PHYSICIAN'S BULLETIN

May 22, 2015: Vol. LI, ISSUE 4

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BILLING UPDATE

Claiming a consultation at the time of colonoscopy for FIT positive Colon Cancer Prevention Program (CCPP) patients

Prior to April 1, 2015, physicians providing colonoscopy services to FIT positive CCPP patients booked for colonoscopy by the Program could not claim a consultation fee at the time of the procedure.

Effective April 1, 2015, DHW has agreed that the CCPP Medical Director will formally refer these patients through the district screening nurses. When a patient is referred from the Colon Cancer Prevention Program for a colonoscopy with a formal referral from the Program's Medical Director, a limited consultation HSC 03.07 may be billed at the time of the colonoscopy procedure, in accordance with the Preamble rules, if the patient has not previously been seen in consultation.

When a patient is referred from the CCPP with a formal referral from the Program's Medical Director for a medical assessment prior to booking a colonoscopy a comprehensive (HSC 03.08) or limited (HSC 03.07) consultation may be billed depending on the situation, in accordance with the Preamble rules.

See March 27, 2015 Bulletin for details on the requirements for a comprehensive consult claim.

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NEW FEES

Effective May 22, 2015 the following new health service code is available for billing:

Category	Code	Modifiers	Description	Base Units	Anaes Units
MASG	60.59B		**Proctectomy with rectal mucosectomy, ileoanal anastomosis, and creation of ileal reservoir (Ileal Pouch Anal Anastomosis)** This is a comprehensive fee for a partial proctectomy, with rectal mucosectomy, ileoanal anastomosis, and creation of an ileal reservoir. Includes sigmoidoscopy when performed. **Billing Guidelines** May not be billed with: 1.24C Sigmoidoscopy May be billed with (usual surgical rules apply): 58.21A Ileostomy (LV50) 57.6B Colectomy (LV 50) **Specialty Restriction** Colorectal surgeon, Surgical oncologist **Location** HOSP	630 MSU	8+T

FEE REVISIONS

Effective May 22, 2015 the following health service code will no longer be active.

Category	Code	Modifiers	Description	Base Units	Anaes Units
VADT	03.26C*		**Female pelvic examination with speculum**	10.5 MSU	
MASG	60.31A		**Proctectomy - mucosectomy, ilio-anal anastomosis and ileal pouch**	500 MSU	8+T
		RO=ABAS		135 MSU	
		RO=ABDM	*Replaced by HSC 60.59B	400 MSU	
		RO=PEAS		68 MSU	
		RO=PRIN		200 MSU	

* MSI Physician's Bulletin Update – May 27, 2015*
The terming of HSC 03.26C Female pelvic examination with speculum, on May 22, 2015 was an error.
In the interim, please submit claims using exceptional circumstances (HSC EC).
Please ensure that an annotation is made in the "text" field indicating: 'as per HSC 03.26C'.

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NEW DIAGNOSTIC CODE

New Diagnostic Code for Vitreomacular Adhesion

A new diagnostic code 37927 for vitreomacular adhesion (VMA) will be added to the list of approved "specified retinal diseases" when billing for:

- HSC 02.02A – Optical Coherence Tomography for Macular Analysis in specific retinal diseases
- HSC 28.73F - Intravitreal injection of a pharmacologic agent for the treatment of specific retinal diseases.

The addition of this diagnostic code is being implemented to accommodate the DHW Pharmacare decision to include Jetrea® (ocriplasmin), as an Exception Status Benefit. Please refer to the January 2015 Pharmacare News, Physicians' Edition Bulletin for details on the Exception Status Criteria.

BILLING CLARIFICATION

Please see the following codes that have expanded descriptions to assist with billing the appropriate code:

Category	Code	Modifiers	Description	Base Units	Anaes Units
MASG	97.14	ME=RADI	**Unilateral extended simple mastectomy** This code applies to both radical and modified radical mastectomies. • **Radical mastectomy**: Excision of breast (skin, parenchyma, nipple and areola), the pectoralis major and minor including axillary lymph nodes • **Modified radical mastectomy**: Excision of breast (skin, parenchyma, nipple and areola), the fascia overlying the pectoralis major with or without the pectoralis minor muscle, including axillary lymph nodes. Removal of axillary lymph nodes includes formal axillary node dissection or lymph node sampling or sentinel node dissection for staging. ***Billing Guidelines** This code may not be billed with: • 52.89E Sentinel Lymph Node Biopsy for cancer • 52.42 Radical excision of axillary lymph nodes	280 MSU	

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BILLING CLARIFICATION CONTINUED

Category	Code	Modifiers	Description	Base Units	Anaes Units
MASG	97.15	ME=RADI	**Bilateral extended simple mastectomy** This code applies to both radical and modified radical mastectomies. • Radical mastectomy: Bilateral excision of breast (skin, parenchyma, nipple and areola), the pectoralis major and minor including axillary lymph nodes • Modified radical mastectomy: Bilateral excision of breast (skin, parenchyma, nipple and areola), the fascia overlying the pectoralis major with or without the pectoralis minor muscle, including axillary lymph nodes. Removal of axillary lymph nodes includes formal axillary node dissection or lymph node sampling or sentinel node dissection for staging. ***Billing Guidelines** This code may not be billed with: • 52.89E Sentinel Lymph Node Biopsy for cancer • 52.42 Radical excision of axillary lymph nodes	420 MSU	

