PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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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 RG=LEFT RG=RIGT RG=BOTH	**Repeat Ulnar Nerve Release at the elbow (cubital tunnel)** 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. Billing Guidelines: Not to be billed with: • HSC 17.05D Explore peripheral nerve transplant or transposition with/without neurolysis, or • HSC 17.5A Exploration of peripheral nerve transplant or nerve transposition with or without neurolysis. Specialty Restrictions: • PLAS • ORTH • GNSG • NUSG	200 4+T

Category	Code	Description	Unit Value
ADON	46.04L	**Intraoperative Placement of Interpleural Catheter for Paravertebral Block** 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. Billable with flank incisions only (see list under Billing Guidelines). Billing Guidelines: May be billed with the following MASG procedures that require a flank incision: • 52.4A Retro-peritoneal lymph node dissection • 67.3 Partial nephrectomy (regions required) • 67.41E Radical nephrectomy lumbar of thoraco-abdominal (regions required) • 67.79A Pyeloureteroplasty (regions required) Specialty Restrictions: • UROL Not to be billed with: • PMNO 16.91M – Acute pain management (non-obstetrical) consultation unrelated to delivery of 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 (nonobstetrical) insertion of CPNB catheter in conjunction with anaesthesia SP=ANAE 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, e.g. 25000 diabetes mellitus
Close contact of at risk individual	V018
Well Senior	V069