PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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NOTICE TO PHYSICIANS

Inside this Issue

System modifications regarding the following health service codes have been implemented. Updated files reflecting changes are available for download on Friday, February 27, 2009. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanation code (EXPLAIN.DAT), and modifier values (MODVALS.DAT)

REMOTE ORTHOPAEDIC CONSULT WITH REVIEW OF PACS IMAGES

The following new temporary Health Service code has been approved for inclusion in the Fee Schedule effective January 1, 2009 until June 30, 2009.

A Remote Orthopaedic Consult with Review of PACS Images will be insured as part of a pilot study that will occur over a six month period commencing January 1, 2009 and billable by Orthopaedic Specialists only.

Category	Code	Description	Unit Value
CONS	03.09D	Remote Orthopaedic Consult With Review Of PACS Images	25

Billing Guidelines:

- This fee may be billed when a physician working in an Emergency Department or a surgeon encounters a complex orthopaedic problem that requires the opinion of an orthopaedic surgeon practicing in the area of concern. The consultant orthopaedic surgeon reviews the PACS (or other such image archival system) images and provides telephone advice to the referring physician and follows up with a formal written report to the referring physician.
- The report must document the history, the presenting complaint, the discussion with the referring physician concerning the patient's physical condition, the results of the review of the PACS images, the consultant's opinion and recommendations for management of the patient in their local community.
- The referring physician must also document that a telephone consultation was requested and provided.
- The referring physician and the orthopaedic consultant must be situated in different facilities.
- If the patient is subsequently seen by the orthopaedic consultant for a comprehensive or limited consultation within 30 days of the Remote Orthopaedic Consult with Review of PACS Images, the consult will not be paid.
- The Remote Orthopaedic Consult with Review of PACS Images is only payable once per case per patient.
- This fee may not be claimed where the purpose of the phone call is only to:
  - Arrange for diagnostic investigations
  - Discuss the results of diagnostic investigations

CASE MANAGEMENT CONFERENCE FEE

A case management conference is a formal, scheduled, multi-disciplinary health team meeting. It is initiated by an employee of the DHA/IWK to discuss the provision of health care to a specific patient. The Case Management Conference Fee is being implemented for both General Practitioners and Specialists.

The following new permanent Health Service code has been approved for inclusion in the Fee Schedule effective January 1, 2009:

Category	Code	Description	Unit Value
VIST	03.03D	Case Management Conference	14 units per 15 minutes for a GP and 16.5 units per 15 minutes for Specialists

Billing Guidelines

- It is a time based fee paid at the sessional rate in 15 minute increments.
- To claim the case conference fee, the physician must participate in the conference for a minimum of 15 minutes and remuneration will be calculated in 15 minute time increments based on the sessional rate. Start and finish times are to be recorded on the patient's chart.
- 80% of a 15 minute time interval must be spent at the conference in order to bill that time interval.
- Neither the patient nor the family need to be present.
- It may be claimed by more than one physician simultaneously as necessary for case management.
- The case conference must be documented in the health record with a list of all physician participants.

The following is an example of claiming Multiples for case conferencing:

Minutes	Multiples	Units	
		GP	Specialist
15	2	14	16.5
30	3	28	33
45	4	42	49.50
60	5	56	66
75	6	70	82.50
90	7	84	99
105	8	98	115.50
120	9	112	132

NEW MODIFIER VALUE

The Department of Health requested the implementation of a new modifier in order to differentiate and track the volume of day time emergency visits in Level 3 and 4 community hospital Emergency Departments versus planned/scheduled outpatient visits. Physicians should continue to bill unscheduled emergency visits using the appropriate visit code including the unscheduled modifier US=UNOF. The new modifier is US=SCHD and it should be included on service encounters in the Outpatient Department that are planned in advance. The time frame for these services is 8:00am – 8:00pm including Saturdays, Sundays and Holidays.

NEW EXPLANATORY CODES

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

VT087	Service encounter has been refused as you have previously been approved this service for this diagnosis.
VT088	Service encounter has been refused as you or another provider have previously been approved this service for this diagnosis.
VT089	Service encounter has been refused as functional center is not indicated.
NR081	Service encounter has been adjudicated according to the weekly maximum of 80 units per week after 56 days from admission.

Effective April 1, 2009 – March 31, 2010

MSI Medical Service Unit (MSU) and Anaesthesia Service Unit (AU)

MSU	$2.26
AU	$16.15

WCB Medical Service Unit and Anaesthesia Service Unit

MSU	$2.51
AU	$17.94

ATTENTION PHYSICIANS

When requesting confidential information from MSI Registration and Enquiry such as Health Card numbers or expiry dates please ensure you have your 6-digit Provider Number available for identification purposes.