* In addition HSC 97.27A Quadrant resection, lumpectomy, radical mastectomy with axillary dissection may not be billed with the following codes:

- 52.89E Sentinel Lymph Node Biopsy for cancer
- 52.42 Radical excision of axillary lymph nodes

BILLING REMINDERS

Consecutive Anaesthetists

As per Preamble section 5.2.51 where one anaesthetist starts a procedure and is replaced by another during an anaesthetic procedure, the first anaesthetist should claim the appropriate basic fee plus time units for the time he/she is present and the second anaesthetist should claim the time units for which he or she is present. The start time of the first anaesthetist shall dictate when double time units begin, for either and both anaesthetists. Services may only be claimed by a physician if they have personally rendered the service (see Preamble section 1.1.6). Anaesthetists are therefore reminded that when consecutive anaesthetists are used each must claim for his/her own anaesthetic time. This applies to both fee-for-service and shadow-billed claims.

Echocardiograms Reminder

When submitting claims for echocardiograms, physicians may claim either I 1312 (Doppler - quantitative) or I1313 (Doppler - qualitative), but not both. A quantitative study includes the elements of a qualitative study.

Cytology Codes

Pathologists are reminded that they may claim either HSC P2330 (cytology with a screener) or P2331 - (interpretation and report - GYN cytology slides) but not both for the same specimen. If a pathologist claims a P2330, then later signs out the case and wishes to change the claim to a P2331, he/she must delete the claim for the P2330 first.

BILLING REMINDERS CONTINUED

Billing of Radiology Services with Premium Fees

MSI has had a number of inquiries from radiologists concerning the use of premium fees (i.e. services claimed with the modifiers US=PREM and US=PR50).

As per Preamble section 5.1.81, premium fees may be claimed when a service (i.e. interpretation of an imaging study), must be performed without delay during designated time periods because of the medical condition of the patient. Premium fees can, therefore, be claimed in situations in which there has been a direct request made to a radiologist for an emergency interpretation of a specific study because of the condition of the patient and the radiologist responds without delay to the request. Services of a non-emergency nature or services of an emergency nature but not performed without delay during these times do not qualify for premium rates. This includes booked procedures performed during premium hours and interpretations done after hours for which there has not been a specific request made to the radiologist about a specific imaging study. If a study has been ordered but the radiologist has not been specifically contacted by the attending physician and requested to provide an emergency interpretation, a premium cannot be claimed.

At the time of implementation of premium fees for radiology in 2002, radiologists were advised that they must maintain a log of bulk billed services that were submitted with premium codes. Although services are no longer bulk billed, all physicians claiming premium fees are required to be able to provide documentation that verifies Preamble requirements for these services have been met.

Intensive Care Units *(5.1.122)*

Intensive care unit (ICU) services refers to services rendered in ICUs approved by the Department of Health and Wellness by physicians who have been assigned by a hospital to the ICU staff by reason of special training or experience. *(5.1.123)*

b) There should only be one day 1 (first day) claimed during the same ICU admission even if the patient's status changes. Day 1 is normally the date of admission to the ICU. However, if the physician does not actually see the patient until the next day, e.g. because a resident is covering, then day 1 can be the date when the patient is first seen by the physician. Day 1 can only be claimed again if the patient is readmitted to the ICU at least 24 hours after discharge. This does not preclude ventilatory care day 1 and critical care day 1 being claimed on the same day. *(5.1.126)*

NEW AND UPDATED EXPLANATORY CODES

Code	Description
CN020	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS AN 03.09B HAS PREVIOUSLY BEEN APPROVED FOR THIS DAY.
CR019	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THE DAY ONE FEE HAS ALREADY BEEN CLAIMED FOR THIS PATIENT DURING THE SAME ICU ADMISSION. PLEASE SUBMIT A NEW CLAIM WITH THE APPROPRIATE DAILY MODIFIER.
GN069	SERVICE ENCOUNTER HAS BEEN DISALLOWED (REFUSED) AS THE SERVICE DATE IS NOT WITHIN THE APPROVED DATE RANGE.
MA061	SERVICE ENCOUNTER HAS BEEN DISALLOWED. PLEASE SUBMIT A REASSESS (ACTION CODE R) ALONG WITH A COPY OF THE OPERATIVE REPORT, AND INDICATE SKIN TO SKIN TIME IN TEXT TO AID IN THE ASSESSMENT.
MJ053	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 01.24C AT THE SAME ENCOUNTER.
VA066	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 60.59B AT THE SAME ENCOUNTER.
VT131	CLAIM HAS BEEN DISALLOWED AS THIS SERVICE SHOULD BE BILLED IN GROUPS OF 3. IF 4 OR MORE ARE NECESSARY, SUBMIT AN ADDITIONAL SERVICE OCCURRENCE FOR EACH ADDITIONAL GROUP OF 3 WITH TEXT.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday, May 22, 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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