# PHYSICIANS' BULLETIN

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NOVA SCOTIA MEDICAL SERVICES INSURANCE

September 19, 2008 Volume XLII - #4

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The Department of Health would like to advise of the following Tariff Agreement modifications effective April 1st, 2008.

The Tariff Agreement between Doctors Nova Scotia and the Department of Health specified an increase to the value of the Medical Service Unit (MSU) effective April 1st , 2008, as well as increases in the number of units associated with selected health service codes. Effective July 25th MSI began paying service encounters using the April 1st, 2008 MSU value.

Any services that have been held for submission due to code unavailability can now be submitted in the usual manner. For electronic submission of claims please include text indicating "tariff agreement change" for services over the 90-day time frame.

Information related to various incentive programs will be detailed in a later bulletin.

## RETROACTIVE PAYMENT

All claims eligible for a Medical Service Unit (MSU) and Anaesthesia Unit (AU) increase with a service date of April 1st, 2008 to July 10th, 2008 inclusive and with a payment date of prior to July 30th will be identified and a retroactive payment will be calculated and paid in the fall of 2008.

If there are any questions regarding the retroactive payment, please contact Heather Etsell at (902) 496-7166.

### RETURN TRIP WHEN TRANSPORTING A PATIENT

When a physician has accompanied a patient, who is transported from one location to another, the previously unpaid return trip by the physician will now be compensated. The time claimed shall not exceed the patient transport time and will be payable at the same rate as the trip to accompany the patient. A revised call back form will be circulated to the Emergency Department Directors and Chief of Staff. Claims can be submitted to either the Emergency Department Director or Chief of Staff for services provided April 1st, 2008 onward.

## COMMUNICATION BY FAX AND EMAIL

Recognizing that methods of communication are changing, all existing Nova Scotia telephone fee codes are amended to include payment for services provided by fax and e-mail. This applies to the following Health Service codes (HSC):

| HSC | Modifiers | Description |
|---|---|---|
| 13.99C | | Supervision of long-term anticoagulant therapy per month (telephone/fax/Email communication) |
| 03.03 | RO=HMTE | Medical Chart Review and/or telephone call, fax or Email. This service is billable up to three per day per patient |
| 03.03 | RO=CRTC | Palliative Care Med Chart Review and/or Telephone call, Fax or Email. This service is billable when initiated by a health care professional – up to three per day per patient |

Fax or email services with date of service April 1st, 2008 onward that have been held should now be submitted in the usual manner. Please include text indicating "tariff agreement change" for services over the 90-day time frame.

## GENERAL PRACTICE OFFICE SERVICES

### General Practice Complex Care Visit (03.03B)

*Complex Care Visit*

Effective April 1st, 2008 the following permanent code has been approved for inclusion in the fee schedule. Held claims for this service can now be submitted. Please include text indicating "tariff agreement change" for services over the 90-day time frame. If your office has previously submitted a regular office visit code you must delete the original claim prior to resubmitting the complex care visit.

The complex care visit code may be billed a maximum of 4 times per patient per year by the family physician and/or the practice providing on-going comprehensive care to a patient who is under active management for 3 or more of the following chronic diseases: asthma, COPD, diabetes, chronic liver disease, hypertension, chronic kidney disease, congestive heart failure, ischaemic heart disease, dementia, chronic neurological disorders, cancer. The physician must spend at least 15 minutes in direct patient intervention.

The term active management is intended to mean that the patient requires ongoing monitoring, maintenance or intervention to control, limit progression or palliate a chronic disease.

The term chronic neurological disorders is intended to include progressive degenerative disorders (such as Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease), stroke or other brain injury with a permanent neurological deficit, paraplegia or quadriplegia and epilepsy.

| Category | Code | Description | Unit Value |
|---|---|---|---|
| VIST | 03.03B | Complex Code | 21 |
| VIST | 03.03B | Complex Code with modifier GPEW | 26.25 |

*Well Baby Visit*

### Well Baby Visit

Effective April 1st, 2008An additional insured well-baby visit for children eighteen months of age is being implemented. The code has a four-week buffer for billing purposes, two weeks prior and two weeks after eighteen months of age. Any services that have been held for submission due to code unavailability can now be submitted in the usual manner. Please include text indicating "tariff agreement change" for services over the 90-day time frame.

