ca |
| GASHA - 7 | Karen MacKinnon | 625-1746 | Karen.Mackinnon@gasha.nshealth.ca |
| | Debbie Cotton | 867-4500 Ext. 4106 | Debbie.Cotton@gasha.nshealth.ca |
| CBDHA - 8 | Kelly MacIsaac | 842-0201 | macisaack@cbdha.nshealth.ca |
| CDHA - 9 | Kim Peterson | 454-8934 | Kim.peterson@cdha.nshealth.ca |
| IWK | Jackie Spiers | 470-3930 | Jackie.spiers@iwk.nshealth.ca |

**APPENDIX A**

**Building a Better Tomorrow Together (BBTT) Education Modules**

Building a Better Tomorrow Together (BBTT) is a series of facilitated continuing education modules for health care professionals and their support staff that enable participants/teams to acquire new knowledge and develop skills in interprofessional collaboration. A certificate of completion/attendance will be awarded at the completion of each three-hour module.

| Enhancing Collaboration | Interpersonal and Communication Skills | Team Functioning | Roles and Responsibilities | Decision Making and Leadership | Conflict Resolution |
|---|---|---|---|---|---|
| • Assessing knowledge/skills in interprofessional collaboration<br>• Characteristics of effective collaborative practice teams<br>• Assessing current collaborative efforts | • Understanding/ respecting different communication styles<br>• Applying communication techniques<br>• Active listening<br>• Communication enhancers/ blockers | • Building an effective team: vision, mission, operating guidelines<br>• Enablers and barriers to team functioning<br>• Conducting interprofessional team meetings<br>• Assessing meetings effectiveness | • Confidence in/knowledge of ones own role<br>• Confidence in/knowledge of others' roles to optimize patient care<br>• Clarifying scopes of practice<br>• Labelling and professional stereotyping<br>• Interprofessionality in teams | • Decision making strategies<br>• Problem solving methodology<br>• Testing for consensus<br>• Leadership roles within teams<br>• The sources and challenges of power in teams | • The nature of the conflict<br>• Recognizing/ managing triggers<br>• Distinguishing constructive and destructive conflict<br>• Understanding/ respecting different conflict resolution styles<br>• Interest based conflict resolution strategies |

| Understanding Primary Health Care | Generations and Learning Styles at Work | Program Planning and Evaluation | Building Community Partnerships |
|---|---|---|---|
| • History and language of primary health care<br>• The Nova Scotia context<br>• Population health and the social determinants of health<br>• Health promotion | • Assessing learning styles<br>• Appreciating generational differences<br>• Disclosing and providing feedback<br>• Exploring self-awareness | • Program planning (steps 1-3)<br>• Program planning (steps 4-6)<br>• Program evaluation | • The three levels of partnerships<br>• Exploring partnerships based on the social determinants of health<br>• Assessing partnership effectiveness |

# Long-Term Care
# Clinical Geriatric Assessment (CGA)

PATIENT ID

WNL: Within Normal Limits ASST: Assisted
IND: Independent DEP: Dependent

Chief lifelong occupation: _____ Education: (yrs) _____

**Cr Cl/eGFR:** _____

**Infection Control**
MRSA _____ Pos _____ Neg
VRE _____ Pos _____ Neg
Flu shot given (d/m/y) _____
Pneumococcal vaccine given (d/m/y) _____
TB test done (d/m/y) _____
Tetanus (d/m/y) _____

| **Cognitive Status** | **Emotional** | | **Behaviours** |
|---|---|---|---|
| ❒ WNL | ❒ WNL | ❒ ⇩Mood | ❒ Verbal Non-aggressive |
| ❒ Dementia | ❒ Depression | ❒ Anxiety | ❒ Verbal Aggressive |
| ❒ Delirium | ❒ Other | | ❒ Physical Non-aggressive |
| MMSE _____ | ❒ Hallucinations/Delusions | | ❒ Physical Aggressive |
| Date (d/m/y): _____ | | | |

**Communication:**

| **Speech** | **Hearing** | **Vision** |
|---|---|---|
| ❒ WNL | ❒ WNL | ❒ WNL |
| ❒ Impaired | ❒ Impaired | ❒ Impaired |

**Foot-care needed** ❒ Yes ❒ No
**Dental care needed** ❒ Yes ❒ No
**Skin Integrity Issues** ❒ Yes ❒ No

**Strength**
❒ WNL ❒ Weak
Upper: Proximal Distal R L
Lower: Proximal Distal R L

| | | | | |
|---|---|---|---|---|
| **Mobility** | Transfers | ❒ IND | ❒ ASST | ❒ DEP |
| | Walking | ❒ IND Slow | ❒ ASST | ❒ DEP |
| | Aid | _____ | | |
| **Balance** | Balance | ❒ WNL | ❒ Impaired | |
| | Falls | ❒ No ❒ Yes | Frequency | |
| **Elimination** | Bowel | ❒ Constip | ❒ Cont | ❒ Incont |
| | Bladder | ❒ Catheter | ❒ Cont | ❒ Incont |
| **Nutrition** | Weight | ❒ STABLE | ❒ LOSS | ❒ GAIN |
| | Appetite | ❒ WNL | ❒ FAIR | ❒ POOR |
| **ADLs** | Feeding | ❒ IND | ❒ ASST | ❒ DEP |
| | Bathing | ❒ IND | ❒ ASST | ❒ DEP |
| | Dressing | ❒ IND | ❒ ASST | ❒ DEP |
| | Toileting | ❒ IND | ❒ ASST | ❒ DEP |

**Personal Directives** ❒ Yes ❒ No
**Substitute Decision Maker:**
_____
**Tel #:** _____

**Code Status:**
❒ Do Not Attempt to Resuscitate
❒ Do Not Hospitalize
❒ Hospitalize
❒ Attempt to Resuscitate

| **Marital Status** | **Family Stress** |
|---|---|
| ❒ Married | ❒ None |
| ❒ Divorced | ❒ Low |
| ❒ Widowed | ❒ Moderate |
| ❒ Single | ❒ High |

| **Problems/Past History/Diagnosis** | **Medication Adjustment Required** | **Associated Medication** |
|---|---|---|
| 1. | ❒ | |
| 2. | ❒ | |
| 3. | ❒ | |
| 4. | ❒ | |
| 5. | ❒ | |
| 6. | ❒ | |
| 7. | ❒ | |
| 8. | ❒ | |
| 9. | ❒ | |
| 10. | ❒ | |
| 11. | ❒ | |
| 12. | ❒ | |

**Current Frailty Score**
Scale ❒ 5. Mildly Frail ❒ 6. Moderately Frail ❒ 7. Severely Frail ❒ 8. Very Severely ill ❒ 9. Terminally Ill

**Note: Shaded areas to be completed by physician.**

**Clinical Frailty Scale***

**5. Mildly Frail** – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

**6. Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and **need help with bathing** and might need minimal assistance (cuing, standby) with dressing.

**7. Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

**8. Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover from even a minor illness.

**9. Terminally Ill** – Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173; 489-495

Adapted from Clinical Frailty Scale ©2007 – 2009. Version 1.2 All rights reserved. Geriatric Medicine Research, Dalhousie University, Halifax, Canada

| CGA Associated Visits | |
|---|---|
| **Date** | **Comments** |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Physician Name (please print): _____ Physician Signature: _____

Signed on (d/m/y): _____ (Visit required on this date)

NOVA SCOTIA MEDICAL SERVICES INSURANCE
P.O. BOX 500 HALIFAX, N.S. B3J 2S1

NOVA SCOTIA

# FAMILY PHYSICIAN MASTER AGREEMENT PROGRAMS
## Billing Reminders and Clarifications

March, 2011

The current Physician Services Master Agreement incorporates a number of new incentive programs and/or fees designed to provide enhanced funding to family physicians in an effort to support system improvement and change.

Each of these new incentive programs and/or new fees includes specific guidelines and eligibility criteria, all of which have been communicated to physicians through MSI bulletins and via the members' side of the Doctors Nova Scotia website, since April 2008.

A number of issues have been identified with some of these programs; specifically there have been issues with previously communicated criteria and billing guidelines not being adhered to on a consistent basis. Similar to all other fees, any new fees which have been approved by the Master Agreement Steering Group for inclusion into the fee guide are subject to audit as per the current process.

The purpose of this notice is to clarify the specific issues as well as offer additional detail (where applicable) pertaining to these programs in an effort to ensure accurate billing of these fees.

### Long Term Care Medication Review

This incentive is available for Family Physicians who complete medication reviews for residents of provincially licensed Nursing Homes and Residential Care Facilities (RCFs) only. Information about eligible facilities can be found on the Department of Health Continuing Care web site at:

http://www.gov.ns.ca/health/ccs/pubs/approved_facilities/Dir_approved_facilities_NH.pdf
http://www.gov.ns.ca/health/ccs/pubs/approved_facilities/Dir_approved_facilities_RCF.pdf

| Category | Code | Description | Unit Value |
|---|---|---|---|
| DEFT | ENH1 | Long Term Care Medication Review | 11.95 |

**Billing Guidelines:**

- To claim the fee, the physician **must review, complete, date and sign** the **pharmacy-generated Medical Administration Recording System (MARS) drug review sheet** for the resident.
- **A maximum of two (2) medication reviews will be payable per resident per fiscal year**, regardless of Nursing home or RCF facility of residence. A facility transfer does not necessarily require a new medication review if the existing medication review is up-to-date.
- The medication review fee is payable in addition to any associated visit fee, if applicable.
- The date of service is the date the MARS form is signed by the physician.
- A copy of the completed and signed MARS form needs to be readily available within the patient record (located in the Nursing Home)

**NOTE:** This fee can only be claimed for reviewing, completing and signing the pharmacy-generated MARS form. The fee is not to be claimed for re-ordering of medications requested by the nursing home or the completion of any other type of form.

**Unattached Patient Bonus**

This incentive is available for all eligible General Practitioners (GPs) who take on a patient who does not have a family physician and meets the supplied criteria, into their community-based family practice. The program is intended to address the specific issue of hospitalized patients or patients treated in the emergency department for medical problems who require follow-up in the community and who do not have a family physician. It is not intended to cover every patient who does not have a family doctor; i.e., situations such as practice closures or patient transfers.

| Category | Code | Description | Payment |
|---|---|---|---|
| DEFT | UPB1 | Unattached Patient Bonus Payment Program | $150.00 (one time per patient) |

**Billing Guidelines**

- The GP has had an established community-based family practice for at least one year prior to taking the Unattached Patient into his/her practice.
- The GP agrees to take the Unattached Patient into his/her practice following an inpatient or medically necessary emergency department hospital encounter where the patient has been identified as an Unattached Patient. The hospital encounter may have been directly with the GP or the GP may agree to take on the patient through a referral from the hospital.
- The GP keeps the Unattached Patient in his/her practice and maintains an open chart for the patient for a minimum of one year.

The GP is considered to have taken on the patient on the date of the initial office visit. The Unattached Patient Bonus may be claimed at the time of the initial visit.

The Unattached Patient Bonus fee is billable in addition to the associated visit fee.

The Unattached patient Bonus may be claimed by eligible GPs paid by fee-for-service and alternative payment plan contracts but not by Locums.

The GP must confirm and document at the initial visit with the Unattached Patient that the patient is unattached (i.e., does not already have a regular family physician). **Information about the hospital encounter that resulted in the GP taking the Unattached Patient into his/her practice must also be recorded in the patient's record.** This can be a referral form from the hospital emergency department, an inpatient hospital report or other documentation. **(Other documentation may include a note by the physician, documenting their discussion with the patient, confirming the hospital encounter)**

**NOTE:** Physicians are advised not to send patients to the emergency department to be referred in an effort to claim this fee. Upon audit, MSI will be verifying that an eligible hospital-based encounter did occur and that there was a medical necessity for the hospital encounter.

**Complex Care Visit**

This fee is billable for general practice office visit services only. It is not available to be billed in Long Term Care facilities at this time.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VIST | 03.03B | Complex Care | 21 |
| VIST | 03.03B | Complex Care with modifier GPEW | 26.25 |

**Documentation must indicate the three eligible chronic diseases under active management or there must be a readily accessible patient profile listing the chronic diseases in the patient record. The documentation or profile may include the date of onset (when/if this is known by the physician)**
A complex care visit code may be billed a **maximum of 4 times per patient per fiscal year (April 1 - March 31)** by the family physician and/or the practice (not by walk-in clinics) providing on-going comprehensive care to an eligible patient.

- An eligible patient must be under active management for **3 or more** of the following chronic diseases (**The diseases listed below are the only diseases currently eligible under this program.):**
  - **Asthma**
  - **COPD**
  - **Diabetes**
  - **Chronic Liver Disease**
  - **Hypertension**
  - **Chronic Renal Failure**
  - **Congestive Heart Failure**
  - **Ischaemic Heart Disease**
  - **Dementia**
  - **Chronic Neurological Disorders**
  - **Cancer**

**NOTE: Chronic Renal Failure is defined as:** (eGFR) <60 mL/min/1.73 m2 for three months or equivalent calculated creatinine clearance.

- The term **active management** is intended to mean that the patient requires on-going monitoring, maintenance or intervention to control, limit progression, or palliate a chronic disease.

- The term **chronic neurological disorders** is intended to include progressive degenerative disorders (such as Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease), stroke or other brain injury with a permanent neurological deficit, paraplegia, or quadriplegia and epilepsy.

- The physician must spend at **least 15 minutes** in direct patient intervention and the visit must address at least one of the chronic diseases either directly or indirectly.

- Start and finish times must be recorded on the patient's chart.

**Case Management Conference**

A case management conference is a formal, scheduled, multi-disciplinary health team meeting. It must be initiated by an employee of the DHA/IWK, or a Director of Nursing, Director of Care of an eligible Long Term Care facility to discuss the provision of health care to a specific patient. The Case Management Fee can be claimed by General Practitioners and Specialists.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VIST | 03.03D | Case Management Conference | 14.5 units per 15 minutes for GP's and 17 units per 15 minutes for Specialists |

**Billing Guidelines**

- It is a time based fee paid at the applicable GP or Specialist sessional rate in 15 minute increments.
- To claim the case management conference fee, the physician must participate in the conference for a minimum of 15 minutes and remuneration will be calculated in 15 minute time increments based on the sessional rate. **Start and finish times** are to be recorded on the patient's chart.
- 80% of a 15 minute time interval must be spent at the conference in order to bill that time interval.
- Neither the patient nor the family need to be present.
- It may be claimed by more than one physician simultaneously as necessary for case management.
- The case conference must be documented in the health record with a list of all physician participants.
- Multi-disciplinary refers to the attendance of two or more licensed health care professionals in addition to a physician.
- In order to qualify, the conference has to be called by non-physician DHA/IWK staff, who are required to be employees of the district, or by the Director of Nursing or Director of Care of an eligible Long Term Care facility. It is not mandatory that more than one physician attend the case conference before the fee code may be claimed.
- The Case Management Conference Fee is not to be used for attendance at regularly scheduled meetings concerning ongoing care planning or patient management for one or more patients; i.e., grand rounds, tumor board case rounds, teaching rounds, transplant rounds or other similar methods of specialist physicians conferring about the medical management of complex cases. It is not to be used in circumstances which are a usual part of patient care such as transfer of care between physicians on evenings and weekends.
- Physician attendance at case management conferences held by video conferencing or teleconferencing is eligible for payment providing all other eligibility requirements are met.

- Each case conference must be specific to an individual patient and the time spent by the physician at the conference must be documented in the health record of that patient. However, consecutive formal scheduled conferences, each pertaining to one named patient, with start and finish times recorded in each health record, would be permitted.

**NOTE:** If the patient is located in an institution, documentation pursuant to the billing guidelines must be located within the patient record in the institution. If the patient is not located in an institution, documentation regarding the case management conference must be readily available; e.g., in the patient record maintained by the physician claiming the fee. The onus will be on the physician billing the fee to ensure appropriate documentation is readily available.

**GP Evening and Weekend Incentive**

This incentive program is intended to promote enhanced evening and weekend access to primary care services provided in the offices of fee-for-service family physicians who have an established practice and provide comprehensive and on-going care for their patients.

**Billing Guidelines:**

- The eligible time periods for claiming the evening and weekend office visit incentive are 6 – 10 p.m. during weekday evenings and 9 a.m. – 5 p.m. on weekends (Saturday and Sunday).

- Physicians should offer and book appointments during these time periods in the same manner as they would for other (weekday) office hours.

- Evening and weekend services eligible for incentive funding are office visit services provided in a community-based family practice in which the physician maintains a comprehensive patient chart to record all patient encounters, provides all necessary follow-up care for each encounter and takes responsibility for initiation and follow-up on all related referrals.

- Eligible physicians may claim an incentive for evening and weekend office services provided for their own patients as well as for patients from the stable patient roster of other eligible physicians within the same practice location, providing the patient's record can be accessed and the encounter is recorded.

- Services provided in walk-in clinics are not eligible for the evening and weekend office visit incentive funding program. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no requirement for an appointment, and episodic care with little or no follow-up. There is no standard patient roster and the patient list is constantly changing.

The following office services are eligible for the 25% evening and weekend incentive providing all other eligibility criteria are met. Only one incentive can be claimed per patient encounter regardless of the number of services provided during the encounter. Claims for eligible services should be submitted with the modifier TI = GPEW.

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| VIST | 03.04 | TI=GPEW | Complete Examination | 30.00 |
| VIST | 03.03 | RP=SUBS<br>TI=GPEW | Office Visit | 16.25 |
| VIST | 03.03A | TI=GPEW | Geriatric Office Visit (for patients aged 65+) | 20.63 |
| VIST | 03.03B | TI=GPEW | Complex Care | 26.25 |
| VIST | 03.04 | RO=PTNT<br>RP=INTL<br>TI=GPEW | Complete Pregnancy Exam | 37.13 |
| VIST | 03.03 | RO=ANTL<br>TI=GPEW | Routine Pre Natal Visit | 16.25 |
| VIST | 03.03 | RO=PTNT<br>TI=GPEW | Post Natal Care Visit | 23.75 |
| VIST | 03.03 | RO=WBCR<br>TI=GPEW | Well Baby Care | 16.25 |
| PSYC | 08.41 | TI=GPEW | Hypnotherapy | 15.88 per 15 mins |
| PSYC | 08.44 | TI=GPEW | Group Therapy (4-8 members) | 4 per 15 mins |
| PSYC | 08.45 | TI=GPEW | Family Therapy (2 or more members) | 16.06 per 15 mins |
| PSYC | 08.49A | TI=GPEW | Counselling | 15.88 per 15 mins |
| PSYC | 08.49B | TI=GPEW | Psychotherapy | 15.88 per 15 mins |
| PSYC | 08.49C | TI=GPEW | Lifestyle Counselling | 15.88 per 15 mins |

**NOTE:** For services where the evening and weekend incentive has been claimed, a record must be maintained and readily available to verify that the patient was booked for an appointment during an incentive-eligible time period. The appointment time should be recorded in the patient's record or office appointment books retained.

APP contract physicians can shadow bill the GP Evening and Weekend Office Visit Incentive (GPEW)

The evening and weekend office visit incentive should not be claimed in circumstances where the patient is booked for an appointment time that is not eligible for the incentive and then the physician "runs late".

**LONG-TERM CARE CLINICAL GERIATRIC ASSESSMENT (CGA)**

Additional new incentive funding is available through the Physicians Master Agreement in 2010/11 to support new programs and/or incentives for family physicians participating in Continuing Care.

Effective January 1, 2011 the following new fee code (billable by general practitioners only) has been approved by the MASG for inclusion in the fee schedule

| Category | Code | Description | Unit Value |
|---|---|---|---|
| DEFT | CGA1 | Long-Term Care Clinical Geriatric Assessment | 26.32 |

**Description:**

The Long-Term Care Clinical Geriatric Assessment (CGA) is an evidence-based clinical process that allows for interdisciplinary input to best assess the complexity of the nursing home resident. The CGA process and form, once completed, gives a point in time assessment of medical, functional and psychosocial needs of the resident which serves as a benchmark to treat to when the clinical condition changes. The physician is directly responsible for completing the medication list, diagnostic categories, cognition, emotional, behaviors, and provides the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessments. The frailty level has been determined to be a predictor of the clinical trajectory of the resident, which is helpful in determining what course of care is reasonable, and a reference to use when discussing a resident's care plan with the resident, families and/or staff. The physician has the option to fill out the other fields on the CGA form as well. However the CGA process is best served when all disciplines involved with the resident complete their sections so as to provide accuracy and encourage dialogue among the clinical team. The other providers who may provide input for the CGA include: nursing, social work, physiotherapy, occupational therapy, pharmacy and/or other health care disciplines consistent with their scope of practice.

The CGA form should be near the front of every nursing home chart and will serve as the lead clinical document that will travel with the resident when a transfer (ER, other facility etc) occurs. In this way accurate clinical information is provided to other caregivers the resident may need to be treated by. This will help ensure accurate communication of the resident's care directives, and all relevant baseline clinical information so any care outside the facility or by any on-call physician can be provided with this vital clinical information that will enhance the quality of care given.

**Billing Guidelines:**

- Effective January 1, 2011, family physicians will be remunerated for the completion of a *Long-Term Care Clinical Geriatric Assessment (CGA)* for residents of licensed Nursing Homes and Residential Care Facilities (RCF's) funded by the Department of Health only.

- The CGA may be billed twice per fiscal year (April 1 – March 31), per resident. The initial CGA is recommended to be completed as soon as possible following Nursing Home or RCF admission, once the physician and clinical team have had time to become familiar with the resident/patient.

- The CGA is normally completed through a collaborative team process involving the family physician and other licensed long-term care healthcare providers. The physician claiming the CGA fee is responsible for the diagnostic section (Cognitive Status, Emotional and Behaviours), the medication section, and providing the final overall opinion of the frailty level of the resident once the other disciplines have

completed their assessment. Other sections of the CGA may be completed by the physician or by other licensed healthcare providers.

- 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.

- Prior to claiming the CGA fee, the physician must review, complete and sign the CGA form in the long-term care facility on the date of the final CGA service encounter and place a note in the resident's clinical record (progress notes) corroborating that the CGA has been completed.

- The date of service is the date when the final CGA service encounter occurs and the CGA form is completed and signed by the physician.

- The CGA fee is billable by eligible fee-for service physicians and by eligible APP contract physicians, based on shadow billings.

It is recommended that the CGA form is attached to any applicable transfer forms, including inter facility transfers whenever possible.

**The CGA form is attached to this Bulletin and also available on the Doctors Nova Scotia members' web site.**

**Eligible APP Physicians will be required to shadow bill the new fee code in order to receive payment. Eligible claims will be reviewed and paid twice per year in the form of a cheque from MSI. Estimated payment dates for this new fee are June and December of each year, with the first payments beginning in June, 2011.**

Please hold eligible service encounters to allow MSI the required time to update the system. Once a Health Service Code has been assigned, it will be published in the MSI Physicians' Bulletin with directions regarding the submission of any held claims.

# Long-Term Care
# Clinical Geriatric Assessment (CGA)

PATIENT ID

WNL: Within Normal Limits ASST: Assisted
IND: Independent DEP: Dependent

Chief lifelong occupation: _____ Education: (yrs) _____

**Cr Cl/eGFR:** _____

**Infection Control**
MRSA _____ Pos _____ Neg
VRE _____ Pos _____ Neg
Flu shot given (d/m/y) _____
Pneumococcal vaccine given (d/m/y) _____
TB test done (d/m/y) _____
Tetanus (d/m/y) _____

**Cognitive Status**
❒ WNL
❒ Dementia
❒ Delirium
MMSE _____

**Emotional**
❒ WNL ❒ ⇩Mood
❒ Depression ❒ Anxiety
❒ Other
❒ Hallucinations/Delusions
Date (d/m/y): _____

**Behaviours**
❒ Verbal Non-aggressive
❒ Verbal Aggressive
❒ Physical Non-aggressive
❒ Physical Aggressive

**Communication:**

| Speech | Hearing | Vision |
|---|---|---|
| ❒ WNL | ❒ WNL | ❒ WNL |
| ❒ Impaired | ❒ Impaired | ❒ Impaired |

**Foot-care needed** ❒ Yes ❒ No
**Dental care needed** ❒ Yes ❒ No
**Skin Integrity Issues** ❒ Yes ❒ No

**Strength**
❒ WNL ❒ Weak
Upper: Proximal Distal R L
Lower: Proximal Distal R L

| | | | | |
|---|---|---|---|---|
| **Mobility** | Transfers | ❒ IND | ❒ ASST | ❒ DEP |
| | Walking | ❒ IND Slow | ❒ ASST | ❒ DEP |
| | Aid | _____ | | |
| **Balance** | Balance | ❒ WNL | | ❒ Impaired |
| | Falls | ❒ No ❒ Yes | | Frequency |
| **Elimination** | Bowel | ❒ Constip | ❒ Cont | ❒ Incont |
| | Bladder | ❒ Catheter | ❒ Cont | ❒ Incont |
| **Nutrition** | Weight | ❒ STABLE | ❒ LOSS | ❒ GAIN |
| | Appetite | ❒ WNL | ❒ FAIR | ❒ POOR |
| **ADLs** | Feeding | ❒ IND | ❒ ASST | ❒ DEP |
| | Bathing | ❒ IND | ❒ ASST | ❒ DEP |
| | Dressing | ❒ IND | ❒ ASST | ❒ DEP |
| | Toileting | ❒ IND | ❒ ASST | ❒ DEP |

**Personal Directives** ❒ Yes ❒ No
**Substitute Decision Maker:**
_____
**Tel #:** _____

**Code Status:**
❒ Do Not Attempt to Resuscitate
❒ Do Not Hospitalize
❒ Hospitalize
❒ Attempt to Resuscitate

**Marital Status**
❒ Married
❒ Divorced
❒ Widowed
❒ Single

**Family Stress**
❒ None
❒ Low
❒ Moderate
❒ High

| Problems/Past History/Diagnosis | Medication Adjustment Required | Associated Medication |
|---|---|---|
| 1. | ❒ | |
| 2. | ❒ | |
| 3. | ❒ | |
| 4. | ❒ | |
| 5. | ❒ | |
| 6. | ❒ | |
| 7. | ❒ | |
| 8. | ❒ | |
| 9. | ❒ | |
| 10. | ❒ | |
| 11. | ❒ | |
| 12. | ❒ | |

**Current Frailty Score**
Scale ❒ 5. Mildly Frail ❒ 6. Moderately Frail ❒ 7. Severely Frail ❒ 8. Very Severely ill ❒ 9. Terminally Ill

**Note: Shaded areas to be completed by physician.**

**Clinical Frailty Scale***

**5. Mildly Frail** – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

**6. Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and **need help with bathing** and might need minimal assistance (cuing, standby) with dressing.

**7. Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

**8. Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover from even a minor illness.

**9. Terminally Ill** – Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173; 489-495

Adapted from Clinical Frailty Scale ©2007 – 2009. Version 1.2 All rights reserved. Geriatric Medicine Research, Dalhousie University, Halifax, Canada

| CGA Associated Visits | |
|---|---|
| **Date** | **Comments** |
| | |
| | |
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| | |
| | |
| | |
| | |
| | |
| | |

Physician Name (please print): _____ Physician Signature: _____

Signed on (d/m/y): _____ (Visit required on this date)

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

January 28, 2011 Volume XLVI - #1

Inside this issue



## LONG-TERM CARE CLINICAL GERIATRIC ASSESSMENT (CGA)

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Effective January 1, 2011 the following new fee code (billable by general practitioners only) has been approved by the MASG for inclusion in the fee schedule:

| Category | | Description | | MSU |
|---|---|---|---|---|
| | | | | |
| DEFT | | Long-Term Care Clinical Geriatric Assessment | | 26.32 units ($60.00) per evaluation |
| | | | | |

**Description:**

Long-Term Care Clinical Geriatric Assessment (CGA) is an evidence-based clinical process that allows for interdisciplinary input to best assess the complexity of the nursing home resident. The CGA process and form, once completed, gives a point in time assessment of medical, functional and psychosocial needs of the resident which serves as a benchmark to treat to when the clinical condition changes. The physician is directly responsible for completing the medication list, diagnostic categories, cognition, emotional, behaviors and provides the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessments. The frailty level has been determined to be a predictor of the clinical trajectory of the resident, which is helpful in determining what course of care is reasonable, and a reference to use when discussing a resident's care plan with the resident, families and/or staff. The physician has the option to fill out the other fields on the CGA form as well. However the CGA process is best served when all disciplines involved with the resident complete their sections so as to provide accuracy and encourage dialogue among the clinical team. The other providers who may provide input for the CGA include: nursing, social work, physiotherapy, occupational therapy, pharmacy and/or other health care disciplines consistent with their scope of practice.

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transfer (ER, other facility etc) occurs. In this way accurate clinical information is provided to other caregivers the resident may need to be treated by. This will help ensure accurate communication of the resident's care directives, and all relevant baseline clinical information so any care outside the facility or by any on-call physician can be provided with this vital clinical information that will enhance the quality of the care given.

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- The CGA is normally completed through a collaborative team process involving the family physician and other licensed long-term care healthcare providers. The physician claiming the CGA fee is responsible for the diagnostic section (Cognitive Status, Emotional and Behaviors), the medication section, and providing the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessment. Other sections of the CGA may be completed by the physician or by other licensed healthcare providers.

- 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 recorded on the CGA form.

- Prior to claiming the CGA fee, the physician must review, complete and sign the CGA form in the long-term care facility on the date of the final CGA service encounter and place a note in the resident's clinical record (progress notes) corroborating that the CGA has been completed.

- The date of the service is the date when the final CGA service encounter occurs and the CGA form is completed and signed by the physician.

- The CGA fee is billable by eligible fee-for service physicians and by eligible APP contract physicians, based on shadow billings.

It is recommended that the CGA form is attached to any applicable transfer forms, including inter facility transfers whenever possible.

**The CGA form is attached to this Bulletin and also on the Doctors Nova Scotia member's website.**

Please hold eligible service encounters to allow MSI the required time to update the system. Once a Health Service Code has been assigned, it will be published in the MSI Physicians Bulletin with directions regarding the submission of any held claims.

