NOVA SCOTIA MEDICAL SERVICES INSURANCE

Bulk Billing Transition

Frequently Asked Questions

Updated May 2015

Table of Contents

NOVA SCOTIA MEDICAL SERVICES INSURANCE

NOVA SCOTIA MEDICAL SERVICES INSURANCE

New / Updated Questions and Scenario Explanations

How long are the interim diagnostic codes going to be used?

The Physician Manual Modernization project is underway and DHW has indicated that any new, permanent codes would be created to align with that project. Current estimates suggest completion in late 2017. Until such a time that new codes are formalized, the interim diagnostic codes will be used.

What are we expected to do if we don't have the required field information for electronic claims submission?

If you are missing information relating to patient identification or other fields in the claims submission form, it is best to first speak with your Health Information Systems contact.

If you are missing information related to diagnostic codes, please refer to the **Interim Diagnostic Code document**. If that does not provide adequate clarification for you, please contact MSI Programs at **MSI_Assessment@medavie.bluecross.ca**, 1-902-496-7011 or toll free at 1-800-553-0585.

Can you please clarify billing procedures? When is it billed at 100% vs 50%?

Any services that are currently bulk billed will continue to be paid at 100% for each service after the transition to patient specific codes. There will be no reduction to 50% for subsequent services provided to a patient on the same day.

Currently VADT and VEDT health service codes are set up such that the first service pays at 100% and subsequent services pay at 50%. There will be no change to the adjudication rules currently used for these services after the transition.

How are multiple procedures performed on the same patient on the same day to be billed?

Each procedure should be billed as its own separate service encounter. If two procedures are performed at the same time, then those procedures should be billed with the same service occurrence number. If the procedures occur at different times, the earlier procedure would be service occurrence 1 and the later would be service occurrence 2, etc. No matter the timing of the procedure all of the previously Bulk Billed codes should be billed at 100%. There is no 50% reduction for subsequent services.

Please clarify who the "initial provider" is – is it the referring doctor or the Radiologist reading the x-ray? How should the service occurrence number be determined? Can we consider all interpretations for one patient by one radiologist each day to be a single encounter?

The service occurrence field for interpretation services is calculated from the point of view of the physician performing the interpretation, not from the visit in which the patient had direct contact with a service provider.

For example: If a hand x-ray for a patient occurs at 10:00 a.m. and 2:00 p.m. with both interpretation requests sent to the same radiologist, that physician would bill those encounters as service occurrence 1 and 2 respectively. If these interpretations are split between two radiologists then each physician would bill service occurrence 1 for their reports. If two interpretation requests are generated for the same patient from the same encounter and sent to the same physician (such as hand x-ray and forearm x-ray at 10:00 a.m.) both of these services should be billed with the same service occurrence number.

What are the technical specifications for electronic submission of service encounters and retrieval of the adjudication responses? What are the requirements to have software accredited?

The technical specifications are available to accredited vendors. To have claims submission software accredited, you must become an accredited software vendor. Interested parties can contact MSI Programs to get the Accredited Software Vendor information kit, which includes the following:

- A Vendor Application Form which must be completed and returned to MSI
- Medical Services Insurance Requirements for Accreditation of Electronic Submission
- MSIeLink Submitter Documentation for Electronic Claims Submission
- Service Encounter Transaction Standards
- Medicare Fee for Service Electronic Statement

We would then follow up with additional documents to aid in the development of your system when the application is received. Once someone has software that has been accredited to submit to MSI, the process to become a registered service bureau is simple.

For more details on this process, please refer to the **MSI Accreditation Process document**

What steps are necessary to become a registered service bureau?

If someone wishes to become an approved service bureau, they can contact MSI Programs and we will send them the following:

- A Service Bureau Submitter Application which needs to be completed, and returned to our office

Once the application has been processed, the name will be added to the listing of Service Bureaus, and the Submitter ID would be assigned. Accredited claims submission software is required by all Service Bureaus. To acquire the accredited software, please refer to the **MSI Accredited Software Companies list** available on the MSI website.

