PHYSICIAN'S BULLETIN
November 21, 2014: Vol. L, ISSUE 6

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

PREPAYMENT ASSESSMENT CHANGES

FALL 2014

The team working on implementing the recommendations in John Carter's Physician Audit and Appeal Practices Report has reached a significant milestone. The threshold for pre-payment assessment of multiple claims in major surgery cases on the same patient, same day by the same provider has been increased from two to four.

MSI will implement the revised thresholds in the computer system effective November 21, 2014. Prepayment assessments will still be conducted on claims with less than four health service codes on a random basis.

Doctors Nova Scotia, Department of Health and Wellness (DHW) and MSI have been working to address the recommendations in John Carter's Physician Audit and Appeal Practices report. As recommended by the Carter report, DHW has reviewed the results of prepayment assessment and based on this review, the thresholds have been raised.

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BULK BILLING TRANSITION PROJECT

FALL 2014

The Department of Health and Wellness and MSI have undertaken a project to align physician billing across Nova Scotia. It is titled **The Bulk Billing Transition Project.** This will move all physicians to electronic claims submissions by the end of 2015.

This project impacts key physician groups who are receiving direct communications on the project. There will be, from time to time, important project updates shared in the MSI Bulletin. These updates apply only to those impacted physician groups.

About the project:

Currently the majority of Radiology, Pathology and some Internal Medicine claims are submitted to MSI under a bulk billing method which consists of manual, non-patient specific claims. By contrast, electronic claim submission, which is used for all other physician billing in the province, provide detailed patient information on every digital claim. This difference between billing systems creates a number of challenges (including incomplete MSI patient histories and an inability to reciprocally bill for non-resident procedures) that can be remedied by moving all billing to an electronic system.

Update to impacted physician groups:

Since the Bulk Billing Transition project implementation began, there have been concerns raised around potential impacts of the new electronic billing requirements, specifically the timing of the transitions.

MSI is committed to working with all stakeholders to ensure a smooth transition we recognize that changes come with challenges. There have been recent discussions between the Department of Health and Wellness, Doctors Nova Scotia, MSI and a number of impacted physician groups regarding project timelines and logistical requirements.

In response to those concerns, and to better assist physicians with their transitions to the new electronic billing system, we are **moving all go-live dates from December 1, 2014 to February 1, 2015.**

This is a new date change for Internal Medicine physicians. This does not impact Radiology or Pathology physicians as the go-live date for both groups was February 1, 2015 prior to this notice.

As we continue with the transition to electronic billing, we will continue this important dialogue with all stakeholders. Project news and changes will be shared in a timely manner with all impacted groups through the FAQ, emails and official bulletin updates.

If you have questions at any time, please contact us at 1-902-496-7011 or visit us online.
www.medavie.bluecross.ca/msiprograms

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NEW FEES

Effective November 21, 2014 the following new health service codes are available for billing:

Category	Code	Modifiers	Description	Base Units	Anaes Units
MASG	60.55C		**Closure of Enterostomy, large or small intestine; with resection and colorectal/ileorectal anastomosis (eg, closure of Hartmann type procedure)** This comprehensive fee includes all of the procedures required to perform the closure of an existing enterostomy including mobilization of the intestine, resection of bowel to remove the enterostomy site, lysis of adhesions, pelvic dissection, exploration and identification of ureter, mobilization of the rectum with resection of the upper rectum as required, and repair of any existing parastomal or incisional hernia. Open, laparoscopic, or combined approach. **Billing Guidelines** Not to be billed with: MASG 57.59 Other partial excision of large intestine MASG 60.52 Other anterior resection **Specialty Restriction:** GNSG **Location:** HOSP	390 MSU	8+T
VEDT	03.38A	RO=INTP	**Inhalation Bronchial Challenge Testing with methacholine or similar compounds – includes baseline spirometry and all spirometric determinations post administration of agent (s).** This fee is for the interpretation of the testing and a written report. The physician must be present in the pulmonary function laboratory during the time of the testing to be available to deal with adverse events. **Billing Guidelines:** Billable only once per patient per day. Not to be billed with any additional spirometry same patient same day. I1110 Simple Spirometry I1140 Flow Volume Loops Billable only when the testing is done in the hospital based pulmonary function laboratory. **Specialty Restriction:** INMD, PEDI **Location:** HOSP	19 MSU	

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FEE REVISIONS

Effective November 21, 2014 the following health service code will have a specialty restriction of UROL.