# Long-Term Care
# Clinical Geriatric Assessment (CGA)

PATIENT ID

WNL: Within Normal Limits ASST: Assisted
IND: Independent DEP: Dependent

Chief lifelong occupation: _____ Education: (yrs) _____

**Cr Cl/eGFR:** _____

**Infection Control**
MRSA _____ Pos _____ Neg
VRE _____ Pos _____ Neg
Flu shot given (d/m/y) _____
Pneumococcal vaccine given (d/m/y) _____
TB test done (d/m/y) _____
Tetanus (d/m/y) _____

| **Cognitive Status** | **Emotional** | | **Behaviours** |
|---|---|---|---|
| ❒ WNL | ❒ WNL | ❒ ⇩Mood | ❒ Verbal Non-aggressive |
| ❒ Dementia | ❒ Depression | ❒ Anxiety | ❒ Verbal Aggressive |
| ❒ Delirium | ❒ Other | | ❒ Physical Non-aggressive |
| MMSE _____ | ❒ Hallucinations/Delusions | | ❒ Physical Aggressive |
| Date (d/m/y): _____ | | | |

**Communication:**

| **Speech** | **Hearing** | **Vision** |
|---|---|---|
| ❒ WNL | ❒ WNL | ❒ WNL |
| ❒ Impaired | ❒ Impaired | ❒ Impaired |

**Foot-care needed** ❒ Yes ❒ No
**Dental care needed** ❒ Yes ❒ No
**Skin Integrity Issues** ❒ Yes ❒ No

**Strength**
❒ WNL ❒ Weak
Upper: Proximal Distal R L
Lower: Proximal Distal R L

| | | | | |
|---|---|---|---|---|
| **Mobility** | Transfers | ❒ IND | ❒ ASST | ❒ DEP |
| | Walking | ❒ IND Slow | ❒ ASST | ❒ DEP |
| | Aid | _____ | | |
| **Balance** | Balance | ❒ WNL | ❒ Impaired | |
| | Falls | ❒ No ❒ Yes | Frequency | |
| **Elimination** | Bowel | ❒ Constip | ❒ Cont | ❒ Incont |
| | Bladder | ❒ Catheter | ❒ Cont | ❒ Incont |
| **Nutrition** | Weight | ❒ STABLE | ❒ LOSS | ❒ GAIN |
| | Appetite | ❒ WNL | ❒ FAIR | ❒ POOR |
| **ADLs** | Feeding | ❒ IND | ❒ ASST | ❒ DEP |
| | Bathing | ❒ IND | ❒ ASST | ❒ DEP |
| | Dressing | ❒ IND | ❒ ASST | ❒ DEP |
| | Toileting | ❒ IND | ❒ ASST | ❒ DEP |

**Personal Directives** ❒ Yes ❒ No
**Substitute Decision Maker:**
_____
**Tel #:** _____

**Code Status:**
❒ Do Not Attempt to Resuscitate
❒ Do Not Hospitalize
❒ Hospitalize
❒ Attempt to Resuscitate

| **Marital Status** | **Family Stress** |
|---|---|
| ❒ Married | ❒ None |
| ❒ Divorced | ❒ Low |
| ❒ Widowed | ❒ Moderate |
| ❒ Single | ❒ High |

| **Problems/Past History/Diagnosis** | **Medication Adjustment Required** | **Associated Medication** |
|---|---|---|
| 1. | ❒ | |
| 2. | ❒ | |
| 3. | ❒ | |
| 4. | ❒ | |
| 5. | ❒ | |
| 6. | ❒ | |
| 7. | ❒ | |
| 8. | ❒ | |
| 9. | ❒ | |
| 10. | ❒ | |
| 11. | ❒ | |
| 12. | ❒ | |

**Current Frailty Score**
Scale ❒ 5. Mildly Frail ❒ 6. Moderately Frail ❒ 7. Severely Frail ❒ 8. Very Severely ill ❒ 9. Terminally Ill

**Note: Shaded areas to be completed by physician.**

**Clinical Frailty Scale***

**5. Mildly Frail** – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

**6. Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and **need help with bathing** and might need minimal assistance (cuing, standby) with dressing.

**7. Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

**8. Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover from even a minor illness.

**9. Terminally Ill** – Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173; 489-495

Adapted from Clinical Frailty Scale ©2007 – 2009. Version 1.2 All rights reserved. Geriatric Medicine Research, Dalhousie University, Halifax, Canada

| CGA Associated Visits | |
|---|---|
| **Date** | **Comments** |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Physician Name (please print): _____ Physician Signature: _____

Signed on (d/m/y): _____ (Visit required on this date)

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

December 8, 2010 Volume XLV - #6

**Inside this Issue**



## REMOTE SURGICAL CONSULT WITH REVIEW OF PACS IMAGES: UPDATE

The term date of June 30, 2010 has been removed on the 03.09D – Remote Surgical Consult with Review of PACS Images services.

*Physicians who have provided this service since July 1, 2010 must submit their claims within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

## WORDING CHANGE

The wording for HSC 03.09B Second Opinion Consultation has been amended to read:
"Review of an outside institution non-plain film imaging study including but not limited to CT, Ultrasound, MRI, Nuclear medicine or angiographic studies at the request of a specialist."

## INTRAOCULAR INJECTION OF AIR

Recently it has come to the attention of MSI Audit that some opthamologists are incorrectly billing HSC 28.73C – intraocular or intravitreal injection of air – when an intraocular injection of medication such as Lucentis or Avastin is carried out. Physicians are advised that the correct "look alike" code for this procedure is HSC 28.73D – intravitreal injection of antibiotics – and this is the code to be claimed for this procedure.

## INFUSION CLINICS

MSI Audit has learned that some physicians are billing MSI for injections of medication carried out by other health care providers at private infusion clinics, such as those run out of physician offices. Physicians are advised that this is an uninsured service and neither a visit nor an injection fee may be claimed for these encounters.

## BILLING REMINDERS

**Donor/Recipient Hepatectomy:** Please ensure that the appropriate health card numbers are being billed for liver transplant codes 62.49A and 62.49B as a patient cannot be both the donor and recipient of a liver.

**03.09B Second Opinion Consultation:** A 03.09B cannot be billed more than once per patient per day (multiples however can be billed for additional films etc. that require a second opinion).

**13.59L RO=PNEU (Pneumococcal Polysaccharide injection):** If medically necessary a total of two 13.59L RO=PNEU may be billed per patient per lifetime.

**WCB codes:** A WCB9 (Expedited non-emergency orthopedic consultation) cannot be billed with a WCB11 (Physician assessment service combined office visit and completion of Form 8/10) or WCB12 (EPS physician assessment service combined office visit and completion of Form 8/10).

## EXPLANATORY CODES

The following explain codes have been added to the system:

**AD038** – Service encounter has been refused as a maximum of two 13.59L RO=PNEU immunizations have been previously paid

**CN020** - Service encounter has been refused as a 03.09B has previously been approved for this day.

**GN047** - Service encounter has been refused. Submit a reassess (action code R) for the original submission to aid in the assessment of your claim.

**GN048** - Service encounter has been disallowed. Submit a reassess (action code R) along with a copy of the record of operation to aid in the assessment of your claim.

**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.

**GN050** - Service encounter has been refused. Resubmit under the same health service code using the appropriate lesser value modifier for the service provided.

**GN051** - Service encounter has been refused as a service occurrence one (1) has not been claimed for this day.

**GN052** - Service encounter has been disallowed. Resubmit with a copy of the time sheet for the surgery performed to aid in the adjudication of your claim.

**MJ025** - Service encounter has been refused as a claim for donor has already been received for this patient. A patient cannot be both a donor and recipient of a liver.

**MJ026** - Service encounter has been refused as a claim for recipient has already been received for this patient. A patient cannot be both a donor and recipient of a liver.

**WB025** - Service encounter has been refused as previous payment under WCB11 or WCB12 has been approved.

**WB026** - Service encounter has been refused as a previous payment under WCB9 has been approved.

## UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, December 10th, 2010. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanation code (EXPLAIN.DAT).

## IS THERE SOMETHING YOU NEED TO TELL US?

- Are you changing your bank account? (form required)
- Are you relocating your office practice?
- Is your MSI business mail properly addressed?
- Are you changing your billing software or service bureau?

For any of the above reasons or other related issues, please contact the Provider Coordinators at **msi.providercoordinators@medavie.bluecross.ca** or send a detailed fax to **469-4674** / **Toll-free 1-877-910-4674**.

If you require banking forms or have other questions, please call:

496-7560
496-7107
496-7190

# 2011 CUT-OFF DATES
# FOR RECEIPT OF
# PAPER & ELECTRONIC CLAIMS

| PAPER CLAIMS | ELECTRONIC CLAIMS | PAYMENT DATE |
|---|---|---|
| December 31, 2010** | January 6, 2011 | January 12, 2011 |
| January 17, 2011 | January 20, 2011 | January 26, 2011 |
| January 31, 2011 | February 3, 2011 | February 9, 2011 |
| February 14, 2011 | February 17, 2011 | February 23, 2011 |
| February 28, 2011 | March 3, 2011 | March 9, 2011 |
| March 14, 2011 | March 17, 2011 | March 23, 2011 |
| March 28, 2011 | March 31, 2011 | April 6, 2011 |
| April 11, 2011 | April 14, 2011 | April 20, 2011 |
| April 25, 2011 | April 28, 2011 | May 4, 2011 |
| May 9, 2011 | May 12, 2011 | May 18, 2011 |
| May 20, 2011** | May 26, 2011 | June 1, 2011 |
| June 6, 2011 | June 9, 2011 | June 15, 2011 |
| June 20, 2011 | June 23, 2011 | June 29, 2011 |
| July 4, 2011 | July 7, 2011 | July 13, 2011 |
| July 18, 2011 | July 21, 2011 | July 27, 2011 |
| July 29, 2011** | August 4, 2011 | August 10, 2011 |
| August 15, 2011 | August 18, 2011 | August 24, 2011 |
| August 29, 2011 | August 31, 2011** | September 7, 2011 |
| September 12, 2011 | September 15, 2011 | September 21, 2011 |
| September 26, 2011 | September 29, 2011 | October 5, 2011 |
| October 7, 2011** | October 13, 2011 | October 19, 2011 |
| October 24, 2011 | October 27, 2011 | November 2, 2011 |
| November 4, 2011** | November 9, 2011** | November 16, 2011 |
| November 21, 2011 | November 24, 2011 | November 30, 2011 |
| December 5, 2011 | December 8, 2011 | December 14, 2011 |
| December 19, 2011 | December 20, 2011** | December 28, 2011 |
| December 30, 2011** | January 5, 2012 | January 11, 2012 |
| 11:00 AM CUT OFF | 11:59 PM CUT OFF | |

NOTE:
Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Radiology, Pathology, Internal Medicine Monthly Statistical Reports and Sessional Payments. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut off date to ensure processing for that payment period.

PLEASE NOTE, THE ** INDICATES A DATE VARIATION

December 9, 2010

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

September 28, 2010 Volume XLV - #4

**Inside this Issue**



## FEE INCREASES

Effective February 1, 2010 the following fee adjustments are now available for billing:

| Category | Code | Description | Adjustment MSU's |
|---|---|---|---|
| VIST | 03.04 | First Examination – Newborn Care Healthy Infant<br>LO=HOSP, FN=INPT, RO=NBCR, RP=INTL (RF=REFD), **SP=PEDI** | Increase to 16 |
| VIST | 03.03 | Subsequent Care – Newborn Healthy Infant<br>LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS (RF=REFD), **SP=PEDI** | Increase to 16 |

*Claims for these codes with a service date from February 01, 2010 to October 01, 2010 will be identified and reconciliation will occur in the winter of 2011. The reconciliation will be calculated after the 90-day waiting period for the submission of claims.*

## NEW FEES

Effective December 01, 2009 the following fee is now available for billing by gynecology oncologists:

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| VIST | 03.04 | RO=CAPT<br>RP=SUBS | Comprehensive reassessment of a cancer patient | 25 |

This code is billable when a comprehensive visit is made by a medical, hematology, gynecology, or radiation oncologist with a cancer patient who is currently undergoing cytotoxic antineoplastic chemotherapy or radiation treatments. It may be claimed once every 21 days during the active treatment cycles. It may not be claimed for hormonal therapy, immunotherapy or when using other biological modifiers. Text is required to indicate the start date and duration of the current treatment cycle.

*Physicians with eligible services must submit their claims within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

## DIAGNOSTIC CODES

The following diagnostic code has been added to the list of acceptable codes for billing optometric CCDX visits:

- 36800 (ambylopia)

## INFLUENZA IMMUNIZATION

For the 2010-2011 season, the influenza immunization is not restricted to certain age groups or risk categories. Please refer to the attached schedule of provincial immunizations for the revised diagnostic codes to be used when billing for the influenza immunization.

## REMINDERS: BILLING GUIDELINES FOR PROVINCIAL IMMUNIZATIONS

Please see the attached Schedule of Provincial Immunizations for billing purposes.

1. If one vaccine is administered but no associated office visit is billed (i.e. the sole purpose for the visit is the immunization), claim the immunization at a full fee.

2. If two vaccines are administered at the same visit but no associated office visit is billed (i.e. the sole purpose for the visit is the immunization), claim for each immunization at a full fee.

3. If one vaccine is administered in conjunction with a billed office visit, claim both the office visit and the immunization at full fee.

4. If two vaccines are administered in conjunction with a billed office visit, the office visit and the first injection can be claimed at full fee. All subsequent injections will be paid at 50 percent.

5. For children under 18 months of age, if a vaccine is administered in conjunction with a well baby care visit, claim the well baby care visit and the immunization.

## UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, October 1, 2010. The files to download are health service (SERVICES.DAT).

## SCHEDULE OF PROVINCIAL IMMUNIZATIONS

Refer to the following fee schedule when claiming for individual immunization(s) not billed in conjunction with an office visit or a single immunization billed in conjunction with an office visit:

| IMMUNIZATION | HEALTH SERVICE CODE | MODIFIER | MSUs | DIAGNOSTIC CODE |
|---|---|---|---|---|
| PENTA (DaPTP, Hib) | 13.59L | RO=PENT | 6.0 | V069 |
| MMR | 13.59L | RO=MMAR | 6.0 | V069 |
| QUAD (DaPTP) | 13.59L | RO=QUAD | 6.0 | V069 |
| Td | 13.59L | RO=TEDI | 6.0 | V069 |
| Influenza - Pregnant | 13.59L | RO=INFL | 6.0 | V221 |
| Influenza - Males and non-pregnant females | 13.59L | RO=INFL | 6.0 | V048 |
| Varicella | 13.59L | RO=VARI | 6.0 | V069 |
| Adacel | 13.59L | RO=ADAC | 6.0 | V069 |
| Menjugate | 13.59L | RO=MENC | 6.0 | V069 |
| Pneumococcal Polysaccharide | 13.59L | RO=PNEU | 6.0 | V069 |
| Pneumococcal Polysaccharide In addition to Influenza | 13.59L | RO=PNEU | 6.0 | V066 |
| Boostrix® | 13.59L | RO=BOTR | 6.0 | V069 |
| Pneumococcal Conjugate | 13.59L | RO=PNEC | 6.0 | V069 |

When claiming immunization with a visit, the visit will be paid in full at 100%. The first inoculation will be in full at 6.0 MSU and all subsequent inoculations will be paid at 3.0 MSU or 50%. If the purpose of the visit is for immunization only, then the first two inoculations will be paid at 100% and all subsequent inoculations at 50% of the specified MSU.

Refer to the following table when claiming for a provincial immunization tray fee:

| HEALTH SERVICE CODE | DESCRIPTION | MSUs |
|---|---|---|
| 13.59M | Provincial Immunization Tray Fee | 1.5 per multiple (Max 4) |

Refer to the following diagnostic code table, when claiming for pneumococcal and varicella immunizations:

| PATIENT'S CONDITION | DIAGNOSTIC CODE |
|---|---|
| At risk irrespective of age | Diagnostic code applicable to condition, e.g. 25000 diabetes mellitus |
| Close contact of at risk individual | V018 |
| Well Senior | V069 |

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

July 19, 2010 Volume XLV - #3

**Inside this Issue**



## NEW FEES

Effective April 1, 2010 the following new Health Service Codes are available for billing:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VEDT | 68.99G | **Renal access and nephroureteral stent placement for stone extraction**<br><br>This procedure establishes a percutaneous tract to allow minimally invasive, percutaneous nephrolithotomy (PNL) for removal of renal calculi. Under local anaesthetic, an access needle is advanced into the specific renal calyx to allow direct access to the renal calculous. A guidewire is advanced through the needle and manipulated down the ureter past the stone(s) into the bladder. A nephroureteral catheter is then introduced. The patient is then transferred to the operating room for PNL under a general anaesthetic. The placement of the stent must be precise as the urologist will go on to dilate that access tract to a 30 French diameter. | 160 |
| VEDT | 68.99H | **Antegrade ureteric stent insertion with or without balloon dilation**<br><br>This procedure is done for ureteric obstruction secondary to stones or malignancy. Under local anaesthetic and conscious sedation, a guidewire is advanced through a preexisting nephrostomy tube, which is then removed. A diagnostic catheter is introduced over the guidewire and then threaded down the ureter, past the obstruction and into the bladder. A double J ureteric stent is advanced over the catheter into the bladder. A nephrostomy tube is then reinserted. A balloon dilation of the stricture may be required. | 120 |

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VEDT | 68.99I | **Balloon dilation of ureteric stricture**<br><br>This procedure is done for ureteric obstruction secondary to stones or malignancy. Under local anaesthetic and conscious sedation, a guidewire is advanced through a preexisting nephrostomy tube, which is then removed. A diagnostic catheter is introduced over the guidewire and then threaded down the ureter, past the obstruction and into the bladder. An angioplasty balloon is advanced over the guidewire and across the stricture and inflated. This may need to be repeated several times in order to alleviate the stricture. | 100 |

*Physicians holding eligible services must submit their claims from April 1st onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

## REVISED LOCUM PROGRAM

Effective July 1, 2010, a revised Locum Program has been approved by the Master Agreement Steering Group.

**Program Guidelines**

Locum Physician Eligibility

- Locum physicians are required to be licensed by the College of Physicians and Surgeons of Nova Scotia.

Locum Coverage Eligibility for Family Practitioners: the following are the criteria for which the Provincial Locum Program will fund locum coverage for a Family Practitioner (all criteria must be met):

- Scheduled leave of physician for vacation, CME, maternity and medical leave OR unplanned leave due to illness
- Physician located in any community outside Capital District Health Authority; and, the following communities within Capital District Health Authority: Musquodoboit Harbour, Middle Musquodoboit, Upper Musquodoboit, Jeddore, Ship Harbour, Sheet Harbour, Brooklyn, Falmouth, Kempt Shore, Newport Corner, Smiths Corner, Summerville, Three Mile Plains, Windsor, and Windsor Forks. Current facilities located in Porters Lake and Mineville, will continue to be eligible for Locum funding until March 31, 2013, based on a five year history of Locum coverage requests. As of April 1, 2013, these facilities will no longer be eligible to receive Locum funding, unless changes to the program are approved through the MASG.

1. Maximum 30 days coverage funded per fiscal year for each physician.

Locum Coverage Eligibility for Specialists: the following are the criteria for which the Provincial Locum Program will fund coverage for Specialists (all criteria must be met).

- Scheduled leave of physicians for vacation, CME, maternity and medical leave OR unplanned leave due to illness; OR, coverage for a position that has been vacated within the previous six months where an ongoing core service is being provided, OR, weekend coverage.

- Coverage for DHAs 1-8
- Core specialty services covered: general internal medicine, general surgery, anaesthesiology, orthopaedic surgery, obstetrics/gynaecology, psychiatry, paediatrics, pathology and radiology.
- Coverage provided for services in a Regional hospital for physician groups that have an active call rotation of 5 or fewer physicians
- Maximum 30 days funded coverage for each core service physician or vacant position per fiscal year; except 45 days coverage for physicians where they are the solo practitioner in a core service.

**Note: Specialists with an active clinical practice will not be funded through the locum program to cover services within their own DHAs**

Services to be provided by locum physicians:

**General Practitioners**

- Office practice coverage
- On-call or emergency department coverage where indicated, as requested on application form

**Specialists**

- Hospital coverage including on-call
- Office coverage where indicated, as requested on application form

**Payment Rates**

The following rates will be paid to physicians for providing locum coverage under the Provincial Locum Program effective July 1, 2010:

**General Practitioners**

- Minimum daily income guarantee: increase from $600 to $700
- *note: physician may request payment by FFS rather than income guarantee, in which case they will receive only per diem and mileage through the Provincial Locum Program, in addition to their FFS billings*
- Top up in addition to minimum daily income guarantee will paid based on volume of services provided, as indicated by shadow billings
- Per diem to cover locum physician expenses, eg food and accommodation: increase from $130 to $150 per day
- Overhead: increase from $180 to $210 per day payable to host practice to cover office overhead expenses;
  ***Note: where the locum physician is eligible to receive a 'top up' payment, the locum physician will receive 70% of the top up payment amount, and the host practice will receive 30% as overhead.***
- Mileage at current Nova Scotia Government rate

**Specialists**

- Minimum daily income guarantee: $1200 (no change from current rate)
  ***Note: physician may request payment by FFS rather than income guarantee, in which case they will receive only per diem and mileage through the Provincial Locum Program, in addition to their FFS billings***
- Top up in addition to minimum daily income guarantee will be paid based on volume of services provided, as indicated by shadow billings
- Per diem to cover locum physician expenses, eg food and accommodation: increase from $130 to $150 per day
- Overhead: $210/day payable to host practice where office coverage is required
- Mileage at Nova Scotia Government rate
- On-call fee to be funded by DOH and administered by the DHA.

**Program Administration**

- The Provincial Locum Program will be administered by Physician Services, Nova Scotia Department of Health
- An application form will be completed and signed by the locum physician and the host DHA (for specialists) or physician/practice (for family physicians) and submitted to Physician Services (Application forms available on the Nova Scotia Department of Health website; as well as members' section on Doctors Nova Scotia website).
- Approval/decline of locum application by Physician Services within 2 working days with notification of locum physician and DHA Chief of Staff or host physician/practice (approval by Physician Services is conditional on granting of license by College of Physicians and Surgeons of Nova Scotia)
- The locum physician must contact MSI (Betty Foster 496-7107 or Emily Pelley 496-7560) prior to starting the locum to receive a locum shadow billing arrangement number, and to provide their banking information. Payment through the Provincial Locum Program can only be provided where the locum physician has obtained a locum shadow billing arrangement number.
- The locum physician will prepare shadow billings for all services provided; the host DHA or host physician/practice will provide administrative support for shadow billing
- At the end of the locum, or on a weekly basis, the locum physician will submit a completed Claim Form to Physician Services for payment. (Send completed forms to Heather Coady at Physician Services, via fax: 902-424-1740 or email: heather.coady@gov.ns.ca .
- Physician Services will verify the Claim Form and submit to MSI for payment
- At the end of the locum, if the locum physician or host physician believes services provided exceed the value of the guaranteed daily rate over the course of the locum, they can apply for a 'top up' payment by contacting Physician Services and requesting a 'reconciliation' of payment.
- Shadow billing - The provision of shadow billings is critical to the budget of the Provincial Locum Program, as the total amount of shadow billings is charged to the FFS cost centre. The locum program is only charged for the difference between the shadow billings and the guaranteed daily rate.

For **General Practice** locums, the office of the host physician is expected to provide administrative support to the locum physician for shadow billing. Payment for the minimum daily guarantee for locum services will be subject to receipt of shadow billings.
For **Specialist** locums, the host DHA is expected to provide administrative support to the locum physician for shadow billing. Payment for locum services will be subject to receipt of shadow billings.

## BILLING CLARIFICATION

In regards to the following Health Service Codes:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VADT | 02.89A | **11-14 week prenatal screening ultrasound** for the determination of nuchal translucency | 35 |
| | | In multifetal pregnancies each additional fetus is paid at 70%. | 24.5 |
| | | Images of the nuchal area, nasal bones, intracranial contents, abdomen, heart and upper and lower extremities must be obtained in addition to the standard images for ultrasound <13 weeks. | |
| | | To be billed by fetal maternal medicine specialists and radiologists only. Operators must be certified by the Fetal Maternal Medicine Foundation of Canada or the UK to perform NT measurements. Operators and the centre in which the service is provided, must supply evidence of current certification and quality assurance results annually to MSI to be kept on file. Only physicians with qualifications as stipulated will be eligible for remuneration for this service. | |

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VADT | 02.89B | **Genetic sonogram** | 60 |
| | | For known or suspected fetal anatomic or genetic abnormality in high risk pregnancies | |
| | | In multifetal pregnancies each additional fetus is paid at 70% | 42 |
| | | Includes all standard biometry and anatomic review, a detailed fetal heart assessment, and an assessment of potential ultrasound markers (soft markers). Soft markers to include: Increased nuchal translucency, Absent nasal bone, Echogenic bowel, Pyelectasis, Ventriculomegaly, Shortened long bones (humerus, femur), Echogenic intracardiac focus, Choroid plexus cysts. | |
| | | May be billed only once per patient per pregnancy. | |
| | | Patients must be at an increased risk for genetic aneuploidy either by maternal age>40, or by past obstetrical or family history. | |
| | | To be billed only by fetal maternal medicine specialists and radiologists with the credentials to perform fetal ultrasound/echocardiography. | |
| | | Sonogram must be performed by the physician specialist for payment. | |

Please be advised the above fees are intended to include all necessary imaging. The bulk billing ultrasound codes are not to be billed in addition to these VADT codes.

## PAYMENT RULES

Please note that payment rules for services will continue to be inserted into the system periodically, as necessary. These rules are created to adhere to the billing guidelines laid out in the Physicians' Manual and Bulletins.

## EXPLANATORY CODES

The following new explanatory codes have been added to the system:

| | |
|---|---|
| VA033 | Service encounter has been refused as you have already claimed the maximum of four subsequent days for invasive EEG video telemetry. |
| VA034 | Service encounter has been refused as you have already claimed the maximum of nine subsequent days for non-invasive EEG video telemetry. |

| | |
|---|---|
| PP023 | Your claim for dental services has been forwarded to Quickcard Solutions Inc. for review. |

## UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, July 23rd, 2010. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanation code (EXPLAIN.DAT).

## ANNOUNCEMENT

We are pleased to announce that Dr. Rhonda Church has joined the MSI Monitoring team of Medavie Blue Cross as the new Medical Consultant effective July 12, 2010. Our previous MSI Monitoring Medical Consultant, Dr. Gayle Higgins, has accepted a position in the MSI Assessment Department and will continue to work with Dr. Church during a transition period until mid-August. If you have any MSI Monitoring related questions, please contact Dr. Church at 902-496-7112.

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

May 14, 2010 Volume XLV - #2

**Inside this Issue**



**Included with this Bulletin**

- CDM Flow Sheet

## NEW FEES

Effective February 01, 2010 the following new Health Service Codes are available for billing:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VADT | 02.89A | **11-14 week prenatal screening ultrasound** for the determination of nuchal translucency | 35 |
| | | In multifetal pregnancies each additional fetus is paid at 70%. | 24.5 |
| | | Images of the nuchal area, nasal bones, intracranial contents, abdomen, heart and upper and lower extremities must be obtained in addition to the standard images for ultrasound <13 weeks. | |
| | | To be billed by fetal maternal medicine specialists and radiologists only. Operators must be certified by the Fetal Maternal Medicine Foundation of Canada or the UK to perform NT measurements. Operators and the centre in which the service is provided, must supply evidence of current certification and quality assurance results annually to MSI to be kept on file. Only physicians with qualifications as stipulated will be eligible for remuneration for this service. | |

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VADT | 02.89B | **Genetic sonogram** | |
| | | For known or suspected fetal anatomic or genetic abnormality in high risk pregnancies | 60 |
| | | In multifetal pregnancies each additional fetus is paid at 70% | 42 |
| | | Includes all standard biometry and anatomic review, a detailed fetal heart assessment, and an assessment of potential ultrasound markers (soft markers). Soft markers to include: Increased nuchal translucency, Absent nasal bone, Echogenic bowel, Pyelectasis, Ventriculomegaly, Shortened long bones (humerus, femur), Echogenic intracardiac focus, Choroid plexus cysts. | |
| | | May be billed only once per patient per pregnancy. | |
| | | Patients must be at an increased risk for genetic aneuploidy either by maternal age>40, or by past obstetrical or family history. | |
| | | To be billed only by fetal maternal medicine specialists or radiologists with the credentials to perform fetal ultrasound/echocardiography. | |
| | | Sonogram must be performed by the physician specialist for payment. | |

*Physicians holding eligible services must submit their claims from February 1st onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

Effective April 01, 2010 the following new Health Service Codes are available for billing:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| | | **Continuous Peripheral Nerve Block (CPNB)** | |
| PMNO | 46.04G | Acute pain management (non-obstetrical) consultation unrelated to delivery of anaesthesia, insertion of CPNB catheter and care on day 1 …. (SP=ANAE) | 75 |
| PMNO | 46.04H | Acute pain management (non-obstetrical) assessment and care following CPNB catheter placement, when the catheter is inserted by another physician, day 1 …. (SP=ANAE) | 44 |
| PMNO | 46.04I | Acute pain management (non-obstetrical) insertion of CPNB catheter in conjunction with anaesthesia …. (SP=ANAE) | 25 |
| PMNO | 46.04J | Acute pain management (non-obstetrical) maintenance of CPNB catheter by primary anaesthetist, day 1 …. (SP=ANAE) | 25 |
| PMNO | 46.04K | Acute pain management (non-obstetrical) CPNB maintenance, per day, day 2 onwards …. (SP=ANAE) | 25 |
| | | **Invasive video EEG telemetry** is the continuous electroencephalographic monitoring of an inpatient using intracranial electrodes with concurrent recorded video monitoring allowing analysis of both the clinical and electrographic features of a recorded event. The intracranial electrodes are placed by a neurosurgeon. | |
| VADT | 03.16F | EEG Video Telemetry – Invasive Day 1 | 150 |
| VADT | 03.16G | EEG Video Telemetry – Invasive subsequent days (maximum 4 days) | 100 |

| Category | Code | Description | Unit Value |
|---|---|---|---|
| | | **Non-invasive video EEG telemetry** is the continuous electroencephalographic monitoring of an inpatient using scalp electrodes with concurrent recorded video monitoring allowing analysis of both the clinical and electrographic features of a recorded event. | |
| VADT | 03.16H | EEG Video Telemetry – Non-invasive Day 1 | 90 |
| VADT | 03.16I | EEG Video Telemetry – Non-invasive Subsequent days (maximum 5 days per week, maximum 2 weeks). | 60 |
| | | The above VADT codes are all LO=HOSP, FN=INPT and are restricted to neurologists and neurosurgeons with subspecialty training in electroencephalography. These codes are for supervision and interpretation. | |

*Physicians holding eligible services must submit their claims from April 1st onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame*.