Will there be an extension of the usual 90 day acceptance window for claims to MSI in recognition of the significant disruption this new process entails?

Outdated claims submissions will be reviewed on a case by case basis and extenuating circumstances will be evaluated. Please see page 5 of the June 2013 Bulletin for details.

How many claims can the system handle? The maximum batch allowance is 99,999 claims but an unofficial guideline is 500 claims per batch. With a claim for every encounter, this will significantly increase volumes. Has the system been tested to handle upwards of 20,000 claims per batch?

MSI conducts volume load testing on a regular basis. A batch can have a maximum of 99,999 transactions, although MSI Programs recommends that batches have between 100 – 500 transactions. This recommendation has always been in place. Following these recommendations will ensure the timely process and adjudication of electronic claims for payment purposes.

There are no issues from a volume perspective for the batch to handle a maximum of 99,999 transactions. However, there may be an issue with claims being processed in a timely manner if a group submits all 20,000 claims in one batch on the evening of cut-off date for electronic claims submission. The claims may not be adjudicated (processed) within the required time frame for payment on the upcoming pay period.

It is also recommended that physicians discuss submission criteria with their chosen software vendor.

Can you provide an example of an appropriate submission for a sample John Doe patient who might have a Chest x-ray?

Sample scenario: An individual is admitted to the Yarmouth Regional Hospital with chest pains on Feb 1, 2015. A chest x-ray is performed at 1:00 p.m. and interpretation occurs by the Radiologist on the same day.

For this claim here is the information required for submission:

- Provider Type = PH
- Provider number = (ex.123456)
- Provider specialty code = (ex.DIRD)
- Patient health card number (ex.1234567890)
- Patient Birth date = (ex. 01 January 1970)
- Health service code = R404 (Chest - Single view)
- Service start date = 01Feb2015
- Service occurrence number =

  1 (1st time the patient was seen that day)
- Diagnostic code = (ex. R999)
- Multiples = 1
- Modifiers = none in this instance
- Facility code = 56
- Functional centre code = INPT (in-patient)
- Location code = HOSP
- Business arrangement number = (ex. 123456)
- Pay to code = BAPY
- Referring provider type and number = Not necessary for this claim, but can be included if you wish.
- Payment responsibility = MSI
- Program code =MC
- Hospital admit date = 01Feb2015
- No electronic text necessary on this particular claim.

If a chest c-ray, CT chest, and bone scan were completed at the same visit, each would be billed as a separate service encounter with the relevant information

What demographics or claim information will MSI require to submit patient specific claims?

Here's a quick list of what will need to be included on the claim for processing. This is the same information that is currently required by other specialties for patient specific electronic billing.

1. Provider Type
2. Provider Number
3. Provider Specialty Code
4. Patient Health Card number (if they are a resident of NS)
5. Patient Birth Date
6. Health Service Code
7. Service Start Date (the date patient had the procedure)
8. Service Occurrence Number
9. At least one diagnostic code on the claim (room for three)
10. Number of multiples being claimed on the service (default is 1)
11. Modifiers if any exist on the service. An example would be a US=PREM for a service performed during premium time.
12. Facility Code (hospital number)
13. Functional Centre Code for area in the hospital (outpatient, in-patient, ICU, etc.)
14. Location code (should be HOSP in most instances for radiology)
15. Physician Business Arrangement Number
16. Pay to code (usually BAPY)
17. Referring Provider Type and Referring Provider Number be necessary for a small number of codes at this time (ex. R1)
18. Payment Responsibility (MSI)
19. Program Code (MC)
20. Hospital Admit Date, depending on which functional centre the service was performed in
21. If the patient is from Out of Province, then information is required such as name, birth date, gender, address, etc.
22. Electronic Text will be necessary to facilitate the payment of some claims

More information on what is required for electronic claims can be found in section 3.2.48 of the 2014 Physician's Manual and in the Fields Required for Patient Specific Billing document found on the MSI website www.medavie.bluecross.ca/msiprograms

What if I don't have access to diagnostic information?