Category	Code	Modifiers	Description	Base Units	Anaes Units
MASG	71.02		**Ureterolysis with freeing or repositioning of ureter for peri-ureteral fibrosis (Regions required)** **Specialty Restriction:** UROL **Location:** HOSP	215 MSU	6+T

Effective November 20, 2014, the following health service codes will no longer be active:

Category	Code	Modifiers	Description	Base Units	Anaes Units
MASG	60.55A		**Colon/rectal reanastomosis after segmental resection where mucus fistula or Hartman procedure exists**	250 MSI	8+T

PROVINCIAL IMMUNIZATION CHANGES

Effective November 20, 2014 the following immunizations are termed:

HSC	Modifier
13.59L	RO=HAHB
13.59L	RO=MENQ
13.59L	RO=MMRT
13.59L	RO=RABI
13.59L	RO=RABV
13.59L	RO=TEIG
13.59L	RO=VAIG

These immunizations are to be administered in high risk/post exposure situations only (as communicated through Public Health). Therefore, the base fee codes (without the high risk modifier) have been termed and replaced by the equivalent with the high risk modifier.

Effective November 21, 2014 the following immunizations are effective:

HSC	Modifier
13.59L	RO=HAHB with PT=RISK (previously implemented in September)
13.59L	RO=MENQ with PT=RISK
13.59L	RO=MMRT with PT=RISK
13.59L	RO=RABI with PT=RISK
13.59L	RO=RABV with PT=RISK
13.59L	RO=TEDV with PT=RISK
13.59L	RO=TEIG with PT=RISK (previously implemented in September)
13.59L	RO=VAIG with PT=RISK (previously implemented in September)

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Immunization Information - Clarification

After release of the last Bulletin, MSI staff received inquiries about criteria for eligibility of some vaccines.

We have been advised by Public Health of the following:

Hepatitis B vaccine is covered for Nova Scotia residents under the following circumstances only:

- Grade 7 students when provided through the school based immunization program
- Post exposure prophylaxis for Hepatitis B
- *Pre-exposure prophylaxis for the following high risk groups:
    - Chronic liver disease
    - Chronic renal disease and dialysis
    - Congenital immunodeficiency
    - Hematopoietic stem cell transplant (HSCT)
    - HIV
    - Illicit drug use
    - High risk sexual practices
    - Solid organ transplant
    - Hemophiliacs and other people receiving repeated infusions of blood or blood products e.g. sickle cell disease.

Rabies vaccine and immunoglobulin are covered for post-exposure prophylaxis only.

Further information may be found at the following site: http://novascotia.ca/dhw/cdpc/documents/Immunization-Manual.pdf

Billing Matters Billing Reminders, New Explanatory Codes

BILLING REMINDERS

Health Service Codes 28.73F (Intravitreal injection of a pharmacologic agent for the treatment of specific retinal diseases) and 02.02A (Optical Coherence Tomography)

Effective November 12, 2013, changes were made to billing rules concerning health service code 28.73F (intravitreal injection of a pharmacologic agent for the treatment of specific retinal diseases) such that this health service code could be claimed for patients with wet age-related macular degeneration (AMD), diabetic macular edema (DME) or retinal vein occlusion (RVO) when treating with an appropriate pharmacologic agent (i.e. intravitreal drugs).

Health service code 02.02A (Optical Coherence Tomography) may be claimed by the ophthalmologist treating a patient with one of these pharmacologic agents for one of the conditions listed above. The OCT may only be billed in association with the injection or to guide whether an injection is required. OCT may be claimed to a maximum of six times per patient per year and a written report of the image interpretation is to be recorded in the clinical record.

Surgical Assistant Claims

As outlined in the July 18, 2014 Physician's Bulletin, surgical assistants are remunerated at 33.8% of the fee paid to the surgeon and the health service codes claimed for surgical assistant services are expected to align with those submitted by the primary surgeon and must adhere to Preamble rules. If a claim for a surgical assistant fee is received in the absence of a claim from the surgeon, the claim will be returned with explanatory code GN064 indicating that the claim cannot be paid as no claim has been submitted by a surgeon for this service.

ICU Day 1

If a patient is transferred from one ICU to a second ICU within the same facility, both physicians may claim ICU codes on the day of transfer but the physician attending the patient in the receiving ICU cannot claim another Day 1. However, if a patient is transferred to a new facility i.e., another hospital, a new ICU day 1 may be claimed.

Within the same facility, a second ICU Day 1 may only be claimed if the patient is discharged from the ICU and readmitted at least 24 hours after the ICU discharge.

BILLING REMINDERS CONTINUED

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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 prescribe, and start and stop times if applicable.

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.

