PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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On-line documentation available at :

www.gov.ns.ca/health/physicians_bulletin

UPCOMING FEES

NOTE: Please hold all eligible service encounters to allow MSI the required time to time to update the system. Once a new Health Service Code has been assigned, it will be published in the MSI Physicians' Bulletin.

The following fees have been approved for inclusion into the Fee Schedule, effective August 1, 2013:

Category	Description	Unit Value	
VEDT	**EVAR – endovascular abdominal aortic aneurysm repair with stent graft**		
	RO=FPHN Vascular surgeon or Interventional radiologist only	380	15+T
	RO=SPHN Vascular surgeon or Interventional radiologist only	228	

Endovascular abdominal aortic aneurysm repair using stent grafting.

Billing Guidelines:
This is a comprehensive fee to include preoperative planning and measurements, arteriotomy(ies) as required, the insertion of all catheters including initial access, intra-operative angiography, interpretation of any images taken at the time of the procedure, balloon angioplasties within the treatment zone, iliac endarterectomy, angioplasty, and/or repair as required, and removal of access catheters with any necessary closure of vessels.

Preamble rules 9.3.3(g) apply.

Second physician specialty restriction is the same as for first physician.

Coming in September!

A new MSI website to better serve you.

New features include:

- A frequently asked questions section
- A searchable PDF of past copies of the MSI bulletin
- Electronic subscription functionality

Watch for it!

Not to be billed with:
MASG 50.37A Aortic graft plus bilateral femoral artery repair
Any additional angioplasties to be billed at LV 50 to a maximum of four, stents billed as ADON 51.59Q to a maximum of four.

Specialty Restriction:
Vascular surgery
Interventional radiology

Location:
Hospital

Category		Unit Value
VIST	**Initial Geriatric Inpatient Medical Assessment**	38.1

Description:
This fee is for the complete initial assessment of the geriatric hospital inpatient, age greater than or equal to 65 years, by the family physician most responsible for the patient's ongoing inpatient hospital care.
Billed only once per patient per admission. May not be billed again for 6 months for the same patient.
This complete assessment is to include all of the following elements and be documented in the health record – include all positive and pertinent negative finds (based on *Guidelines for Medical Record-keeping 2008,* CPSNS):

1. Complete history: Extended history of the Chief Complaint, review of systems related to the problem, complete past medical and social history, pertinent family history.

2. Comprehensive Physical Examination: Extensive examination of the affected body area(s) and related system(s) plus extensive multisystem examination (3 or more systems in total).

3. Review of patient's hospital documents relating to current and prior visits.

4. Obtaining collateral history and information from caregivers.

5. Performance of a complete medication review to include collateral information from pharmacy and long term care facility as appropriate.

6. Obtaining advanced care directives (code status).

7. Reviewing and documenting relevant laboratory, imaging, and other test results pertaining to the present visit.

8. Formulating diagnoses and identifying important issues affecting the present admission.

9. Initiating an appropriate and timely management plan including a treatment plan, further investigations, advanced care planning and specialist or interdisciplinary consultation.

Billing Guidelines:
Not to be billed for transfers within the same hospital.

Recognized Systems:
- Eyes
- Ears, nose, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

Specialty Restriction:
GENP

Location:
Hospital only

Category		Unit Value
VIST	**Geriatrician's Initial Comprehensive Geriatric Consultation to Include CGA (Comprehensive Geriatric Assessment)**	150

Description:
For the comprehensive assessment of the frail patient 65 years or older (frailty as characterized by low functional reserve, decreased muscle strength, and high susceptibility to disease). To be billed only when the entire assessment is performed by a physician with a Geriatric Medicine Subspecialty or Internal Medicine plus completion of a minimum 8 weeks training (PGY4 or greater) in geriatric assessment. The Comprehensive Geriatric Assessment will include all of the following elements and be documented in the heath record in addition to Start and Stop times. Assessment required a minimum of 90 minutes of patient to physician contact.

A) Assessment of cognition – usually using the Mini-Mental State Examination. If cognitive impairment is present, whether it meets the criteria for dementia, delirium or depression.
B) Other aspects of the mental state. Such as the presence of depression or other mood disorder. The presence of perceptual disturbances. Motivation. Health attitude.
C) Evaluation of special senses – functional ability in speech, hearing and vision is recorded.
D) Neuromascular examination to assess strength and specifically to evaluate deconditioning.
E) A functional assessment of mobility and balance to include detailed recording of the hierarchal assessment of balance and mobility (MacKnight C., Rockwood K., A hierarchical assessment of balance and mobility, Age and Ageing, 1995;24:126-130) is carried out.
F) Bowel and bladder function is recorded.
G) A brief nutritional screen focusing on weight and appetite is completed.
H) Functional capacity in personal instrumental and basic activities of daily living is recorded.