The 'diagnosis information' is the diagnosis of the physician submitting the claim. We recognize that currently there are not sufficient codes for the broader interpretations as needed for patient specific billing. To address this, we have developed an interim solution with new diagnostic codes for those general interpretations.

Interim diagnostic codes for all three specialties can be found on the MSI website under the Bulk Billing Transition Project section.

How do I determine the appropriate Service Occurrence if I'm performing an interpretation?

The service occurrence field is not quite as straight forward for interpretations as it is for physicians who actually have direct contact with the patient. As such, the only way to base which SOC to use would be from the point of view of the Radiologist.

Example: if an x-ray service occurs at 10:00a.m., then another at 3:00p.m., and both are sent to the same Radiologist, the 1st x-ray would be SOC = 1 and the 2nd would be SOC = 2. If the different x-rays are sent to two separate Radiologists, both would bill SOC = 1 as it is the first "encounter" each Radiologist had with the patient on that day. We would not expect the Radiologists to base their SOC on the service encounters of other physicians they may not have knowledge of.

If two different x-rays for the same individual were to occur at 10:00a.m. and sent to the same Radiologist for interpretation, then both those services should be billed as SOC = 1.

We have been in talks with representatives from Meditech and Capital health to insure the time of service is provided on their reports so that the radiologist can determine which SOC should be used.

Why can't we establish a direct data feed from the hospital admin systems to MSI?

Claims submission requires more than just a direct data feed from an IT system to MSI. Claims submission requires an interface that can support two-way communication that allows, not only that MSI receive data, but also allows MSI to send responses back to the physicians.

This two way communication is essential. When a claim is submitted, MSI sends an adjudication response to the physician. This adjudication response advises whether a claim was accepted, or, if it was not, the reason why and what follow-up is required.

General

What are the acronyms used?

BA – Business Arrangement

HSCs – Health Service Codes

IM – Internal Medicine

RAD – Radiology

PATH - Pathology

What facility number should I use when submitting a Pathology Claim?

MSI requests that you use the facility number i.e. hospital where the pathology specimen was accessioned (signed out). This will provide an accurate facility number of where the reports are stored.

Why is the process for claims changing?

There are two primary factors driving the change. First, Bulk Billing does not require physicians to include patient-specific details when submitting their claims. This results in incomplete MSI patient histories. Secondly, this lack of patient specific information prevents the Department of Health and Wellness from reciprocally billing other provinces for medical services provided to non-resident patients. Both of these issues are resolved by linking patient specific information to the health services code.

Who is impacted by this change?

This transition impacts radiology, pathology and some internal medicine codes. Radiologists, Pathologists, Internal Medicine physicians and those in specialty groups using approved bulk billing codes will be directly impacted by the change. The administrative requirements for electronic billing may impact billing departments at the outset of the transition.

Why is it changing now?

The system for claims submission is evolving. As we move to the new system there is a need to have patient specific data which is not possible with bulk billing claims. The next milestone of the system evolution is the removal of bulk billing as an administrative option which will be in place as of July 1, 2015.

How do I determine if I'm already set up in the system?

Contact the Provider Coordinators to review your file and your BA status. They can be reached at:

Local Fax: 902-469-4674

Toll Free Fax: 1-877-910-4674

Email: msiproviders@medavie.ca

Who do I speak with if I have questions?

The MSI General Assessment Team can assist with additional questions. They can be reached at:

Local Phone: 902-496-7011

Toll-Free Phone: 1-866-553-0585

Email: MSI_Assessment@medavie.ca

Who do I speak with if I have trouble with claims submissions or set up?