## FEE ADJUSTMENTS

Effective February 01, 2010 the following fee adjustments are now available for billing:

| Category | Code | Description | Adjustment MSUs |
|---|---|---|---|
| GENP | 03.04 | First Examination – Newborn Care Healthy Infant LO=HOSP, FN=INPT, RO=NBCR, RP=INTL (RF=REFD) | 16 |
| GENP | 03.03 | Subsequent Care – Newborn Healthy Infant LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS (RF=REFD) | 16 |
| OBGY | 03.04 | First Examination – Newborn Care LO=HOSP, FN=INPT, RO=NBCR, RP=INTL (RF=REFD) | 16 |
| OBGY | 03.03 | Subsequent Care – Newborn LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS (RF=REFD) | 16 |
| GENP | 03.03 | Post Partum Visit LO=HOSP, FN=INPT, RO=PTPP (RF=REFD) | 16 |

| Category | Code | Description | Adjustment MSUs |
|---|---|---|---|
| OBGY | 03.03 | Post Partum Care, Per Visit LO=HOSP, FN=INPT, RO=PTPP (RF=REFD) | 16 |

*Claims for these codes with a service date from February 01, 2010 to May 13, 2010 will be identified and reconciliation will occur in the fall of 2010. The reconciliation will be calculated after the 90-day waiting period for the submission of claims.*

Effective April 01, 2010 the following fee adjustments are now available for billing:

| Category | Code | Description | Adjustment AUs |
|---|---|---|---|
| VEDT | 02.79B | **PET/CT Scan and interpretation,** one body region | 4+T |
| VEDT | 02.79C | **PET/CT Scan and interpretation,** multiple body regions (including whole body scan) | 4+T |

*Physicians holding eligible services must submit their claims from April 1st onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

Also effective April 01, 2010 the following health service codes have been revised to include multiples (up to a maximum of 4):

| Category | Code | New Description | Unit Value | |
|---|---|---|---|---|
| MISG | 95.54A | **Suture extensor tendon –***plus multiples, if applicable* | 50 | 4+T |
| MASG | 95.54B | **Suture flexor tendon –** *plus multiples, if applicable* | 106 | 4+T |
| MASG | 95.65F | **Tendon Transfer -** *plus multiples, if applicable* | 96 | 4+T |

With these revisions, health service codes 95.54F, 95.54G, 95.54H, 95.54I, and 95.65B are no longer necessary and have been termed for March 31, 2010, although the system will still recognize these codes and pay claims up until May 13, 2010. *I you have submitted these health service codes with a date of service April 1, 2010 to May 13, 2010 please write to MSI attention Karen Gillis and your submission will be will be reviewed with an adjustment made of necessary based on the information provided.*

## UPCOMING FEES

The following Interventional Radiology fees have been approved by the Master Agreement Steering Group (MASG) for inclusion into the Fee Schedule, effective April 1, 2010.

| Category | Description | Unit Value |
|---|---|---|
| | **Balloon dilation of ureteric stricture** | |
| VEDT | This procedure is done for ureteric obstruction secondary to stones or malignancy. Under local anaesthetic and conscious sedation, a guidewire is advanced through a preexisting nephrostomy tube, which is then removed. A diagnostic catheter is introduced over the guidewire and then threaded down the ureter, past the obstruction and into the bladder. An angioplasty balloon is advanced over the guidewire and across the stricture and inflated. this may need to be repeated several times in order to alleviate the stricture. | 100 |
| | **Renal access and nephroureteral stent placement for stone extraction** | |
| VEDT | This procedure establishes a percutaneous tract to allow minimally invasive, percutaneous nephrolithotomy (PNL) for removal of renal calculi. Under local anaesthetic, an access needle is advanced into the specific renal calyx to allow direct access to the renal calculous. A guidewire is advanced through the needle and manipulated down the ureter past the stone(s) into the bladder. A nephroureteral catheter is then introduced. The patient is then transferred to the operating room for PNL under a general anaesthetic. The placement of the stent must be precise as the urologist will go on to dilate that access tract to a 30 French diameter. | 160 |
| | **Antegrade ureteric stent insertion with or without balloon dilation** | |
| VEDT | This procedure is done for ureteric obstruction secondary to stones or malignancy. Under local anaesthetic and conscious sedation, a guidewire is advanced through a preexisting nephrostomy tube, which is then removed. A diagnostic catheter is introduced over the guidewire and then threaded down the ureter, past the obstruction and into the bladder. A double J ureteric stent is advanced over the catheter into the bladder. A nephrostomy tube is then reinserted. A balloon dilation of the stricture may be required. | 120 |

*NOTE: Please hold all eligible service encounters to allow MSI the required time to update the system . Once a new Health Service Code has been assigned, it will be published in the MSI Physicians' Bulletin.*

**PREAMBLE REVISION**

The Master Agreement Steering Group (MASG) has approved the following preamble amendment, effective April 1, 2010.

8.2.3 Calculation of Anaesthetic Fees

(b) Anaesthetic Time Units, except where otherwise specified, are computed by allowing one unit for each fifteen minutes, or part thereof, of anaesthesia time. Double time units apply when anaesthetic time extends beyond one hour for procedures with basic anaesthetic values of 4 or 5 units and after two hours when the basic is 6 units or greater. *For the purposes of calculating anaesthesia time units and with reference Preamble Section 1.8.5, Physician Record Requirements to Support Claims, time should be calculated from the time documented in the perioperative record when both the patient and anaesthetist are present in the OR and time ends when both the patient and anaesthetist leave the OR. In addition to this documented time an additional 15 minutes may be claimed for the preoperative assessment and anaesthesia setup, another 15 minutes may be claimed for the postoperative attendance of the patient as per section 8.2.2 (c). These 2 additional units may be claimed without the need for any additional documentation requirements over and above that recorded in the perioperative record.*

*In unusual circumstances where the preoperative care is prolonged or repeat trips back to PACU are required, additional time may be added to the anaesthesia time. This additional time must be clearly documented by the anaesthetist in the patient medical record with start and stop times as per Section 1.8.5 of the Preamble.*

If resuscitation is necessary during the anaesthetic time, add the time for resuscitation to the anaesthetic time. Resuscitation and anaesthesia time cannot be claimed simultaneously.

**It is understood that there may be overlapping time units in anaesthesia.**

## CHRONIC DISEASE MANAGEMENT INCENTIVE PROGRAM

Effective April 01, 2010 the Chronic Disease Management (CDM) Incentive Program has been adjusted as follows:

| Category | Code | Modifiers | Description | Adjustment MUs |
|---|---|---|---|---|
| DEFT | CDM1 | | Family Physician Chronic Disease Management Incentive Program | 35.09 |
| DEFT | CDM1 | RP=CON2 | Family Physician Chronic Disease Management Incentive Program – 2nd condition | 17.55 |

*Claims for these codes with a service date from April 01, 2010 to May 13, 2010 will be identified and reconciliation will occur in the fall of 2010. The reconciliation will be calculated after the 90-day waiting period for the submission of claims.*

As outlined in the Physician Services Master Agreement, Schedule "K" Chronic Disease Management Incentives, additional funding is available for expansion of the existing Family Physician Chronic Disease Management Incentive Program in 2010/11.

The program strategy and general guidelines for the 2010/11 Family Physician Chronic Disease Management (CDM) Incentive Program remain the same as those for the 2009/10 program.

Qualifying chronic diseases are expanded in 2010/11 to include:

- **Type 1 and Type 2 Diabetes** as evidenced by FPG ³7.0mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L; and,

- **Ischaemic Heart Disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram. This patient population includes the 2009/10 program population of patients receiving post-MI care for up to 5 years.

In order to claim the 2010/11 incentive, the following 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 common indicators plus the indicators for diabetes only, IHD only, or diabetes and IHD if both chronic diseases are present.

*Common indicators for either Diabetes or IHD*

- Blood pressure – 2 times per year
- Smoking cessation – once per year if smoker (document smoker or nonsmoker)
- Lipids – once per year
- Weight/nutrition counseling – once per year

PLUS EITHER OF THE FOLLOWING:

*Indicators for Diabetes only*

- HbA1C – ordered 2 times per year
- Renal function – ACR or eGFR ordered once per year
- Foot exam with monofilament or 128hz tuning fork – referred or completed once per year
- Eye exam – discussed and/or referred once per year for routine dilated eye exam

*Indicators for IHD only*

- ASA/Anti-platelet therapy – considered/reviewed once per year
- Beta-blocker – considered/reviewed once per year
- ACEI/ARB – considered/reviewed once per year
- Discuss Nitroglycerin
- Consider further cardiac investigations

Eligible GPs will be paid a base incentive payment of $80 (35.09 MUs) once per fiscal year for managing an annual cycle of care and addressing the required indicators/risk factors for each patient with one qualifying chronic disease. An additional $40 (17.55 MUs) will be paid per fiscal year if the patient is managed for a second qualifying chronic condition.

CDM Incentive Billing Rules for 2010/11

1. The CDM incentive fee for 2010/11 can be claimed by family physicians starting April 1, 2010.

2. The base incentive fee may be claimed once per fiscal year for each patient managed for one qualifying chronic disease condition. An additional incentive amount per patient may be claimed once per fiscal year as part of the fee if the patient has an additional qualifying condition.

3. The family physician is expected to act as a case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations or referrals.

4. Patients must be seen a minimum of two times per year by a licensed health care provider (includes physicians) in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.

5. Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.

6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year by March 31 of that year.

7. In 2010/11 (April 1, 2010 to March 31, 2011), the CDM incentive can be claimed if the following conditions are met:

    - The patient is seen by the family physician in relation to their chronic disease(s) at least once in the 2010/11 fiscal year;
    - 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 flow sheet at or before the time of billing.

The 2010/11 Family Physician Chronic Disease Management Flow Sheet has been revised to reflect the program changes and continues to be optional.

### REMINDER UNBUNDLING OF CODES

Section 9.3.3 (a) of the Preamble in the Physician's Manual restricts the unbundling of a procedure fee into its constituent parts and billing for the parts individually or in combination with the procedural fee. For example, a laparoscopic assisted vaginal hysterectomy should be billed as 80.4B and not vaginal hysterectomy plus laparoscopy (80.4 + 66.83)

Effective July 01, 2010 MSI will begin an initiative to assess claims submitted where more than one procedure is claimed for the same patient on the same day.

Please be advised that the manual assessment of these claims may increase turnaround time, as well as a request for operative reports.

## EXPLANATORY CODES

The following new explanatory codes have been added to the system:

| | |
|---|---|
| GN046 | Service encounter has been disallowed as text provided does not include the time of the encounter. |
| NR082 | Please contact MSI regarding this claim. |

## UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, May 14th, 2010. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanation code (EXPLAIN.DAT).

**Optional**

# Family Physician Chronic Disease Management (CDM) Flow Sheet 2010/11

Patient Name: _____ Diabetes: ☐ Type 1 ☐ Type 2 ☐ IHD

Date of birth: _____ (dd/mm/yy) Date(s) of Diagnosis: DM _____ (mm/yy) IHD _____ (mm/yy)

Co morbidities: ☐ HTN ☐ Dyslipidemia ☐ PAD ☐ Renal Disease ☐ A Fib
☐ TIA/CVA ☐ Angina ☐ Mental Health Diagnosis ☐ CHF
Other: _____

Interventions: PCI/Stent _____ ☐ Bare metal ☐ Drug-eluting
CABG _____ Cardiac Cath. _____

Current Medication: _____

_____

| | REQUIRED COMMON INDICATORS FOR DIABETES AND IHD | Date / / | Date / / | Date / / | Date / / |
|---|---|---|---|---|---|
| 2/YR | Blood pressure | | | | |
| ANNUALLY | Smoker ☐ Yes ☐ No If yes, discuss smoking cessation | | | | |
| | Weight/Nutrition Counselling | | | | |
| | Lipids Discuss statins LDL-C (mmol/L) TC/HDL-C | | | | |
| | REQUIRED INDICATORS FOR DIABETES ONLY | | | | |
| 2/YR | HbA1C | | | | |
| ANNUALLY | Renal Function ACR or eGFR | | | | |
| | Foot Exam Check for lesions. Use 10-g monofilament or 128Hz tuning fork | | | | |
| | Eye Exam Discuss and/or refer | | | | |
| | REQUIRED INDICATORS FOR IHD ONLY | | | | |
| ANNUALLY | ASA/Anti-platelet Therapy Review | | | | |
| | Beta-blocker Review | | | | |
| | ACEI/ARB Review | | | | |
| | Discuss Nitroglycerin | | | | |
| | Consider further cardiac investigations | | | | |

*OPTIONAL ITEMS - REMINDERS*

Self Management Referrals ☐ Diabetic Centre ☐ Cardiac Rehab ☐ Your Way to Wellness
Screen for ☐ Depression ☐ Erectile Dysfunction
Vaccinations ☐ Influenza Date: _____ ☐ Pneumovax Date: _____
Exercise/Activity ☐ Discussion
Lifestyle Choices ☐ Alcohol Use ☐ Stress
Economics ☐ Pharmacare ☐ Third Party Insurance ☐ No Insurance
End of Life Care Discussion ☐

**Date CDM Incentive Code Billed:** _____

## SELECTED CHRONIC DISEASE MANAGEMENT GUIDELINE INDICATORS

| Common CDM Indicators | Target | Comments |
|---|---|---|
| Blood Pressure | If diabetic or CKD <130/80 mmHg<br>No diabetes or CKD <140/90 mmHg<br>In children: <95th %ile for age, gender and height | |
| Lipids | LDL-C: < 2.0 >50% reduction | Test every 1-3 years as clinically indicated |
| Weight/Waist circumference/<br>Nutrition counseling | BMI: <25 kg/$m^2$ or<br>In children: <85th %ile for age<br>Waist circumference: M: <102 cm, F: <88 cm | |
| Smoking Cessation | | |

| Diabetes Indicators | Target | Comments |
|---|---|---|
| HbA1C | < 7% | Measure every 6 mos in stable, well managed adults. If not achieved, can measure every 3 mos |
| Renal Function | ACR: <2.0 for males; <2.8 for females<br>eGFR: >60 mL/min | In presence of CKD, at least every 6 months. Referral to nephrologist/internist if eGFR <30 mL/min |
| Routine foot examination | | Test with monofilament or 128hz tuning fork |
| Routine dilated eye examination | | By optometrist or ophthalmologist |

| IHD Indicators | Duration | Comments |
|---|---|---|
| Beta-blocker | STEMI: Indefinitely<br>Non-STEMI: Indefinitely unless low risk | |
| ACEI/ARB | Indefinitely unless low risk | ACEI: Titrate to target dose. Consider ARB if contraindication or intolerance to ACEI |
| ASA/Anti-platelet therapy:<br>ASA 81 to 325 mg OD<br><br>Clopidogrel 75 mg OD | ASA indefinitely -STEMI and Non-STEMI<br><br>Clopidogrel: STEMI - Only if had PCI<br>Minimum 1 mo. post bare metal stent<br>Min. 12 mo. post drug-eluting stent<br><br>Clopidogrel: Non-STEMI<br>No PCI: Low risk - 3 mo; Inc. risk - 12 mo.; Very high risk - >12 mo.<br>PCI: Low risk & bare metal stent - 3 mo.; Increased risk regardless of stent or ≥1 drug-eluting stent - 12 mo.; very high risk regardless of stent or ≥3 drug-eluting stents or complex PCI - >12 mo | Clopidogrel: STEMI<br>Dependent on type of stent and risk profile<br><br>Clopidogrel: Non-STEMI<br>Depends on risk of recurrent event & stent type |
| Discuss Nitroglycerin | | |
| Consider further cardiac investigations | | |

## CHRONIC DISEASE MANAGEMENT (CDM) INCENTIVE FEE BILLING RULES

1. The CDM Incentive fee for 2010/11 can be claimed by family physicians starting April 1, 2010.
2. The base incentive fee may be claimed once per fiscal year for each patient managed for one qualifying chronic disease condition. An additional incentive amount per patient may be claimed once per fiscal year as part of the fee if the patient has an additional qualifying condition.
3. The family physician is expected to act as case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations or referrals.
4. Patients must be seen a minimum of two times per year by a licensed health care provider (includes physicians) in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.
5. Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.
6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year by March 31 of that year.
7. The qualifying chronic diseases eligible for the CDM incentive payment in 2010/11 are **Type 1 and Type 2 Diabetes** (FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L) and/or **Ischaemic Heart Disease** (IHD) characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram (includes post-MI <=5 yr).
8. In year two (April 1, 2010 to March 31, 2011), the CDM incentive can be claimed if the following conditions are met:
   - the patient is seen by the family physician in relation to their chronic disease(s) at least once in the 2010/11 fiscal year;
   - 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 (see front of flow sheet) and documented in the clinical record or optional flow sheet at or before the time of billing.

# PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

March 17, 2010 Volume XLV - #1


**Inside this Issue**



## MEDICAL SERVICE UNIT / ANAESTHESIA UNIT

Effective April 1, 2010, the Medical Service Unit (MSU) value will be increased from $2.26 to $2.28 and the Anaesthesia Unit (AU) value will be increased from $16.15 to $16.31.

## WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC UNIT

Effective April 1, 2010 the Workers' Compensation Board MSU value will increase from $2.51 to $2.53 and the Workers' Compensation Board anaesthetic unit value will increase from $17.94 to $18.12.

## SESSIONAL PAYMENTS

Effective April 1, 2010 the Sessional payment rates for General Practitioners will increase to 58 MSUs while the rate for Specialists increases to 68 MSUs as per the tariff agreement.

## PSYCHIATRY FEES

Effective April 1, 2010 the hourly Psychiatry rate for General Practitioners will increase to $98.31 while the hourly rate for Specilaists increases to $135.66 as per the tariff agreement.

## 2010 MSI PHYSICIAN'S MANUAL

The 2010 MSI Physician's Manual is now available on-line at the followng link:
http://www.gov.ns.ca/health/reports/pubs/MSI_Physicians_Manual_2010.pdf

**NEW FEES**

Effective December 01, 2009 the following new Health Service Code is available for billing:

| Category | Code | Description/Restrictions | Unit Value |
|---|---|---|---|
| VADT | 13.55B | Administration by a physician of a test dose of a chemotherapeutic agent when there is a risk of a severe allergic reaction e.g. L-asparaginase *Maximum once per patient per drug* | 15 |

*Physicians holding eligible services must submit their claims from December 1st onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

Effective December 1, 2009 a new modifier has been created for use with health service code 03.03 to bill the telephone advice and medical chart review of a cancer patient by the medical oncologist at the request of the physician(s) monitoring the patient's care outside the Cancer Care Centre**.**

| Category | Code | Modifiers | Description/Restrictions | Unit Value |
|---|---|---|---|---|
| VIST | 03.03 | RO=TCCP | Telephone advice and medical chart review of a cancer patient by the Oncologist | 11.5 |

This code is only payable when the call is initiated by the physician(s) in the patient's home community who are responsible for monitoring administration of chemotherapy between visits to the oncologist. Both physicians must keep a detailed record of the phone call.

*Physicians holding eligible services must submit their claims from December 1st onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

Effective December 1, 2009 a new modifier has been created for use with health service code 03.04 to bill a comprehensive reassessment of a cancer patient.

| Category | Code | Modifier | Description/Restrictions | Unit Value |
|---|---|---|---|---|
| VIST | 03.04 | RO=CAPT<br>RP=SUBS | Comprehensive reassessment of a cancer patient | 25 |

This code is billable when a comprehensive visit is made by a medical or radiation oncologist with a cancer patient who is currently undergoing cytotoxic antineoplastic chemotherapy or radiation treatments. It may be claimed once every 21 days during the

active treatment cycles. It may not be claimed for hormonal therapy, immunotherapy or when using other biological modifiers. Text is required to indicate the start date and duration of the current treatment cycle.

*Physicians holding eligible services must submit their claims from December 1st onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

Effective February 01, 2010 the following new Health Service Codes are available for billing:

| Category | Code | Description/Restrictions | Unit Value |
|---|---|---|---|
| MASG | 77.19C | **Laparoscopic Ovarian Cystectomy** – Regions Required | 150 6+T |
| MASG | 79.4B | **Rescue Cerclage Suture**<br>Performed when cervical os is dilated greater than or equal to two centimeters and the membranes are visible in the vagina | 120 4+T |
| MISG | 79.4C | **Removal Cerclage Suture**<br>Only to be billed when performed in the OR. AN=GENL or AN=REGL, otherwise removal is considered included in the insertion fee and only a visit may be claimed | 50 4+T |
| MASG | 87.82A | **Obstetrical Trauma – Repair 3rd degree laceration**<br>With rupture of the external and internal anal sphincter, and rectal mucosa intact – meticulous, layered anatomic reapproximation. Consultation and procedure.<br>*Not billable with:*<br>HSC **87.82B** Obstetrical Trauma – Repair 4th degree laceration<br>HSC **61.69E** Repair of anal sphincter<br>HSC **61.69F** Repair of anal sphincter and anorectal ring<br>HSC **83.61** Suture of vulva and perineum<br><br>*A detailed description of the degree of obstetrical trauma and the meticulous, layered closure must be documented in the operative report.* | 75 4+T |
| MASG | 87.82B | **Obstetrical Trauma – Repair 4th degree laceration**<br>With rupture of the external, internal anal sphincter, and rectal mucosa – meticulous, layered reapproximation. Consultation and procedure.<br><br>*Not billable with:*<br>HSC **87.82A** Obstetrical Trauma –Repair 3rd degree laceration<br>HSC **61.69E** Repair of anal sphincter<br>HSC **61.69F** Repair of anal sphincter and anorectal ring | 100 4+T |

| Category | Code | Description/Restrictions | Unit Value |
|---|---|---|---|
| | | HSC **83.61** Suture of vulva and perineum<br><br>*A detailed description of the degree of obstetrical trauma and the meticulous, layered closure must be documented in the operative report.* | |
| MASG | 87.99B | **Application of Uterine Compression Sutures** (e.g. B-Lynch suture)<br>Used in the surgical management of severe post partum hemorrhage secondary to uterine atony, to include ligation of uterine and ovarian vessels as required.<br>*Not Billable with:*<br>HSC **87.94A** Repair of Inverted Uterus<br>HSC **80.3** Total Abdominal Hysterectomy<br><br>*The operative report must document the presence of post partum uterine atony unresponsive to conservative measures including the administration of uterotonic medications, uterine massage, and possibly the ligation of uterine and ovarian vessels*. | 200 6+T |

*Physicians who have provided any of these new services since February 1,2010 may re-submitt using the new service codes*

The following new fees have been approved by MASG for inclusion in the fee schedule effective February 1, 2010:

| Category | Description/Restrictions | Unit Value |
|---|---|---|
| VADT | **11-14 week prenatal screening ultrasound** for the determination of nuchal translucency | 35 |
| | In multifetal pregnancies each additional fetus is paid at 70% | 24.5 |
| | Images of the nuchal area, nasal bones, intracranial contents, abdomen, heart and upper and lower extremities must be obtained in addition to the standard images for ultrasound <13 weeks.<br><br>To be billed by fetal maternal medicine specialists and radiologists only. Operators must be certified by the Fetal Maternal Medicine Foundation of Canada or the UK to perform NT measurements. Operators and the centre in which the service is provided, must supply evidence of current certification and quality assurance results annually to MSI to be kept on file. Only physicians with qualifications as stipulated will be eligible for remuneration for this service. | |

*Until further notice please hold eligible service encounters to allow MSI the required time to update the system.*

| Category | Description/Restrictions | Unit Value |
|---|---|---|
| VADT | **Genetic sonogram** | 60 |
| | for known or suspected fetal anatomic or genetic abnormality in high risk pregnancies | |
| | In multifetal pregnancies each additional fetus is paid at 70% | 42 |
| | Includes all standard biometry and anatomic review, a detailed fetal heart assessment, and an assessment of potential ultrasound markers (soft markers). Soft Markers to include: Increased nuchal translucency, Absent nasal bone, Echogenic bowel, Pyelectasis, Ventriculomegaly, Shortened long bones (humerus, femur), Echogenic intracardiac focus, Choroid plexus cysts. | |
| | May be billed only once per patient per pregnancy. | |
| | Patients must be at an increased risk for genetic aneuploidy either by maternal age >40, or by past obstetrical or family history. | |
| | To be billed only by fetal maternal medicine specialists and radiologists with the credentials to perform fetal ultrasound/echocardiography. | |
| | Sonogram must be performed by the physician specialist for payment. | |

*Until further notice please hold eligible service encounters to allow MSI the required time to update the system.*

The following new fees have been approved by MASG for inclusion in the fee schedule effective April 1, 2010:

| Category | Description/Restrictions | Unit Value |
|---|---|---|
| PMNO | **Continuous Peripheral Nerve Block (CPNB**) | |
| | Acute pain management (non-obstetrical) consultation unrelated to delivery of anaesthesia, insertion of CPNB catheter and care on day 1 …. (SP=ANAE) | 75 |
| | Acute pain management (non-obstetrical) assessment and care following CPNB catheter placement, when the catheter is inserted by another physician, day 1 …. (SP=ANAE) | 44 |
| | Acute pain management (non-obstetrical) insertion of CPNB catheter in conjunction with anaesthesia …. (SP=ANAE) | 25 |
| | Acute pain management (non-obstetrical) maintenance of CPNB catheter by primary anaesthetist, day 1 …. (SP=ANAE) | 25 |
| | Acute pain management (non-obstetrical) CPNB maintenance, per day, day 2 onwards …. (SP=ANAE) | 25 |

| Category | Description/Restrictions | Unit Value |
|---|---|---|
| VADT | **Invasive video EEG telemetry**<br>is the continuous electroencephalographic monitoring of an inpatient using intracranial electrodes with concurrent recorded video monitoring allowing analysis of both the clinical and electrographic features of a recorded event. The intracranial electrodes are placed by a neurosurgeon | |
| | EEG Video Telemetry - Invasive Day1 | 150 |
| | EEG Video Telemetry - Invasive Subsequent days (maximum 4 days) | 100 |
| | **Non-invasive video EEG telemetry**<br>is the continuous electroencephalographic monitoring of an inpatient using scalp electrodes with concurrent recorded video monitoring allowing analysis of both the clinical and electrographic features of a recorded event. | |
| | EEG Video Telemetry - Non-invasive Day 1 | 90 |
| | EEG Video Telemetry - Non-invasive Subsequent days (maximum 5 days per week, maximum 2 weeks) | 60 |
| | The above codes are all LO=HOSP, FN=INPT and are restricted to neurologists and neurosurgeons with subspecialty training in electroencephalography. These codes are for supervision and interpretation. | |

*Until further notice please hold eligible service encounters to allow MSI the required time to update the system.*

## FEE CODE CORRECTION

In the Physicians' Bulletin dated December 17, 2009 the Long Term Care Medication Review fee was incorrectly listed with the health service code ENHI. Here is the correct code:

| Category | Code | Description/Restrictions | Unit Value |
|---|---|---|---|
| DEFT | ENH1 | Long Term Care Medication Review | 11.95 |

## FEE REVISIONS

Effective December 01, 2009 the following interim fees have been made permanent:

| Category | Code | Description/Restrictions | Unit Value |
|---|---|---|---|
| VEDT | 02.79B | PET/CT Scan and interpretation, one body region | 87 |

| Category | Code | Description/Restrictions | Unit Value |
|---|---|---|---|
| VEDT | 02.79C | PET/CT Scan and interpretation, multiple body regions (including whole body scan) | 125 |

*These interim fees were originally termed on December 31, 2009. Physicians holding eligible services must submit their claims from January 1, 2010 onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

Effective December 01, 2009 the following fee increase is in effect:

| Category | Code | Description/Restrictions | New Unit Value |
|---|---|---|---|
| VIST | 03.03 | Acute or Chronic Home Care, Medical Chart review and/or Telephone Call, Fax, or Email – up to 3 per day per patient LO=HMHC, RO=HMTE, SP=GENP, (RF=REFD)<br>Note: Each additional group of 3 /per day/per patient can be claimed at 11.5 MSU | 11.5 |

*Claims for this code with a service date from December 01, 2009 to March 18, 2010 will be identified and reconciliation will occur in the summer of 2010. The reconciliation will be calculated after the 90-day waiting period for the submission of claims.*

Effective February 01, 2010 the following fees may now include a surgical assistant at the standard 33.8% rate:

| Category | Code | Description/Restrictions | Unit Value |
|---|---|---|---|
| MASG | 79.4 | Repair of internal cervical os (incompetent cervix, any suture repair) | 75 4+T<br>(25 with RO=SRAS) |
| OBST | 79.4A | Suture of incompetent cervix during pregnancy | 75 4+T<br>(25 with RO=SRAS) |

Effective February 01, 2010 the following fee increase is in effect:

| Category | Code | Description/Restrictions | New Unit Value |
|---|---|---|---|
| MASG | 87.6 | Removal of retained placenta – consultation and procedure | 70 4+T |

*Claims for this code with a service date from February 01, 2010 to March 18, 2010 will be identified and reconciliation will occur in the summer of 2010. The reconciliation will be calculated after the 90-day waiting period for the submission of claims.*

Effective April 1, 2010 the following Surgical Pathology fees will be increased:

| Category | Description/Restrictions | Unit Value |
|---|---|---|
| P2345 | Surgicals, gross and microscopic 3 or more separate surgical specimens | 29.62 |
| P2346 | Surgicals, gross and microscopic, single large complex ca specimen including lymph nodes | 29.62 |

Two new bulk billing sheets are included with this bulletin for Pathology billings beginning April 01, 2010. If you create your own billing sheets please ensure that you update the values for these services as well as their applicable premium fees.

