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 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** 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** 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** With rupture of the external and internal anal sphincter, and rectal mucosa intact – meticulous, layered anatomic reapproximation. Consultation and procedure. *Not billable with:* HSC **87.82B** Obstetrical Trauma – Repair 4th degree laceration HSC **61.69E** Repair of anal sphincter HSC **61.69F** Repair of anal sphincter and anorectal ring HSC **83.61** Suture of vulva and perineum *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** With rupture of the external, internal anal sphincter, and rectal mucosa – meticulous, layered reapproximation. Consultation and procedure. *Not billable with:* HSC **87.82A** Obstetrical Trauma –Repair 3rd degree laceration HSC **61.69E** Repair of anal sphincter 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 *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) Used in the surgical management of severe post partum hemorrhage secondary to uterine atony, to include ligation of uterine and ovarian vessels as required. *Not Billable with:* HSC **87.94A** Repair of Inverted Uterus HSC **80.3** Total Abdominal Hysterectomy *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. 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** 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 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) 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 (25 with RO=SRAS)
OBST	79.4A	Suture of incompetent cervix during pregnancy	75 4+T (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
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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:	

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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