PHYSICIAN'S BULLETIN
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NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

PHYSICIAN REGISTRATION PROCESS FOR THE INTERIM FEDERAL HEALTH PROGRAM

The Interim Federal Health Program (IFHP) provides limited, temporary coverage of health-care benefits to people in the following groups who are not eligible for provincial or territorial health insurance:

- protected persons, including resettled refugees;
- refugee claimants; and
- certain other groups.

Basic coverage (similar to health-care coverage provided by provincial/territorial health insurance plans)

- in-patient and out-patient hospital services
- services provided by medical doctors, registered nurses and other health-care professionals licensed in Canada, including pre- and post-natal care
- laboratory, diagnostic and ambulance services

Physicians interested in registering to direct bill for services through this program must register with Medavie Blue Cross to provide services and products to Interim Federal Health Program (IFHP) beneficiaries. To access the provider registration form, please visit: https://provider.medavie.bluecross.ca/.

There is an information handbook for health care professionals available on the Government of Canada website. Please visit: http://www.cic.gc.ca/english/refugees/outside/arriving-healthcare/practitioners.asp for more information.

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FEE REVISIONS

Effective July 28, 2016 the billing guidelines associated with the following health service code have been updated to include R1213 and R1264.

Category	Code	Modifiers	Description	Base 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 **R1213 Ultrasound Kidneys 18.75** **R1264 Cerebral 33.49 (IWK Only)** Not to be billed when the scan is performed by the radiology resident or fellow. **Specialty Restriction** DIRD, RADI **Location** HOSP	30 MSU

Effective April 1, 2016 the surgical assist modifier has been added to the following health service code.

Category	Code	Modifiers	Description	Base Units
MAAS	98.11	**RO=SRAS**	**Debridement of wound or infected tissue**	IC

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FEE REVISIONS CONTINUED

Effective April 1, 2016 premium modifiers US=PREM and US=PR50 have been added to the following health service code.

Category	Code	Modifiers	Description	Base Units
BULK	R1264	US=PREM US=PR50	**Cerebral Ultrasound** In specific clinical circumstances at the IWK Health Centre a cerebral ultrasound and interpretation may be required without delay due to the medical condition of the patient, such as an emergency procedure for neonates with suspected intracranial haemorrhage. In these cases it would be appropriate for the radiologist to claim premium time on the interpretation. **Billing Guidelines** Premiums on R1264 may only be claimed from the IWK **Specialty Restriction** DIRD, RADI **Location** HOSP	33.49 MSU

INTERIM BILLING PROCESS

Medical Assistance in Dying (MAID)

Physicians providing MAID are now able to bill MSI for providing this service. New health service codes are being created for this purpose. In the interim, physicians may bill EC for the following:

First physician:
EC - 30 MSU for the first 30 mins and 15 MSU per 15 mins thereafter to a maximum of 2 hours.
Start and stop times must be recorded in the patient's medical record for the face to face component of the service and on the MSI claim form. Start and stop times for the non-face to face components must also be documented in the patient's medical record and on the MSI claim form. Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family if required. Total duration of all face-to-face and non-face-to face components of the patient's care may be claimed. Physicians may not claim for services provided by non-medical personnel such as nurses and nurse practitioners nor for the services of medical trainees such as residents.

Second Physician:
EC - 30 MSU for the first 30 mins and 15 MSU per 15 mins thereafter to a maximum of 2 hours.
Start and stop times must be recorded in the patient's medical record for the face to face component of the service and on the MSI claim form. Start and stop times for the non-face to face components must also be documented in the patient's medical record and on the MSI claim form. Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family if required. Total duration of all face-to-face and non-face-to face components of the patient's care may be claimed. Physicians may not claim for services provided by non-medical personnel such as nurses, nurse practitioners and pharmacists nor for the services of medical trainees such as residents.

