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)** 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** 2 Level cervical Laminoplasty to include osteotomies, and insertion of hardware for fixation of lamina, with duraplasty and lysis of adhesions as required. For the treatment of cervical myelopathy and myeloradiculopathy Not to be billed with laminectomy codes: 16.09A through D 16.1A and B 16.2A and B 16.3A through C 16.49A 16.5A and B 16.93D	500 8+T
MASG	90.40B	**Repair of Sternal Non-union** 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. Not to be billed with: 90.4A Reclosure of sternal wound….150 98.79A Reclosure of sternal wound….150 (regions required) 90.69B Removal of internal fixation-metal plate, band, screw or nail….71 (regions required) 89.3A Sternal Split 200 MSU Not to be billed with BOGR codes. For example: BOGR 90.00A Bone graft – clavicle….175 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** 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. Not to be billed with HSC 66.19 Other Laparotomy, or HSC 66.83 Laparoscopy. RG=ASCE – Ascending RG=DESC – Descending RG=DTSE – Other Segments	350 8+T
MASG	60.52B	**Laparoscopic Assisted Anterior Resection** 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. This is intended to be a comprehensive fee for the entire procedure. 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** 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. 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** To be used for open, complex fasciectomy for excision of Dupuytren's disease involving the palmar fascia. To include local tissue shifts, Z plasty, harvesting and placement of skin graft as required for wound closure. Not to be billed with 98.51C, 98.51D Local Tissue shifts – Z plasty and flaps, skin grafts. **Clinical example:** 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)** 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. To include any necessary joint or tendon releases; local tissue shifts, Z plasty, harvesting and placement of skin graft as required for wound closure. Not to be billed with: 98.51C, 98.51D Local Tissue shifts – Z plasty and flaps, 95.01 incision of tendon sheath, 92.63A Excision (capsulectomy, synovectomy, debridement) of metacarpophalangeal joint. 93.79B, C, or E Arthroplasty or reconstruction of interphalangeal and/or metacarpophalangeal joint(s). **Clinical example:** 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** 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. *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** Tomosynthesis of both breasts for diagnostic purposes 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. *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 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** 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: 1. Visual inspection of the vulva and perineum 2. Insertion of the speculum into the vagina to inspect the vault and cervix 3. Bimanual examination of the pelvis 4. Conduction of a pelvi-rectal examination where indicated. Billing Guidelines Not billable with Pap smear VADT 03.26A, or ADON 03.26B	10.5
ADON	**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) 67.41G Nephro-ureterectomy with resection of ureterovesical junction (regions required) 67.79A Pyeloureteroplasty (regions required) <u>Not to be billed with:</u> 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)** 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)** 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** Posterior Fossa Craniotomy for the excision of intracranial, infratentorial lesions, such as cysts, tumors or intracerebral hematoma. Billing Guidelines: May be billed with ADON 15.12B Duraplasty	975 14+T

Category	Description	Unit Value
MASG	**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.	125 4+T
MASG RP=REPT	**Repeat Ulnar Nerve Release at the elbow (cubital tunnel)** 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. **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.	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** Abdominal approach to the removal of the uterus without the cervix. 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. 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** Abdominal approach to the removal of the uterus without the cervix, with repair of rectocele and/or cystocele. 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. 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** Removal of the uterus and cervix using the abdominal approach. 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** 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.

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** Abdominal approach to the removal of the uterus and cervix, with retropubic incontinence repair such as urethropexy. This is intended to be a comprehensive fee for the entire procedure. Not to be billed with HSC 71.5A Urethrovesical Suspension for Stress Incontinence.	287 6+T
MASG	80.4	**Vaginal Hysterectomy** Removal of the uterus and cervix using the vaginal approach. 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** Vaginal approach to the removal of the uterus and cervix, with repair of rectocele and/or 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	287 6+T

Category	Code	Description	Unit Value
VEDT	16.91R	Continuous Conduction Anaesthesia for relief of pain in labour 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. To be billed only by the physician who initiates the epidural. Once per patient per labour. 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:

Carol Walker
Senior Policy Analyst
Doctors Nova Scotia
(902)468-8935 ext. 238 or carol.walker@doctorsn.com

Patrick Riley
Manager, Physician Master Agreement
Nova Scotia Department of Health and Wellness
(902) 424-2155 or patrick.riley@gov.ns.ca

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, e.g. 25000 diabetes mellitus
Close contact of at risk individual	V018
Well Senior	V069