*Evening and weekend Office Incentive*

### General Practice Evening and Weekend Office Visit Incentive

The existing funding model for the General Practice Evening and Weekend Office Visit Incentive Program will change from an unpredictable fluctuating amount to a fixed incentive value of 25%. All other program rules remain the same. Monthly bottom line adjustments for the incentive portion will cease for claims with a date of service April 1st, 2008 onward.

All eligible claims with a date of service April 1st, 2008 to September 18th, 2008 will be identified and a retroactive payment will be calculated and paid in the winter of 2008/2009. The retro will be calculated after the 90-day waiting period for the submission of claims.

## HOSPITAL SERVICES

The following changes were effective April 1st, 2008:

In-patient hospital care by General Practice physicians will see an increase in the fee for the first in-patient visit from 25 to 30 units.

The General Practice daily hospital visit fee will increase from 15 to 16 units.

The hospital discharge fee will increase from 8 to 10 units for all physicians.

Effective April 1, 2008, the billing of daily hospital visits has increased from 28 to 56 days from the admission date. The rule limiting payment of five visits in a seven days period, will not apply until after 56 days of hospitalization.

All eligible claims with a date of service April 1st, 2008 to September 18th, 2008 will be identified and a retroactive payment will be calculated and paid in the winter of 2008/2009. The retro will be calculated after the 90-day waiting period for the submission of claims.

| HEALTH SERVICE CODE | MODIFIERS | DESCRIPTION | CURRENT UNITS | UNITS EFFECTIVE SEPT 19, 2008 |
|---|---|---|---|---|
| | | | | |
| 03.04 (General Practice Only) | LO=HOSP, FN=INPT, RP=INTL (RF=REFD) | First Examination | 25 | 30 |
| 03.03 (GP's Only) | LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) | Subsequent Visit – Daily up to 56 days - | 15 | 16 |

| HEALTH SERVICE CODE | MODIFIERS | DESCRIPTION | CURRENT UNITS | UNITS EFFECTIVE SEPT 19, 2008 |
|---|---|---|---|---|
| 03.03 (GP's Only) | LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, (RF=REFD) | Subsequent Visit – Weekly after 56 days – Maximum 80 units per week | 15 | 16 |
| 03.02 A (All Specialties) | LO=HOSP, FN=INPT | Hospital Discharge Fee | 8 | 10 |

## COMPLEX SURGICAL PATHOLOGY

Effective April 1st, 2008 the following fees apply for complex surgical pathology:

**Pathology non-patient-specific bulk billing fees**

| | | |
|---|---|---|
| P2345 | Surgicals, gross and microscopic 3 or more separate specimens | 25.76 units |
| P3345 | Surgicals, gross and microscopic 3 or more separate specimens (35% premium fee) | 34.78 units |
| P5345 | Surgicals, gross and microscopic 3 or more separate specimens (50% premium fee) | 38.64 units |
| P2346 | Surgicals, gross and microscopic, single large complex CA specimen including lymph nodes | 25.76 units |
| P3346 | Surgicals, gross and microscopic, single large complex CA specimen including lymph nodes (35% premium fee) | 34.78 units |
| P5346 | Surgicals, gross and microscopic, single large complex CA specimen including lymph nodes (50% premium fee) | 38.64 units |

### Billing guidelines for surgicals, gross and microscopic specimens.

When more than one surgical specimen is received from a patient the following rules apply:

- P2325 may be claimed for each specimen taken from anatomically distinct surgical sites.
- P2345 may be claimed when 3 or more separate surgical specimens are taken from the same anatomic site.
- P2346 may be claimed when a single large complex cancer specimen, which includes lymph nodes, is examined for the purpose of providing a pathologic cancer staging.

***Definitions*:**
Anatomically distinct surgical site: For the purposes of correctly interpreting anatomic pathology fee code P2325 the body is considered to be divided into the following distinct anatomical areas:
head and neck; upper limbs; lower limbs; trunk (anterior and posterior). The following organ systems are also considered to be distinct surgical sites: upper GI tract; lower GI tract; female reproductive system; male reproductive system; separate organs within the abdominal or thoracic cavities may be claimed as distinct sites. For example, 2 separate skin specimens from the right and left arms are considered as one site, specimens from uterus and ovary are one site, specimens from colon and liver are two sites.

