PHYSICIAN'S BULLETIN
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NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

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 prescribed, and start and stop times for time based codes.

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.

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INTERIM FEES - REVISED

The effective date of the following interim health services codes have been extended to March 1, 2015. These codes were originally introduced in the October 2015 bulletin with an effective date of April 1, 2015.

Note: Physicians holding eligible services must submit their claims from the month of March 2015 within 90 days of the date of this bulletin. Please ensure previously paid claims for these services are deleted prior to resubmitting a new claim. Please contact MSI directly for detailed instructions on how to submit these outdated eligible services.

Category	Code	Description	Base Units
VEDT	03.38B	**Exercise Induced Asthma Assessment, interpretation. Includes interpretation of all serial spirometry, flow/volume loops, bronchodilation responsiveness, and oximetry required to assess the patient.** This code is used to report the interpretation of all spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation work, flow/volume loops, oximetry, and bronchodilation responsiveness, as required, to properly assess the response of the patient to exercise. **Billing Guidelines** Only for interpretation of tests performed in a hospital pulmonary function laboratory (Preamble 5.3.190). Do not report with: • I1110 Simple spirometry • I1140 Flow /volume loops • Bronchodilation responsiveness **Specialty Restriction** RSMD, INMD **Location** HOSP	20 MSU

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INTERIM FEES - REVISED CONTINUED

Category	Code	Description	Base Units
VEDT	03.38C	**Bronchodilation responsiveness: interpretation of spirometry (including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation work), pre- and post-bronchodilator administration.** This code is used to report the interpretation of spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation work, before and after the administration of a bronchodilator. This includes all testing required to properly assess the response of the patient **Billing Guidelines** Only for interpretation of tests performed in a hospital pulmonary function laboratory (Preamble 5.3.190). Do not report with: • I1110 Simple spirometry • I1140 Flow /volume loops • Exercise testing for assessment of asthma. **Specialty Restriction** RSMD, INMD **Location** HOSP	10 MSU
VEDT	03.38D	**Six Minute Walk Test, interpretation, when this is the sole procedure.** For the interpretation of the results of the six minute walk test when this is the only pulmonary function test performed for that patient that day. Results must include: the distance walked, pulse oximetry readings, heart rate, and subjective exertion. **Billing Guidelines** Only for interpretation of tests performed in a hospital pulmonary function laboratory (Preamble 5.3.190). Do not report with: • Any other pulmonary function tests same patient same day. **Specialty Restriction** RSMD, INMD **Location** HOSP	2 MSU

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FEE REVISIONS

Please visit the Bulk Billing Transition section of the MSI website for updates to the Radiology Rules Communication document.

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Billing Matters Billing Reminders, New Explanatory Codes

BILLING REMINDERS

WCB Physician Report Form 8/10s

The Workers' Compensation Board continues to monitor the submission of Physician Report Form 8/10s for quality, completeness and legibility and for inappropriate submission of reports in Long Term Benefits cases. The WCB will reverse the report portion of the fee ($64.16) if the contract conditions are not met. The WCB 28 (visit) will continue be paid in these instances.

HSC 13.53A and 13.53C Insertion and Removal of Intradermal Progestin Contraceptive Device

Physicians are reminded that these HSCs are for the insertion or removal of intradermal progestin contraceptive devices only. They may not be used for insertion or removal of intrauterine progestin contraceptive devices.

MRI Interpretation-Repeat Sequence

The claim for a MRI interpretation repeat sequence fee should only be made after the matching base spin echo or inversion recovery MRI interpretation has been claimed and accepted at the same occurrence. All interpretation requests generated from the same encounter should be claimed using the same service occurrence number.

NEW EXPLANATORY CODES

Code	Description
BK052	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED THIS MRI INTERPRETATION SERVICE FOR THE SAME PATIENT ON THE SAME DAY.
BK053	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A REPEAT SEQUENCE CAN ONLY BE CLAIMED AFTER THE MATCHING BASE MULTISECTION MRI FEE IS CLAIMED FOR THE SAME OCCURRENCE. PLEASE CLAIM THE BASE FEE FOR THIS MRI BEFORE SUBMITTING A RE-ADJUDICATE FOR THIS CLAIM.
BK054	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED THIS SERVICE FOR THE SAME PATIENT ON THE SAME DAY.
BK055	SERVICE ENCOUNTER HAS BEEN REFUSED AS A FEE FOR GATING MAY ONLY BE CLAIMED AFTER A MRI THORAX WITH MULTIPLE SEQUENCES HAS BEEN CLAIMED DURING THE SAME ENCOUNTER.
MJ054	HSC 46.41 DECORTICATION OF LUNG MAY NOT BE BILLED WITH ANY OTHER MAJOR SURGERY.
WB004	WCB HAS ADJUSTED THIS CLAIM BASED ON AN AUDIT OF THE FORM 8/10 FOR LEGIBILITY, COMPLETENESS OR QUALITY AS PER CONTRACT CONDITIONS. THE VISIT FEE ONLY (WCB28) WILL BE PAID ON THIS CLAIM.
WB024	WCB HAS ADJUSTED THIS CLAIM TO THE APPROPRIATE VISIT FEE AS THE CLIENT IS ON LONG TERM BENEFITS AND FORM 8/10 IS ONLY NECESSARY WHEN THERE IS A CHANGE IN CONDITION OR TREATMENT AS PER CONTRACT CONDITIONS.
MA069	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PATIENT IS OVER 6 MONTHS OLD.
VA072	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THERE IS ALREADY A CLAIM AT THE SAME ENCOUNTER FOR A PROCEDURE THAT INCLUDES INTRAVENOUS INSERTION.

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Code	Description
GN079	SERVICE ENCOUNTER HAS BEEN DISALLOWED. IV INSERTION IS CONSIDERED A PART OF THIS PROCEDURE AND IT HAS ALREADY BEEN CLAIMED AT THE SAME SERVICE ENCOUNTER.
VT133	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC WCB28 FOR THIS PATIENT ON THE SAME DAY.

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In every issue Helpful links, contact information, updated files

UPDATED FILES

Updated files reflecting changes are available for download on Friday, January 29, 2016. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT), explanatory codes (EXPLAIN.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

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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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