PHYSICIAN'S BULLETIN

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MSI News

BULK BILLING TRANSITION PROJECT

CLAIMS SYSTEM UNDERGOING MODERNIZATION – AN ARTICLE BY DR. RHONDA CHURCH

Historically, many hospital based services provided by some specialties such as pathology, radiology and internal medicine have had a unique payment system known as bulk billing. Physicians submit claims for services based on the number of services provided. MSI is in the process of transitioning to the standard patient-specific claims system for these services. Rather than these claims being submitted as the total number of services provided, a standard claim which includes information such as the patient's name, health card number, and date of service will be needed.

The primary reasons why this transition is taking place are as follows:

- The current bulk billing structure creates critical information gaps, most notably in patient history. The move to patient specific billing will result in improvements to the longitudinal patient record.
- Under the current bulk-billed system, the Department of Health and Wellness cannot reciprocally bill for services provided to out of province residents. The transition to an electronic claims submission system remedies that situation, as this method requires patient specific details with each billing code.

Transition timeline
A detailed communications package was mailed (September 2014) to physicians who will be affected by this change. Internal Medicine services successfully transitioned from bulk billing to electronic claims on March 1, 2015. Pathology and Radiology services will transition on April 1, 2015.

New health codes
Billing rules as established in the Preamble, Physician's Manual and Bulletins remain unchanged. However, some existing health service codes have been deleted and replaced with modifiers to allow claims for 35% and 50% premium modifiers.

Service date requirement
One other notable requirement is that the date of service on the claim must reflect the date the patient received the service rather than the date the physician interpreted the study or signed the final report. For example, if a chest radiograph or a surgical biopsy is taken on April 5th but the study was reported on the April 6th and the report signed on the April 7th, the date on the claim should be April 5th. This will provide consistency in billing practices and assist in retrieval of the clinical record, should it be required to substantiate the claim.

MSI News Continued

Medavie Blue Cross, as the administrator of the MSI program, is committed to a smooth transition for all Internal Medicine, Pathology and Radiology physicians and stakeholders. As we continue with the transition to electronic billing, we will continue the important dialogue with all stakeholders that has already begun.

Project news and changes will continue to be shared with all affected specialties through the various documents on MSI Website, emails and official bulletin updates. For up-to-date information, please visit the Bulk Billing Transition page on the MSI website.

The following documents are a few of the important information documents that have been published on the MSI Website for your reference:

Internal Medicine Rules Communication

Radiology Rules Communication

Pathology Rules Communication

Questions concerning new or existing business arrangements may be directed to msiproviders@medavie.ca and those concerning the claims submission process to MSI_Assessment@medavie.ca

Rhonda Church, MD,
Medical Consultant, MSI Programs, Medavie Blue Cross

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NEW FEES

Effective April 1, 2015 the following new health service code is available for billing:

Category	Code	Modifiers	Description	Base Units	Anaes Units
ADON	02.89C		**Ultrasound performed by radiologist during premium time** This add-on fee is to be used when an ultrasound must be performed directly by the radiologist due to the absence of an ultrasound technologist, and when it must be done without delay due to the medical condition of the patient during designated times where premium fees may be claimed (Preamble 5.1.84). Each ultrasound must be performed directly by the radiologist (not the resident or fellow) and must include archived diagnostic ultrasound images, a written permanent report, and a verbal report when requested. **Billing Guidelines** Add on to the following HSC's only when US=PREM, or US=PR50: R1205 Ultrasound Abdomen General 25.39 R1212 Ultrasound Appendix 18.75 R1220 Ultrasound Pelvis 18.75 R1225 Endovaginal 26.95 R1226 Endovaginal with pelvic 38.70 R1275 Ultrasound Scrotum 25.45 R1345 Doppler – extremities 18.75 Not to be billed when the scan is performed by the radiology resident or fellow. **Specialty Restriction** DIRD, RADI **Location** HOSP	30 MSU	

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PREAMBLE REVISIONS

<u>PREMIUM FEES</u>

Effective March 27, 2015, select interventional cardiology procedures will be eligible for premium fees, when performed in a cardiac catheterization laboratory.

Eligible interventional cardiology procedures:

Category	Code	Description
VADT	49.96B	Left heart catheterization with angiograms and selective coronary arteriogram
VADT	48.0A	Percutaneous coronary angioplasty (including selective coronary arteriography and right heart catheterization)
VADT	48.0F	Insertion of intracoronary stent - includes one angiogram When a stentor is called in to place a stent during angioplasty by another interventional cardiologist, only 50 units is payable to the stentor. When three or more stents are placed, an additional 25 units is payable regardless of the number of additional stents) - plus multiples, if applicable

Note: Documentation of the time of the procedure and the reason for it being performed during premium hours must appear on the health record for audit purposes. Electively booked procedures do not qualify for premium billing.

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BILLING CLARIFICATION

Non-insured Services - Psychotherapy

Effective April 1, 2015 the following are excluded from the definition of insured psychotherapy and will be added to the list of services not insured by MSI:

- Mindfulness, movement therapy, energy therapy, and other types of alternative or integrative treatments.