INTERIM BILLING PROCESS CONTINUED

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Prescribing or Administering Physician:
This physician must be either the first physician or the second physician.
EC - 30 MSU for the first 30 mins and 15 MSU per 15 mins thereafter to a maximum of 2 hours.
Start and stop times must be recorded in the patient's medical record for the face to face component of the service and on the MSI claim form. Start and stop times for the non-face to face components must also be documented in the patient's medical record and on the MSI claim form. Non face to face components include all documentation required by the pharmacist and the administration process. Total duration of all face-to-face and non-face-to face components of the patient's care may be claimed. Physicians may not claim for services provided by non-medical personnel such as nurses, nurse practitioners and pharmacists nor for the services of medical trainees such as residents.

If the first or second physician is a specialist and the patient has been formally referred the physician may bill the appropriate specialist prolonged consult fee with the same time documentation requirements as noted above.

If the prescribing or administering physician is a specialist the same EC code noted above will apply.

MAID must be noted in text on the MSI claim form.

PROVINCIAL IMMUNIZATION CORRECTION

Please disregard the fee revision notification of RO=ADPO, which was included in the May 19, 2016 Physician's Bulletin. This modifier has been replaced by RO=TDPP.

Billing Matters Billing Reminders, New Explanatory Codes

BILLING REMINDERS

Reminder – Pathology Consultations

MSI has received a number of queries from pathologists concerning how to claim for review of material submitted by another institution for a second opinion.

Effective April 1, 2016 MSI implemented two interim health service codes for anatomical pathology consultations. These were communicated in the March, 2016 Bulletin and are as follows:

Category	Code	Description	Base Units
CONS	03.09I	**Anatomic Pathology Consultation** **Diagnostic Consultation, with review of records and specimens, with report on referred material prepared elsewhere.** This is a comprehensive, diagnostic consultation on materials prepared in a separate licensed pathology laboratory. The service includes: a review of the consultation documents submitted by the referring physician, including clinical reports and laboratory data, discussion with the referring pathologist, as appropriate, literature review, and generation of the report to the referring physician. **Billing Guidelines** May not be billed with any other diagnostic tests on the same case. **Specialty Restriction** PATH **Location** HOSP	45 MSU

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Category	Code	Description	Base Units
CONS	03.09J	**Anatomic Pathology Consultation** **Special Diagnostic Consultation, with review of records and specimens, with report on referred material and requiring preparation of additional slides, and/or ordering and interpretation of special tests.** This is a comprehensive, special diagnostic consultation on materials prepared in a separate licensed pathology laboratory that require the ordering and interpretation of additional slides and routine staining (e.g. H&E), and/or the ordering and interpretation of special diagnostic tests such as electron microscopy, immunohistochemistry, and molecular tests. The service includes: a review of the consultation documents submitted by the referring physician, including clinical reports and laboratory data, discussion with the referring pathologist, as appropriate, ordering and interpretation of additional slides and routine staining (e.g. H&E), literature review, and generation of the report to the referring physician. The following special tests maybe reported in addition to the consultation: electron microscopy, immunohistochemistry, and molecular tests. **Billing Guidelines** The interpretation of the following special tests: • Electron Microscopy • Immunohistochemistry • Molecular Tests May be billed in addition to the consultation, as required, using the same service date as the consultation. **Specialty Restriction** PATH **Location** HOSP	60 MSU

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These HSCs are for use when a pathologist has been asked to review material sent by an outside institution or when a second opinion is medically necessary from a pathologist who has additional training/expertise in the area of concern. They may not be claimed for quality assurance activities. When claiming these HSCs the date of service on the claim should reflect the date the pathologist has rendered the opinion.