Effective April 1, 2010 the Case Management Conference Fee rates will be increased:

| Category | Code | Description/Restrictions | New Unit Value |
|---|---|---|---|
| VIST | 03.03D | Case Management Conference | 14.5 units per 15 minutes for a GP and 17 units per 15 minutes for Specialists |

## FEE ADJUSTMENTS

The following fee adjustments have been approved by MASG for inclusion in the fee schedule effective April 1, 2010:

| Category | Code | Description | Adjustment |
|---|---|---|---|
| VEDT | 02.79B | **PET/CT scan and interpretation**, one body region | Add anesthesia 4+T |
| VEDT | 02.79C | **PET/CT scan and interpretation**, multiple body regions (including whole body scan) | Add anesthesia 4+T |

*Until further notice please hold eligible anesthetic service encounters to allow MSI the required time to update the system*.

| Category | Code | Description | Adjustment MSUs |
|---|---|---|---|
| GENP | 03.04 | First Examination - Newborn Care Healthy Infant LO=HOSP,FN=INPT,RO=NBCR,RP=INTL(RF=REFD).....13.5 | Increase to 16 |
| GENP | 03.03 | Subsequent Care - Newborn Healthy Infant LO=HOSP,FN=INPT,RO=NBCR,RP=SUBS(RF=REFD).....13.5 | Increase to 16 |
| OBGY | 03.04 | First Examination - Newborn Care | Increase to 16 |

| Category | Code | Description | Adjustment MSUs |
|---|---|---|---|
| | | LO=HOSP,FN=INPT,RP=INTL,RO =NBCR(RF=REFD).....13.3 | |
| OBGY | 03.03 | Subsequent Care - Newborn LO=HOSP,FN=INPT,RO=NBCR,R P=SUBS(RF=REFD).....7.3 | Increase to 16 |
| GENP | 03.03 | Post Partum Visit LO=HOSP,FN=INPT,RO=PTPP(R F=REFD) ..... .....13.5 | Increase to 16 |
| OBGY | 03.03 | Post Partum Care; Per Visit LO=HOSP,FN=INPT,RO=PTPP(R F=REFD) .....13.5 | Increase to 16 |

Please continue to submit in the normal manner. Ninety days after the system has been updated, a retro active payment will be processed.

| Category | Code | Description | Adjustment MSUs |
|---|---|---|---|
| MISG | 95.54A | **Suture extensor tendon** -single | Amend to allow multiples |
| MASG | 95.54B | **Suture flexor tendon --**single | Amend to allow multiples |
| MASG | 95.65F | **Tendon transfer** -single | Amend to allow multiples |

Please continue to submit in the normal manner. Ninety days after the system has been updated, a retro active payment will be processed.

## SERVICE OCCURRENCE NUMBER USAGE

Effective April 01, 2010 service encounters with an occurrence number greater than one will require text in order for the claim to be paid. This text must indicate the medical necessity of the subsequent visit as well as the time of the occurrence. Any claims submitted with an occurrence number greater than one without text will be paid at zero. The physician will have the option to resubmit with explanatory text.

As a reminder, the service occurrence field is used to indicate the number of separate times the same provider sees the same patient on the same day. For example, if the patient has an office visit in the morning followed by an influenza immunization, both of these claims should be submitted with service occurrence number one. If a patient were to have an office visit in the morning for a cough and return later that afternoon with complaint of a headache, the morning visit would be submitted with occurrence number one and the afternoon visit with occurrence number two.

An example of incorrect usage would be to assign service occurrence numbers 1, 2, and 3 respectively to a visit, immunization, and tray fee that were all provided at the same encounter. In this instance all three of these services should use service occurrence number 1.

## LOCAL TISSUE SHIFTS - CLARIFICATION

When billing either of the following services:

| Category | Code | Description/Restrictions | Unit Value |
|---|---|---|---|
| MASG | 98.51C | Local tissue shifts – advancements, rotations, transpositions, 'Z' plasty - single | 96 4+T |
| MASG | 98.51D | Local tissue shifts – advancements, rotations, transpositions, 'Z' plasty - multiple | 144 4+T |

The 'single' and 'multiple' refers to the number of flaps used to close a single incision.

## GENERAL PRACTICE COMPREHENSIVE CARE INCENTIVE PROGRAM – YEAR 3 (2010/11) ADDITIONAL CATEGORY

Selected GP Procedures will become a new eligible service category for CCIP in 2010/11 in addition to the existing eligible categories: Nursing Home Visits; Inpatient Hospital Care; Obstetrical Deliveries; Maternity and Newborn Care; Home Visits; and, All Office Visits for Children under Two Years. Procedures for inpatients, which are already included in the CCIP as part of the Inpatient Hospital Services category, are not included.

Qualifying GP procedures were selected according to the following principles:

- The intent of providing an incentive for GP procedures is to recognize and encourage family physicians to perform procedures that promote better patient-centered care.
- If a GP carries out a procedure, the need for the patient to see a specialist may be reduced.
- The procedure is within the scope of practice of a GP.
- Fee codes that are frequently billed incorrectly and identified by DOH/MSI as a major audit problem are not included.
- The provision of an incentive for GP procedures is intended to encourage comprehensive care not high frequency billing of a single procedure.

The procedures included in the CCIP Selected GP Procedures service category will be reviewed periodically as the fee schedule, procedures and standards of practice change.

Activity for the *Selected GP Procedures* service category will be measured by the number of services billed.

To qualify for CCIP payments in 2010/11, family physicians must:

- Have minimum fee-for-service or shadow billings of $100,000, including minimum office billings of $25,000, during the 12 month CCIP calculation period from July 1, 2009 to June 30, 2010; and,
- Reach the first activity threshold for at least two CCIP-eligible service categories.

CCIP activity thresholds and an estimated payment grid for 2010/11 will be developed and presented to the MASG at a later date when more complete 2009/10 billing information is available.

Procedures included in the Selected GP Procedures category for 2010/11 are the following:

| Code | Description | Eligible Locations |
|---|---|---|
| 01.24B | Proctoscopic Examination | Any except inpatient |
| 10.15 | Insertion Of Vaginal Diaphragm | Any except inpatient |
| 10.16 | Insertion Of Other Vaginal Pessary | Any except inpatient |
| 11.02 | Replacement Of Gastrostomy Tube | Any except inpatient |
| 12.01 | Removal Of Intraluminal Foreign Body From Nose Without Incision (ME=SIMP) | Any except inpatient |
| 12.21 | Removal Of Intraluminal Foreign Body From Ear Without Incision (ME=SIMP) | Any except inpatient |
| 25.1A | Removal Embedded Foreign Body Cornea (No Anaesthetic) | Any except inpatient |
| 61.37 | Evacuation Of Thrombosed Hemorrhoids | Any except inpatient |
| 69.94 | Insertion Of Indwelling Urinary Catheter | Any except inpatient |
| 81.8 | Insertion Of Intrauterine Contraceptive Device | Any except inpatient |
| 93.92A | Injection Of Therapeutic Substance Into Joint Or Ligament Including Aspiration If Necessary | Any except inpatient |
| 95.92A | Injection Of Therapeutic Substance Into Tendon Including Aspiration If Necessary | Any except inpatient |
| 95.93A | Injection Of Therapeutic Substance Into Bursa Including Aspiration If Necessary | Any except inpatient |
| 95.94A | Injection Of Therapeutic Substance Into Other Soft Tissue Including Aspiration If Necessary | Any except inpatient |
| 98.02 | Incision Of Pilonidal Sinus Or Cyst (AN=LOCL) | Any except inpatient |
| 98.03 | Other Incision With Drainage Of Skin And Subcutaneous Tissue (AN=LOCL) | Any except inpatient |
| 98.03C | Incision Of Hematoma (AN=LOCL) | Any except inpatient |
| 98.04 | Incision With Removal Of Foreign Body Of Skin And Subcutaneous Tissue (AN=LOCL) | Any except inpatient |
| 98.04A | Suture Minor Laceration With Removal Of Foreign Body | Office only |

| Code | Description | Eligible Locations |
|---|---|---|
| 98.12A | Removal Of Fibroma | Any except inpatient |
| 98.12B | Carcinoma Of Skin - Local Excision, Primary Closure | Any except inpatient |
| 98.12W | Simple Excision Of Warts, Including Papillomata, Keratoses, Nevi, Moles, Pyogenic Granulomata, Etc. For Malignant Or Pre-Malignant Condition - Includes Clinical Suspicion Of Malignancy. | Any except inpatient |
| 98.12Y | Excision - Sebaceous Cyst On Face / Neck - Infected Or Other Medical Reason For Excision | Any except inpatient |
| 98.12Z | Excision - Sebaceous Cyst On Other Area - Infected Or Other Medical Reason For Excision | Any except inpatient |
| 98.22 | Suture Of Skin And Subcutaneous Tissue Of Other Sites | Office only |
| 98.22A | Suture Of Simple Wounds Or Lacerations - Child's Face | Office only |
| 98.22D | Suture Minor Laceration Or Foreign Body Wound | Office only |
| 98.22E | Suture Minor Lacerations Or Simple Wounds | Office only |
| 98.81C | Biopsy Of Skin/Mucosa-Malignant Or Recognized Pre Malignant Condition Or Biopsy Necessary For Histological Diagnosis For Patient Management. | Any except inpatient |
| 98.81D | Punch Biopsy Of Skin Or Mucosa-Malignant Or Recognized Pre Malignant Condition Or Biopsy Necessary For Histological Diagnosis For Patient Management. | Any except inpatient |
| 98.96C | Excision Of Fingernail - Simple, Complete, Partial Or Wedge | Any except inpatient |
| 98.96D | Excision Of Toenail - Simple, Complete, Partial Or Wedge | Any except inpatient |

## FAMILY PHYSICIAN CHRONIC DISEASE MANAGEMENT INCENTIVE PROGRAM

On February 25, 2009 the Master Agreement Steering Group approved the recommendations of the Comprehensive Care Working Group for implementation of a new Family Physician Chronic Disease Management Incentive Program starting April 1, 2009. The program is intended to recognize the additional work of General Practitioners, beyond office visits, of providing guidelines-based care to patients with chronic diseases.

Providing all eligibility requirements are met, the CDM incentive can be billed once per patient per Fiscal year.

**In order to receive payment for services provided in Fiscal 2009/10, all claims must be submitted to MSI by March 31, 2010.**

## COMPLEX CARE CODE – CLARIFICATION

On July 30, 2008 a new Complex Care Code was approved for inclusion in the fee guide.

A complex care visit code may be billed a maximum of 4 times per patient per Fiscal year by the family physician and/or the practice providing on-going comprehensive care to patient who is under active management for 3 or more of the following chronic diseases: asthma, COPD, diabetes, chronic liver disease, hypertension, chronic renal failure, congestive heart failure, ischaemic heart disease, dementia, chronic neurological disorders, cancer. The physician must spend at least 15 minutes in direct patient intervention.

The Complex Care Code is billable for GP office visit services only. It is not available to be billed in Long Term Care facilities at this time.

## ELECTRONIC MEDICAL RECORDS (EMR) – UPDATE

The 2008-2013 Physician Services Master Agreement between the Department of Health and Doctors Nova Scotia contains funding provisions for Electronic Medical Records.

As per schedule “I” in the Master Agreement, there are three specific funding envelopes:

1. A one-time physician specific EMR Investment Grant
2. An annual physician specific EMR Participation Grant
3. An annual physician specific EMR Utilization Grant

Annual payments pursuant to both the EMR Participation and Utilization Grants are currently being processed and will be sent to eligible physicians by the end of March 2010. These payments are being made based on the eligibility requirements that were met during the period from April 1, 2009 to March 31, 2010.

EMR Utilization payments have been calculated based on individual physician response to the on-line EMR application/questionnaire.

## FYI - HELPFUL BANKING INFORMATION

Physicians currently receiving payment through MSI will have subsequent Business Arrangements set up with available banking information on file unless otherwise notified. (Revised form is attached)

## EXPLANATORY CODES

The following new explanatory codes have been added to the system:

| | |
|---|---|
| CN019 | Service encounter has been disallowed as a consultation is considered included in the fee for an obstetrical trauma repair. |
| GN044 | Service encounter has been disallowed as a service occurrence other than 1 has been used without explanatory text. |
| GN045 | Service encounter has been disallowed as text provided does not include the original service encounter number. |
| MJ022 | Service encounter has been refused as a total abdominal hysterectomy or repair of inverted uterus has already been claimed by you for this date. |
| MJ023 | Service encounter has been refused as you have already claimed a repair of obstetrical trauma or anal sphincter on this date. |
| MJ024 | Service encounter has been refused as you have already claimed a repair of obstetrical trauma on this date. |
| VT090 | Service encounter has been disallowed as electronic text is required to indicate the start date and duration of the current treatment cycle. |
| WB024 | WCB has advised the adjustment of this claim to the appropriate visit fee as the client is on long term disability and form 8/10 is not applicable. |

## UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, March 19th, 2010. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanation code (EXPLAIN.DAT), and modifier values (MODVALS.DAT)

PROGRAMS OF THE NOVA SCOTIA DEPT. OF HEALTH
PO BOX 500 HALIFAX NOVA SCOTIA B3J 2S1
TELEPHONE (902) 468-9700

**NOVA SCOTIA MEDICAL SERVICES INSURANCE**

## PATHOLOGY STATISTICAL BILLING REPORT - PREMIUM FEES

| | |
|---|---|
| Provider Name or Group Name: | |
| Provider Number or Group Number: | |
| Institution Name and Number: | |
| Business Arrangement Number: | |
| Billing Period From: | |
| Billing Period To: | |
| Contact Name / Phone Number: | |

| CODE | EXAMINATION DESCRIPTION-PREMIUM TIME | Premium value | Unit value | In patient | Out patient | No. of exams | TOTAL UNITS |
|---|---|---|---|---|---|---|---|
| P3320 | Autopsy, gross (all ages) | 35% | 166.73 | | | | |
| P5320 | Autopsy, gross (all ages) | 50% | 185.25 | | | | |
| P3321 | Autopsy, gross, negative cranium | 35% | 128.82 | | | | |
| P5321 | Autopsy, gross, negative cranium | 50% | 143.13 | | | | |
| P3322 | Autopsy, gross, limited | 35% | 37.89 | | | | |
| P5322 | Autopsy, gross, limited | 50% | 42.11 | | | | |
| P3323 | Autopsy Tissues (Maximum 25 per autopsy) | 35% | 13.49 | | | | |
| P5323 | Autopsy Tissues (Maximum 25 per autopsy) | 50% | 13.49 | | | | |
| P3324 | Surgicals, gross | 35% | 16.30 | | | | |
| P5324 | Surgicals, gross | 50% | 16.30 | | | | |
| P3325 | Surgicals, gross and microscopic | 35% | 28.08 | | | | |
| P5325 | Surgicals, gross and microscopic | 50% | 28.62 | | | | |
| P3326 | Frozen Sections | 35% | 43.19 | | | | |
| P5326 | Frozen Sections | 50% | 47.99 | | | | |
| P3327 | Bone Marrow interpretation | 35% | 24.44 | | | | |
| P5327 | Bone Marrow interpretation | 50% | 24.44 | | | | |
| P3328 | Interpretation - fine needle aspiration biopsy | 35% | 24.00 | | | | |
| P5328 | Interpretation - fine needle aspiration biopsy | 50% | 24.00 | | | | |
| P3329 | Cell Block | 35% | 23.60 | | | | |
| P5329 | Cell Block | 50% | 23.60 | | | | |
| P3330 | Cytology (with a screener) | 35% | 10.00 | | | | |
| P5330 | Cytology (with a screener) | 50% | 10.00 | | | | |
| P3331 | Interpretation & Report - GYN cytology slides | 35% | 14.00 | | | | |
| P5331 | Interpretation & Report - GYN cytology slides | 50% | 14.00 | | | | |
| P3332 | Interpretation & Report - NON GYN cytology slides | 35% | 14.61 | | | | |
| P5332 | Interpretation & Report - NON GYN cytology slides | 50% | 14.61 | | | | |
| P3333 | Sex Chromatin Analysis | 35% | 14.61 | | | | |
| P5333 | Sex Chromatin Analysis | 50% | 14.61 | | | | |
| P3334 | Karyotype Test A - 5 cells & 2 karyotypes | 35% | 25.84 | | | | |
| P5334 | Karyotype Test A - 5 cells & 2 karyotypes | 50% | 25.84 | | | | |
| P3335 | Karyotype Test B - 30 cells & 4 karyotypes | 35% | 31.46 | | | | |
| P5335 | Karyotype Test B - 30 cells & 4 karyotypes | 50% | 33.69 | | | | |
| P3336 | Electron Microscopy Anatomical Pathology only | 35% | 71.42 | | | | |
| P5336 | Electron Microscopy Anatomical Pathology only | 50% | 79.35 | | | | |
| P3345 | Surgicals, gross and microscopic 3 or more separate surgical specimens | 35% | 39.99 | | | | |
| P5345 | Surgicals, gross and microscopic 3 or more separate surgical specimens | 50% | 44.43 | | | | |
| P3346 | Surgicals, gross and microscopic, single large complex CA specimens including lymph notes | 35% | 39.99 | | | | |
| P5346 | Surgicals, gross and microscopic, single large complex CA specimens including lymph notes | 50% | 44.43 | | | | |
| | | | | | | **TOTAL UNITS CLAIMED:** | |

PROGRAMS OF THE NOVA SCOTIA DEPT. OF HEALTH
PO BOX 500 HALIFAX NOVA SCOTIA B3J 2S1
TELEPHONE (902) 468-9700

**NOVA SCOTIA MEDICAL SERVICES INSURANCE**

# PATHOLOGY STATISTICAL BILLING REPORT

| | |
|---|---|
| Provider Name or Group Name: | |
| Provider Number or Group Number: | |
| Institution Name and Number: | |
| Business Arrangement Number: | |
| Billing Period From: | |
| Billing Period To: | |
| Contact Name / Phone Number: | |

| CODE | EXAMINATION DESCRIPTION | UNITS | In Patient | Out Patient | Number of Exams | TOTAL UNITS |
|---|---|---|---|---|---|---|
| P2320 | Autopsy, gross (all ages) | 123.50 | | | | |
| P2321 | Autopsy, gross, negative cranium | 95.42 | | | | |
| P2322 | Autopsy, gross, limited | 28.07 | | | | |
| P2323 | Autopsy Tissues (Maximum 25 per autopsy) | 4.49 | | | | |
| P2324 | Surgicals, gross | 7.30 | | | | |
| P2325 | Surgicals, gross and microscopic | 19.08 | | | | |
| P2326 | Frozen Sections | 31.99 | | | | |
| P2327 | Bone Marrow interpretation | 15.44 | | | | |
| P2328 | Interpretation–fine needle aspiration biopsy | 15.00 | | | | |
| P2329 | Cell Block | 14.60 | | | | |
| P2330 | Cytology (with a screener) | 1.00 | | | | |
| P2331 | Interpretation & Report–GYN cytology slides | 5.00 | | | | |
| P2332 | Interpretation & Report–NON GYN cytology slides | 5.61 | | | | |
| P2333 | Sex Chromatin Analysis | 5.61 | | | | |
| P2334 | Karyotype Test A–5 cells & 2 karyotypes | 16.84 | | | | |
| P2335 | Karyotype Test B–30 cells & 4 karyotypes | 22.46 | | | | |
| P2336 | Electron Microscopy Anatomical Pathology only | 52.90 | | | | |
| P2337 | * Immunohistochemistry–Head and Neck | 10.00 | | | | |
| P2338 | * Immunohistochemistry–Anterior Torso | 10.00 | | | | |
| P2339 | * Immunohistochemistry–Posterior Torso | 10.00 | | | | |
| P2340 | * Immunohistochemistry–Right arm | 10.00 | | | | |
| P2341 | * Immunohistochemistry–Left arm | 10.00 | | | | |
| P2342 | * Immunohistochemistry–Right leg | 10.00 | | | | |
| P2343 | * Immunohistochemistry–Left leg | 10.00 | | | | |
| P2344 | Liquid based preparation (thin prep) non gynaecological cytology (per slide) | 15.00 | | | | |
| P2345 | Surgicals, gross and microscopic 3 or more separate surgical specimens | 29.62 | | | | |
| P2346 | Surgicals, gross and microscopic, single large complex CA specimen including lymph notes | 29.62 | | | | |
| * Immunohistochemistry Staining and Interpretation of Surgical (Anatomic) Pathology Specimens | | | | | **TOTAL UNITS CLAIMED:** | |

NOVA SCOTIA MEDICAL SERVICES INSURANCE
P.O. BOX 500 HALIFAX, N.S. B3J 2S1

NOVA SCOTIA Health

# MSI PROVIDER BUSINESS ARRANGEMENT (BA) FORM

(Please complete and return to MSI)

## PROVIDER INFORMATION

Service Provider Number (If known): _____

Service Provider Name: _____

Incorporated Name (If applicable): _____

Email Address: _____

Service Provider Address: _____

_____

Phone Number: _____ Fax Number: _____

**Please indicate which of the following applies:**

☐ 1. *Change of Bank Account Only Business Arrangement Number(s): _____

☐ 2. **New / Additional Business Arrangement - Same Bank Account

☐ 3. *New Bank Account / New Business Arrangement

## BANKING INFORMATION

***ONLY BANKING FROM CANADIAN INSTITUTIONS WILL BE ACCEPTED***

***A LINE OF CREDIT ACCOUNT WILL NOT BE ACCEPTED***

Name of Financial Institution: _____

Address: _____

_____

Phone Number: _____

## BANK ACCOUNT INFORMATION

Bank Number: _____ Branch: _____ Account: _____

***PLEASE ENCLOSE A VOID CHEQUE (COPIES ACCEPTED)***

I/We hereby authorize Nova Scotia Medical Services Insurance to make deposits to my/our account at the financial institution described above. I/We will advise MSI of any changes in my/our account information.

***Any subsequent Business Arrangement(s) will be set up with banking information on file unless otherwise informed.***

**Signature:** _____ **Please Print Name:** _____

Please Scan and Email to msi.providercoordinators@medavie.bluecross.ca OR Fax to (902) 490-2275

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

December 17, 2009 Volume XLIV - #5

**Inside this Issue**



## NEW FEES

The following fees have been approved by the Master Agreement Steering Group (MASG) for inclusion into the Fee Schedule, effective December 1, 2009.

| Category | Description/Restrictions | Unit Value |
|---|---|---|
| VADT | Administration by a physician of a test dose of a chemotherapeutic agent when there is a risk of a severe allergic reaction e.g. L-asparaginase<br>• Maximum once per patient per drug | 15 |
| VIST | Telephone advice and medical chart review of a cancer patient by the medical oncologist at the request of the physician(s) monitoring the patient's care outside the Cancer Care Centre<br>• Only payable when the call is initiated by the physician(s) in the patient's home community who are responsible for monitoring the administration of chemotherapy between visits to the oncologist.<br>• Both physicians must keep a detailed record of the phone call | 11.5 |
| VIST | Comprehensive reassessment of a cancer patient<br>• This is a comprehensive visit by a medical or radiation oncologist with a cancer patient who is currently undergoing cytotoxic antineoplastic chemotherapy or radiation treatments. It may be claimed once every 21 days during the active treatment cycles. It may not be claimed for hormonal therapy, immunotherapy or when using other biological modifiers. | 25 |

***NOTE**: Please hold all eligible service encounters to allow MSI the required time to update the system. Once a new Health Service Code has been assigned it will be published in the MSI Physicians' Bulletin.*

## FEE REVISION

Effective December 1, 2009, the following interim fees have been made permanent through approval by the Master Agreement Steering Group (MASG).

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VEDT | 02.79B | PET/CT Scan and interpretation one body region | 87 |
| VEDT | 02.79C | PET/CT Scan and interpretation, Multiple body regions (including whole body scan) | 125 |

**Indications for PET/CT- see additional indication Pancreatic Cancer**

| Cancer | Indications |
|---|---|
| Breast | Evaluation of recurrence/residual disease, distant metastases (staging/restaging) and disease/therapeutic monitoring |
| Colorectal | Evaluation of recurrence/restaging, distant metastases and disease/therapeutic monitoring |
| Lung | Diagnosis of single pulmonary nodule, staging distant metastases, recurrence/restaging and disease/therapeutic monitoring |
| Head and Neck | Diagnosis of occult and synchronous tumours and recurrence/restaging and radiation planning |
| Lymphoma | Staging, restaging and monitoring |
| Oesophageal | Staging, restaging and monitoring |
| Melanoma | Recurrence/restaging, distant metastases |
| Thyroid | Limited to recurrent disease not confirmed by $I^{131}$ scintigraphy |
| Pancreatic | Diagnosis when conventional imagining results are inclusive |

***NOTE**: The current interim fees will terminate effective December 31, 2009. Please hold eligible service encounters from January 1, 2010 onward to allow MSI the required time to update the system.*

## FEE INCREASE

Effective December 1, 2009 the Master Agreement Steering Group (MASG) has approved the following fee increase:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VIST | 03.03 | Acute or Chronic Home Care, Medical Chart review and/or Telephone Advice – up to 3 telephone calls per day per patient LO=HMHC, RO=HMTE, SP=GENP (RF=REFD)<br><br>Note: Each additional group of 3 calls/per day/per patient can be billed claimed at 11.5 MSU | 11.5 |

***NOTE**: Please continue to submit in the normal manner. Ninety days after the system has been updated, a retroactive payment will be processed.*

## PREAMBLE REVISION

The Master Agreement Steering Group (MASG) has approved the following preamble amendment, effective December 1, 2009.

8.2.3 Calculation of Anaesthetic Fees

(b) Anaesthetic Time Units, except where otherwise specified, are computed by allowing one unit for each fifteen minutes, or part thereof, of anaesthesia time. Double time units apply when anaesthetic time extends beyond one hour for procedures with basic anaesthetic values of 4 or 5 units and after two hours when the basic is 6 units or greater. For the purposes of calculating anaesthesia time units and with reference to Preamble Section 1.8.5, Physician Record Requirements to Support Claims, time should be calculated from the time documented in the perioperative record when both the patient and anaesthetist are present in the OR and time ends when both the patient and anaesthetist leave the OR. In addition to this documented time an additional single time unit may be claimed for the preoperative assessment and anaesthesia setup, another single time unit may be claimed for the postoperative attendance of the patient as per section 8.2.2 (c). These 2 additional units may be claimed without the need for any additional documentation requirements over and above that recorded in the perioperative record.

In unusual circumstances where the preoperative care is prolonged or repeat trips back to PACU are required, additional time may be added to the anaesthesia time. This additional time must be clearly documented by the anaesthetist in the patient medical record with start and stop times as per Section 1.8.5 of the Preamble.

If resuscitation is necessary during the anaesthetic time, add the time for resuscitation to the anaesthetic time. Resuscitation and anaesthesia time cannot be claimed simultaneously.

## BILLING REMINDER:SERVICE OCCURRENCE NUMBER

The service occurrence number is the number of separate times the physician sees the same patient on the same day. For example if a patient has a procedure in the morning and the physician has to drain a haematoma later that day, these are two separate service occurrences and should be recorded in the service occurrence number field as occurrences 1 and 2.

If more than one service is provided to the patient at one encounter then all the services performed during that encounter should be given the same service occurrence number. For example, if a patient has two procedures done during the same encounter with the physician this is a single service occurrence.

## GENERAL PRACTICE COMMUNITY REMOTE PRACTICE ON–CALL PROGRAM: UPDATE

The existing General Practice Community Remote Practice On-Call Program in effect as of March 31, 2008 will be continued in its current form until March 31, 2010. As of April 1, 2010, program eligibility requirements regarding 45km radius from the nearest hospital emergency department, in order to qualify for funding, will be strictly enforced. More information will be provided to current program participants in the new year.

## ELECTRONIC MEDICAL RECORDS (EMR) – UPDATE

The 2008-2013 Physician Services Master Agreement between the Department of Health and Doctors Nova Scotia contains funding provisions for Electronic Medical Records.

In year two of this agreement, there is a commitment to provide additional funding through an Annual EMR Utilization Grant. This particular funding is designed to recognize and value the extent of defined EMR utilization.

In early January, 2010, physicians who use an EMR will be invited to apply for an EMR utilization grant. The payments will be based on each physician's individual level of use. Physicians who maximize the use of their EMR will be eligible to receive higher incentive payments under this program.

## LONG TERM CARE – MEDICATION REVIEW

As previously communicated in the July 10, 2009 MSI Physicians' Bulletin, a new fee was approved effective April 1, 2009, available for Family Physicians who complete medication reviews for residents of provincially licensed Nursing Homes and Residential Care Facilities (RCF's) only.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| DEFT | ENHI | Long Term Care Medication Review | 11.95 |

Billing Guidelines:

- To claim the fee, the physician must review, complete, date and sign the pharmacy-generated Medical Administration Recording System (MARS) drug review sheet for the resident.
- A maximum of two (2) medications reviews will be payable per resident per fiscal year, regardless of Nursing home or RCF facility of resident. A facility transfer does not necessarily require a new medication review if the existing medication review is up-to-date.
- The medication review fee is payable in addition to any associated visit fee, if applicable.
- The date of service is the date the MARS form is signed by the physician.

## GP COMPREHENSIVE CARE INCENTIVE PROGRAM – Year 2 (2009/10)

Effective April 1, 2008, funding is provided for a Comprehensive Care Incentive Program (CCIP) as outlined in the Physician Services Master Agreement, Schedule J Comprehensive Care Incentives. The CCIP provides financial incentives for General Practitioners (GPs) to provide a comprehensive breadth of services for their patients. In 2009/10 the available funding increases by $1.4 million from $600,000 to a total of $2 million allowing the program to expand.

