NOVA SCOTIA MEDICAL SERVICES INSURANCE

Billing Education Article By Dr. Rhonda Church

MSI'S YEAR END PROVIDES USEFUL INFORMATION FOR PHYSICIANS ON CLAIMS SUBMISSION

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I am often asked by physicians what they can do to audit-proof their practices. As MSI's fiscal year comes to a close, I'm sharing some of the most common concerns seen in MSI audits over the past year. Hopefully, this will enable you and your billing clerk to have an opportunity to review the Preamble requirements for the health service codes you use most often and make any necessary changes, or to contact MSI with any questions.

Although MSI is in the process of finalizing the audit plan for 2014-15, it's expected it will continue to audit health service codes where there have been difficulties.
Below is a list of the most common concerns in MSI audits:

• No documentation
As outlined early in the Preamble, all claims submitted to MSI must be supported by an appropriate clinical record. Before claims are submitted, take the time to ensure your clinical record is complete.

• Claiming for services of other health-care providers
Services of non-physicians such as nurses and nurse practitioners aren't insured by MSI. Physicians can only claim for visits they have personally rendered. In situations in which a physician directly employs a nurse or nurse practitioner, some procedural codes may be claimed for procedures done by nurses as long as the physician is on the premises. This exception doesn't apply to visit codes.

• Claiming for a more costly visit or procedure
MSI sees situations in which a comprehensive visit or comprehensive consultation, for example, was claimed when a limited visit or limited consultation was documented. Preamble rules concerning comprehensive and limited visits and consultations are covered in section 7.

• Claiming a consultation instead of a continuing or directive care visit
For each consultation claimed, there must be a valid referral from a physician or other allowed group of health-care providers. Follow-up visits requested by the patient or the consultant subsequent to the consultation should be claimed as continuing or directive care.

• Lack of start and finish times
Start and finish times for time-based services are required to be recorded directly on the clinical record.

• More than one physician claiming ICU visits over a 24-hour period
ICU visit fees cover care over a 24-hour period. If more than one physician is providing care in the ICU, additional visits can't be claimed. Physicians working in such circumstances should discuss with their colleagues who will be claiming for the care of the patient.

• Incorrect use of premiums
Certain services can be claimed with a 35 per cent or 50 per cent premium if they are provided during designated time periods and on an emergency basis because of the condition of the patient. The physician is required to respond immediately when called. As well, Preamble rules stipulate that visits requested during one time period and performed in another must be claimed using the lower of the two rates. At the time of audit, MSI encounters situations in which a service was incorrectly claimed using a premium because the Preamble requirements weren't met, or for which the wrong premium code was claimed.

• Incomplete documentation for services in long-term care facilities
The most common issues seen are lack of progress notes to support a visit claimed to MSI or incomplete mandatory portions of the Clinical Geriatric Assessment Tool.

As always, MSI welcomes inquiries. We can be reached via email at MSI_Assessment@medavie.bluecross.ca

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