***Clarification:***
Frozen Sections (Intraoperative consult with tissue): For the purposes of correctly interpreting anatomic pathology fee code P2326 all frozen sections taken from one surgical specimen are considered to be one frozen section. When separate organs or anatomic areas are sent for frozen section then it is appropriate to bill for two frozen sections; separate sentinel nodes may also be considered as separate specimens. For example, examination of several margins from one skin cancer is one frozen section, examination of multiple margins from two separate skin cancers (even though they may be within the same anatomically distinct surgical site as defined above) can be considered as two frozen sections.

## FACILITY-BASED PSYCHIATRY

Effective April 1s, 2008 the hourly rates for Psychiatry are: $129.50 for certified specialists and $93.08 for non-certified specialists. The previous sessional rates for Psychiatry no longer apply and are all converted to the above hourly rates.

All eligible claims with a date of service April 1st, 2008 to September 18th, 2008 will be identified and a retroactive payment will be calculated and paid in the fall of 2008.

## MSI ASSESSMENT CONTACT NUMBERS

For MSI Assessment Inquires, please call the following numbers:

Local Telephone Number: (902) 496-7011

Toll-Free: 1-866-553-0585

Fax Number: (902) 490-2275

## CHANGE TO EXISTING EXPLANATORY CODE

| | |
|---|---|
| **AD004** | Service encounter has been refused as this service has previously been approved. |
| **AD027** | Service encounter has been refused as a portion of this service has been previously approved. |

## NEW EXPLANATORY CODES

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

**PC027** Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 20 hours per year for family therapy has previously been approved.

**PC028** Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 20 hours per year for group therapy has previously been approved.

**PC029** Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 20 hours per year for individual therapy has previously been approved.

**PC030** Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 10 hours per year for hypnotherapy has previously been approved.

**PC031** Service encounter has been refused as you have not indicated that prior approval as been issued. Maximum limit of 2 hours per year for lifestyle counselling has previously been approved.

**PC032** Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 5 hours per year for counselling has previously been approved.

**VT079** Service encounter has been refused as the maximum number of complex care visits for the year has previously been approved.

**VT080** Service encounter has been refused as modifier DA value is inappropriate after 56 days from hospital admission.

**VT081** Service encounter has been refused as the maximum of 8 well baby care visits in the first 13 months of life has previously been approved.

**VT082** Service encounter has been refused as the maximum of 8 well baby care visits in the first 13 months of life has previously been approved.

**VT083** Service encounter has been refused as the patient is not insured for this service at this time.

**VT084** Service encounter has been refused as the patient is not insured for this service at this time.

**VT085** Service encounter has been refused as the maximum of 9 well baby care visits has previously been approved.

**VT086** Service encounter has been refused as only one well baby care visit is insured when patient is aged 18 months.

## WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

The (WCB) and Doctors Nova Scotia signed an agreement that came into effect on December 1, 2006. The agreement increased fees to physicians in recognition of new service requirements to improve outcomes for injured workers and helping them achieve a safe and timely return to work.

### WCB Medical Service Unit

April 1, 2008 – March 31, 2009 $2.48

### Anaesthesia Unit

April 1, 2008 – March 31, 2009 $17.68

In order to implement the agreement it was necessary to make a few changes to the billing process, including adding and deleting some billing codes. Effectively immediately some of these codes are being reinstated to properly remunerate physicians for those scenarios that are not by their nature in keeping with the service requirements expected and related to cases that do not have RTW documentation expectations. Please refer to the attached table that explains the various services and their corresponding billing codes.

Continuing to work is a critical component of injury recovery. Work is healthy. The WCB is doing its part to address the length of time injured workers are off work and improve health outcomes. But we can't do it alone. As a physician you play a key role in helping maintain a workers' connection to the workplace.

If you have any questions regarding these changes please contact Jennifer Prosper directly at (902) 491-8356 or toll free 1-800-870-3331.

## WCB PHYSICIAN SERVICE INFORMATION SHEET

The following table lists and describes the various services physicians provide regarding injured workers in Nova Scotia and their associated WCB Health Services Codes.