Reminder – Botox Guidelines

MSI insures the injection of Botox by physicians for the following clinical indications only:

- focal spasticity related to stroke, multiple sclerosis, spinal cord or traumatic brain injury
- laryngeal dystonia
- equinus foot deformity in cerebral palsy patients 2 years of age and older
- cervical dystonia
- blepharospasm, hemifacial spasm (VII nerve disorder) or strabismus in patients 12 years of age and older
- achalasia
- urinary incontinence due to neurogenic detrusor overactivity resulting from neurogenic bladder associated with multiple sclerosis (MS) or subcervical spinal cord injury (SCI) in patients who have failed to respond to behavioural modification and anticholinergics and/or are intolerant to anticholinergics
- idiopathic overactive bladder unresponsive to behaviour modification, medications and peripheral nerve stimulation

Reminder - Storage and Maintenance of Clinical Records

As per Preamble section 1.1.40, physicians are required to maintain records supporting services claimed to MSI for a period of five years in order to substantiate claims submitted. When implementing business practices at the time of entering into a group practice or locum tenens, or when winding down a practice, physicians should confirm that their records will be easily retrievable if they are required to substantiate claims to MSI.

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Reminder – Psychotherapy and Counselling Services

Physicians are reminded that the following services require a minimum of two time intervals/three multiples be claimed (i.e. a minimum of 30 minutes):

HSC 08.19A Child Psychiatric Assessment
HSC 08.43A Behavioural Management
HSC 08.49B Psychotherapy
HSC 08.44 Group Psychotherapy
HSC 08.45 Family Therapy
HSC 08.41 Hypnotherapy
HSC 08.5B Psychiatric Care by a Psychiatrist

HSC 08.5A Clinical Psychiatry by a Psychiatrist requires a minimum of four time intervals/five multiples (i.e. 60 minutes) be claimed.

As always, start and finish times must be recorded on the patient record and additionally in the text field in the claim. Physicians must spend at least 80% of the time claimed in direct intervention with the patient(s).

Reminder – Comprehensive Visits

Physicians are reminded that health service codes exist for both comprehensive and limited visit services. Health service code 03.04 is an un-referred comprehensive visit and health service code 03.03 is an un-referred 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.

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BILLING REMINDERS CONTINUED

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Reminder – Telemedicine Fees

Physicians are reminded that the modifier ME=TELE is to be used to indicate telemedicine consultation when using the provincial telehealth network. It cannot be used when providing services utilizing other platforms, such as Skype, email or telephone.

Reminder – The "Meet and Greet"

Physicians are reminded that Preamble rules stipulate that all services billed to MSI must be medically necessary i.e. there must be a specific health related concern/complaint that has led the patient to seek medical attention. It is not appropriate to bill MSI for a "meet and greet" visit with a new patient unless a health related concern/complaint has been addressed at the visit. Similarly, it is not appropriate to bill a comprehensive visit or counselling for such encounters unless the visit is medically necessary and Preamble requirements for these codes have been satisfied.

Reminder – HLA Typing and HLA Identification/Crossmatch

HLA typing (04.49A) is a service provided for a patient awaiting a transplant, HLA identification/crossmatch is conducted on the potential donor. A patient should not receive both of these services on the same day as an individual cannot be both a donor and a recipient at the same time.

NOTICE

Payment Statement Recreation

During the period of December 23, 2015 – April 13, 2016 it was identified that reversed claims were not represented on the pay statements accessed via your software vendor.
Upon request, MSI will begin regenerating statements for the following payment dates:

December 23, 2015
January 6, 2016
January 20, 2016
February 3, 2016
February 17, 2016
April 13, 2016

Please note, if you have already made a request for a corrected statement, you do not need to send in your request a second time. We have all requests on file and will begin the process of sending these statements out effective immediately. We appreciate your patience during this time while we work through the back log.

For any physicians who have not yet made a request for a regenerated statement, you can do so by sending a fax to MSI at 902-490-2275. Please send the fax on letter head and include the provider number, business arrangement, contact number and payment date for which you require the statement regenerated.

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NEW EXPLANATORY CODES

Code	Description
VE017	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 04.49B HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY.
VE018	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 04.49A HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY.
BK057	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE CANNOT BE BILLED FROM THIS FACILITY.
GN080	MSI RESULT

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

UPDATED FILES

Updated files reflecting changes are available for download on Thursday, July 28, 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/

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