NEW EXPLANATORY CODES

Code	Description
AD054	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 90.09G FOR THIS PATIENT ON THIS DAY.
BK017	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR AN ULTRASOUND OF THE AORTA, APPENDIX, KIDNEYS, OR PYLORUS AT THE SAME ENCOUNTER. THESE ARE MEANT TO BE INCLUDED IN THE ABDOMEN GENERAL ULTRASOUND FEE.
BK018	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR AN ABDOMEN GENERAL ULTRASOUND AT THE SAME ENCOUNTER. AN ULTRASOUND OF THE AORTA, APPENDIX, KIDNEYS, OR PYLORUS IS MEANT TO BE INCLUDED IN THE ABDOMEN GENERAL ULTRASOUND FEE.
BK019	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR AN U/S OF THE AORTA, APPENDIX, KIDNEYS, OR PYLORUS AT THE SAME ENCOUNTER. THESE FEES ARE NOT CUMULATIVE. AN ABDOMINAL GENERAL U/S (HSC R1205) IS THE COMPOSITE FEE FOR THESE SERVICES.
BK020	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS FEE IS CONSIDERED TO BE AN ADD ON CODE AND MAY ONLY BE CLAIMED AFTER A BASE SERVICE HAS BEEN BILLED.

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BK021	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR AN ENDOVAGINAL U/S (R1225) AT THE SAME ENCOUNTER. TO CLAIM FOR BOTH, PLEASE SUBMIT A DELETE FOR THE ENDOVAGINAL U/S AND CREATE A NEW CLAIM FOR ENDOVAGINAL WITH PELVIC (R1226).
BK022	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR AN PELVIC ULTRASOUND (R1220) AT THE SAME ENCOUNTER. TO CLAIM FOR BOTH, PLEASE SUBMIT A DELETE FOR THE PELVIC ULTRASOUND AND CREATE A NEW CLAIM FOR ENDOVAGINAL WITH PELVIC (R1226).
BK023	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR THE ENDOVAGINAL AND PELVIC ULTRASOUND COMBINATION FEE AT THE SAME ENCOUNTER.
BK024	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED A CLAIM FOR EITHER THE STAND ALONE PELVIS ULTRASOUND OR ENDOVAGINAL ULTRASOUND FEE.
BK025	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED FOR ANOTHER CODE AT THE SAME ENCOUNTER. WHEN THE INTRAOPERATIVE CODE IS USED, NO OTHER CODE MAY BE CLAIMED FOR THAT EXAMINATION.
BK026	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED FOR AN INTRAOPERATIVE ULTRASOUND FEE AT THE SAME ENCOUNTER. WHEN THE INTRAOPERATIVE CODE IS USED, NO OTHER CODE MAY BE CLAIMED FOR THAT EXAMINATION.
BK027	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.38A HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY.
BK028	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED THE BILATERAL FEE CODE FOR THIS SERVICE AT THE SAME ENCOUNTER.
BK029	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED THE UNILATERAL FEE CODE FOR THIS SERVICE AT THE SAME ENCOUNTER. PLEASE SUBMIT A DELETE FOR THE UNILATERAL SERVICE BEFORE CLAIMING THE BILATERAL FEE.
BK030	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED A VENOGRAM EXTREMITY CLAIM AT THE SAME ENCOUNTER. THE VENOGRAM EXTREMITY FEE INCLUDES THE CENTRAL FILM.
BK031	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED A CENTRAL FILM CLAIM AT THE SAME ENCOUNTER. A VENOGRAM EXTREMITY FEE INCLUDES THE CENTRAL FILM. PLEASE SUBMIT A DELETE FOR HSC R605 BEFORE RESUBMITTING THE VENOGRAM EXTREMITY FEE.
BK032	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED A RENAL SCAN AND RENOGRAM CLAIM AT THE SAME ENCOUNTER.
BK033	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY SUBMITTED AN A.C.E. RENAL SCAN CLAIM AT THE SAME ENCOUNTER.
BK034	SERVICE ENCOUNTER HAS BEEN DISALLOWED. PLEASE RESUBMIT, INDICATING IN THE TEXT FIELD WHO PERFORMED THE INJECTION.
BK035	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS FEE IS CONSIDERED TO BE AN ADD ON CODE AND MAY ONLY BE CLAIMED AFTER A RENAL SCAN (R1875, R1880, OR R1881) HAS BEEN BILLED.
BK036	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR THE MULTIPLE AREAS FEE AT THE SAME ENCOUNTER.
BK037	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED FOR THE SINGLE AREA FEE AT THE SAME ENCOUNTER.
BK038	SERVICE ENCOUNTER HAS BEEN REFUSED AS AN AUTOPSY HAS ALREADY BEEN CLAIMED FOR THIS INDIVIDUAL.
BK039	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED A VISIT FOR THIS INDIVIDUAL AT THE SAME ENCOUNTER.
BK040	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED A CONSULT FOR THIS INDIVIDUAL AT THE SAME ENCOUNTER.
MJ047	SERVICE ENCOUINTER HAS BEEN REFUSED AS HSC 57.59 OR 60.52 HAS PREVIOUSLY BEEN BILLED FOR THIS PATIENT ON THE SAME DAY.