The MSI General Assessment Team (contact information above) can assist with claims submission and set up troubleshooting.

Why is the roll out structured in phases?

The phased approach has been established to give adequate time for impacted physicians to adapt their billing systems and set up BAs where necessary. The groups were selected based on size and estimated impact.

What do I use for a payment responsibility?

Normally the payment responsibility for most services is entered as MSI. However, there are instances where the payment responsibility will change, for example; service encounters under Workers' Compensation Board (WCB), Out of Province (OOP) and Community Services (COM). If the service encounter is for services provided to a non-resident registered with another provincial health plan except Quebec the home province code is entered in this field, e.g. NB, ON, PE. The service also requires a person data record for the non-resident.

Acceptable province codes:

NB - New Brunswick
PE - Prince Edward Island
NL - Newfoundland
ON - Ontario
MB - Manitoba
SK – Saskatchewan
AB - Alberta
BC - British Columbia
YT - Yukon Territories
NT - Northwest Territories
NU - Nunavut

Is it appropriate to bill both MSI & Workers' Compensation Board (WCB) for the same service?

No, it is not appropriate to bill both MSI and WCB for the same service.

Can Worker's Compensation Board (WCB) service encounters for non-residents be billed to MSI?

No, WCB service encounter for a non-resident cannot be submitted electronically to MSI for payment. Service encounters for services provided to a non-resident temporarily working for a Nova Scotia company, as a result of an on the job injury, should be submitted directly to the Nova Scotia WCB at the following address:

Workers' Compensation Board of Nova Scotia
5668 South Street
PO Box 1150
Halifax NS B3J 2Y2

Service encounters and appropriate WCB forms provided to a non-resident working for a non-Nova Scotia company must be sent directly to the WCB of their home province. Check with the patient to determine which province is responsible for the WCB claim.

Are there any age limitations associated with Workers' Compensation Board (WCB) claims?

Yes, WCB claims can only be claimed for Nova Scotia residents 16 years of age and over who are eligible for MSI coverage.

Fees

Will there be an increase to fees from my software vendor?

All vendor fee questions are best directed to your vendor.

Important dates

When does the transition start, when is the final cut off from bulk billing?

New go-live dates for all groups:

Internal Medicine - new go live date March 1, 2015
Radiology - new go live date April 1, 2015
Pathology - new go live date April 1, 2015

All claims performed with a service date on or after the respective go live dates, will only be accepted as electronic claims submissions.

How will I submit claims with a service date prior to the go live date?

IM claims performed with a service date prior to the go live date of March 1, 2015 will only be accepted via bulk billed claims submissions. MSI Bulk Billed functionality will only be available until July 1, 2015 therefore all IM claims prior to March 1, 2015 must be submitted prior to July 1, 2015.

RAD and PATH claims performed with a service date prior to the go live date of April 1, 2015 will only be accepted via bulk billed claims submissions. MSI Bulk Billed functionality will only be available until July 1, 2015 therefore all RAD and PATH claims prior to April 1, 2015 must be submitted prior to July 1, 2015.

Will the cut off dates change as a result of this transition?

The submission date will change; the payment date remains the same. Under the bulk billing system, claims were due on Mondays by 11:00am. Payments were made on Wednesday of the following week. Now, with electronic claims submissions, claims must be received, processed and accepted by 11:59pm on the cut-off date (usually every second Thursday) to ensure processing for that payment period. This usually gives physicians an additional three (3) days to submit electronic claims. Payment schedules are published before the beginning of each year, with the MSI Physicians' Bulletin and on the MSI Website.

Vendors/Billing Services

Will physicians receive any assistance to purchase a vendor system?

No, there is no funding available to assist with the transition to electronic claims.

Where can I find someone to enter my billings into the new system?

