PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

July 18, 2014 Volume L #4

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NEW FEES

Note: Physicians holding eligible services must submit their claims from April 1, 2014 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 April 1, 2014 the following new health service codes are available for billing:

Category	Code	Description	Unit Value
MASG	17.5C	**Nerve Transfer with Microneural Coaptation for the treatment of proximal 3rd, 4th, or 5th degree nerve injury to the brachial plexus or other major peripheral nerve:** This is a time-based, comprehensive fee for nerve transfer using microneural coaptation, with the surgical microscope, of a healthy donor nerve (distal) to the injured recipient nerve (proximal). This procedure is for proximal 3rd, 4th, or 5th degree nerve injury to the brachial plexus or other major peripheral nerve. The fee includes all nerve dissection, nerve stimulation, incisions, tendon transfers and repairs required to accomplish the repair. No other HSC's may be billed during the skin-to-skin time period used to calculate the surgical fee. Operative report and record of operation must be submitted for billing. **Billing Guidelines** No other HSC's to be billed during the skin-to-skin surgical time used to calculate the surgical fee. **Specialty Restriction** PLAS **Location** HOSP **Regions** Right, left, bilateral	IC at 130 MSU/hr 4+T

Note: Physicians holding eligible services must submit their claims from June 1, 2014 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 June 1, 2014 the following new health service codes are available for billing:

Category	Code	Description	Unit Value	
MASG	65.59D	**Total Abdominal Wall Reconstruction with myofascial advancement flaps (Interim Fee):** This is a comprehensive fee for the repair of a massive, complex abdominal wall hernia. The procedure includes the reduction of the hernia, all lysis of adhesions, bowel resection as required, removal of pre-existing mesh as required, rectus muscle mobilization, fascial bipartition with component separation, with or without placement of mesh or biologic graft, and skin excision. Operative report and record of operation must be submitted with billing claim. **Billing Guidelines** Not to be billed with lysis of adhesions, bowel resection or any other intra-abdominal procedure same patient same day. Physician must document skin-to-skin operating time in the claim as well as in the record of operation. In the event that skin-to-skin time exceeds 5 hours and 30 minutes, the physician may bill for this procedure via EC at 130 MSU/hour. **Specialty Restriction** GNSG, PLAS **Location** HOSP	585	8+T

Category	Code	Description	Unit Value	
MAFR	91.35G	**Open Reduction and Internal Fixation (ORIF) Bicondylar Tibial Plateau Fracture:** This is a comprehensive fee for the repair of a bicondylar tibial plateau fracture to include all surgical exposure, fracture reduction, bone grafting, meniscal repair, stabilization of the fracture including all plates and screws, IM nails, and external fixator as required. **Billing Guidelines** Not to be billed with: BOGR 90.06A - Bone graft - tibia ADON 90.09A - Morselized allograft MASG 92.15 - Other arthrotomy MASG 92.89N - Arthroscopic meniscal repair On same patient, same side, same day. **Specialty Restriction** ORTH	250	4+T

Location
HOSP

Regions
Right, left, bilateral

Category	Code	Description	Unit Value
MASG	90.69D	**Removal of Complex Internal Fixation Device(s) (IM nail, locking plate) as sole operative procedure:** This fee code applies to the removal of intermedullary nails and locking plates when performed as the sole operative procedure at that operative site. Not paid in addition to, or part of, another orthopaedic procedure unless the internal fixation device is removed from a separate operative site. Not to be billed when followed by a revision fixation in which case the MAFR code and MASG 90.69B-Removal of internal fixation should be billed. **Billing Guidelines** Not to be billed with: Any other fracture code same patient, same day, same region/site. **Specialty Restriction** ORTH **Location** HOSP **Regions** Right, left, bilateral	110 4+T