CCIP Eligibility Criteria – 2009/10

To qualify for CCIP payments, family physicians must:

- Have minimum fee-for-service or shadow billings of $100,000, including minimum office billings of $25,000, during the 12 month CCIP calculation period from July 1, 2008 to June 30, 2009; and,
- Reach the first activity threshold for at least two CCIP-eligible service categories.

The CCIP is paid in recognition of past services provided. A physician who has left Nova Scotia or is no longer practicing is entitled to a CCIP payment providing: all CCIP eligibility criteria are met; the physician practiced in Nova Scotia during the term of the current Master Agreement; and, the physician has left a forwarding address.

CCIP Service Categories – 2009/10

There are six CCIP eligible service categories for year two (2009/10):

- Nursing Home Visits
- Inpatient Hospital Care
- Obstetrical Deliveries
- Maternity and Newborn Care
- Home Visits **(new)**
- All Office Visits for Children under Two Years, including well baby and other office visits **(new)**

CCIP Activity Thresholds and Measures – 2009/10

Three activity thresholds have been established for each service category.

The eligible service categories, activity thresholds and measures for 2009/10 are the following:

| **CCIP Service Categories – 2009/10** | | | | | | |
|---|---|---|---|---|---|---|
| | **Nursing Home visits** | **In Patient Hospital Care** | **Obstetrical Deliveries** | **Maternity & Newborn Visits** | **All Office Visits for Children under 2 years** | **Home Visits** |
| **Activity Thresholds** | Measure: Total # of visits | Measure: Total $ value of all services provided | Measure: Total # of deliveries | Measure: Total # of visits: # prenatal # post-natal # post-partum # newborn | Measure: Total # of visits (all types) | Measure: Total # of visits |
| Threshold 1 | 6 | $2,900 | 4 | 5 | 37 | 3 |
| Threshold 2 | 32 | $18,900 | 15 | 18 | 106 | 10 |
| Threshold 3 | 171 | $42,000 | 35 | 70 | 206 | 29 |

For the calculation of the measures and eligible billings for each CCIP service category:

- Nursing Home Visits: Includes all institutional visit codes (HSC 03.03 or 03.04) with LO = NRHM. Measure is total number of visits.

- Inpatient Hospital Care: Includes all services (consultations, visits and procedures) provided for hospital inpatients (LO = HOSP, FN=INPT). Measure is total payments in dollars.

- Obstetrical Deliveries: Includes all billings for HSC 87.98 Delivery NEC. Measure is total number of deliveries

- Maternity and Newborn Visits: Maternity visits includes all prenatal, post natal and post partum visits (HSC 03.03 or 03.04) with the modifiers RO = ANTL or PTNT or PTPP in office or in hospital. Newborn visits includes all visits (HSC 03.03 or 03.04) with the modifier RO = NBCR in hospital. Measure is total number of visits.

- All Office Visits for Children under 2 years: Includes all office visits (HSC 03.03 or 03.04) for children under 2 years of age with LO = OFFC. This includes regular office visits and well baby visits. Measure is total number of visits.

- Home Visits: Includes all visits (HSC 03.03 or 03.04) with LO = HOME. Measure is total number of visits.

CCIP Payments – 2009/10

Physicians who qualify for a CCIP payment will be remunerated according to the following payment grid:

| **CCIP Payment Grid – 2009/10** | | | | | |
|---|---|---|---|---|---|
| **Activity Thresholds** | Number of Service Categories* | | | | |
| | 2 | 3 | 4 | 5 | 6 |
| Threshold 1 | $100 | $400 | $600 | $650 | $700 |
| Threshold 2 | $200 | $700 | $1,350 | $1,400 | $1,475 |
| Threshold 3 | $500 | $1,000 | $1,500 | $1,525 | $1,625 |

*** In addition to an office practice**

**CCIP Incentive Payments for 2009/2010 will be made to eligible physicians in December 2009.**

## HOLIDAY DATES FOR 2010

Please refer to the attached schedule of the dates MSI will accept as “Holidays”.

## CUT-OFF DATES FOR THE RECEIPT OF PAPER & ELECTRONIC CLAIMS

Please refer to the attached schedule regarding the cut-off dates for receipt of paper and electronic claims.

# 2010 CUT-OFF DATES
# FOR RECEIPT OF
# PAPER & ELECTRONIC CLAIMS

| PAPER CLAIMS | ELECTRONIC CLAIMS | PAYMENT DATE |
|---|---|---|
| January 4, 2010 | January 7, 2010 | January 13, 2010 |
| January 18, 2010 | January 21, 2010 | January 27, 2010 |
| February 1, 2010 | February 4, 2010 | February 10, 2010 |
| February 15, 2010 | February 18, 2010 | February 24, 2010 |
| March 1, 2010 | March 4, 2010 | March 10, 2010 |
| March 15, 2010 | March 18, 2010 | March 24, 2010 |
| March 29, 2010 | **March 31, 2010**** | April 7, 2010 |
| April 12, 2010 | April 15, 2010 | April 21, 2010 |
| April 26, 2010 | April 29, 2010 | May 5, 2010 |
| May 10, 2010 | May 13, 2010 | May 19, 2010 |
| **May 21, 2010**** | May 27, 2010 | June 2, 2010 |
| June 7, 2010 | June 10, 2010 | June 16, 2010 |
| June 21, 2010 | June 24, 2010 | June 30, 2010 |
| July 5, 2010 | July 8, 2010 | July 14, 2010 |
| July 19, 2010 | July 22, 2010 | July 28, 2010 |
| **July 30, 2010**** | August 5, 2010 | August 11, 2010 |
| August 16, 2010 | August 19, 2010 | August 25, 2010 |
| August 30, 2010 | September 2, 2010 | September 8, 2010 |
| September 13, 2010 | September 16, 2010 | September 22, 2010 |
| September 27, 2010 | September 30, 2010 | October 6, 2010 |
| **October 8, 2010**** | October 14, 2010 | October 20, 2010 |
| October 25, 2010 | October 28, 2010 | November 3, 2010 |
| November 8, 2010 | November 11, 2010 | November 17, 2010 |
| November 22, 2010 | November 25, 2010 | December 1, 2010 |
| December 6, 2010 | December 9, 2010 | December 15, 2010 |
| **December 17, 2010**** | **December 21, 2010**** | December 29, 2010 |
| January 3, 2011 | January 6, 2011 | January 12, 2011 |
| **11:00 AM CUT OFF** | **11:59PM CUT OFF** | |

**NOTE:**
Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Radiology, Pathology, Internal Medicine Monthly Statistical Reports and Sessional Payments. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut off date to ensure processing for that payment period.

**PLEASE NOTE, THE ** INDICATES A DATE VARIATION**

November, 2009

## HOLIDAY DATES FOR 2010

Please make a note in your schedule of the following dates MSI will accept as "Holidays."

| | |
|---|---|
| NEW YEAR'S DAY | FRIDAY, JANUARY 1, 2010 |
| GOOD FRIDAY | FRIDAY, APRIL 2, 2010 |
| EASTER MONDAY | MONDAY, APRIL 5, 2010 |
| VICTORIA DAY | MONDAY, MAY 24, 2010 |
| CANADA DAY | THURSDAY, JULY 1, 2010 |
| CIVIC HOLIDAY | *IF APPLICABLE* |
| LABOUR DAY | MONDAY, SEPTEMBER 6, 2010 |
| THANKSGIVING DAY | MONDAY, OCTOBER 11, 2010 |
| REMEMBRANCE DAY | THURSDAY, NOVEMBER 11, 2010 |
| CHRISTMAS DAY | MONDAY, DECEMBER 27, 2010 |
| BOXING DAY | TUESDAY, DECEMBER 28, 2010 |
| NEW YEAR'S DAY | MONDAY, JANUARY 3, 2011 |

MSI Assessment Department (902) 496-7011
Fax Number (902) 490-2275
Toll Free Number 1-866-553-0585

Updated: December 23, 2009

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

September 25, 2009 Volume XLIII - #4

**Inside this Issue**



## NEW FEES

Effective July 1, 2009 the following new Health Service Codes are available for billing:

| Category | Code | Description | Unit Value | |
|---|---|---|---|---|
| MASG | 78.49A | Sterilization by transcervical tubal occlusion (both tubes) | 90 | 4+T |
| VADT | 49.87A | Removal of Loop Recorder | 40 | 4+T |
| PMNO | 46.04D | Acute pain management (non-obstetrical) consultation, insertion of interpleural catheter and care on day 1 when unrelated to the delivery of anaesthesia | 54 | |
| PMNO | 46.04E | Acute pain management (non-obstetrical) consultation, insertion of interpleural catheter and care on day 1 when in addition to delivery of anaesthesia on that day | 30 | |
| PMNO | 46.04F | Acute pain management (non-obstetrical) interpleural catheter maintenance care, per day, day 2 onwards | 20 | |

*Physicians holding eligible services must submit their claims from July 1, 2009 onward within 90 days of the bulletin date. Please include text referring to this bulletin for any service over the 90 day time frame.*

Effective August 1, 2009 the following new Health Service Codes are available for billing:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MASG | 49.87B | Removal of cardiac pacemaker system using laser sheath removal of the pacemaker leads (multiples allowed to a maximum of two) | 200 14+T |
| VEDT | 97.99A | Breast MRI guided placement of MRI compatible clip, with or without biopsy (includes all necessary imaging) | 70 |

Health Service Code 49.87B includes any necessary debridement of the chest wall and any imaging performed in relation to the surgery. It is not payable in addition to other codes.

*Physicians must submit their claims from August 1, 2009 onward within 90 days of the bulletin date. Please include text referring to this bulletin for any service over the 90 day time frame.*

## TELEPHONE ADVICE AND MEDICAL CHART REVIEW

Effective August 1, 2009 a new modifier has been created for use with Health Service Code 03.03 to bill the telephone advice and medical chart review of a liver recipient at the request of the physician(s) monitoring the patient's care outside the transplant centre.

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| VIST | 03.03 | RO=TALR | Telephone advice and medical chart review of liver transplant recipient | 11.5 |

This code is only payable when the call is initiated by the physician(s) in the patient's home community who is responsible for monitoring the patient between visits to the transplant hepatologist. Both physicians must keep a detailed record of the phone call.

*Physicians must submit their claims from August 1, 2009 onward within 90 days of the bulletin date. Please include text referring to this bulletin for any service over the 90 day time frame.*

## TELEMEDICINE FEES

Effective August 1, 2009 a new modifier, ME=TELE, has been created to indicate telemedicine consultation. Please ensure that this modifier is included when you bill a telemedicine consult

| | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| CONS | 03.07 | ME=TELE | Limited Consultation | As per normal consult rate |
| CONS | 03.08 | ME=TELE | Comprehensive Consultation | As per normal consult rate |

## PALLIATIVE CARE CODES

The original implementation date for Palliative Care Codes was June 1, 2005. At that time the codes paid at 80% of the listed unit value (*MSI Physicians' Bulletin – May 26, 2005, Pg 2*). *Effective October 2, 2009, these codes will pay at 100% of the assigned unit value. A retroactive payment will be calculated and paid early in 2010.*

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| CONS | 03.09C | | Palliative Care Consult | 52 |
| VIST | 03.03C | RO=PCSV | Palliative Care Support Visit | 25.4 for 1st 30 mins, 12.7 per each additional 15 mins (max 1 hour total) |

Effective August 1, 2009, the Palliative Care Telephone advice and/or medical chart review code was increased from 7.3 units to 11.5 units. All applicable claims will be identified and a retroactive payment will be forthcoming.

Claims with a date of service October 2, 2009 onward will pay as follows.

| Code | Modifiers | Description | Unit Value |
|---|---|---|---|
| 03.03 | RO=CRTC | Telephone advice and/or medical chart review of palliative care patient | 11.5 |

To claim this service the call must be initiated by a health care professional, and covers up to 3 telephone calls per day per patient. Each additional group of 3 calls/per day/ per patient can be claimed at 11.5 units.

## PANDAMIC INFLUENZA IMMUNIZATION

A new modifier has been created to identify a pandemic influenza immunization effective September 1, 2009. The modifier is RO=PAND, and it follows the same guidelines as other immunizations.

| Category | Code | Modifiers | Description | Unit Value |
|---|---|---|---|---|
| ADON | 13.59L | RO=PAND | Provincial immunization injections | 6 |

## REMINDERS: BILLING GUIDELINES FOR PROVINCIAL IMMUNIZATIONS

Please see the attached Schedule of Provincial Immunizations for billing purposes. When billing the influenza injection please include the applicable “at risk” diagnostic code.

If one vaccine is administered but no associated office visit is billed (i.e. the sole purpose for the visit is the immunization), claim the immunization at a full fee.

If two vaccines are administered at the same visit but no associated office visit is billed (i.e. the sole purpose for the visit is the immunization), claim for each immunization at a full fee.

If one vaccine is administered in conjunction with a billed office visit, claim both the office visit and the immunization at full fee.

If two vaccines are administered in conjunction with a billed office visit, the office visit and the first injection can be claimed at full fee. All subsequent injections will be paid at 50 percent.

For children 18 months of age and under, if a vaccine is administered in conjunction with a well baby care visit, claim the well baby care visit and the immunization.

For vaccines administered to people not eligible to receive a provincially funded vaccine, submit Health Service Code 13.59L, the modifier for the vaccine given (see Appendix A) and the appropriate diagnostic code. Enter 0 in the “Claimed Unit Value” field and Y in the “Unit Value Indicator” field. It is very important to remove the Y before submitting subsequent services.

There have been additions to the high risk groups for seasonal influenza. These include anyone who lives with or cares for children under the age of 24 months, and anyone living in a home that is expecting a newborn during influenza season.

## REMOTE SURGICAL CONSULT WITH REVIEW OF PACS IMAGES - PROGRAM EXPANSION AND FEE INCREASE

Following a six-month pilot program, the fee for Remote Surgical Consult with Review of PACS Images has been increased from 25 to 35 units and has been extended to all surgical specialties effective July 1, 2009. This expanded pilot program will be re-evaluated in approximately six months time.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| CONS | 03.09D | Remote Surgical Consult with Review of PACS Images | 35 |

*Eligible services can now be submitted for dates of service July 1, 2009 onward. Physicians have 90 days from the date of this Bulletin to submit these claims. Please include text referring to this bulletin for any service over the 90 day time frame.*

### Billing Guidelines:

- This fee may be billed when a physician working in an Emergency Department or a surgeon encounters a complex surgical problem that requires the opinion of a surgeon practicing in the area of concern. The consultant surgeon reviews the PACS (or other such archival system) images and provides telephone advice to the referring physician and follows with a formal written report to the referring physician.
- The report must document the history, presenting complaint, the discussion with the referring physician concerning the patient's physical condition, the results of the review of the PACS images, the consultants' opinion and recommendations for management of the patient in their local community.
- The referring physician must also document that a telephone consultation was requested and provided.
- The referring physician and the surgical consultant must be situated in different facilities.
- If the patient is subsequently seen by the surgical consultant for a comprehensive or limited consultation within 30 days of the Remote Surgical Consult with Review of PACS Images, the consultant will not be paid
- The fee is only payable once per case per patient.
- This fee may not be claimed where the purpose of the phone call is to:
    - Arrange for diagnostic investigations
    - Discuss the results of diagnostic investigations

## BARIATRIC SURGERY

This is to inform physicians that a bariatric surgery program has been available in Nova Scotia since September 2008. The "Obesity Network" clinic functions in conjunction with the QEII Health Sciences Centre, and as is the policy of this multidisciplinary clinic, the provision of bariatric surgery (sleeve gastrectomy) is just one facet of a broad-based weight loss program. A referral to this clinic at the QEII may be faxed to (902) 425-3817, and should contain a complete medical history of the patient.

## UNATTACHED PATIENT BONUS

Effective July 1, 2008 this incentive is available for all eligible General Practitioners (GPs) who take on a patient that does not have a family physician, and meet the supplied criteria:

| Category | Code | Description | Payment |
|---|---|---|---|
| DEFT | UPB1 | Unattached Patient Bonus Payment Program | $150.00 (one time per patient) |

### Billing Guidelines

- The GP has had an established community-based family practice for at least one year prior to taking the Unattached Patient into his/her practice.

- The GP agrees to take the Unattached Patient into his/her practice following an inpatient or emergency department hospital encounter where the patient has been identified as an Unattached Patient. The hospital encounter may have been directly with the GP or the GP may agree to take on the patient through a referral from the hospital.

- The GP keeps the Unattached Patient in his/her practice and maintains an open chart for the patient for a minimum of one year.

**The GP is considered to have taken on the patient on the date of the initial office visit. The Unattached Patient Bonus may be claimed at the time of the initial visit.**

**The Unattached Patient Bonus fee is billable in addition to the associated visit fee.**

The Unattached patient Bonus may be claimed by eligible GPs paid by fee-for-service and alternative payment plan contracts.

Eligible APP Physicians will be required to shadow bill the new fee code in order to receive payment under this incentive program. Eligible claims will be reviewed and paid twice per year in the form of a cheque from MSI. Estimated payment dates for this incentive program for APP physicians are December and June of each year, with the first payments beginning in December 2009.

The Unattached Patient Bonus may not be claimed by Locum Physicians.

Starting July 14, 2009, the GP is expected to confirm and document at the initial visit with the Unattached Patient that the patient is unattached (i.e. does not already have a regular family physician). Information about the hospital encounter that resulted in the GP taking the Unattached Patient into his/her practice should also be recorded in the patient's record. This can be a referral form from the hospital emergency department, an inpatient hospital report or other documentation.

For Unattached Patients taken into a GP practice from July 1, 2008 to July 14, 2009, the Unattached Patient Bonus fee may be claimed retroactively. Documentation of the patient's unattached status and the associated hospital encounter, if not recorded on the patient's record, is not required for payment, however all other eligibility criteria must be met.

*Physicians holding eligible services must submit their claims within 90 days from the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.*

## ADJUSTMENTS TO EXISTING HEALTH SERVICE CODES

Listed in the July 10, 2009 bulletin were new Health Service Codes 50.0A, 50.6D, 48.0J, and 06.39D with an effective date of April 01, 2009. This effective date has now been changed to January 1, 2009. All services with a date of January 1, 2009 to March 31, 2009 that have been held should now be submitted in the usual manner. Please include text referring to this bulletin for services over the 90-day time frame.

Effective July 1, 2009, Health Service Code 07.08C (Nerve conduction studies, per nerve studied) has changed from an ADON to a VADT. The unit value for this procedure has increased to 27 units, with a maximum of 6 multiples.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VADT | 07.08C | Nerve conduction studies, per nerve studied | 27 |

*Claims previously submitted with a date of July 1, 2009 to October 1, 2009 will be identified and re-assessed by MSI staff to ensure correct payment.*

Also effective July 1, 2009, the following Health Service Codes have been revised to include multiples (up to a maximum of 4):

| Category | Code | New Description | Unit Value | |
|---|---|---|---|---|
| MASG | 93.71A | Replacement of metacarpophalangeal or interphalangeal joint of hand by synthetic prosthesis – single (regions required) plus multiples if applicable | 150 | 4+T |
| MASG | 94.44A | Suture flexor tendon – single (regions required) plus multiples if applicable | 106 | 4+T |
| MISG | 94.45A | Suture extensor tendon – single (regions required) plus multiples if applicable | 50 | 4+T |
| MASG | 94.55D | Tendon transfer – single (regions required) plus multiples if applicable | 96 | 4+T |

With these revisions, Health Service Codes 93.71B, 94.44B, 94.44C, 94.45B, 94.45C, and 94.55E are no longer necessary and have been termed for June 30, 2009, *Claims previously submitted with a date of July 1, 2009 to October 1, 2009 will be identified and re-assessed by MSI staff to ensure correct payment.*

## CASE MANAGEMENT CONFERENCE FEE – UPDATE

Effective July 22, 2009, the Case Management Conference Fee payment has been expanded to include all conferences which are called and coordinated by Directors of Nursing or Directors of Care in all eligible Long Term Care facilities. Physicians may now claim the Case Management Conference Fee for their participation in conferences called by these individuals.

The radiologist specialties that were previously unable to bill this fee can now submit their claims.

All services with a date of January 1, 2009 onward that have been held should now be submitted in the usual manner. Please include text referring to this bulletin for services over the 90-day time frame.

Just a reminder for the year 2009-2010 the case management conference fee (03.09D) pays at 14.75 units for General Practitioners and at 16.75 units for Specialists.

## ICU CODES FOR "STEP-DOWN" PATIENTS

The Intensive Care Codes are intended for use by physicians when claiming for services rendered in intensive care units (ICUs) approved by the Department of Health (see section 7.91 of the Preamble). It has come to the attention of MSI that some physicians are claiming these ICU codes for services rendered to patients who are not physically in an intensive care unit but are in step-down or intermediate units. This practice is contrary to the Preamble rules and such services will be subject to audit.

At present, there are no codes specifically designated for patients in step-down or intermediate care units. If felt to be appropriate, an application for such fee codes should be made to the Fee Schedule Advisory Committee as outlined on page 7 of the May 7, 2009 Physicians' Bulletin.

## SERVICES WITH RO=INTP

For clarification purposes, any claim with the modifier RO=INTP (role = interpretation) must be submitted with the date the services were performed and not the date of interpretation.

## ASSISTANT CLAIMS WITH DIAGNOSTIC AND THERAPEUTIC PROCEDURES

It has come to the attention of MSI that assistant claims are being submitted by physicians when Diagnostic and Therapeutic (D&T) procedure are performed. Physicians are reminded that service encounters by assistants are not applicable to such procedures with exceptions as outlined in Section 9.2.6 of the Preamble of the Physician's Manual.

## GP SURGICAL ASSIST INCENTIVE PROGRAM – 2009/10

The GP Surgical Assist Incentive Program will maintain the majority of the 2008/09 program principles while being restructured to provide an incentive payment for all GP's who carry out surgical assist.

Starting in fiscal year 2009/10, GP surgical assist incentive payments will be provided to all eligible GP's as follows:

- All GP's who provide surgical assists during the year will receive an incentive payment for providing elective (non-premium time) surgical assists. Qualifying surgical assists billings up to a maximum of $30,000 per physician per year will be eligible for an incentive payment.
- GP's who meet the criteria of total MSI payments of $75,000 during the year, including office billings of $25,000 or more, will receive an incentive payment of 40% of their individual qualifying surgical assist billings.
- GP's who do not meet the criteria of total MSI payments of $75,000 during the year, including office billings of $25,000 or more, will receive an incentive payment of 20% of their individual qualifying surgical assist billings.
- All surgical assist payments will be based on surgical assist billings for the period April 1 to March 31 and will be paid out by the following July 30.

## GP COMPLEX CARE VISIT FEE - UPDATE

Effective October 2, 2009, the General Practice Complex Care Visit Fee (which can be claimed four times per patient per fiscal year) will no longer be tracked automatically by MSI's billing system. Physicians are now responsible to track their own Complex Care Visit claims to ensure they do not exceed the allowable maximum of four claims per patient in one fiscal year (April 1 – March 31). As with all MSI claims, Complex Care Visit claims will be subject to audit, making independent tracking by the physician very important.

Because the MSI system tracks claims based on a 365 day rolling year rather than the Master Agreement's fiscal year, some Complex Care Visit claims may have been rejected. Physicians who have had Complex Care Visit claims rejected in the past year as a result of MSI's 365 day rolling year rule can resubmit these claims starting October 2, 2009.

Please take note that physicians must have their resubmitted claims ( any claim over 90 days) in to MSI within 90 days from the date of this bulletin as well as including text on the resubmitted claims referencing the October 2 MSI Bulletin.

## GENERAL PRACTICE REMOTE PRACTICE ON-CALL – UPDATE

As per the current Master Agreement, Schedule "G" the Community Remote Practice On-Call program in effect as of March 31, 2008, will be continued in its current form, until March 31, 2010. As of April 1, 2010, the rule/criteria regarding 45km radius from the nearest hospital emergency department, in order to determine eligibility for funding, will be strictly enforced.

Also, no new physicians or locations will be added to the program until such time as the On-Call Program Redesign Working Group presents to the Master Agreement Steering Group, any proposed changes to this program.

## ELECTRONIC MEDICAL RECORDS (EMR) – UPDATE

The 2008 – 2013 Physician Services Master Agreement between the Department of Health and Doctors Nova Scotia contains funding provisions for Electronic Medical Records.

In year two of this agreement, there is a commitment to provide additional funding through an Annual EMR Utilization Grant. This particular funding is designed to recognize and value the extent of defined EMR Utilization. The eligibility and payment criteria for this year two grant are close to being complete, but not yet finalized. For now, physicians are encouraged to maximize the use of their electronic medical records. From patient charting, to e-lab results to medication management, increased use will likely result in increased payments. In the coming months, current EMR users will be asked to complete a self-assessment survey to report on their current EMR use as a means to determine eligibility and payment levels.

## EXPLANATORY CODES

The following new explanatory code has been added to the system:

| | |
|---|---|
| DE012 | Service encounter has been refused as there is already one unattached patient bonus payment claim on history |

## UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, October 2nd, 2009. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanation code (EXPLAIN.DAT), and modifier values (MODVALS.DAT)

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

July 10, 2009 Volume XLIII - #3

# NOTICE TO PHYSICIANS

**Inside this Issue**



## ELECTRONIC MEDICAL RECORDS (EMR) - UPDATE

The 2008-2013 Physician Services Master Agreement between the Department of Health and Doctors Nova Scotia contains funding provisions for Electronic Medical Records.

The EMR funding provision consists of three specific funding envelopes:

1. One time EMR Investment Grant
2. Annual EMR Participation Grant
3. Annual EMR Utilization Grant

As of June 2009, funding for both the Investment and Participation portions of this incentive have been paid to a number of physicians across the province who have met the specific eligibility criteria related to both of these grants. Funding continues to be distributed in this fiscal year under the terms of the Master Agreement, to those physicians who continue to invest in EMR

With regards to the third envelope of funding (Annual Utilization Grant) and pursuant to schedule "I" item 2 (c) within the Physician Master Agreement:

***"An Annual Physician –specific "EMR Utilization Grant" effective April 1st, 2009 of an amount to be determined, to recognize and value the extent of defined EMR functionality utilizations***

The Electronic Medical Records (EMR) working group had been given an extension to July 30th, 2009 in an effort to present a more detailed and comprehensive recommendation to the Master Agreement Steering Group given the scope of the work involved in identifying key criteria for the Utilization Grant portion of the EMR Funding.

The intent of the EMR Utilization Grant is to encourage and recognize physicians financially for the extent of their efforts in the use of the EMR in their practice. The EMR Working group has been focusing on a Utilization Eligibility Grant Model that has the following two key components:

- Scaled EMR Functionality categories
- Scaled evidence-based EMR user utilization

The Working Group has committed to presenting their recommendations to the Master Agreement Steering Group in late July at which time further communication will be made including eligibility and payment levels

## REMOTE PRACTICE ON-CALL

As per the current Master Agreement, Schedule "G" the Community Remote Practice On-Call program in effect as of March 31, 2008, has been extended to September 30, 2009 assuming a new program is in place or to when a new program subsequently begins for physicians who are currently paid through the program. No new physicians will be added to the program.

The On-Call Programs Redesign Working Group continues to meet regarding the design of a new revised program which will be presented to the Master Agreement Steering Group.

## NEW FEES

The following new Health Service Codes are now available for billing effective April 01, 2009:

| Category | Code | Description | Unit Value | |
|---|---|---|---|---|
| MASG | 80.4B | Laparoscopic Assisted Vaginal Hysterectomy | 220 | 6+T |
| MASG | 80.2C | Laparoscopic Supracervical Hysterectomy | 235 | 6+T |
| MASG | 81.91B | Intrauterine Balloon for PPH Tamponade | 70 | 4+T |
| VADT | 50.0A | Percutaneous Image Guided retrieval of Intravascular Foreign Body | 150 | 10+T |
| VADT | 50.6D | Percutaneous Image Guided IVC Filter Removal | 135 | 10+T |
| VADT | 49.7A | Implantation Loop Recorder | 70 | 4+T |
| ADON | 48.0J | Subintimal Recanalisation of Vascular Occlusion (as an add on to Angioplasty or stent, but not both) | 125 | |
| VADT | 06.39D | Percutaneous Image Guided Radiofrequency Ablation of Solid Tumour | 250 | 4+T |
| VEDT | 02.76A | Bilateral breast MRI – first sequence<br>Subsequent sequence (maximum 3 multiples) | 46.6<br>23.3 | |

## UNITS PER HOUR

Effective June 1 2009 EC/IC claims will be assessed at the following the payment rates:

- 100 units per hour for surgical and interventional procedures
- 67 units per hour for specialist, non-surgical, non-interventional services and this rate will increase with the yearly increases for sessional rates as per the Master Agreement
- 60 units per hour will remain as the rate for any GP non-surgical, non-interventional services until such time as their sessional rate exceeds 60 units per hour

## FAMILY PHYSICIAN CHRONIC DISEASE MANAGEMENT INCENTIVE PROGRAM

Effective April 01, 2009 this incentive is available for Family Physicians who manage patients with one or more selected qualifying chronic disease(s).

| Category | Code | Modifier | Description | Unit Value |
|---|---|---|---|---|
| DEFT | CDM1 | | Family Physician Chronic Disease Management Incentive Program | 17.70 |
| DEFT | CDM1 | RP=CON2 | Family Physician Chronic Disease Management Incentive Program – 2nd condition | 8.85 |

**Billing Guidelines:**

- A patient-centered approach rather than a disease-centered approach will be used for the CDM Incentive program. Priority indicators will be tracked on a per patient rather than a per disease basis, recognizing that many patients have more than one chronic disease and many chronic diseases have indicators/risk factors in common.
- Eligible GPs will be paid a base incentive annually for each patient they manage for one of the qualifying chronic disease conditions. Physicians may also receive an additional incentive amount per patient annually if the patient has an additional qualifying condition(s)
- The family physician is being provided with CDM incentive payments for acting as a case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations or referrals.
- Patients must be seen a minimum of two times per year by a licensed health care provider in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive.
- Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.

