PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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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 • 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 • 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. • Both physicians must keep a detailed record of the phone call	11.5
VIST	Comprehensive reassessment of a cancer patient • 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) 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

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