I) Sleep disruptions are recorded as is the presence of daytime somnolence.

J) Social Assessment. To include information about the extent of social engagement, the presence of a caregiver, the marital state and living arrangements of the individual, condition of the house and whether or not they need to be able to navigate stairs in order to be safe at home. The presence of supports is recorded as well as some information about the caregiver, including their coping ability, their own health and their outlook.

K) Documentation of advanced care directives.

CGA procedure: Note 1: For people being assessed during an acute illness, items D through H are recorded both for the baseline state (2 weeks previously) and currently.

CGA procedure Note 2: All this information is in addition to the general medical information recorded in the general medicine consult.

Billing Guidelines:
Time based fee requiring a minimum of 90 minutes.
Greater than 80% of time must be spent in direct patient contact.
No other fee codes may be billed for that patient in the same time period.

This Initial Assessment may be billed only once per patient per lifetime.

Specialty Restriction:
Geriatric Medicine
Internal Medicine with a minimum of 8 weeks recognized Geriatric subspecialty training (PGY4 level or greater)

Location:
Hospital/Clinic/Office

Category		Unit Value
MASG	**Esophagectomy with immediate reconstruction by Interposition of Hollow Viscus (Stomach, colon, or small bowel)**	1000
	AP=ABDO	7+T
	AP=CERV	6+T
	AP=THOR	13+T

Description:
This is a comprehensive fee for the total, or near total (greater than 2/3) removal of the esophagus with immediate reconstruction using the interposition of a hollow viscus stomach, colon, or small bowel), includes esophagogastrostomy, vagotomy, proximal gastrectomy, pyloromyotomy, bowel mobilization and preparation, and feeding tube placement where required.

Billing Guidelines:
Not to be billed with:
MASG 54.33A Resection of esophagus one stage
MASG 54.42 Esophagogastrostomy (intrathoracic)
MASG 54.43 Esohageal anastomosis with interposition of small bowel
MASG 54.44A Esophageal bypass with colon/jejunum
MASG 54.45 Esophageal anastomosis with interposition of colon intrathoracic

MASG 54.47 Esophageal anastomosis with other interposition (intrathoracic)
MASG 46.2 Medistinal tissue destruction
MASG 55.1 Percutaneous gastrostomy
MASG 55.3 Pyloromotomy
MASG 55.5 Partial gastrectomy with anastomosis to esophagus
MASG 58.39A Percutaneous jejunostomy

Specialty Restriction:
GNSG, THSG

Location:
Hospital Only

Category		Unit Value	
MASG	**Comprehensive Anal Sphincteroplasty for the Treatment of Anal Incontinence**	220	4+T

Description:
Comprehensive fee for the layered repair of the anal sphincter complex for the treatment of anal incontinence. Includes repair of internal and external anal sphincter, approximation of transverse perineal muscles, reattachment of bulbocavernosus muscles and perineal body reconstruction.

Billing Guidelines:
Not to be billed for acute anal sphincter trauma (use HSC 61.69E for acute non-obstetrical trauma, and HSC 87.82A or B, as appropriate, for acute obstetrical trauma). Not to be billed with MASG 83.61 (suture of vulva and perineum).

Specialty Restriction:
GNSG, OBGY

Location:
Hospital Only

Category		Unit Value	
ADON	**Multiple births by Caesarian Section**	35	Time only

Description:
This fee is an add on to HSC 86.1 Cervical Caesarian Section, or 86.1A Caesarian Section with tubal ligation when greater than one delivery is performed. This compensates for the additional complexity of multiple births.

Billing Guidelines:
May be billed by the primary surgeon only, once per patient for multiple births by caesarian section. No matter how many births, this fee may only be billed once. Not to be added to the GP delivery fee.

Specialty Restriction:
OBGY

Location:
Hospital Only

NEW FEES

Note: Physicians holding eligible services must submit their claims from May 1, 2013 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.

Effective May 1, 2013 the following new health service code is available for billing:

Category	Code		Unit Value
VIST	03.03G	**Examination of a victim of an alleged sexual assault and evidence collection** Description: This all-inclusive fee includes all aspects of the medical history, the medical, psychological and forensic examination, including collection of evidence according to the protocol prescribed by the Department of Justice for the investigation of an alleged sexual assault and the initial medical treatment of the victim by the physician. Billing Guidelines: Not to be billed with any other fees during the same time period. To be eligible for this fee, the evidence must be collected and the documentation submitted according to the Dept of Justice protocol. Specialty Restriction: GENP, EMMD, COMD Location: Regional Hospitals only *Physician Testimony – Sexual Assault Prosecution* In the event that a charge of sexual assault is laid and a prosecution results, a physician may be subpoenaed by the Crown to testify in court. All costs associated with preparation for that court appearance and testifying in court should be submitted in an invoice to the Nova Scotia Public Prosecution Service by the physician.	245 MSU + 15 units per 15 mins after 3 hours (maximum 6 x 15 min time intervals)

Effective June 1, 2013 the following new health service codes are available for billing:

Note: Physicians holding eligible services must submit their claims from June 1, 2013 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).