- Providing all eligibility requirements are met, the CDM incentive can be billed once per patient per fiscal year.
- The family physician claiming the CDM incentive fee must keep a record that supports the claim, either through chart notes or an optional one-page flow/tracking sheet.

**Year One (2009/10) Program**

*Qualifying Chronic Diseases*

The chronic diseases eligible for CDM incentive payments in year one (2009/10) are Type 1 and Type 2 Diabetes (FPG3 7.0mmol/L or Casual PG3 11.1mmol/L + symptoms or 2hPG in a 75-g OGTT3 11.1mmol/L and/or Post Myocardial Infarction (post-MI) follow-up for up to 5 years after the most recently diagnosed MI.

*Required indicators/Risk factors*

In order to claim the year one CDM incentive, the following indicators/risk factors are required to be addressed as part of the annual cycle of care for diabetes and/or post-MI. The required indicators include all the common indicators listed below plus the indicators for diabetes only, post-MI only, or diabetes and post-MI if both chronic diseases are present.

Common Indicators for Either Diabetes or Post-MI
- Blood pressure – 2 times per year
- Lipids – once per year
- Weight/nutrition counseling – once per year and
- Smoking cessation – once per year if smoker (document smoker or nonsmoker)

**PLUS EITHER OR BOTH OF THE FOLLOWING:**

Indicators for Diabetes only
- HbA1C – ordered 2 times per year
- Renal function – ordered once per year
- Foot exam with monofilament or 128hz tuning fork – referred or completed once per year and
- Eye exam – referred once per year for routine a dilated eye exam

Indicators for Post MI only
- Beta-blocker – considered/reviewed once per year
- ACE/ARB – considered/reviewed once per year and
- ASA/Anti-platelet therapy – considered/reviewed once per year

**CDM Incentive Payment for 2009/10**

- For 2009/10 (April 1, 2009 to March 31, 2010), family physicians will be paid a yearly base incentive payment of 17.70 units for managing an annual cycle of care addressing the required indicators/risk factors for each patient with a qualifying chronic disease. An additional annual incentive of 8.85 units will be paid if the patient has an additional qualifying chronic condition which is also addressed.
- In year one of the program (April 1, 2009 to March 31, 2010), the CDM incentive can be claimed if the following conditions are met:
  - the patient is seen by the physician in relation of their chronic disease(s) at least once in 2009/10;
  - the patient has had at least one other appointment with a licensed health care provider in relation to their chronic disease(s) in the previous 12 months; and,

- the CDM indicators/risk factors required for the CDM incentive payment have been addressed at the required frequency and documented in the clinical record or optional flow sheet at or before the time of billing.

### *Clarification of Required CDM Indicators*

Please note there was a misprint in the June 2009 Doctors Nova Scotia Magazine on the billing guidelines for the required CDM indicators for 2009/10. The billing guidelines outlined in the May 7, 2009 MSI Bulletin should be followed.

### *Clarification of Licensed Health Care Providers*

The following bullet point regarding eligibility criteria was communicated in the May 7, 2009 MSI Physician Bulletin

- Patients must be seen a minimum of two times per year by a licensed health care provider in relation to their chronic disease (s), including at least one visit with the family physician claiming the CDM incentive

For purposes of clarification the term **"licensed health care provider"** includes physicians as well as other licensed professionals including, but not limited to Nurse Practitioner, RN. i.e. the second required visit may also be the family physician.

### *Clarification for APP Physicians*

A new Family Physician Chronic Disease Management Incentive program was approved to begin April 1, 2009.

Complete details surrounding this new programs were communicated in the May 7, 2009 MSI Physicians' Bulletin.

The Master Agreement Steering Group agreed that APP General Practitioners would be eligible to claim this incentive in addition to their contract, providing all other eligibility criteria have been met as communicated in the May 7,2009 MSI Physicians' Bulletin.

Eligible APP Physicians will be required to shadow bill the new fee code in order to receive payment under this incentive program. Eligible claims will be reviewed and paid twice per year in the form of a cheque from MSI. Estimated payment dates for this incentive program for APP physicians are October and May of each year, with the first payment to commence in October 2009.

## FAMILY PHYSICIAN ENHANCED CONTINUING CARE PROGRAM

Effective April 01, 2009 this incentive is available for Family Physicians who complete medication reviews for residents of provincially licensed Nursing Homes and Residential Care Facilities (RCFs) only.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| DEFT | ENH1 | Family Physician Enhanced Continuing Care Program | 11.95 |

**Billing Guidelines:**

- To claim the fee, the physician must review, complete, date and sign the pharmacy-generated Medical Administration Recording System (MARS) drug review sheet for the resident.
- A maximum of two (2) medications reviews will be payable per resident per fiscal year, regardless of Nursing home or RCF facility of residence. A facility transfer does not necessarily require a new medication review if the existing medication review is up-to-date.
- The medication review fee is payable in addition to any associated visit fee, if applicable.
- The date of service is the date the MARS form is signed by the physician.

## NEW MODIFIER VALUE FOR BOOSTRIX® VACCINE

A new modifier has been created to use when billing the Boostrix® vaccine, which will be replacing Adacel® for booster immunization against infection by diphtheria, tetanus and whooping cough.

| Category | Code | Modifier | Description | Unit Value |
|---|---|---|---|---|
| ADON | 13.59L | RO=BOTR | Provincial Immunization Injections | 6 |

## TEMPORARY FEE CODE EXTENSIONS

The following temporary fee codes have been extended and will be in effect until December 31, 2009:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VEDT | 02.79B | PET/CT scan and interpretation, one body region | 87 |
| VEDT | 02.79C | PET/CT scan and interpretation, multiple body regions (including whole body scan) | 125 |

## CASE MANAGEMENT CONFERENCE FEE - UPDATE

The restriction on specialties and on the location for Case Management Conference is now lifted as previously communicated in the May 7, 2009 MSI Bulletin. Physicians holding eligible service encounters should now submit their claims to MSI within 90 days.

## UNATTACHED PATIENT BONUS

A new Unattached Patient Bonus Payment Program began July 1, 2008 for all eligible General Practitioners (GPs). An Unattached Patient is a patient who does not have a family physician.

Eligible GPs are able to claim a one-time Unattached Patient Bonus payment of $150 per new Unattached Patient providing the following criteria are met:

- The GP has had an established community-based family practice for at least one year prior to taking the Unattached Patient into his/her practice.

- The GP agrees to take the Unattached Patient into his/her practice following an inpatient or emergency department hospital encounter where the patient has been identified as an Unattached Patient. The hospital encounter may have been directly with the GP or the GP may agree to take on the patient through a referral from the hospital.

- The GP keeps the Unattached Patient in his/her practice and maintains an open chart for the patient for a minimum of one year.

**The GP is considered to have taken on the patient on the date of the initial office visit. The Unattached Patient Bonus may be claimed at the time of the initial visit**

**The Unattached Patient Bonus fee is billable in addition to the associated visit fee.**

The Unattached Patient Bonus may be claimed by eligible GPs paid by fee-for-service and alternative payment plan contracts.

Eligible APP Physicians will be required to shadow bill the new fee code in order to receive payment under this incentive program. Eligible claims will be reviewed and paid twice per year in the form of a cheque from MSI. Estimated payment dates for this incentive program for APP physicians are December and June of each year, with the first payments beginning in December 2009

The Unattached Patient Bonus may not be claimed by Locum Physicians.

Starting July 14, 2009, the GP is expected to confirm and document at the initial visit with the Unattached Patient that the patient is unattached (i.e. does not already have a regular family physician). Information about the hospital encounter that resulted in the GP taking the Unattached Patient into his/her practice should also be recorded in the patient's record. This can be a referral form from the hospital emergency department, an inpatient hospital report or other documentation.

For Unattached Patients taken into a GP practice from July 1, 2008 to July 14, 2009, the Unattached Patient Bonus fee may be claimed retroactively. Documentation of the patient's unattached status and the associated hospital encounter, if not recorded on the patient's record, is not required for payment, however all other eligibility criteria must be met.

*Please hold all eligible service encounters to allow MSI the required time to update the system. Once a new Health Service Code has been assigned, it will be published in the MSI Physicians' Bulletin*

## FEE SCHEDULE ADVISORY COMMITTEE UPDATE

The following new fees have been approved by the Master Agreement Steering Group (MASG) for inclusion into the Fee Schedule, effective July 1, 2009.

| Category | Description | Unit Value | Anaes Units |
|---|---|---|---|
| MASG | Sterilisation by transcervical tubal occlusion (both tubes) | 90 | 4 + T |
| VADT | Removal of Loop Recorder | 40 | 4 + T |
| PMNO | Acute pain management (non-obstetrical) consultation, insertion of interpleural catheter and care on day 1 when unrelated to delivery of anaesthesia | 54 | |
| PMNO | Acute pain management (non-obstetrical) insertion of interpleural catheter and care on day 1 when in addition to delivery of anaesthesia on that day | 30 | |
| PMNO | Acute pain management (non-obstetrical) interpleural catheter maintenance care, per day, day 2 onwards | 20 | |

*Please hold all eligible service encounters to allow MSI the required time to update the system. Once Health Service Codes have been assigned, they will be published in the MSI Physicians' Bulletin. The 90 day rule will be waived for these fees until the permanent code descriptions and modifiers are published.*

## FEE REVISION AND PREAMBLE CLARIFICATION

MASG has approved the following effective July 1st 2009:

- 07.08C Nerve conduction studies, per nerve studied will change from ADON to VADT .with a maximum of 6 multiples
- 07.08C will increase from 13.5 units to 27 units

*Please hold all eligible service encounters to allow MSI the required time to update the system. Once Health Service Codes have been assigned, they will be published in the MSI Physicians' Bulletin. The 90 day rule will be waived for these fees until the permanent code descriptions and modifiers are published.*

***Billing Clarificaiton***

- Codes 07.08A *Electromyography, major with muscles of more than one region examined and 07.08B Electromyography, minor, examination of a specific muscle/region*: "region" is intended to mean one of the four following anatomical

areas: head and neck; both upper limbs; both lower limbs; trunk (anterior and posterior)

- Code 07.08C *Nerve conduction studies, per nerve studied: "per nerve studied"* is intended to mean both the motor and sensory nerve conduction examination of a single nerve (mixed, motor or sensory). Multiples may be claimed when another nerve (mixed, motor or sensory) is examined and when separate nerve conduction studies of a major nerve branch are required.

## FEE ADJUSTMENTS

Master Agreement Steering Group (MASG) has approved the following revisions effective July 1st 2009 subject to further consultation with MSI regarding implementation:

HSC 93.71A change description to read as follows: *Replacement of metacarpophalangeal or interphalangeal joint of hand by synthetic prosthesis - single (regions required) plus multiples* 150 4+T

HSC 93.71B suggested to be termed

HSC 94.44A change description to read as follows**:** *Suture flexor tendon - single (regions required) plus multiples* 106 4+T

HSC 94.44B and 94.44C suggested to be termed

HSC 94.45A change description to read as follows: *Suture extensor tendon - single (regions required) plus multiples* 50 4+T

HSC 94.45B and 94.45C suggested to be termed

HSC 94.55D change description to read as follows: *Tendon transfer - single (regions required) plus multiples* 96 4+T

HSC 94.55E suggested to be termed

Multiples will be limited to a maximum of 4 for each of the above codes.

*Please hold all eligible service encounters to allow MSI the required time to update the system. Once Health Service Codes have been assigned, they will be published in the MSI Physicians' Bulletin. The 90 day rule will be waived for these fees until the permanent code descriptions and modifiers are published.*

## REMOTE ORTHOPAEDIC CONSULT WITH REVIEW OF PACS IMAGES

Remote Orthopaedic Consult with Review of PACS Images fee code has been termed as of June 30, 2009. Effective July 1, 2009 the Master Agreement Steering Group has agreed to increase the fee from 25 to 35 units as well as extend the fee to include all surgical designations.

*Please hold all eligible service encounters to allow MSI the required time to update the system. Once Health Service Codes have been assigned, they will be published in the MSI Physicians' Bulletin. The 90 day rule will be waived for these fees until the permanent code descriptions and modifiers are published.*

## MSI PREAMBLE REMINDER

A major consult will only be paid if the full preamble requirements for a comprehensive consult are met**.**

## MSI DOCUMENTATION REMINDER

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribed.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptions, or emotional problems, the physician “deliberately established a professional relationship with the patient for the purposes of removing, modifying or retarding existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development.” There should be evidence of the discussions that took place between the physician and the patient, the patient’s response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional well being of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by “long discussion,” “long talk,” “counselled,” “supportive psychotherapy,” etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service, then the service is not paid for or a lesser benefit is given.

Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

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

## NEW EXPLANATORY CODES

The following new explanatory codes have been added to the system.

| | |
|---|---|
| DE009 | Service Encounter has been refused as this service has already been approved for this year |
| DE010 | Service Encounter has been refused as two medication reviews have previously been approved for this year |
| DE011 | Service Encounter has been refused as the second condition amount has already been approved for this year |

The following explanatory codes have been changed to read as follows:

| | |
|---|---|
| VT086 | Service Encounter has been refused as only one well baby care visit is insured when patient age is 18 months |
| VT033 | Service Encounter has be adjudicated according to the weekly maximum of 44 units allowed per week after 56 days from admission |
| VT044 | Service Encounter has been refused as a modifier DA value is inappropriate after 56 days from admission |

## UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, July 10, 2009. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanation code (EXPLAIN.DAT), and modifier values (MODVALS.DAT)

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

May 7, 2009 Volume XLIII - #2

# NOTICE TO PHYSICIANS

**Inside this Issue**



## WELL BABY VISIT CLARIFICATION COMPREHENSIVE CARE INCENTIVE PROGRAM (CCIP)

The Physician Master Agreement includes a financial incentive program targeted to those family physicians who provide a breadth of primary health care services. Within the agreed to service categories, there is a measurement for Well Baby Visits as part of the overall breadth of services currently eligible under this program

In an effort to ensure Well Baby Visits are identified correctly as such and to ensure physician activity within this measurement area is captured, the following fee code with the modifier RO = WBCR must be used

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VIST | 03.03 | Well Baby Care<br>LO=OFFC, RO=WBCR (RF=REFD) | 13 |

## FAMILY PHYSICIAN CHRONIC DISEASE MANAGEMENT INCENTIVE PROGRAM

A new Family Physician Chronic Disease Management Incentive program was approved to begin April 1, 2009

The program is intended to recognize the additional work of General Practitioners, beyond office visits, of providing an annual cycle of guidelines-based care to patients with selected qualifying chronic disease(s).

- A patient-centered approach rather than a disease-centered approach will be used for the CDM Incentive program. Priority indicators will be tracked on a per patient rather than a per disease basis, recognizing that many patients have more than one chronic disease and many chronic diseases have indicators/risk factors in common.
- Eligible GPs will be paid a base incentive annually for each patient they manage for one of the qualifying chronic disease conditions. Physicians may also receive an additional incentive amount per patient annually if the patient has an additional qualifying condition(s).
- A new fee code will be implemented for claiming the annual CDM incentive base payment. A modifier (or set of modifiers) to the fee code will be created to allow additional incentive amounts to be claimed for patients who have more than one qualifying chronic condition. The new fee code will be process specific, not disease specific, to allow for the addition of qualifying indicators/risk factors in later years without the need to add more fee codes.

- The family physician is being provided with CDM incentive payments for acting as a case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations or referrals.
- Patients must be seen a minimum of two times per year by a licensed health care provider in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive.
- Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.
- Providing all eligibility requirements are met, the CDM incentive can be billed once per patient per fiscal year.
- The family physician claiming the CDM incentive fee must keep a record that supports the claim, either through chart notes or an optional one-page flow/tracking sheet.

**Year One (2009/10) Program**

*Qualifying Chronic Diseases*

The chronic diseases eligible for CDM incentive payments in year one (2009/10) are Type 1 and Type 2 Diabetes (FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L) and/or Post Myocardial Infarction (post-MI) follow-up for up to 5 years after the most recently diagnosed MI.

*Required Indicators/Risk factors*

In order to claim the year one CDM incentive, the following indicators/risk factors are required to be addressed as part of the annual cycle of care for diabetes and/or post-MI. The required indicators include all the common indicators listed below plus the indicators for diabetes only, post-MI only, or diabetes and post-MI if both chronic diseases are present.

*Common Indicators for Either Diabetes or Post-MI*

- Blood pressure – 2 times per year
- Lipids – once per year
- Weight/nutrition counseling – once per year
- Smoking cessation – once per year if smoker (document smoker or nonsmoker)

*PLUS EITHER OR BOTH OF THE FOLLOWING:*

*Indicators for Diabetes only*

- HbA1C – ordered 2 times per year
- Renal function – ordered once per year
- Foot exam with monofilament or 128hz tuning fork – referred or completed once per year
- Eye exam – referred once per year for routine a dilated eye exam

*Indicators for Post MI only*

- Beta-blocker – considered/reviewed once per year
- ACE/ARB – considered/reviewed once per year
- ASA/Anti-platelet therapy – considered/reviewed once per year

**CDM Incentive Payment**

- For 2009/10 (April 1, 2009 to March 31, 2010), family physicians will be paid a yearly base incentive payment of 17.70 units for managing an annual cycle of care addressing the required indicators/risk factors for each patient with a qualifying chronic disease. An additional annual incentive of 8.85 units will be paid if the patient has an additional qualifying chronic condition which is also addressed.
- In year one of the program (April 1, 2009 to March 31, 2010), the CDM incentive can be claimed if the following conditions are met:
  - the patient is seen by the physician in relation to their chronic disease(s) at least once in 2009/10;
  - the patient has had at least one other appointment with a licensed health care provider in relation to their chronic disease(s) in the previous 12 months; and,
  - the CDM indicators/risk factors required for the CDM incentive payment have been addressed at the required frequency and documented in the clinical record or optional flow sheet at or before the time of billing.

**The *Optional Family Physician Chronic Disease Management (CDM) Flow Sheet* is attached to this Bulletin**

Please hold eligible service encounters to allow MSI the required time to update the system. Once Health Service Codes have been assigned, they will be published in the MSI Physicians' Bulletin

## CASE MANAGEMENT CONFERENCE – CLARIFICATION OF ELIGIBLE SERVICES

There have been numerous inquiries requesting clarification of eligible services for the new Case Management Conference Fee. The Case Management Conference fee was published in the Bulletin Feb 26, 2009.

A case management conference is a formal, scheduled, multi-disciplinary health team meeting. It is initiated by an employee of the DHA/IWK to discuss the provision of health care to a specific patient. The *Case Management Conference Fee* is being implemented for both General Practitioners and Specialists.

The following new permanent Health Service code has been approved for inclusion in the Fee Schedule effective January 1, 2009:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VIST | 03.03D | Case Management Conference | 14 units per 15 minutes for a GP and 16.5 units per 15 minutes for Specialists |

**Based on the extent of the inquiries surrounding clarification of this new fee, the following additional information is being provided:**

- There is no restriction on specialties or on the location of where the fee can be claimed providing the case management conference has been initiated by a DHA/IWK employee and all other eligibility criteria are met. **The Health Service Code was initially set up as Location (Hospital) only. Please hold eligible service encounters for locations other than hospitals to allow MSI the required time to update the system.**

- The fee 'is not" restricted to larger centers ( ie: CDHA & Cape Breton)

- Multi-disciplinary refers to the attendance of two or more licensed health care professionals in addition to a physician

- In order to qualify, the conference has to be called by **non-physician** DHA/IWK staff, who are required to be employees of the district

- It is not mandatory that more than one physician attend the case conference before the fee code may be claimed

- The Case Management Conference Fee is not to be used for attendance at regularly scheduled meetings concerning ongoing care planning or patient management for one or more patients i.e.: grand rounds, tumor board case rounds, teaching rounds, transplant rounds or other similar methods of specialist physicians conferring about the medical management of complex cases

- Physician attendance at case management conferences held by video conferencing or teleconferencing is eligible for payment providing all other eligibility requirements are met

- Each case conference must be specific to an individual patient; the time spent by the physician at the conference must be documented in the health record of that patient. However consecutive formal scheduled conferences, each pertaining to one named patient, with start and finish times recorded in each health record, would be permitted.

## FAMILY PHYSICIAN AND REGIONAL SPECIALIST ALTERNATIVE PAYMENT PLAN UPDATE

A working group of the Master Agreement Steering Group has been established to develop new template contracts for all alternative payment plans (APPs) that are non-academic. All existing contracts have been extended, unless otherwise notified, at the agreed upon rates as outlined in the Master Agreement.

This working group is also responsible for establishing guidelines to enable GPs on a current remuneration of fee-for-service to convert to an APP. These guidelines will be published and communicated to physicians once they are completed.

## FAMILY PHYSICIAN ENHANCED CONTINUING CARE PROGRAM

A new incentive program to support enhanced Continuing Care by Family Physicians was approved to begin April 1, 2009. To support this new initiative, a new permanent Health Service code has been approved for inclusion into the fee schedule effective April 1, 2009

- Effective April 1, 2009, family physicians will be remunerated for the completion of medication reviews for residents of provincially licensed Nursing Homes and Residential Care Facilities (RCFs) only. Please see attached listing of all provincially licensed Nursing Homes and Residential Care Facilities under the Department of Health. Being as this list may be updated periodically; physicians are encouraged to check for updates through the Doctors Nova Scotia website in the members section. A complete and up to date list can be found by clicking on the following links:

  ***Nursing Homes and Homes for the Aged Directory***
  ***Residential Care Facilities for Seniors Directory***

- A new fee code will be implemented payable at the rate of 11.95 units per medication review.

- To claim the fee, the physician must review, complete, date and sign the pharmacy-generated Medical Administration Recording System (MARS) drug review sheet for the resident.

- A maximum of two (2) medications reviews will be payable per resident per fiscal year, regardless of Nursing Home or RCF facility of residence. A facility transfer does not necessarily require a new medication review if the existing medication review is up-to-date.

- The medication review fee is payable in addition to any associated visit fee, if applicable.

- The date of service is the date the MARS form is signed by the physician.

- Please hold eligible service encounters to allow MSI the required time to update the system. Once Health Service Codes have been assigned they will be published in the MSI Physicians' Bulletin.

## GP CONSULT FEE - MIDWIFERY

In support of the Midwifery Act that came into effect in March 2008, the Preamble has been amended to include midwife in the list of health care providers that can request a consultation from a physician.

Preamble 7.5.1

> A consultation is a service resulting from a formal request by the patient's physician, nurse practitioner, midwife, optometrist or dentist, after appropriate evaluation of the patient, for an opinion from a physician qualified to furnish advice. This may arise when the complexity, obscurity or seriousness of the patient's condition demands a further opinion, when the patient requires access to specialized diagnostic or therapeutic services, or when the patient, or an authorized person acting on the patient's behalf, requests another opinion.

A consultation requires a written report to the referring physician, nurse practitioner, midwife, optometrist or dentist; an evaluation of relevant body systems; an appropriate record; and, advice to the patient. It may include the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient, other persons relevant to the case, and the referring physician, nurse practitioner, midwife, optometrist or dentist. The composition of a consultation will vary with a particular specialty.

The following Health Service codes have been approved for use by General Practitioners, other than the patient's regular attending physician, who receive a formal request from a Midwife to provide consulting services .

| Category | Code | Description | Unit Value |
|---|---|---|---|
| CONS | 03.08 | Consultation | 30 |
| CONS | 03.07 | **Repeat Consultation**<br>RF=REFD, RP=REPT | 13 |

The MSI midwife number of the referring midwife must appear on the service encounter.

**NEW FEES**

The following new fees have been approved by MASG for inclusion in the fee schedule effective April 1, 2009.

| Category | Description | Unit Value | Anaes Units |
|---|---|---|---|
| MASG | Laparoscopic Assisted Vaginal Hysterectomy | 220 | 6 + T |
| MASG | Laparoscopic Supracervical Hysterectomy | 235 | 6 + T |
| MASG | Intrauterine Balloon for PPH Tamponade | 70 | 4 + T |
| VADT | Percutaneous Image Guided retrieval of Intravascular Foreign Body | 150 | 10 + T |
| VADT | Percutaneous Image Guided IVC Filter Removal | 135 | 10 + T |
| VADT | Implantation Loop Recorder | 70 | 4 + T |

| Category | Description | Unit Value | Anaes Units |
|---|---|---|---|
| ADON | Subintimal Recanalisation of Vascular Occlusion (as add on to Angioplasty or stent) | 125 | |
| | Percutaneous Image Guided Radiofrequency Ablation of Solid Tumour | 250 | 4 + T |
| | Bilateral Breast MRI – first sequence units<br>Subsequent sequence (maximum 3 multiples) units | 46.6<br>23.3 | |

Please hold eligible service encounters to allow MSI the required time to update the system. Once Health Service Codes have been assigned and tested they will be published in the MSI Physicians' Bulletin. The 90 day rule will be waived for these fees until the permanent code descriptions and modifiers are published.

## NEW PROCESS FOR AMENDING THE MSI PHYSICIAN'S MANUAL

All new requests for fee codes, fee adjustments, and changes to the Preamble to the MSI Physician's Manual are being handled by the Fee Schedule Advisory Committee (FSAC), which was formed for this purpose by the Master Agreement Steering Group (MASG).

The Master Agreement provides dedicated funding and the new process for making adjustments to the Nova Scotia fee schedule. Total new funding of $2 million ($500,000 annually during the first four years of the agreement) is provided for adjustments to the existing fee codes and Preamble. Total new funding of $3.5 million ($1 million in years one, three and four, and $500,000 in year two) is provided to support the addition of new fees.

## FEE SCHEDULE ADVISORY COMMITTEE

The Fee Schedule Advisory Committee is comprised of members from Doctors Nova Scotia, the Department of Health and the District Health Authorities. Its mandate is to provide advice and recommendations to the MASG on all matters pertaining to the fee schedule including:

- introduction of new fees;
- revisions or deletions of existing fee codes;
- additions, revisions or clarifications of the Preamble to the MSI Physician's Manual

### Application submissions

Requests may be submitted by all stakeholders including physicians, Doctors Nova Scotia, MSI, the Department of Health, and the District Health Authorities/IWK.

There are two submission dates per year, April 1 and November 1. Applications received after either date will be considered for the following deadline.

All requests will be responded to within 30 days with an explanation of the process to be followed. More information may be requested from the applicant. If the necessary

information/documentation isn't received within the specified timeframe, the request will be removed from the FSAC's active list of submissions.

Decisions will be made by October 31 and March 31 for the April and November submission batches. To be considered and to have this deadline applied, submissions must be received complete by April 1 and November 1.

The April 1, 2009 deadline has been extended to June 1, 2009. After that the regular schedule will resume with the next intake scheduled for November 1, 2009.

The application form and information sheet are available from Doctors Nova Scotia on the members' side of the Doctors Nova Scotia web site (www.doctorsns.com) under Physician Payment/Fee-for Service. Information can also be obtained by contacting Doctors Nova Scotia Policy Analyst, Jennifer Girard.

The application forms must be completed electronically (no handwritten applications please) and submitted via e-mail, fax or mail to:

Jennifer Girard
Policy Analyst, Doctors Nova Scotia
25 Spectacle Lake Drive,
Dartmouth NS B3B 1X7
Phone: (902) 468-8935 ext 231 or 1-800-563-3427
Fax: (902) 468-6578
E-mail: jennifer.girard@doctorsns.com

**Review of applications**
All applications will be reviewed and directed to the most appropriate process: information request, fee request or Preamble request.

Each request will be subjected to an evidence-based screening process. At any time during this screening process, the FSAC may ask the applicant for more information or clarification to ensure the application is evaluated fairly.

At the end of the evaluation process, if there is a high volume of acceptable requests, a prioritization methodology will be applied to all applications awaiting final approval.

**Recommendations**
All funding recommendations will be submitted to MASG for final approval.

## SURGICAL ASSISTANTS – UPDATE

The incentive payment for GP Surgical Assistants for the fiscal year 2008-2009 will be distributed within the next few weeks. Family Doctors will be eligible for the incentive payment if they have an annual MSI income of $75,000 or greater which includes an office based practice income of $25,000 or greater and in addition they have an annual income of less than $30,000 from elective (non-premium) surgical assists. The money available under this program will be distributed on a pro rata basis to the eligible Family Physicians in May, 2009.

## HELPFUL BILLING HINTS

Several physicians noticed when the Family Physician Comprehensive Care Incentive Program (CCIP) letters and cheques went out earlier this year that their incentive payment was less than they expected. This is because the incentive payments are based on MSI billings. If incorrect health service codes or modifiers are used when

billing MSI for services, physicians may find that the service is not rejected in their adjudication file. Therefore, they may be unaware that the health service code or modifier used was incorrect until the code is either not captured by an incentive program or is audited post payment.

The Well Baby Visit modifier described earlier in this Bulletin is a good example. For instance, when a healthy baby is seen in the office for a Well Baby Visit but instead the service is billed as a regular office visit, a fee of 13 units will be paid. However, the Well Baby Visit fee will not be captured by the Comprehensive Care Incentive Program and eligibility for an incentive payment will be reduced.

VIST 03.03 **Office Visit**
LO-OFFC, RP=SUBS (REFD).....13

VIST 03.03 **Well Baby Care**
LO=OFFC, RO=WBCR (RF=REFD).....13

Please ensure your office staff are aware of the RO = WBCR modifier so that all your Well Baby Visits are properly captured, including the new Well Baby Visit at 18 months.

## REMINDER: MAJOR/MINOR SURGERY RESTRICTION

Section 9.3.3 (c) of the Preamble of the Physician's Manual states: "When one physician performs a definitive procedure on an organ or within a body cavity, only that service should be claimed. The procedure used to provide surgical exposure should not be claimed; e.g,, a laparotomy is not to be claimed to provide access to the abdominal cavity except when no definitive procedure is performed within the abdomen. When one physician provides surgical exposure for a procedure performed by a physician in another speciality, the exposure and definitive procedures may be claimed separately by the respective physicians."

Physicians are reminded that this section applies to both laparotomy and laparoscopy procedures.