BILLING REMINDERS

Immunizations Given by Pharmacists

Beginning in 2013, Nova Scotia pharmacists have been authorized to provide some immunizations to Nova Scotia residents. It has come to MSI's attention that some physicians are claiming for vaccines administered by pharmacists. A physician cannot claim for vaccines administered by a pharmacist.

Synoptic Reporting

This is a reminder that no matter how a patient health record is reported (dictation, synoptic reporting, hand written, etc.) all elements associated with an appropriate claim are still required. Physicians are responsible for ensuring that an appropriate medical record is maintained for all services claimed to MSI (Preamble Section 1.1.33), regardless of the reporting method. In particular, where a procedural code is claimed, the patient record of that procedure must contain information that is sufficient to verify the type and extent of the procedure according to the fees claimed (Preamble Section 1.1.35). While we recognize the potential benefits of synoptic reporting, physicians need to ensure the report is complete. Synoptic reporting software used should enable free text to assist physicians to tailor the information in the medical report, as needed, to reflect the services provided to the patient. If a free text option is not available, it is the physician's responsibility to ensure supporting documentation is incorporated into the medical report as required.

Shadow Billing

All Physicians must submit original claims to MSI within 90 days of the date of service. This includes physicians who shadow bill.

Claims for registered hospital in-patients must also be submitted within the 90-day time limitation regardless if the patient has been discharged or continues on an in-patient basis. It is incumbent on the physician to obtain the required billing information for these patients and submit claims within the prescribed time limitations. Explanations relating to late discharge summaries, or facilities not consolidating the required information for the physician, cannot be accepted as a valid explanation for a late submission.

Service Encounters submitted over the 90-day time limitation will be adjudicated to pay "zero" with the following exceptions:

- Reciprocal billing claims (out of province) must be submitted within 12 months of the date of service.
- Resubmission of refused claims or incorrect billings. These claims must be resubmitted to MSI within 185 days of the date of service. Each resubmission must contain an annotation in the text field of the Service Encounter submission referencing the previous Service Encounter Number.

BILLING REMINDERS CONTINUED

Comprehensive Visit Services

Health service codes exist for both comprehensive and limited visit services. Health service code 03.04 is an unreferred comprehensive visit and health service code 03.03 is an unreferred limited visit. The referred equivalents are health service codes 03.08 (comprehensive consultation) and 03.07 (limited consultation).

Comprehensive visits may be claimed when necessitated by the seriousness, complexity or obscurity of the patient's complaint(s) or medical condition and ensuring a complete history is recorded and a physical examination appropriate to the physician's specialty and working diagnosis are documented. This is outlined in Preamble sections 5.1.7 and 5.1.8.

Documentation of all of the following provide a clear indication that a comprehensive visit or comprehensive consultation has taken place:

A detailed patient history including:

- Relevant history of presenting complaint
- Relevant past medical and surgical history
- Medication list
- Allergies
- Family history, as appropriate
- Social history, as appropriate

As well as a physical exam including:

- A complete physical examination, appropriate to the physician's specialty and relevant to the presenting complaint.
- Documentation describing the pertinent positive and negative findings of the physical examination. It is not adequate to indicate that the "physical exam is normal" without indicating what was examined.

In situations in which these criteria are not met, it would be appropriate to claim the visit as a limited visit or limited consultation.

Services Not Insured by MSI

Services available to residents of Nova Scotia under the Workers' Compensation Act or through the Department of Veterans Affairs are not insured by MSI. Please refer to Preamble sections 2.2.1 and 2.2.2. The physician must determine who has responsibility for payment, if any.

For example:

- Physician services related to a Workers' Compensation Board (WCB) covered work injury. WCB claims are to be billed to WCB, these services are not insured by MSI.
- Physician services related to a Veterans Affairs Canada (VAC) recognized service disability. These claims are to be billed to VAC, they are not insured by MSI.

NEW AND UPDATED EXPLANATORY CODES

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New explanatory codes effective March 27, 2015

Code	Description
AD055	SERVICE ENCOUNTER HAS BEEN REFUSED AS THERE IS NO CLAIM FOR AN ELIGIBLE PREMIUM SERVICE BILLED AT THE SAME ENCOUNTER.
BK041	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS FACILITY IS NOT PERMITTED TO CLAIM FOR THESE MAMMOGRAM FEES.
BK042	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR RENAL STATIC IMAGING AT THE SAME ENCOUNTER.

Below is an explanatory code that will be updated effective March 27, 2015 to state the following:

Code	Description
GN064	SURGICAL ASSIST CLAIMS (RO=SRAS) CANNOT BE CLAIMED UNTIL AFTER THE SURGEONS CLAIM HAS BEEN RECEIVED AND PROCESSED. ONCE THIS IS COMPLETE, YOU MAY RESUBMIT USING THE SAME HSC AS THE SURGEON.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday, March 27, 2015. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanatory codes (EXPLAIN.DAT), modifier values (MODVALS.DAT) and diagnostic codes (DIAG_CD.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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