Some of these codes were temporarily disabled but have now been reinstated. Please ensure to use these codes for billing purposes from now on.

| | Service Type | Description | Health Service Code (Amount Paid @ $2.48/unit) |
|---|---|---|---|
| 1 | Physician Assessment | A worker visits a physician's office, a Physician Assessment is conducted, and a Form 8/10 is completed in compliance with the mandatory criteria outlined in the Doctors Nova Scotia agreement. As this agreement is specific to general practitioners, specialists should use the codes applicable to the services they are providing (see – #s 10 and 11 for further clarification). | WCB11* ($123.40) |
| 2 | Enhanced Physician Services (EPS) Physician Assessment** | A worker visits an EPS physician's office as a result of an EPS referral. A thorough Physician Assessment is conducted and a Form 8/10 is completed in compliance with the mandatory criteria outlined in the Doctors Nova Scotia contract and individual EPS physician letters of agreement. *(This code must only be used by EPS physicians)*.* | WCB12 ($153.56) |
| 3 | Chart Summaries/Written Reports [$37.50 per 15 minute interval (multiplies) – time based billing] | The WCB requests a physician write a report summarizing a worker's chart or answering specific questions - the physician can bill based on the **time** it has taken to prepare this information. This should not be billed in conjunction with WCB 14. | WCB13 ($37.50) |
| 4 | Chart Summaries/Written Reports ($125.01 per page – method based billing) | The WCB requests a physician write a report summarizing a worker's chart or answering specific questions - the physician can bill based on the **length of the report.** This should not be billed in conjunction with WCB13. | WCB14 ($125.02) |
| 5 | Case Conferencing and Teleconferencing (Treating Physician) | Conferencing with employers - the WCB and other health care providers may be invoiced by the treating physician at $75.00 per half hour – billable in quarters. This conferencing is at the request of the case worker and may entail either phone, or on-site "face to face" communication to discuss the worker's functional status, management and/or return to work planning. | WCB15 ($75.00) |
| 6 | Case Conferencing and Teleconferencing (EPS Physician) | Conferencing with employers - the WCB and other health care providers may be invoiced by the treating physician at $100.04 per half hour – billable in quarters. This conferencing is at the request of the case worker and may entail either phone, or on-site "face to face" communication to discuss the worker's functional status, management and/or return to work planning. | WCB16 ($100.04) |
| 7 | Photocopies | Photocopying of chart notes at the request of WCB will be compensated at a minimum of $25 or as negotiated on a case by case basis with the WCB case worker and/or WCB Health Services Department. | WCB17 ($25.00) |
| 8 | Inpatient Visit (hospital visit) | The worker is in the hospital and the physician is providing a 'check in' on rounds. No Physician's Report (Form 8/10) completion warranted. | 03.03 ($39.68) |
| 9 | Long Term Benefit Recipient (office visit ) | The worker is a long term benefit recipient and there is no change in treatment or medical status. No Form 8/10 completion warranted. | 03.03 ($32.24) – under 65 years of age<br><br>03.03A ($40.92) – over 65 years of age |
| 10 | Limited Visit (office visit ) | A limited assessment for diagnosis and treatment of a patient's condition. It includes a history of the presenting problem and an evaluation of relevant body systems. | 03.03 ($32.24) – under 65 years of age<br><br>03.03A ($40.92) – over |

| | Service Type | Description | Health Service Code (Amount Paid @ $2.48/unit) |
|---|---|---|---|
| | | | 65 years of age |
| 11 | Limited Visit (office visit) | RP=SUBS, TI=GPEW (LO=OFFC) | 03.03 ($40.30) – under 65 years of age |
| 12 | Limited Visit (office visit) | TI=GPEW (LO=OFFC) | 03.03A ($51.16) – over 65 years of age |
| 13 | Comprehensive Visit | In-depth evaluation of a patient necessitated by the seriousness, complexity, or obscurity of the patient's complaint or medical condition. This service includes ensuring a complete history is recorded in the medical record and performing a physical examination appropriate to the physician's specialty and the working diagnosis. | 03.04 ($59.52) |
| 14 | Comprehensive Visit | TI=GPEW (LO=OFFC) | 03.04 ($74.40) |
| 15 | Denied Claim | Physician has been notified that the patient's claim is deemed non-WCB. | Physician bills service to MSI in the usual manner. |