## LOCATION MODIFIER FOR EXERCISE STRESS TESTS

As per Section 9.2.2 (b) (i) of the Preamble of the Physician's Manual, exercise stress tests are approved for payment when performed in a hospital setting only (section 5.2.9 of the Billing Instruction Manual outlines the approved hospitals).

A review of stress test claims indicates that many are being submitted with the location "office", (as an ambulatory care centre clinic, or a private office), although they are being performed in the hospital setting. These claims should be submitted with the location of hospital (LO=HOSP) and the functional centre of out-patient department (FN=OTPT).

**REMINDER TO ALL PHYSICIANS**

*The new "Master Agreement" is available on the Doctors Nova Scotia website in the member's only section*

*We would encourage you to take some time to review the contract and contact either Patrick Riley (Department of Health) or Carol Walker (Doctors Nova Scotia) should you have any specific questions.*

**REVISED PREAMBLE 2008**

*The newly revised Preamble to the MSI Physician's Manual has been posted on the Members Section of the Doctors Nova Scotia website. Physicians wanting a hard copy of the Preamble may contact Medavie Blue Cross at 1-866-553-0585. The Preamble will be regularly updated as the work of the Fee Schedule Advisory Committee progresses*

# Optional
# Family Physician Chronic Disease Management (CDM) Flow Sheet

Patient Name: _____ Diabetes: ☐ Type I ☐ Type II ☐ Post MI 5 yr

Date of birth: _____ Date(s) of Diagnosis: _____ _____

Comorbidities: ☐ HTN ☐ Dyslipidemia ☐ PAD ☐ Renal Disease ☐ A Fib
☐ TIA/CVA ☐ Angina ☐ Mental Health Diagnosis
Other: _____

Interventions: PCI/Stent _____ CABG _____

Current Medication: _____
_____

| | REQUIRED COMMON INDICATORS FOR DIABETES AND POST-MI | Date / / | Date / / | Date / / | Date / / |
|---|---|---|---|---|---|
| 2/YR | Blood Pressure | | | | |
| ANNUALLY | Smoker ☐ Yes ☐ No If yes, discuss smoking cessation | | | | |
| ANNUALLY | Weight/Nutrition Counseling | | | | |
| ANNUALLY | Lipids Discuss statins LDL-C (mmol/L) TC/HDL-C | | | | |
| | REQUIRED INDICATORS FOR DIABETES ONLY | | | | |
| 2/YR | HbgA1C | | | | |
| ANNUALLY | Renal Function | | | | |
| ANNUALLY | Foot Exam Check for lesions. Use 10-g monofilamant or 128Hz tuning fork | | | | |
| ANNUALLY | Eye Exam Date Referred: Referred to: | | | | |
| | REQUIRED INDICATORS FOR POST-MI UP TO 5 YEARS ONLY | | | | |
| ANNUALLY | ASA/Anti-platelet Therapy Review | | | | |
| ANNUALLY | Betablocker Review | | | | |
| ANNUALLY | ACE/ARB Review | | | | |

*OPTIONAL ITEMS*

REMINDERS

Self Management Referrals ☐ Diabetic Clinic ☐ Cardiac Rehab ☐ Other: _____
Screen for ☐ Depression ☐ Erectile Dysfunction
Vaccinations ☐ Influenza Date: _____ ☐ Pneumovax Date: _____
Exercise/Activity ☐ Discussion
Lifestyle Choices ☐ Alcohol use ☐ Stress
Economics ☐ Pharmacare ☐ Provincial Diabetic Program ☐ Third Party Insurance ☐ No Insurance

**Date CDM Incentive Code Billed:** _____

**SELECTED CHRONIC DISEASE MANAGEMENT GUIDELINE INDICATORS**

| Common CDM Indicators | Target | Comments |
|---|---|---|
| Blood Pressure | <130/80 mmHg<br>In children: <95th %ile for age, gender and height | |
| Lipids | LDL-C: ≤ 2.0<br>TC: HDL-C: <4 | Test every 1-3 years as clinically indicated |
| Weight/Waist circumference/ Nutrition counseling | BMI: <25 kg/$m^2$ or<br>In children: <85th %ile for age<br>Waist circumference: M: <102 cm, F: <88 cm | |
| Smoking Cessation | | |

| Diabetes Indicators | Target | Comments |
|---|---|---|
| HbA1C | ≤ 7% | Measure every 6 mos in stable, well managed adults. If not achieved, can measure every 3 mos |
| Renal Function | ACR: <2.0 for males; <2.8 for females<br>eGFR: >60 mL/min | In presence of CKD, at least every 6 months.<br>Referral to nephrologist/internist if eGFR <30 mL/min |
| Routine foot examination | | Test with monofilament or 128hz tuning fork |
| Routine eye examination | | Routine dilated eye exam |

| Post MI Indicators (Medications) | Duration | Comments |
|---|---|---|
| Beta Blocker | STEMI: Indefinitely<br>Non-STEMI: Indefinitely unless low risk | |
| ACE/ARB | Indefinitely unless low risk | ACE: Titrate to target dose.<br>Consider ARB if contraindications or intolerance to ACE |
| ASA/Anti-platelet therapy:<br>ASA 81 to 325 mg OD<br><br>Clopidogrel 75 mg OD | ASA indefinitely -STEMI and Non-STEMI<br><br>Clopidogrel: STEMI - Only if had PCI<br>Minimum 1 mo. post bare metal stent<br>Min. 12 mo. post drug-eluting stent<br><br>Clopidogrel: Non-STEMI<br>No PCI: Low risk - 3 mo; Inc. risk - 12 mo.; Very high risk - >12 mo.<br>PCI: Low risk & bare metal stent - 3 mo.; Increased risk regardless of stent or ≥1 drug-eluting stent - 12 mo.; very high risk regardless of stent or ≥3 drug-eluting stents or complex PCI - >12 mo | Clopidogrel: STEMI<br>Dependent on type of stent and risk profile<br><br>Clopidogrel: Non-STEMI<br>Depends on risk of recurrent event & stent type |

**CHRONIC DISEASE MANAGEMENT (CDM) INCENTIVE FEE BILLING RULES**

1. The CDM Incentive fee can be claimed by family physicians starting April 1, 2009.
2. The base incentive fee may be claimed once per fiscal year for each patient managed for one qualifying chronic disease condition. An additional incentive amount per patient may be claimed once per fiscal year as part of the fee if the patient has an additional qualifying condition.
3. The family physician is expected to act as case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations or referrals.
4. Patients must be seen a minimum of two times per year by a licensed health care provider in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.
5. Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.
6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year.
7. The qualifying chronic diseases eligible for the CDM incentive payment in 2009/10 are Type 1 and Type 2 Diabetes (FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L) and/or Post Myocardial Infarction (post-MI) follow-up for up to 5 years after the most recently diagnosed MI.
8. In year one (April 1, 2009 to March 31, 2010), the CDM incentive can be claimed if the following conditions are met:
    * the patient is seen by the physician in relation to their chronic disease(s) at least once in the 2009/10 fiscal year;
    * the patient has had at least one other appointment with a 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 (see front of flow sheet) and documented in the clinical record or optinal flow sheet at or before the time of billing.

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

February 26, 2009 Volume XLIII - #1

# NOTICE TO PHYSICIANS

**Inside this Issue**



System modifications regarding the following health service codes have been implemented. Updated files reflecting changes are available for download on Friday, February 27, 2009. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanation code (EXPLAIN.DAT), and modifier values (MODVALS.DAT)

## REMOTE ORTHOPAEDIC CONSULT WITH REVIEW OF PACS IMAGES

The following new temporary Health Service code has been approved for inclusion in the Fee Schedule effective January 1, 2009 until June 30, 2009.

A Remote Orthopaedic Consult with Review of PACS Images will be insured as part of a pilot study that will occur over a six month period commencing January 1, 2009 and billable by Orthopaedic Specialists only.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| CONS | 03.09D | Remote Orthopaedic Consult With Review Of PACS Images | 25 |

**Billing Guidelines:**

- This fee may be billed when a physician working in an Emergency Department or a surgeon encounters a complex orthopaedic problem that requires the opinion of an orthopaedic surgeon practicing in the area of concern. The consultant orthopaedic surgeon reviews the PACS (or other such image archival system) images and provides telephone advice to the referring physician and follows up with a formal written report to the referring physician.
- The report must document the history, the presenting complaint, the discussion with the referring physician concerning the patient's physical condition, the results of the review of the PACS images, the consultant's opinion and recommendations for management of the patient in their local community.
- The referring physician must also document that a telephone consultation was requested and provided.
- The referring physician and the orthopaedic consultant must be situated in different facilities.
- If the patient is subsequently seen by the orthopaedic consultant for a comprehensive or limited consultation within 30 days of the Remote Orthopaedic Consult with Review of PACS Images, the consult will not be paid.
- The Remote Orthopaedic Consult with Review of PACS Images is only payable once per case per patient.
- This fee may not be claimed where the purpose of the phone call is only to:
  - Arrange for diagnostic investigations
  - Discuss the results of diagnostic investigations

## CASE MANAGEMENT CONFERENCE FEE

A case management conference is a formal, scheduled, multi-disciplinary health team meeting. It is initiated by an employee of the DHA/IWK to discuss the provision of health care to a specific patient. The Case Management Conference Fee is being implemented for both General Practitioners and Specialists.

The following new permanent Health Service code has been approved for inclusion in the Fee Schedule effective January 1, 2009:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VIST | 03.03D | Case Management Conference | 14 units per 15 minutes for a GP and 16.5 units per 15 minutes for Specialists |

**Billing Guidelines**

- It is a time based fee paid at the sessional rate in 15 minute increments.
- To claim the case conference fee, the physician must participate in the conference for a minimum of 15 minutes and remuneration will be calculated in 15 minute time increments based on the sessional rate. Start and finish times are to be recorded on the patient's chart.
- 80% of a 15 minute time interval must be spent at the conference in order to bill that time interval.
- Neither the patient nor the family need to be present.
- It may be claimed by more than one physician simultaneously as necessary for case management.
- The case conference must be documented in the health record with a list of all physician participants.

The following is an example of claiming Multiples for case conferencing:

| Minutes | Multiples | Units | |
|---|---|---|---|
| | | GP | Specialist |
| 15 | 2 | 14 | 16.5 |
| 30 | 3 | 28 | 33 |
| 45 | 4 | 42 | 49.50 |
| 60 | 5 | 56 | 66 |
| 75 | 6 | 70 | 82.50 |
| 90 | 7 | 84 | 99 |
| 105 | 8 | 98 | 115.50 |
| 120 | 9 | 112 | 132 |

## NEW MODIFIER VALUE

The Department of Health requested the implementation of a new modifier in order to differentiate and track the volume of day time emergency visits in Level 3 and 4 community hospital Emergency Departments versus planned/scheduled outpatient visits. Physicians should continue to bill unscheduled emergency visits using the appropriate visit code including the unscheduled modifier US=UNOF. The new modifier is US=SCHD and it should be included on service encounters in the Outpatient Department that are planned in advance. The time frame for these services is 8:00am – 8:00pm including Saturdays, Sundays and Holidays.

## NEW EXPLANATORY CODES

The following new explanatory codes have been added to the system.

| | |
|---|---|
| VT087 | Service encounter has been refused as you have previously been approved this service for this diagnosis. |
| VT088 | Service encounter has been refused as you or another provider have previously been approved this service for this diagnosis. |
| VT089 | Service encounter has been refused as functional center is not indicated. |
| NR081 | Service encounter has been adjudicated according to the weekly maximum of 80 units per week after 56 days from admission. |

### Effective April 1, 2009 – March 31, 2010

### MSI Medical Service Unit (MSU) and Anaesthesia Service Unit (AU)

| | |
|---|---|
| MSU | $2.26 |
| AU | $16.15 |

### WCB Medical Service Unit and Anaesthesia Service Unit

| | |
|---|---|
| MSU | $2.51 |
| AU | $17.94 |

## ATTENTION PHYSICIANS

When requesting confidential information from MSI Registration and Enquiry such as Health Card numbers or expiry dates please ensure you have your 6-digit Provider Number available for identification purposes.

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

December 19, 2008 Volume XLII - #5

**Inside this Issue**



## REMOTE PICTURE and COMMUNICATION SYSTEM CONSULT – ORTHOPAEDIC SURGERY

The following new temporary Health Service code has been approved for inclusion in the Fee Schedule effective January 1, 2009 until June 30, 2009.

A remote picture and communication system consult will be insured as part of a pilot study that will occur over a six month period commencing January 1, 2009 and billable by Orthopaedic Specialists only.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| CONS | 03.09D | Remote Consultation by Picture archiving and Communication System (PACS) – Specialty Specific (Orthopaedic Surgery) | 25 |

Until further notice please hold eligible service encounters to allow MSI the required time to update the system.

**Billing Guidelines:**

- This fee may be billed when a physician working in an Emergency Department or a surgeon encounters a complex orthopaedic problem that requires the opinion of an orthopaedic surgeon practicing in the area of concern. The consultant orthopaedic surgeon reviews the PACS (or other such image archival system) images and provides telephone advice to the referring physician and follows up with a formal written report to the referring physician.
- The report must document the history, the presenting complaint, the discussion with the referring physician concerning the patient's physical condition, the results of the review of the PACS images, the consultant's opinion and recommendations for management of the patient in their local community.
- The referring physician must also document that a telephone consultation was requested and provided.
- The referring physician and the orthopaedic consultant must be situated in different facilities.
- If the patient is subsequently seen by the orthopaedic consultant for a comprehensive or limited consultation within 30 days of the remote PACS consult, the PACS consult will not be paid.
- The remote PACS consult is only payable once per case per patient.
- This fee may not be claimed where the purpose of the phone call is only to:
  - Arrange for diagnostic investigations
  - Discuss the results of diagnostic investigations

## CASE MANAGEMENT CONFERENCE FEE

A case management conference is a formal, scheduled, multi-disciplinary health team meeting. It is initiated by an employee of the DHA/IWK to discuss the provision of health care to a specific patient.

The following new permanent Health Service code has been approved for inclusion in the Fee Schedule effective January 1, 2009:

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VIST | 03.03D | Case Management Conference | 14 units per 15 minutes to a maximum of 2 hours |

Until further notice please hold eligible service encounters to allow MSI the required time to update the system.

**Billing Guidelines**

- It is a time based fee paid at the sessional rate in 15 minute increments.
- To claim the case conference fee, the physician must participate in the conference for a minimum of 15 minutes and remuneration will be calculated in 15 minute time increments based on the sessional rate. Start and finish times are to be recorded on the patient's chart.
- 80% of a 15 minute time interval must be spent at the conference in order to bill that time interval.
- Neither the patient nor the family need to be present.
- It may be claimed by more than one physician simultaneously as necessary for case management.
- The case conference must be documented in the health record with a list of all physician participants.

The *Case Management Conference Fee* is being implemented for General Practitioners at this time. Work is underway on exploring implementation options for other physician groups.

## COMPLEX CARE CODE 03.03B

***Bolded and italicized*** section of the following paragraph has been added for clarification purposes:

A complex care visit code may be billed a maximum of 4 times per patient per year by the family physician and/or the practice (not by walk-in clinics) providing on-going comprehensive care to a patient who is under active management for 3 or more of the following chronic diseases: asthma, COPD, diabetes, chronic liver disease, hypertension, chronic renal failure, congestive heart failure, ischaemic heart disease, dementia, chronic neurological disorders, cancer. The physician must spend at least 15 minutes in direct patient intervention. ***The visit must address at least one of the chronic diseases either directly or indirectly. Start and finish times are to be recorded on the patient's chart.***

## CHANGES TO THE MSI PHYSICIAN'S MANUAL - PREAMBLE

**Preamble 7.2.5 (c):**
The following wording has been added to Section 7.2.5 (c) to clarify the billing options for the admitting physician when a patient who had a comprehensive exam by the Family Doctor in the Emergency Department is admitted to the hospital and subsequently has a comprehensive exam by the admitting Family Doctor:

If a patient has a comprehensive visit in the Emergency Department (ED) by the Family Doctor covering the ED and is then admitted and has a second comprehensive visit by a different (admitting) family doctor, the ED physician may claim the Complete Examination code and the admitting physician may claim the First Examination code.

**Preamble 5.4.5:**
Reminder: Please note Section 5.4.5 of the Preamble states that when physicians are providing non-insured services, they are required to advise the patient of insured alternatives, if any exist. It has come to the attention of MSI and the Department of Health that this may not be occurring in all cases. Please ensure patients are provided with a clear understanding of available alternatives.

It is anticipated in early 2009, the New Preamble will be located at *www.doctorsns.com* under the Members Only section, click on Physician Payment (found in the left margin) and then on Fee-for-service. A list of available documents is on the right.

## WCB NOTICE OF CORRECTION

Physicians' Bulletin dated September 19, 2008, page 8 of 9 under heading service type "Physician Assessment"; please note the description should indicate "physicians" versus "general practitioner". If you have any questions please contact Jennifer Prosper directly at 491-8356 or toll-free at 1-800-870-3331.

## HOLIDAY DATES FOR 2008

Please refer to the attached schedule of the dates MSI will accept as "Holidays".

## CUT-OFF DATES FOR RECEIPT OF PAPER & ELECTRONIC CLAIMS

Please refer to the attached schedule regarding cut-off dates for receipt of paper and electronic claims **paying particular attention to the dates in bold print.**

**The staff at MSI would like to extend warm wishes**

**for the Holiday Season!**

# 2009 CUT-OFF DATES FOR RECEIPT OF PAPER & ELECTRONIC CLAIMS

| PAPER CLAIMS | ELECTRONIC CLAIMS | PAYMENT DATE |
|---|---|---|
| January 5, 2009 | January 8, 2009 | January 14, 2009 |
| January 19, 2009 | January 22, 2009 | January 28, 2009 |
| February 2, 2009 | February 5, 2009 | February 11, 2009 |
| February 16, 2009 | February 19, 2009 | February 25, 2009 |
| March 2, 2009 | March 5, 2009 | March 11, 2009 |
| March 16, 2009 | March 19, 2009 | March 25, 2009 |
| March 30, 2009 | April 2, 2009 | April 8, 2009 |
| April 13, 2009 | April 16, 2009 | April 22, 2009 |
| April 27, 2009 | April 30, 2009 | May 6, 2009 |
| May 11, 2009 | May 14, 2009 | May 20, 2009 |
| May 25, 2009 | May 28, 2009 | June 3, 2009 |
| June 8, 2009 | June 11, 2009 | June 17, 2009 |
| **June 19, 2009 **** | **June 24, 2009 **** | **June 30, 2009 **** |
| July 6, 2009 | July 9, 2009 | July 15, 2009 |
| July 20, 2009 | July 23, 2009 | July 29, 2009 |
| **July 31, 2009 **** | August 6, 2009 | August 12, 2009 |
| August 17, 2009 | August 20, 2009 | August 26, 2009 |
| August 31, 2009 | September 3, 2009 | September 9, 2009 |
| September 14, 2009 | September 17, 2009 | September 23, 2009 |
| September 28, 2009 | October 1, 2009 | October 7, 2009 |
| **October 9, 2009 **** | October 15, 2009 | October 21, 2009 |
| October 26, 2009 | October 29, 2009 | November 4, 2009 |
| **November 6, 2009 **** | November 12, 2009 | November 18, 2009 |
| November 23, 2009 | November 26, 2009 | December 2, 2009 |
| December 7, 2009 | December 10, 2009 | December 16, 2009 |
| **December 18, 2009 **** | **December 22, 2009 **** | December 30, 2009 |
| January 4, 2010 | January 7, 2010 | January 13, 2010 |
| **11:00 AM CUT OFF** | **11:59PM CUT OFF** | |

**NOTE:**
Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Radiology, Pathology, Internal Medicine Monthly Statistical Reports and Sessional Payments. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut off date to ensure processing for that payment period.

**PLEASE NOTE, THE ** INDICATES A DATE VARIATION**

November 19, 2008

## HOLIDAY DATES FOR 2009

Please make a note in your schedule of the following dates MSI will accept as “Holidays.”

| | |
|---|---|
| NEW YEAR’S DAY | THURSDAY, JANUARY 1, 2009 |
| GOOD FRIDAY | FRIDAY, APRIL 10, 2009 |
| EASTER MONDAY | MONDAY, APRIL 13, 2009 |
| VICTORIA DAY | MONDAY, MAY 18, 2009 |
| CANADA DAY | WEDNESDAY, JULY 1, 2009 |
| CIVIC HOLIDAY | *IF APPLICABLE* |
| LABOUR DAY | MONDAY, SEPTEMBER 7, 2009 |
| THANKSGIVING DAY | MONDAY, OCTOBER 12, 2009 |
| REMEMBRANCE DAY | WEDNESDAY, NOVEMBER 11, 2009 |
| CHRISTMAS DAY | FRIDAY, DECEMBER 25, 2009 |
| BOXING DAY | MONDAY, DECEMBER 28, 2009 |
| NEW YEAR’S DAY | FRIDAY, JANUARY 1, 2010 |

MSI Assessment Department (902) 496-7011
Fax Number (902) 490-2275
Toll Free Number 1-866-553-0585

# PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

September 19, 2008 Volume XLII - #4


**Inside this Issue**



The Department of Health would like to advise of the following Tariff Agreement modifications effective April 1st, 2008.

The Tariff Agreement between Doctors Nova Scotia and the Department of Health specified an increase to the value of the Medical Service Unit (MSU) effective April 1st , 2008, as well as increases in the number of units associated with selected health service codes. Effective July 25th MSI began paying service encounters using the April 1st, 2008 MSU value.

Any services that have been held for submission due to code unavailability can now be submitted in the usual manner. For electronic submission of claims please include text indicating "tariff agreement change" for services over the 90-day time frame.

Information related to various incentive programs will be detailed in a later bulletin.

## RETROACTIVE PAYMENT

All claims eligible for a Medical Service Unit (MSU) and Anaesthesia Unit (AU) increase with a service date of April 1st, 2008 to July 10th, 2008 inclusive and with a payment date of prior to July 30th will be identified and a retroactive payment will be calculated and paid in the fall of 2008.

If there are any questions regarding the retroactive payment, please contact Heather Etsell at (902) 496-7166.

## RETURN TRIP WHEN TRANSPORTING A PATIENT

When a physician has accompanied a patient, who is transported from one location to another, the previously unpaid return trip by the physician will now be compensated. The time claimed shall not exceed the patient transport time and will be payable at the same rate as the trip to accompany the patient. A revised call back form will be circulated to the Emergency Department Directors and Chief of Staff. Claims can be submitted to either the Emergency Department Director or Chief of Staff for services provided April 1st, 2008 onward.

## COMMUNICATION BY FAX AND EMAIL

Recognizing that methods of communication are changing, all existing Nova Scotia telephone fee codes are amended to include payment for services provided by fax and e-mail. This applies to the following Health Service codes (HSC):

| HSC | Modifiers | Description |
|---|---|---|
| 13.99C | | Supervision of long-term anticoagulant therapy per month (telephone/fax/Email communication) |
| 03.03 | RO=HMTE | Medical Chart Review and/or telephone call, fax or Email. This service is billable up to three per day per patient |
| 03.03 | RO=CRTC | Palliative Care Med Chart Review and/or Telephone call, Fax or Email. This service is billable when initiated by a health care professional – up to three per day per patient |

Fax or email services with date of service April 1st, 2008 onward that have been held should now be submitted in the usual manner. Please include text indicating "tariff agreement change" for services over the 90-day time frame.

## GENERAL PRACTICE OFFICE SERVICES

### General Practice Complex Care Visit (03.03B)

*Complex Care Visit*

Effective April 1st, 2008 the following permanent code has been approved for inclusion in the fee schedule. Held claims for this service can now be submitted. Please include text indicating "tariff agreement change" for services over the 90-day time frame. If your office has previously submitted a regular office visit code you must delete the original claim prior to resubmitting the complex care visit.

The complex care visit code may be billed a maximum of 4 times per patient per year by the family physician and/or the practice providing on-going comprehensive care to a patient who is under active management for 3 or more of the following chronic diseases: asthma, COPD, diabetes, chronic liver disease, hypertension, chronic kidney disease, congestive heart failure, ischaemic heart disease, dementia, chronic neurological disorders, cancer. The physician must spend at least 15 minutes in direct patient intervention.

The term active management is intended to mean that the patient requires ongoing monitoring, maintenance or intervention to control, limit progression or palliate a chronic disease.

The term chronic neurological disorders is intended to include progressive degenerative disorders (such as Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease), stroke or other brain injury with a permanent neurological deficit, paraplegia or quadriplegia and epilepsy.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VIST | 03.03B | Complex Code | 21 |
| VIST | 03.03B | Complex Code with modifier GPEW | 26.25 |

*Well Baby Visit*

**Well Baby Visit**

Effective April 1st, 2008An additional insured well-baby visit for children eighteen months of age is being implemented. The code has a four-week buffer for billing purposes, two weeks prior and two weeks after eighteen months of age. Any services that have been held for submission due to code unavailability can now be submitted in the usual manner. Please include text indicating "tariff agreement change" for services over the 90-day time frame.

*Evening and weekend Office Incentive*

**General Practice Evening and Weekend Office Visit Incentive**

The existing funding model for the General Practice Evening and Weekend Office Visit Incentive Program will change from an unpredictable fluctuating amount to a fixed incentive value of 25%. All other program rules remain the same. Monthly bottom line adjustments for the incentive portion will cease for claims with a date of service April 1st, 2008 onward.

All eligible claims with a date of service April 1st, 2008 to September 18th, 2008 will be identified and a retroactive payment will be calculated and paid in the winter of 2008/2009. The retro will be calculated after the 90-day waiting period for the submission of claims.

## HOSPITAL SERVICES

The following changes were effective April 1st, 2008:

In-patient hospital care by General Practice physicians will see an increase in the fee for the first in-patient visit from 25 to 30 units.

The General Practice daily hospital visit fee will increase from 15 to 16 units.

The hospital discharge fee will increase from 8 to 10 units for all physicians.

Effective April 1, 2008, the billing of daily hospital visits has increased from 28 to 56 days from the admission date. The rule limiting payment of five visits in a seven days period, will not apply until after 56 days of hospitalization.

All eligible claims with a date of service April 1st, 2008 to September 18th, 2008 will be identified and a retroactive payment will be calculated and paid in the winter of 2008/2009. The retro will be calculated after the 90-day waiting period for the submission of claims.

| HEALTH SERVICE CODE | MODIFIERS | DESCRIPTION | CURRENT UNITS | UNITS EFFECTIVE SEPT 19, 2008 |
|---|---|---|---|---|
| | | | | |
| 03.04 (General Practice Only) | LO=HOSP, FN=INPT, RP=INTL (RF=REFD) | First Examination | 25 | 30 |
| 03.03 (GP's Only) | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) | Subsequent Visit – Daily up to 56 days - | 15 | 16 |

| HEALTH SERVICE CODE | MODIFIERS | DESCRIPTION | CURRENT UNITS | UNITS EFFECTIVE SEPT 19, 2008 |
|---|---|---|---|---|
| 03.03 (GP's Only) | LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, (RF=REFD) | Subsequent Visit – Weekly after 56 days – Maximum 80 units per week | 15 | 16 |
| 03.02 A (All Specialties) | LO=HOSP, FN=INPT | Hospital Discharge Fee | 8 | 10 |

## COMPLEX SURGICAL PATHOLOGY

Effective April 1st, 2008 the following fees apply for complex surgical pathology:

**Pathology non-patient-specific bulk billing fees**

| | | |
|---|---|---|
| P2345 | Surgicals, gross and microscopic 3 or more separate specimens | 25.76 units |
| P3345 | Surgicals, gross and microscopic 3 or more separate specimens (35% premium fee) | 34.78 units |
| P5345 | Surgicals, gross and microscopic 3 or more separate specimens (50% premium fee) | 38.64 units |
| P2346 | Surgicals, gross and microscopic, single large complex CA specimen including lymph nodes | 25.76 units |
| P3346 | Surgicals, gross and microscopic, single large complex CA specimen including lymph nodes (35% premium fee) | 34.78 units |
| P5346 | Surgicals, gross and microscopic, single large complex CA specimen including lymph nodes (50% premium fee) | 38.64 units |

### Billing guidelines for surgicals, gross and microscopic specimens.

When more than one surgical specimen is received from a patient the following rules apply:

- P2325 may be claimed for each specimen taken from anatomically distinct surgical sites.
- P2345 may be claimed when 3 or more separate surgical specimens are taken from the same anatomic site.
- P2346 may be claimed when a single large complex cancer specimen, which includes lymph nodes, is examined for the purpose of providing a pathologic cancer staging.

***Definitions*:**

Anatomically distinct surgical site: For the purposes of correctly interpreting anatomic pathology fee code P2325 the body is considered to be divided into the following distinct anatomical areas:

head and neck; upper limbs; lower limbs; trunk (anterior and posterior). The following organ systems are also considered to be distinct surgical sites: upper GI tract; lower GI tract; female reproductive system; male reproductive system; separate organs within the abdominal or thoracic cavities may be claimed as distinct sites. For example, 2 separate skin specimens from the right and left arms are considered as one site, specimens from uterus and ovary are one site, specimens from colon and liver are two sites.

***Clarification:***
Frozen Sections (Intraoperative consult with tissue): For the purposes of correctly interpreting anatomic pathology fee code P2326 all frozen sections taken from one surgical specimen are considered to be one frozen section. When separate organs or anatomic areas are sent for frozen section then it is appropriate to bill for two frozen sections; separate sentinel nodes may also be considered as separate specimens. For example, examination of several margins from one skin cancer is one frozen section, examination of multiple margins from two separate skin cancers (even though they may be within the same anatomically distinct surgical site as defined above) can be considered as two frozen sections.

## FACILITY-BASED PSYCHIATRY

Effective April 1$^{s}$, 2008 the hourly rates for Psychiatry are: $129.50 for certified specialists and $93.08 for non-certified specialists. The previous sessional rates for Psychiatry no longer apply and are all converted to the above hourly rates.

All eligible claims with a date of service April 1$^{st}$, 2008 to September 18$^{th}$, 2008 will be identified and a retroactive payment will be calculated and paid in the fall of 2008.