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MJ048	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 60.55C HAS PREVIOUSLY BEEN BILLED FOR THIS PATIENT ON THE SAME DAY.
MJ049	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 90.06B FOR THIS PATIENT ON THIS DAY.
VE009	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THE SAME DAY.
VE010	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC I 1110 OR I 1140 HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY.

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In every issue Helpful links, contact information, events and news, updated files

UPDATED FILES

Updated files reflecting changes are available for download on Friday, November 21, 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).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

www.medavie.bluecross.ca\msiprograms

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

Phone: 902-496-7011
Toll-Free: 1-866-553-0585
Fax: 902-490-2275
Email: MSI_Assessment@medavie.bluecross.ca

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

Phone: 902-424-5818
Toll-Free: 1-800-387-6665 (in Nova Scotia)
TTY/TDD: 1-800-670-8888

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2015 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

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PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE
December 23, 2014 **	**December 31, 2014****	January 7, 2015
January 12, 2015	January 15, 2015	January 21, 2015
January 26, 2015	January 29, 2015	February 4, 2015
February 6, 2015**	**February 11, 2015****	February 18, 2015
February 23, 2015	February 26, 2015	March 4, 2015
March 9, 2015	March 12, 2015	March 18, 2015
March 23, 2015	March 26, 2015	April 1, 2015
April 6, 2015	April 9, 2015	April 15, 2015
April 20, 2015	April 23, 2015	April 29, 2015
May 4, 2015	May 7, 2015	May 13, 2015
May 15, 2015**	May 21, 2015	May 27, 2015
June 1, 2015	June 4, 2015	June 10, 2015
June 15, 2015	June 18, 2015	June 24, 2015
June 26, 2015**	July 2, 2015	July 8, 2015
July 13, 2015	July 16, 2015	July 22, 2015
July 24, 2015**	**July 29, 2015****	August 5, 2015
August 10, 2015	August 13, 2015	August 19, 2015
August 24, 2015	August 27, 2015	September 2, 2015
September 4, 2015**	September 10, 2015**	September 16, 2015
September 21, 2015	September 24, 2015	September 30, 2015
October 2, 2015**	**October 7, 2015****	October 14, 2015
October 19, 2015	October 22, 2015	October 28, 2015
October 30, 2015**	**November 4, 2015****	**November 10, 2015****
November 16, 2015	November 19, 2015	November 25, 2015
November 30, 2015	December 3, 2015	December 9, 2015
December 14, 2015	December 17, 2015	December 23, 2015
December 23, 2015**	**December 30, 2015****	January 6, 2016
11:00 AM CUT OFF	**11:59 PM CUT OFF**	

NOTE:

Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Radiology, Pathology, Internal Medicine Monthly Statistical Reports, Sessional Payments and Locum Claim Forms. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut off date to ensure processing for that payment period.

PLEASE NOTE, THE ** INDICATES A DATE VARIATION

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HOLIDAY DATES FOR 2015

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Please make a note in your schedule of the following dates MSI will accept as "Holidays."	
NEW YEAR'S DAY	THURSDAY, JANUARY 1, 2015
HERITAGE DAY	MONDAY, FEBRUARY 16, 2015
GOOD FRIDAY	FRIDAY, APRIL 3, 2015
EASTER MONDAY	MONDAY, APRIL 6, 2015
VICTORIA DAY	MONDAY, MAY 18, 2015
CANADA DAY	WEDNESDAY, JULY 1, 2015
CIVIC HOLIDAY	MONDAY, AUGUST 3. 2015
LABOUR DAY	MONDAY, SEPTEMBER 7, 2015
THANKSGIVING DAY	MONDAY, OCTOBER 12, 2015
REMEMBRANCE DAY	WEDNESDAY, NOVEMBER 11, 2015
CHRISTMAS DAY	FRIDAY, DECEMBER 25, 2015
BOXING DAY	MONDAY, DECEMBER 28, 2015
NEW YEAR'S DAY	FRIDAY, JANUARY 1, 2016

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Season's Greetings
from the staff of MSI Programs