Category	Code	Description	Unit Value
VADT	09.03A	**Examination for Retinopathy of Prematurity:** To be billed in addition to the visit fee for the comprehensive ophthalmological examination of both eyes, including all ophthalmic testing, in an infant with an underlying diagnosis of retinopathy of prematurity in the neonatal intensive care setting. **Billing Guidelines** Billable only when the functional centre is the neonatal intensive care unit. Not to be billed with: 09.02 - Comprehensive eye examination 09.04 - Eye exam under anaesthesia. **Specialty Restriction** Paediatric Ophthalmology **Location** HOSP, NICU	15

Category	Code	Description	Unit Value
MASG	71.4C	**Synthetic mid urethral sling for female urinary incontinence, any approach:** This is a comprehensive fee for the surgical treatment of female urinary incontinence by the placement of a synthetic mid urethral sling (for example TVT, TOT) by any approach, including cystoscopy when performed. **Billing Guidelines** Not to be billed with VADT 01.34A - Cystoscopy same patient same day. **Specialty Restriction** UROL, OBGY **Location** HOSP Please note that this code replaces the previous interim code 71.4B (Urethral sling using prosthetic material such as TVT, TOT etc, by any method) effective June 1, 2014.	150 4+T

Category	Code	Description	Unit Value
MASG	71.4D	**Pubo-vaginal sling with autologous fascia for female urinary incontinence, includes cystoscopy as required:** This is a comprehensive fee for the surgical treatment of female urinary incontinence using autologous fascia. This fee includes the harvesting of fascia lata or rectus fascia as required, the placement of the sling using both an abdominal and vaginal approach, and cystoscopy as required. If the skin-to-skin operative time extends beyond 4 hours, then bill IC@ 130 MSU/hr including operative report and record of operation with the claim. Not to be billed for synthetic Mid Urethral Sling (e.g. TVT, TOT). **Billing Guidelines** Not to be billed with VADT 01.34A – Cystoscopy, same patient, same day. Not to be billed for synthetic mid urethral Sling (e.g. TVT, TOT), as described in code above. **Specialty Restriction** UROL, OBGY **Location** HOSP	350 6+T

UPDATE – MSI ELIGIBILITY FOR NS RESIDENTS ON VACATION OUT OF PROVINCE

The Department of Health and Wellness will be extending the length time Nova Scotia residents are eligible for Medical Services Insurance (MSI) while out of the province for vacation. As of August 1, 2014, Nova Scotians are eligible for MSI benefits for an additional month while on vacation outside of the province for a maximum of 7 months in each calendar year. Vacationers are required to inform MSI of their absence by telephoning 902-496-7008 (local) or 1-800-563-8880 (toll-free) or submitting an email to msi@medavie.ca.

In order to allow vacationers an adequate supply of medications while travelling outside the province for more than 100 days, the Nova Scotia Family and Senior's Pharmacare Programs will allow pharmacies to dispense up to three 90 day refills to allow for a 270 day maximum supply of medication for beneficiaries to bring with them as vacation supply.

ELECTIVE OUT OF PROVINCE SERVICES (WITHIN CANADA)

Prior approval is required from the Nova Scotia Department of Health and Wellness before referring a patient out of province for insured health services unavailable in Nova Scotia if the patient wishes to be considered for travel and accommodation assistance. Approval must be sought through the Medical Consultant, MSI. The referral must be from a specialist registered in Nova Scotia, who is actively involved in the eligible resident's care. The referral must include the following:

- A description of the eligible resident's relevant medical history.
- A description of the health services requested as well as an estimation of the expected benefit to the patient.
- A description of any follow-up requirements.
- Information on the available health services in Nova Scotia and an explanation of why these are not sufficient for the resident's needs.
- A written recommendation in support of the out-of-province health services, confirming that this is the specialist's recommendation and that the referral is not being provided solely at the request of the patient.
- Written confirmation of the medical evidence, and the patient's medical requirement for travel with an escort, if required.
- The contact information of the physician who will be treating the patient so a copy of the approval documentation can be forwarded to their office.
- The costs for an escort will not be covered by DHW if there is no medical evidence to support the need for an escort. Evidence of medical need for an escort is not required if the resident is under 19 years of age.
- When the proposed health service is a new or emerging health service, documentation must be included of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.