Category	Code	Modifiers		Unit Value
MASG	94.13E	RG=LEFT RG=RIGT RG=BOTH	**Release of a single digit including the interphalangeal joint(s) for Dupuytren's disease**	120 4+T

Description:
Release of Dupuytren's contracture of a single digit including PIP and/or DIP joint to be used when palmar disease is not present. Dupuytren's involvement of digit must include the PIP and/or DIP 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.

Billing Guidelines:
Not to be billed with 98.51 C, 98.51 D Local Tissue shifts - Z plasty and flaps, 95.01 incision of tendon sheath,
92.63 A Excision (capsulectomy, synovectomy, debridement) of metacarpophalangeal joint,
92.63 B Excision (capsulectomy, synovectomy, debridement) of interphalangeal joint.
93.79 B, C, or E Arthroplasty or reconstruction of interphalangeal and/or metacarpophalangeal joint(s)

ADON 94.13D may be added if multiple digits are involved without palmar surgery.

Specialty Restriction:
PLAS, ORTH (With proof of Hand Fellowship)

Location:
Regional Hospitals only

Category	Code	Modifiers		Unit Value
CRCR	03.05	IN=CP01 IN=CP10 IN=CP11 ME=ECMO	**Comprehensive care for patient requiring Extracorporeal Membrane Oxygenation (ECMO)** Description: For the comprehensive care of the patient in the ICU/Critical care unit requiring ECMO Billing Guidelines: This replaces other critical care daily fees when the physician is responsible for critical care, ventilatory support, and manages extracorporeal membrane oxygenation for the patient in a designated intensive care area. Preamble rules as per Critical care/intensive care apply. Location: IWK and QEII Critical Care Units	First Day 205.08 Day 2-10 inclusive 102.9 Eleventh Day Onward 51.45

Effective July 1, 2013 the following new Workers' Compensation Board fee is available for billing:

Note: Physicians holding eligible services must submit their claims from July 1, 2013 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).

Category	Code	Modifiers		Value
WCB	WCB20		**Carpal Tunnel Syndrome (CTS) Form Payment** Description: To be claimed for completion of the carpal tunnel syndrome form located on the WCB website (http://www.wcb.ns.ca). Billing Guidelines: This fee includes a visit as well as completion of the form. This form is only to be used upon request from the WCB case worker. Specialty Restriction: GENP	$123.40

Effective September 1, 2013 the following new health service code will be available for billing:

Category	Code	Modifiers		Unit Value
ADON	13.59L	RO=MENQ	**Meningococcal Quadrivalent vaccine** Description: For high risk individuals with the following conditions: (one dose) splenic disorders; complement, properdin, factor D or primary antibody deficiencies; post exposure prophylaxis for Meningococcal A, C, Y, W-135 serotypes and (three doses) for hematopoietic stem cell transplant.	6

PATHOLOGY FEE INCREASE

Effective July 1, 2013 the following pathology fees will be increased by 25% (Relative calculations are based on Preamble Section 7.4.2):

Code	Description	Old Fee Value	New Fee Value
P2325	Surgicals, gross and microscopic	19.08	23.85
P3325	Surgicals, gross and microscopic (premium 35%)	28.08	32.85
P5325	Surgicals, gross and microscopic (premium 50%)	28.62	35.78
P2328	Interpretation - fine needle aspiration biopsy	15	18.75
P3328	Interpretation - fine needle aspiration biopsy (premium 35%)	24	27.75
P5328	Interpretation - fine needle aspiration biopsy (premium 50%)	24	28.13
P2332	Interpretation and report - NON GYN cytology slides	5.61	7.01
P3332	Interpretation and report - NON GYN cytology slides (premium 35%)	14.61	16.01
P5332	Interpretation and report - NON GYN cytology slides (premium 50%)	14.61	16.01
P2345	Surgicals, gross and microscopic - three or more separate surgical specimens	29.62	37.03
P3345	Surgicals, gross and microscopic - three or more separate surgical specimens (premium 35%)	39.99	49.99
P5345	Surgicals, gross and microscopic - three or more separate surgical specimens (premium 50%)	44.43	55.55
P2346	Surgicals, gross and microscopic - single large complex CA specimen including lymph nodes	29.62	37.03
P3346	Surgicals, gross and microscopic - single large complex CA specimen including lymph nodes (premium 35%)	39.99	49.99
P5346	Surgicals, gross and microscopic - single large complex CA specimen including lymph nodes (premium 50%)	44.43	55.55

NOTE: Please continue to submit claims for these services in the usual manner. Once MSI updates the system it will be published in the MSI Physicians' Bulletin. Claims for these codes with a service date from July 1, 2013 to fall 2013 will be identified and a reconcilliation will occur in the winter of 2013. The reconciliation will be calculated after the 90 day waiting period for submission of claims.

