# Billing Education Article By Dr. Rhonda Church

## BULK BILLING UPDATE - TRANSITION RESULTS IN DIALOGUE ON NEW AND EXISTING CODES

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Earlier this year, MSI transitioned the claims processing system for a number of services from the previous bulk-billed system to a patient-specific claims process. The earlier system had been in place for many years and involved submitting claims without patient-identifying data. This process had a number of issues, including the inability to recoup the cost of studies done on residents of other provinces under the existing reciprocal agreement.

Since the transition, we've fielded many questions concerning how to claim for particular clinical services. One of the challenges has been that health service codes (HSCs) do not exist for a number of newer clinical services and physicians had been using proxy or "look-alike" codes, or combinations of existing codes, to claim for these services prior to the transition to patient-specific codes.

In many cases, our advice to physicians has been that in the absence of an HSC that precisely describes the clinical service they are providing, an application should be made to the Fee Schedule Advisory Committee (FSAC) for a new HSC. The FSAC includes representatives from Doctors Nova Scotia and the Department of Health and Wellness, and is responsible for vetting HSC applications and determining the remuneration rate for approved services. A number of applications submitted after the bulk-billing transition are in various stages of the committee's review process.

For the information of physicians in affected specialties, here are some additional questions we've received and our responses.

**Q. As a radiologist, how do I claim for insertion of a PICC line?**
A. There is no specific HSC for PICC line insertion; an application should be made to the FSAC for this service. In the meantime, as per Preamble section 4.1.11, this service should be submitted as EC (Exceptional Clinical Circumstances) and will be paid at the rate of 24U (the rate for insertion of a central venous pressure catheter) pending a decision from the FSAC. This fee includes all aspects of the procedure and additional claims should not be made for services used to identify the vein, such as ultrasound or venography.

**Q. I am a paediatrician and I am concerned that the previously bulk-billed services cannot be claimed together with a visit code. There are occasions when a child has a diagnostic study done and I see the child for a visit the same day after the study has been completed.**
A. Absolutely, we understand that there will be many occasions where this is the case. In that circumstance, claim the diagnostic study (spirometry, EEG, echocardiogram, etc.) as service occurrence number one and your visit as service occurrence number two.

**Q. I work in the laboratory of a regional hospital and assist with entry of data into Meditech, which is later used for billing purposes for our pathologists. If two separate specimens come into the lab from a patient's colon, should these be claimed as two P2325's?**
A. Preamble section 5.3.196-5.1.198 discusses multiple claims for P2325 and states that multiple claims may only be made if the surgical specimens come from anatomically distinct sites. Two specimens from the colon are therefore to be claimed as a single P2325 multiple, regardless of how they are accessioned in the lab.

A full discussion – including a Q-and-A section – concerning bulk-billing issues can be found in the Bulk Billing Transition section of the MSI website.

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