## MSI ASSESSMENT CONTACT NUMBERS

For MSI Assessment Inquires, please call the following numbers:

Local Telephone Number: (902) 496-7011

Toll-Free: 1-866-553-0585

Fax Number: (902) 490-2275

## CHANGE TO EXISTING EXPLANATORY CODE

| | |
|---|---|
| **AD004** | Service encounter has been refused as this service has previously been approved. |
| **AD027** | Service encounter has been refused as a portion of this service has been previously approved. |

## NEW EXPLANATORY CODES

The following new explanatory codes have been added to the system.

| | |
|---|---|
| **PC027** | Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 20 hours per year for family therapy has previously been approved. |
| **PC028** | Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 20 hours per year for group therapy has previously been approved. |
| **PC029** | Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 20 hours per year for individual therapy has previously been approved. |
| **PC030** | Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 10 hours per year for hypnotherapy has previously been approved. |
| **PC031** | Service encounter has been refused as you have not indicated that prior approval as been issued. Maximum limit of 2 hours per year for lifestyle counselling has previously been approved. |
| **PC032** | Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 5 hours per year for counselling has previously been approved. |
| **VT079** | Service encounter has been refused as the maximum number of complex care visits for the year has previously been approved. |
| **VT080** | Service encounter has been refused as modifier DA value is inappropriate after 56 days from hospital admission. |
| **VT081** | Service encounter has been refused as the maximum of 8 well baby care visits in the first 13 months of life has previously been approved. |
| **VT082** | Service encounter has been refused as the maximum of 8 well baby care visits in the first 13 months of life has previously been approved. |
| **VT083** | Service encounter has been refused as the patient is not insured for this service at this time. |
| **VT084** | Service encounter has been refused as the patient is not insured for this service at this time. |
| **VT085** | Service encounter has been refused as the maximum of 9 well baby care visits has previously been approved. |
| **VT086** | Service encounter has been refused as only one well baby care visit is insured when patient is aged 18 months. |

## WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

The (WCB) and Doctors Nova Scotia signed an agreement that came into effect on December 1, 2006. The agreement increased fees to physicians in recognition of new service requirements to improve outcomes for injured workers and helping them achieve a safe and timely return to work.

**WCB Medical Service Unit**

| | |
|---|---|
| April 1, 2008 – March 31, 2009 | $2.48 |

**Anaesthesia Unit**

| | |
|---|---|
| April 1, 2008 – March 31, 2009 | $17.68 |

In order to implement the agreement it was necessary to make a few changes to the billing process, including adding and deleting some billing codes. Effectively immediately some of these codes are being reinstated to properly remunerate physicians for those scenarios that are not by their nature in keeping with the service requirements expected and related to cases that do not have RTW documentation expectations. Please refer to the attached table that explains the various services and their corresponding billing codes.

Continuing to work is a critical component of injury recovery. Work is healthy. The WCB is doing its part to address the length of time injured workers are off work and improve health outcomes. But we can't do it alone. As a physician you play a key role in helping maintain a workers' connection to the workplace.

If you have any questions regarding these changes please contact Jennifer Prosper directly at (902) 491-8356 or toll free 1-800-870-3331.

## WCB PHYSICIAN SERVICE INFORMATION SHEET

The following table lists and describes the various services physicians provide regarding injured workers in Nova Scotia and their associated WCB Health Services Codes.

Some of these codes were temporarily disabled but have now been reinstated. Please ensure to use these codes for billing purposes from now on.

| | Service Type | Description | Health Service Code (Amount Paid @ $2.48/unit) |
|---|---|---|---|
| 1 | Physician Assessment | A worker visits a physician's office, a Physician Assessment is conducted, and a Form 8/10 is completed in compliance with the mandatory criteria outlined in the Doctors Nova Scotia agreement. As this agreement is specific to general practitioners, specialists should use the codes applicable to the services they are providing (see – #s 10 and 11 for further clarification). | WCB11* ($123.40) |
| 2 | Enhanced Physician Services (EPS) Physician Assessment** | A worker visits an EPS physician's office as a result of an EPS referral. A thorough Physician Assessment is conducted and a Form 8/10 is completed in compliance with the mandatory criteria outlined in the Doctors Nova Scotia contract and individual EPS physician letters of agreement. *(This code must only be used by EPS physicians)*.* | WCB12 ($153.56) |
| 3 | Chart Summaries/Written Reports [$37.50 per 15 minute interval (multiplies) – time based billing] | The WCB requests a physician write a report summarizing a worker's chart or answering specific questions - the physician can bill based on the **time** it has taken to prepare this information. This should not be billed in conjunction with WCB 14. | WCB13 ($37.50) |
| 4 | Chart Summaries/Written Reports ($125.01 per page – method based billing) | The WCB requests a physician write a report summarizing a worker's chart or answering specific questions - the physician can bill based on the **length of the report.** This should not be billed in conjunction with WCB13. | WCB14 ($125.02) |
| 5 | Case Conferencing and Teleconferencing (Treating Physician) | Conferencing with employers - the WCB and other health care providers may be invoiced by the treating physician at $75.00 per half hour – billable in quarters. This conferencing is at the request of the case worker and may entail either phone, or on-site "face to face" communication to discuss the worker's functional status, management and/or return to work planning. | WCB15 ($75.00) |
| 6 | Case Conferencing and Teleconferencing (EPS Physician) | Conferencing with employers - the WCB and other health care providers may be invoiced by the treating physician at $100.04 per half hour – billable in quarters. This conferencing is at the request of the case worker and may entail either phone, or on-site "face to face" communication to discuss the worker's functional status, management and/or return to work planning. | WCB16 ($100.04) |
| 7 | Photocopies | Photocopying of chart notes at the request of WCB will be compensated at a minimum of $25 or as negotiated on a case by case basis with the WCB case worker and/or WCB Health Services Department. | WCB17 ($25.00) |
| 8 | Inpatient Visit (hospital visit) | The worker is in the hospital and the physician is providing a 'check in' on rounds. No Physician's Report (Form 8/10) completion warranted. | 03.03 ($39.68) |
| 9 | Long Term Benefit Recipient (office visit ) | The worker is a long term benefit recipient and there is no change in treatment or medical status. No Form 8/10 completion warranted. | 03.03 ($32.24) – under 65 years of age<br><br>03.03A ($40.92) – over 65 years of age |
| 10 | Limited Visit (office visit ) | 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. | 03.03 ($32.24) – under 65 years of age<br><br>03.03A ($40.92) – over |

| | **Service Type** | **Description** | **Health Service Code (Amount Paid @ $2.48/unit)** |
|---|---|---|---|
| | | | 65 years of age |
| 11 | Limited Visit (office visit) | RP=SUBS, TI=GPEW (LO=OFFC) | 03.03 ($40.30) – under 65 years of age |
| 12 | Limited Visit (office visit) | TI=GPEW (LO=OFFC) | 03.03A ($51.16) – over 65 years of age |
| 13 | Comprehensive Visit | In-depth evaluation of a patient necessitated by the seriousness, complexity, or obscurity of the patient's complaint or medical condition. This service includes ensuring a complete history is recorded in the medical record and performing a physical examination appropriate to the physician's specialty and the working diagnosis. | 03.04 ($59.52) |
| 14 | Comprehensive Visit | TI=GPEW (LO=OFFC) | 03.04 ($74.40) |
| 15 | Denied Claim | Physician has been notified that the patient's claim is deemed non-WCB. | Physician bills service to MSI in the usual manner. |

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

July 22, 2008 Volume XLII - #3

**Inside this Issue**



The Department of Health would like to advise you of the following Tariff Agreement modifications effective April 1, 2008.

The proposed Tariff Agreement between Doctors Nova Scotia and the Department of Health specified an increase to the value of the Medical Service Unit (MSU) effective April 1, 2008. Any service encounters submitted on or after July 11, 2008, with a date of service of April 1, 2008 onward, will be paid according to the new MSU value.

Additional information related to the proposed Tariff Agreement between Doctors Nova Scotia and the Department of Health will be detailed in a later bulletin.

## RETROACTIVE PAYMENT

All claims eligible for a Medical Service Unit (MSU) and Anaesthesia Unit (AU) increase with a service date of April 1, 2008 to July 10, 2008 inclusive and a date of payment prior to July 30, 2008 will be identified and a retroactive payment will be calculated and paid in the fall of 2008.

If there are any questions regarding the retroactive payment, please contact Heather Etsell at (902) 496-7166.

## MSI MEDICAL SERVICE UNIT

The MSU value increase April 1, 2008 is as follows:

| | |
|---|---|
| April 1, 2008 – March 31, 2009 | $2.23 |

## MSI ANAESTHESIA UNIT

The AU value increase April 1, 2008 is as follows:

| | |
|---|---|
| April 1, 2008 – March 31, 2009 | $15.91 |

## ALTERNATIVE PAYMENT PLANS (APP)

The funding rates per full-time equivalent (FTE) for regional anaesthesia, geriatric specialist and palliative care specialist APP contracts are increased as follows: Effective April 1, 2008: MSU Increase plus $15,000

The funding rates per full-time equivalent (FTE) for regional paediatrics, obstetrics/gynecology and neonatology and psychiatry APP contracts are increased as follows: Effective April 1, 2008: MSU Increase plus $5,000

*Alternative Payment Plans*

The funding rates per full-time equivalent (FTE) for general practice APP contracts are increased as follows: Effective April 1, 2008: MSU Increase plus $5,000. These increases apply to all general practice APPs including family physicians, general practitioner/nurse practitioner, general practitioner palliative care, general practitioner geriatric, clinician assessment for practice program and group APP contract.

## GENERAL PRACTICE COMMUNITY REMOTE ON-CALL

The existing Community Remote Practice On-Call Program will continue for the period of April 1, 2008 until March 31, 2009. All physicians who are currently paid through this program will be "grandfathered". The biweekly payment is 447.23 MSU at a MSU value of $2.23.

## EMERGENCY DEPARTMENT FUNDING

*Emergency Department Funding*

Effective April 1, 2008, QEII, IWK and Regional Hospital's Emergency Department physician funding will increase to 70 MSUs per hour at a MSU value of $2.23.

Effective April 1, 2008, all other Emergency Department's current arrangement for "billable hours" be paid at the increased MSU value of $2.23.

## SESSIONAL PAYMENTS

The sessional payment rates for both General Practitioners and Specialists increase for this year of the agreement is as follows:

| | Hourly Rate in MSUs | |
|---|---|---|
| | **General Practitioners** | **Specialists** |
| April 1, 2008 | 56 | 66 |

## GENERAL PRACTICE EVENING AND WEEKEND OFFICE VISIT INCENTIVE PROGRAM

Family physicians should continue to submit eligible claims with the GPEW modifier. These payments will no longer show as a bottom line adjustment. Additional information related to this incentive program will be detailed in a later bulletin.

## INTERIM FEE CODES FOR PET/CT SCAN AND INTERPRETATION

*Interim Fee for PET/CT Scan*

The following two new fee codes for PET/CT scanning and interpretation for the section of Radiology have been set up with an effective date of June 23, 2008. The codes are temporary for one year. These services are to be patient specific and billed electronically.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VEDT | 02.79B | PET/CT scan and interpretation, one body region | 87 |
| VEDT | 02.79C | PET/CT scan and interpretation, multiple body regions (including whole body scan) | 125 |

The Scans can only be ordered by a Medical, Surgical or Radiation Oncologist directly involved in the cancer management of the patient. The ordering Oncologist is responsible for documenting the medical necessity of the scan and that it is within the current list of indications.

### Indications for PET/CT

| Cancer | Indications |
|---|---|
| Breast | Evaluation of recurrence/residual disease, distant metastases (staging/restaging) and disease/therapeutic monitoring |
| Colorectal | Evaluation of recurrence/restaging, distant metastases and disease/therapeutic monitoring |
| Lung | Diagnosis of single pulmonary nodule, staging distant metastases, recurrence/restaging and disease/therapeutic monitoring |
| Head and Neck | Diagnosis of occult and synchronous tumours and recurrence/restaging and radiation planning |
| Lymphoma | Staging, restaging and monitoring |
| Oesophageal | Staging, restaging and monitoring |
| Melanoma | Recurrence/restaging, distant metastases |
| Thyroid | Limited to recurrent disease not confirmed by $I^{131}$ scintigraphy |

## MSI DOCUMENTATION REMINDER

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribed.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptions, or emotional problems, the physician “deliberately established a professional relationship with the patient for the purposes of removing, modifying or retarding existing symptoms,

of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional well being of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy," etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

*Appropriate Documentation is Required on All Claims Submitted*

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service, then the service is not paid for or a lesser benefit is given.

Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

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

## MSI MEDICAL CONSULTANT, MSI MONITORING

*New Staff*

We are pleased to announce that Dr Gayle Higgins has joined the MSI Monitoring department of Medavie Blue Cross earlier this month. Although Dr Karen Sample retired June 30/08 after having spent 13 years with our organization, she has agreed to continue on a part time basis for 6 months to ensure a smooth transition of responsibilities. If you have any MSI related questions or concerns, please do not hesitate to contact Dr Higgins at 496 -7112.


**YOUR HEALTH SERVICES PARTNER SINCE 1943**

COMPETITION #0523508

# MEDICAL CONSULTANT

## MEDICAL SERVICES INSURANCE (MSI)

*Founded in 1943, Medavie Blue Cross provides reliable, cost-effective health, dental, travel, life and disability benefits to more than one million group and individual subscribers.*

*At Medavie Blue Cross we understand that our employees play a key role in building a strong and successful organization. We believe in our people and encourage them to learn and grow within the company. We live up to our core purpose of "improving lives through our products and services, people and expertise" through our strong focus on customer service and access to state-of-the-art technology. Are you looking for challenging, fast-paced and team-oriented work? The career you've been looking for may be waiting for you at Medavie Blue Cross.*

Medavie Blue Cross administers Medical Services Insurance (MSI) programs on behalf of the Nova Scotia Department of Health. We are currently searching for a physician to join the MSI Programs team of the Government Programs Division, in a part-time capacity. Reporting to the Manager, your primary function will be to support the MSI claims adjudication system. In this role, you will be responsible to provide a professional link between the physicians, government and patients. You will also work closely with our client, the Nova Scotia Department of Health, advising on MSI related matters.

As an ideal candidate, you are licenced as a physician in Nova Scotia with a minimum of 15 years experience in a range of practice settings and an understanding of the fee-for-service billing system. A surgical and administrative background would be an asset.

If you are interested in working with a team of professionals in a challenging role and you possess the necessary qualifications, please follow the instructions for applying online via the career section of the Medavie Blue Cross Corporate website at **www.medavie.bluecross.ca** no later than **Friday August 15, 2008.**

MEDAVIE BLUE CROSS™ 65 years

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**www.medavie.bluecross.ca**

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

June 17, 2008 Volume XLII - #2

**In this Issue**



## OPHTHALMOLOGY REVISED UNIT VALUES

Subsequent to the Joint Fee Schedule Committee meeting of December 11, 2007 the following fee revisions were approved for inclusion in the Ophthalmology Section of the MSI Physician's Manual effective May 1, 2008. All *eligible* claims with a service date of May 1, 2008 will be identified and a retroactive payment will be calculated and paid in the fall of 2008. A waiting period of 90 days is required before calculating the retro given that physicians have a three-month period to submit claims for payment.

| Category | Code | Description | Revised Unit Value |
|---|---|---|---|
| CONS | 03.08 | Major Consultation | 37.6 |
| MASG | 21.5A | Excision of lacrimal gland (regions required) | 200 |
| MASG | 21.71 | Dacryocystorhinostomy (DCR) (regions required) | 325 |
| MASG | 22.13B | Excision of malignant eyelid lesion with reconstruction (regions required) | 200 |
| MASG | 23.2B | Strabismus repair one or two muscles same or different eye (age modifier required) AG=CH16 | 180 |
| MASG | 23.2B | Strabismus repair one or two muscles same or different eye (age modifier required) AG=ADUT | 190 |
| ADON | 23.2C | Strabismus repair (additional muscles over two) – plus multiples Age modifier required AG=CH16 | 50 |
| ADON | 23.2C | Strabismus repair (additional muscles over two) – plus multiples Age modifier required AG=ADUT | 30 |
| ADON | 23.99A | Adjustable suture in addition to strabismus repair (regions required) | 100 |
| MASG | 25.55 | Penetrating keratoplasty (with homograft) (regions required) | 345 |
| MASG | 27.72 | Insertion of intraocular lens prosthesis with cataract extraction, one stage (regions required) | 300 |
| MASG | 29.21 | Removal of ocular contents with implant into scleral shell (regions required) | 200 |

| Category | Code | Description | Revised Unit Value |
|---|---|---|---|
| MASG | 29.29 | Other evisceration of eyeball (regions required) | 150 |
| MASG | 29.31 | Enucleation of eyeball with implant into tenon's capsule with muscles (regions required) | 200 |
| MASG | 29.49A | Exenteration and skin graft (regions required) | 350 |
| MASG | 29.94A | Excision of tumor Kronlein Procedure (regions required) | 400 |
| MASG | 29.94B | Tumor – removal by anterior route (regions required) | 300 |
| MASG | 29.94C | Tumor – removal by intracranial route (regions required) | 300 |

## BILATERAL BILLING OF COCHLEAR IMPLANTS

Health Service Code 32.95B: Cochlear implant – to include mastoidectomy and facial nerve decompression (regions required) has been expanded to allow for bilateral billing. A region of RG=BOTH has been added to the service code.

### New Code – ORIF Phalangeal Fractures

Health Service Code 91.32E has been expanded to include phalangeal fractures. The description for this code now reads 'Open reduction and internal fixation using plates and/or screws – phalangeal or metacarpal fractures.'

## UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, June 13, 2008. The files to download are health service (services.dat), health service codes (servdsc.dat) and explanatory codes (explain.dat)

PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

March 26, 2008 Volume XLII - #1

**In this Issue**



## Out of Country Elective Specialized Services

Funding for eligible residents of Nova Scotia who are referred outside of Canada for elective specialized physician services not available in Canada will be considered where it can be demonstrated that the individual has a significant medical problem which has been unresponsive to all reasonable attempts to treat it utilizing services available within Canada and the proposed treatment is of proven medical benefit.

Certain conditions apply to consideration of such requests:

- The province will only consider payment for elective out of country services if prior authorization has been obtained from DoH/MSI.

- Applications for prior approval of elective out of country services must be submitted to the Medical Consultant at MSI by an appropriate specialist whose name is on the Specialist Register of the College of Physicians and Surgeons of Nova Scotia and who is actively involved in the eligible resident's care in NS. A copy of the application must be sent to the Director, Insured Services, DoH.

Applications for elective out of country specialist services must be accompanied by:

- A description of the eligible resident's relevant medical history.
- A description of the medical services requested as well as an estimation of the likelihood of a positive outcome.
- A description of any out of country follow-up requirements.
- Information on the available medical services in Canada and an explanation of why these are not sufficient for the resident's needs.
- When the proposed treatment is a new or emerging medical service, documentation of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.
- A written recommendation in support of the out of country service, confirming that that this is the specialist's recommendation and that the referral is not being provided solely at the request of the patient.

MSI will review the application and provide a response to the referring specialist within 30 days of receiving a complete application.

## UPDATED FILES - Availability

Updated files reflecting changes are available for download on **Friday, March 28, 2008**. The files to download are health service (services.dat), health service codes (serv dsc.dat), and explanatory codes (explain.dat).

## BREAST RECONSTRUCTION – Malignant or Pre-Malignant Conditions

The following health service codes relating to breast reconstruction will no longer require prior approval when performed for malignant or pre-malignant conditions.

| Fee Code | Description |
|---|---|
| 97.31C | Functional pedicled breast reduction (regions required) |
| 97.32B | (Bilateral) functional pedicled breast reduction |

## CORRECTIONS

Previously published incorrectly as 91.32D, bulletin dated December 7, 2007.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| MAFR | 91.32E (RG=RIGT, LEFT, or BOTH) | Open reduction and internal fixation – using plates and/or screws – metacarpal | 105<br><br>Anaesthesia<br>4 + T |

This code is now available for billing. Please refrain from using health service code EC for this service.

### Change in Unit Value

Health service code 26.53 for RG=RIGT and RG=LEFT from 152.55 units to the correct amount of 113 units.

## OUTDATED CLAIMS POLICY (periodic publication)

All original claims must be submitted to MSI within 90 days of the date of service. Claims that are outside of the specified time limitations will only be considered if extenuating circumstances can be demonstrated for a late submission – and prior written approval has been obtained from MSI.

Explanations relating to mislaid, misfiled, or lost claims cannot be accepted by MSI as valid explanations for a late submission.

Claims for registered hospital in-patients must also be submitted within the 90-day time limitation regardless if the patient has been discharged or continues on an in-patient basis. It is incumbent on the physician to obtain the required billing information for these patients and submit claims within the prescribed time limitations. Explanations relating to late discharge summaries, or facilities not consolidating the required information for the physician, cannot be accepted as a valid explanation for a late submission.

Service Encounters submitted over the 90-day time limitation will be adjudicated to pay "zero" with the following exceptions:

a. Reciprocal billing claims (out of province) must be submitted within 12 months of the date of service.

b. Resubmission of refused claims or incorrect billings. These claims must be resubmitted to MSI within 6 months (185 days) of the date of service. Each resubmission must contain an annotation in the text field of the Service Encounter submission referencing the previous Service Encounter Number. Please note: Failure to annotate the text field with the previous Service Encounter Number will result in an adjudication paid at "zero."

c. Shadow Services: Although the system rules are not applied to these services, in the interests of maintaining appropriate and comprehensive records, you are encouraged to submit these services within the prescribed time lines.

MSI would also like to bring to your attention the significance of the clause concerning "prior written approval." Prior authorization for a late submission is granted at the discretion of the Manager, MSI Programs.

This authorization is rarely withheld when a reasonable explanation for an expected delay is provided. Conversely, requests for late submissions, after the claims have already become outdated, are rarely authorized unless true extenuating circumstances can be demonstrated.

In situations where you know that your claims will not be submitted within the prescribed time lines, loss in revenue can be largely avoided with a simple one-page fax to MSI requesting an extension.

# Bulletin

Ontario

| Bulletin Number | Date | Direct inquiries to |
|---|---|---|
| 4460 | November 30, 2007 | Ministry of Health and Long-Term Care Office Locations |
| Distribution | | (address below) |
| Physicians, Hospitals, Clinics and Laboratories | | |

Subject: **Health Card Security Enhancements**

The Ministry of Health and Long-Term Care recognizes the importance of having a secure Health Card and is introducing changes to enhance the security of its current card. These additional security enhancements will make the Health Card more tamperproof and counterfeit resistant. In order to further protect personal health information, address information has been removed from the back of the Health Card.

Ontarians will not receive an enhanced Health Card until their current card expires, or a replacement card is required. Both the red and white and the current photo health card remain acceptable as proof of entitlement to medically necessary insured health services providing they are valid and belong to the person presenting the card.

The additional security features include:

- A new security background
- Secondary photo and signature
- Tactile features (Health Number, Version Code, and Ontario trillium logo)
- A 2D bar code


This image is provided as a sample only to illustrate the enhanced Health Card.

**Office locations**

**Barrie**
34 Simcoe St.
Suite 102
L4N 6T4

**Mississauga**
201 City Centre Dr.
P.O. Box 7020, Stn. A
L5A 3M1

**Owen Sound**
1400 1st Ave. W
Suite # 2.
N4K 6Z9

**Thunder Bay**
435 James St. S.,
Suite 113
P7E 6T1

**Etobicoke**
3300 Bloor St. W., Unit 142
M8X 2W8

**Newmarket**
465 Davis Dr.
Unit 108
L3Y 8T2

**Peterborough**
550 Lansdowne St. W.
K9J 8J8

**Timmins**
38 Pine St. N.,
Suite 110
P4N 6K6

**Hamilton**
119 King St. W
P.O. Box 2280, Stn. A
L8N 4C8

**North Bay**
101-447 McKeown Ave.
P1B 9S9

**St. Catharines**
301 St. Paul St.
Mezzanine Level
L2R 3M8

**Toronto**
47 Sheppard Ave.E.
Suite 417
M2N 7E7

**Kenora**
220-808 Robertson St.
P9N 1X9

**North York**
4400 Dufferin St N
M3H 6A8

**Sarnia**
452 Christina St. N.
N7T 5W4

**Toronto-Downtown**
777 Bay St,
Suite M212
M5G 2C8

**Kingston**
1055 Princess St.
P.O. Box 9000
K7L 5A9

**Oakville**
Oakville Town Centre II
220 North Service Rd. W.
L6M 2Y3

**Sault Ste. Marie**
Roberta Bondar Place
70 Foster Dr., Ste. 100
P6A 6V4

**Windsor**
1427 Ouellette Ave.
N8X 1K1

**Kitchener**
1400 Weber St. E. Unit B2
N2A 3Z8

**Oshawa**
Exec. Tower,
Oshawa Centre.
419 King St. W.
P.O. Box 635 L1H 8L4

**Scarborough**
2063 Lawrence Ave. E.
M1R 2Z4

**Head Office**
P.O. Box 48
Kingston, ON
K7L 5J3

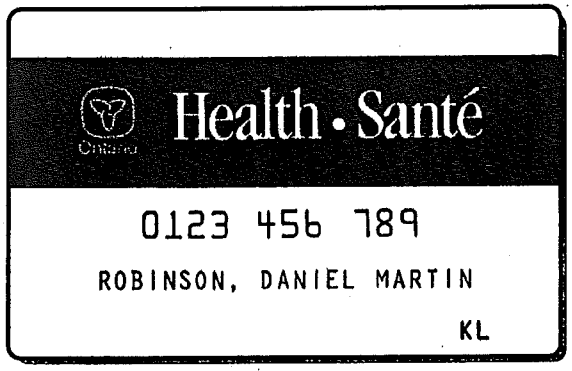
**London**
217 York St., 5th Floor
Station A
N6A 4L6

**Ottawa**
Fuller Building
75 Albert Street
K1P 5Y9

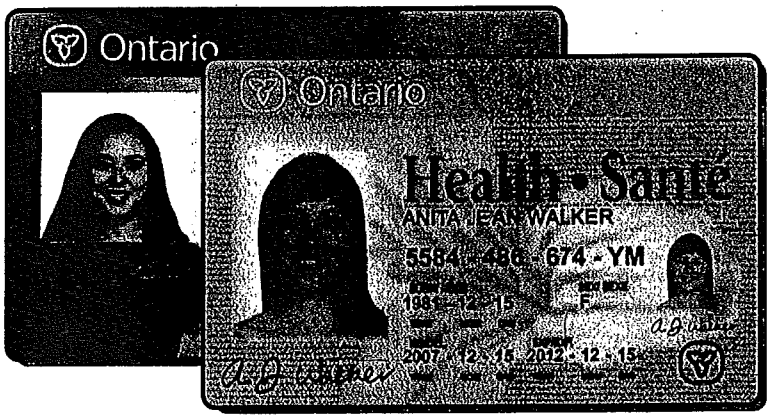
**Sudbury**
199 Larch St.,
Suite 801
P3E 5R1

# It is important to carry your health card at all times

You may have a red and white




or photo health card.




Either card is acceptable for insured health services, but it must be valid and belong to you.

Ontario

# Manitoba Memorandum

DATE: January 16, 2008

TO: IHIACC Members

FROM: D. Slobogian-Jones
Manager
Out-of-Province
Benefits/Reciprocal
Agreements
PHONE NO: 204-786-7380
EMAIL: Deb.Slobogian-Jones@gov.mb.ca

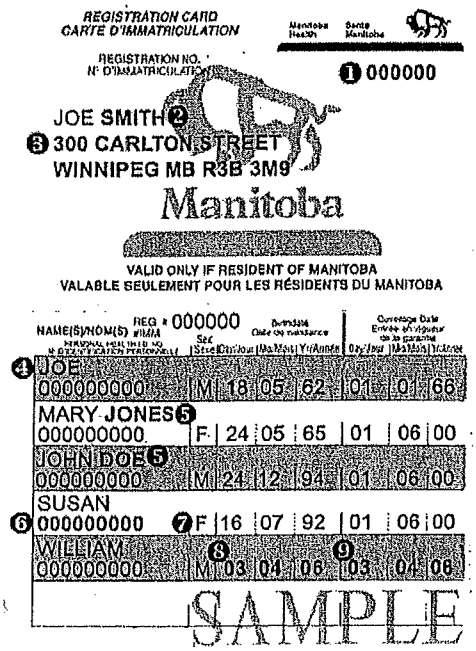
SUBJECT: **Manitoba Health Card Enhancement**

Please find below a copy of Manitoba Health's enhanced Health Card. The main added feature on the enhanced card is that all alternate surnames are clearly shown beside each family member

Manitobans will receive the enhanced Health Card when their current card needs to be replaced (address changed, etc), or if newly registering to the province. Both the old and the new card will remain acceptable as proof of entitlement to medically necessary insured health services providing they belong to the person presenting the card.

If you have any questions, please feel free to contact me at the phone number provided above.

## *HOW TO READ THE MANITOBA HEALTH REGISTRATION CARD*




1. **This is the Manitoba Health Registration Number.** This is always a maximum of 6 (six) numeric with no alphabetic characters. eg. 000000
2. **This is the Family Surname.** This person is designated as the head of the family. *All correspondence is addressed to this person. eg. Joe Smith*
3. **This is the Family Address.** eg. 300 Carlton Street Winnipeg MB R3B 3M9
4. **This is the Patient's Given Name.** eg. Joe
5. **This is the Patient's Alternate Surname.** Claims must be submitted using the Alternate Surname. *There can be multiple surnames on the Manitoba Health Card. eg. Jones, Doe, and Smith.*
6. **This is the Patient's Personal Health Number.** This is found under the Given Name and is always 9 (nine) numeric with no alphabetic characters. eg. 000000000
7. **This is the Patient's Sex – Male or Female.** eg. M
8. **This is the Patient's Date of Birth (Day/Month/Year)** eg. 24/12/94
9. **This is the Patient's Effective Coverage Date (Day/Month/Year).** The Coverage Date indicates the day the Patient becomes eligible for Health Benefits. eg. 03/04/06

Manitoba