PREAMBLE REVISIONS

8.3.3 Obstetrical Delivery
(b) Multiple Deliveries

(i) Multiple vaginal births are paid additional fees.
(ii) In the case of multiple births, when both a vaginal delivery and a Caesarean Section must be performed, the C-section is claimed at full fee and the vaginal delivery at 65%.
(ii) **When multiple babies are delivered by Caesarean Section, one service encounter may be made with the addition of the fee for multiple births by caesarian section where appropriate.**

BILLING REMINDERS

Endometrial Ablation (HSC 80.19A) - Unbundling of Procedural Code

Preamble section 9.3.3 prohibits the unbundling of procedural codes into constituent parts and billing MSI separately for them as well as claiming for the means used to access the surgical site. Therefore, when claiming HSC 80.19 A Endometrial ablation including D&C it is not appropriate to also claim for HSC 80.81 Hysteroscopy, 81.09 D&C, 81.09A Endocervical Curettage, 81.69A Endometrial Biopsy, 80.19B Endometrial Polypectomy or 03.26 Gynaecologic Examination as these are part of the endometrial ablation.

Billing for Institutional Visits

MSI staff have recently had a number of inquiries regarding billing for institutional visits. Institutional visits may be claimed for services provided in licensed and approved chronic care hospitals, residential centres, nursing homes and homes for special care. These visits may not be claimed for seniors' apartments or unlicensed boarding homes. The latter should be claimed using the appropriate home visit codes. For both institutional and home visits, there must be a specific request for the physician to visit the patient for a specific medical problem. It is not permitted to claim for regular "rounds" or visits either in institutions or a patient's home in the absence of such a patient-specific request.

ANNOUNCEMENTS

Nova Scotia Locum Program – Important Update

Please be advised that effective **Monday July 22, 2013**, the administration of the Provincial Locum Program will be managed through Medavie Blue Cross.

As of July 22, 2013, all completed application forms, payment claim forms and queries are to be sent to Locumprogram@medavie.ca or via local fax at (902) 496-3060. Toll free fax is 1-855-350-3060.

Completed application forms and payment claim forms can also be sent to the following mailing address:

MSI – Locum Program
PO Box 500
Halifax, NS B3J 2S1

If you have any questions regarding the Locum program, please contact Jillian Hounsell at (902) 496-7104 or via email at Locumprogram@medavie.ca

Please take note that only the administration of the Locum program has changed. All criteria, payment rates and approved Locum guidelines remain the same. Current Locum program application and payment claim forms, including approved Locum program guidelines can be found on the following website: Physicians.NovaScotia.ca

New Medical Consultant

We are pleased to announce that Dr. Scott Farrell has joined the MSI Program's team at Medavie Blue Cross as the new part-time Medical Consultant. Dr. Scott Farrell and Dr. Andrew Watson will be working as part-time Medical Consultants. If you have any MSI Assessment related questions for the Medical Consultants they can be reached at 496-7145 or by e-mail at MSI_MedicalConsultant@medavie.bluecross.ca.

EXPLANATORY CODES

The following new explanatory codes have been added to the system:

AN003 Service encounter has been refused as this service can only be claimed by Anaesthesiologists.

GN062 Service encounter has been refused as you have not supplied the start and end times in the electronic text field.

MA033 Service encounter has been refused as you have previously claimed health service code 26.62 or 26.62B at the same encounter.

MA034 Service encounter has been refused as you have previously claimed a composite cataract fee at the same encounter.

MJ041 Service encounter has been refused as you have already billed a service that is included in this fee.

MJ042 Service encounter has been refused as you have already billed HSC 94.13E at the same encounter.

PP026 The remainder of your claims have been forwarded to MSI Pharmacare for review.

VT109 Service encounter has been refused as no other fees are payable during the same time period as 03.03G.

VT110 Service encounter has been refused as HSC 03.03G is not payable when other fees are billed during the same time period.

UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, July 19th, 2013. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), modifier values (MODVALS.DAT), and explanatory codes (EXPLAIN.DAT).