MSI will review the application and provide a response to the appropriate specialist within 30 days of receiving a complete application.

Upon approval of the application, the Department of Health and Wellness will contact the eligible resident and provide the appropriate application forms for travel and accommodation assistance.

ELECTIVE OUT OF COUNTRY SERVICES

Individuals requiring elective, insured health services that are not available within Canada must be authorized by the DHW prior to making any medical and/or travel arrangement to ensure the service will be insured and in order for the DHW/MSI to negotiate a reasonable and fair compensation with out of country providers prior to the provision of services.

In order for a patient to be referred outside Canada for treatment, prior written approval is required from the Medical Consultant, MSI. The referral must be from a specialist registered in Nova Scotia, who is actively involved in the eligible resident's care. The referral must include the following:

- A description of the eligible resident's relevant medical history.
- A description of the health services requested as well as an estimation of the expected benefit to the patient.
- A description of any follow-up requirements.
- Information on the available health services in Canada and an explanation of why these are not sufficient for the resident's needs.
- A written recommendation in support of the out-of-country health services, confirming that this is the specialist's recommendation and that the referral is not being provided solely at the request of the patient.
- Written confirmation of the medical evidence, and the patient's medical requirement for travel with an escort, if required.
- The contact information of the physician who will be treating the patient so a copy of the approval documentation can be forwarded to their office.
- The costs for an escort will not be covered by DHW if there is no medical evidence to support the need for an escort. Evidence of medical need for an escort is not required if the resident is under 19 years of age.
- When the proposed health service is a new or emerging health service, documentation must be included of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.

MSI will review the application and provide a response to the appropriate specialist within 30 days of receiving a complete application.

Upon approval of the application, the Department of Health and Wellness will contact the eligible resident and provide the appropriate application forms for travel and accommodation assistance.

AUDIT TIME PERIOD

When an onsite billing audit is required, the audit is typically based upon a random sample of services, of a selected service type, drawn from the most recent two-year period. The period may be expanded to cover a longer time period depending upon the nature of any identified billing issues or other information.

There may be instances where services are selected in a non-random manner based on specific criteria related to the identified billing issue.

MMR VACCINE FUNDING

In Nova Scotia the following groups are eligible to receive measles vaccine as part of the publicly funded immunization program:

Infants and Children:

1. Two doses of a measles-containing vaccine MMR(V) are recommended. The first dose should be given on or after the first birthday and the second dose should be given at the 4-6 year old visit but may be given as early as 18 months.

2. For travel to regions where measles is a concern, http://travel.gc.ca/travelling/health-safety/travel-health-notices/measles, MMR may be given as early as six months of age following a risk assessment. Under these circumstances, the routine two dose series must be started on or after the first birthday, for a total of three doses.

   In general, there is no need to provide early vaccination for infants travelling within Canada. There may be exceptions if there is recent measles activity within the family or closed community to which a visit is planned.

To support the addition of immunization of infants 6-11 months of age, new billing codes have been added as follows:

MSI billing modifier for infants between 6 months and 1 week prior to 12 months of age who are travelling to areas of risk for measles. (There is no change to billing practices for the administration of routine childhood immunizations.)

Immunization	Health Service Code	Modifier	MSUs
Injection for Measles, Mumps and Rubella for travel of infants only to areas of risk.	*13.59L*	*RO=MMRT*	*6.0*
This immunization is only to be claimed for infants between 6 months and 1 week prior to 12 months of age who are travelling to areas of risk. **Text is also required from the physician stating the reasoning for administering the immunization prior to 12 months.**			

Adolescents and Adults:

Adults born in or after 1970 should receive two doses of measles-containing vaccine, unless they have documented immunity (serology) from measles disease, or have documented evidence of receiving two valid doses of measles containing vaccine.

