PHYSICIANS' BULLETIN

msi
NOVA SCOTIA MEDICAL SERVICES INSURANCE

March 28, 2013 Volume XLIX - #2

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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 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).