It is generally safe to assume that Canadian residents born **before 1970**, regardless of place of birth, have naturally-acquired immunity against measles, mumps and rubella. However, **international travelers** of this age should receive one dose of measles containing vaccine (**not publically funded**) if they do not have one of the following:

- documented evidence of receiving measles-containing vaccine on or after their first birthday;
- laboratory evidence of immunity (e.g. through blood testing); or
- a history of laboratory confirmed measles disease.

BILLING REMINDERS

3D CT RECONSTRUCTION CODES

Effective August 1, 2014, health service codes 1180, 3180, and 5180 may only be claimed when 3D reconstruction has been carried out. They may not be claimed for 2D reconstruction or multiplanar reconstruction.

SURGICAL ASSISTANT CLAIMS

Preamble 9.5.1 states that a surgical assistant's surgical encounter is 33.8% of the surgical fee. The health service codes claimed for surgical assistant services are expected to align with those submitted by the primary surgeon and all surgical assistant claims should adhere to the preamble guidelines. Physicians are reminded that all claims, including claims for surgical assistant services, are subject to MSI monitoring and audit processes.

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).

The initiative to assess claims submitted where more than one procedure is claimed for the same patient on the same day is ongoing. Please be advised that as the manual assessment of these claims continues, operative reports may be requested.

DAILY HOSPITAL AND OFFICE VISITS - SECOND OCCURENCE CLAIMS

As per Preamble section 7.2.4, **limited hospital visits are for the daily care of the patient**. This composite fee includes reviewing lab work, discussions with patients and/or their families and instances in which the physician

electively returns to reassess a patient. Additional visits may not be claimed for such activities as they are included in the daily rate.

If a physician is requested by hospital staff to reassess a patient in an emergent situation and the physician responds immediately, an urgent visit may be claimed. **Urgent visits may only be claimed if the physician travels to see the patient**. As per Preamble section 2.31, movement within a hospital or long term care facility or from an office attached to a hospital is not considered travel and therefore does not meet the requirements for an urgent visit.

If more than one visit is provided by the same physician to the same patient on the same day at separate times, **documentation of the necessity for the extra visit(s) must be recorded on the chart**. Time of service occurrence must be provided on second and subsequent visits, per Preamble 7.2.3. When submitting the claim, the service occurrence field is used to indicate the number of separate service encounters with an occurrence number greater than one. Text is required in order for the claim to be paid. This text must indicate the medical necessity of the subsequent visit as well as the time of the occurrence. Any claims submitted with an occurrence number greater than one without text will be paid at zero.

EXPLANATORY CODES

AD049 Service encounter has been refused as the patient's age is not between 6 months and one week prior to 12 months.

AD050 Service encounter has been refused as electronic text is required stating the reasoning for administering the MMRT immunization.

MA061 Service encounter has been disallowed as this claim is incomplete. Please resubmit with text specifying the skin to skin operating time.

MA062 Service encounter has been refused as a cystoscopy has previously been billed for this patient on the same day.

MA063 Service encounter has been refused as cystoscopy is included in the fee for HSC 71.4C which has been previously billed for this patient on this day.

MF006 Service encounter has been refused as you have previously claimed HSC 90.06A, 90.09A, 92.15, or 92.89N for the same patient on the same day.

MF007 Service encounter has been refused as you have previously billed for an ORIF Bicondylar Tibial Plateau Fracture for this patient on this day.

MF008 Service encounter has been refused as you have previously claimed a fracture code for the same site/region on this day.

MJ045 Service encounter has been refused as HSC 01.34A has already been billed for this patient on this day.

VA059 Service encounter has been refused as HSC 71.4D has already been billed on this day which includes cystoscopy.

VA060 Service encounter has been refused as you have previously billed HSC 09.02 or 09.04 for this patient at the same encounter.

VE008 Service encounter has been refused as you have previously billed HSC 09.03A for this patient at the same encounter.

WB031 Service encounter has been refused as the provider indicated is not valid for this service.

UPDATED FILES AVAILABILITY

Updated files reflecting changes are available for download on Friday, July 18th, 2014. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanatory codes (EXPLAIN.DAT), and modifier values (MODVALS.DAT).