Doctors Nova Scotia can provide information on service bureau billing agencies. For further information, please contact:

Brent Andrews
EMR advisor (Districts 1,2,3,4, 9 and IWK)
(902) 225-8577 (cell)
brent.andrews@doctorsns.com

Derek Stewart
EMR advisor (Districts 4, 5, 6, 7, 8)
1-800-563-3427 ext. 298 (office)
(902) 565-4568 (cell)
derek.stewart@doctorsns.com

A list of services bureaus can also be found in your transition information kit, as well as on the MSI website: www.medavie.bluecross.ca/msiprograms

Where can I find a list of software vendors?

A list of vendors that are currently registered with MSI can be found in your transition information kit, as well as on the MSI website: www.medavie.bluecross.ca/msiprograms

Process

Is there any incentive to start billing electronically right away? What is the practical impact?

There are a few immediate benefits to physicians: you go paperless and no longer have to fill out the billing sheets to submit to MSI. Claims can be adjudicated as soon as they are entered into the system, and a response is sent immediately.

I have a departmental billing group that handles these claims. How are they being advised of these changes?

District Health Authorities Vice Presidents of Medicine have been informed of these changes as have the impacted physician groups. It is the responsibility of both the VPs and the physicians to share the details of these changes with their billing staff. A letter is included in your package that can be shared with district administration, which helps explain the new requirements.

How can I enter billings myself?

Specialized software is needed to submit electronic billing to MSI. A list of Accredited Software Vendors is included at the end of this document. Your office would need to purchase an online billing system. Alternatively, you can secure the services of a service bureau; a list of suppliers is included at the end of this document.

Why is bulk billing being phased out for electronic billing?

Bulk billing was a manual process, and does not require patient specific information in the claims submission. Electronic billing streamlines all physicians billing in the province into one system, decreases the turnaround times for adjudication and allows for the input of additional patient information. Identification of the patient will allow the Department of Health and Wellness to reciprocally bill other provinces for specialized services performed on non-resident patients. These benefits are not currently realized under the bulk billing system.

Will we need new Business Arrangements?

Only if you do not currently have one for electronic billing or if you would like an additional BA for tracking purposes. Some Radiology, Pathology, Internal Medicine and specialty group physicians already have a Business Arrangement for electronic billing. To set up a new Business Arrangement, you can speak with the Provider Coordinators. They can be reached at:

Local Fax: 902-469-4674

Toll Free Fax: 1-877-910-4674

Email: msiproviders@medavie.ca

Will I still receive a paper statement?

No, paper statements will cease. You will now be able to download your statement through MSI e-link. Should you have questions about downloading your statement, please discuss with your vendor. Alternatively, if a service bureau is submitting your claims, you may ask them for a print-out of your payment statement.

Codes

Will there be new codes?

Generally, the codes will stay the same. Older premium codes (3000s and 5000s) will be removed and replaced with premium modifiers (US=PREM and US=PR50) on the base fee codes. These modifiers also align with all other fee for service premium services. The interim diagnostic codes for all three specialties can be found on the MSI website under the Bulk Billing Transition Project section.

Are there rules surrounding the codes, will the rules change?

Rules outlined in the Physicians Manual, MSI Physicians' Bulletins, and Department of Health and Wellness policy documents remain in place. Rules for each specialty are posted on the MSI website under the Bulk Billing Transition Project section.

Are the codes still going to be paid the same units or will they have an increase?

The codes will remain at the same unit value.

Questions? Give us a call.

MSI's General Assessment Team is here to help you with the transition to electronic claims submissions. If you have questions not covered in this package, please contact us.

Local Phone: 902-496-7011

Toll-Free Phone: 1-866-553-0585

Email: MSI_Assessment@medavie.ca

Available 8:00 am to 5:00pm Monday to Friday (excluding holidays)

Our Provider Coordinators are ready to help you set up a Business Agreement. If you have questions about this process, please contact us.

Local Fax: 902-469-4674

Toll Free Fax: 1-877-910-4674

Email: msiproviders@medavie.ca

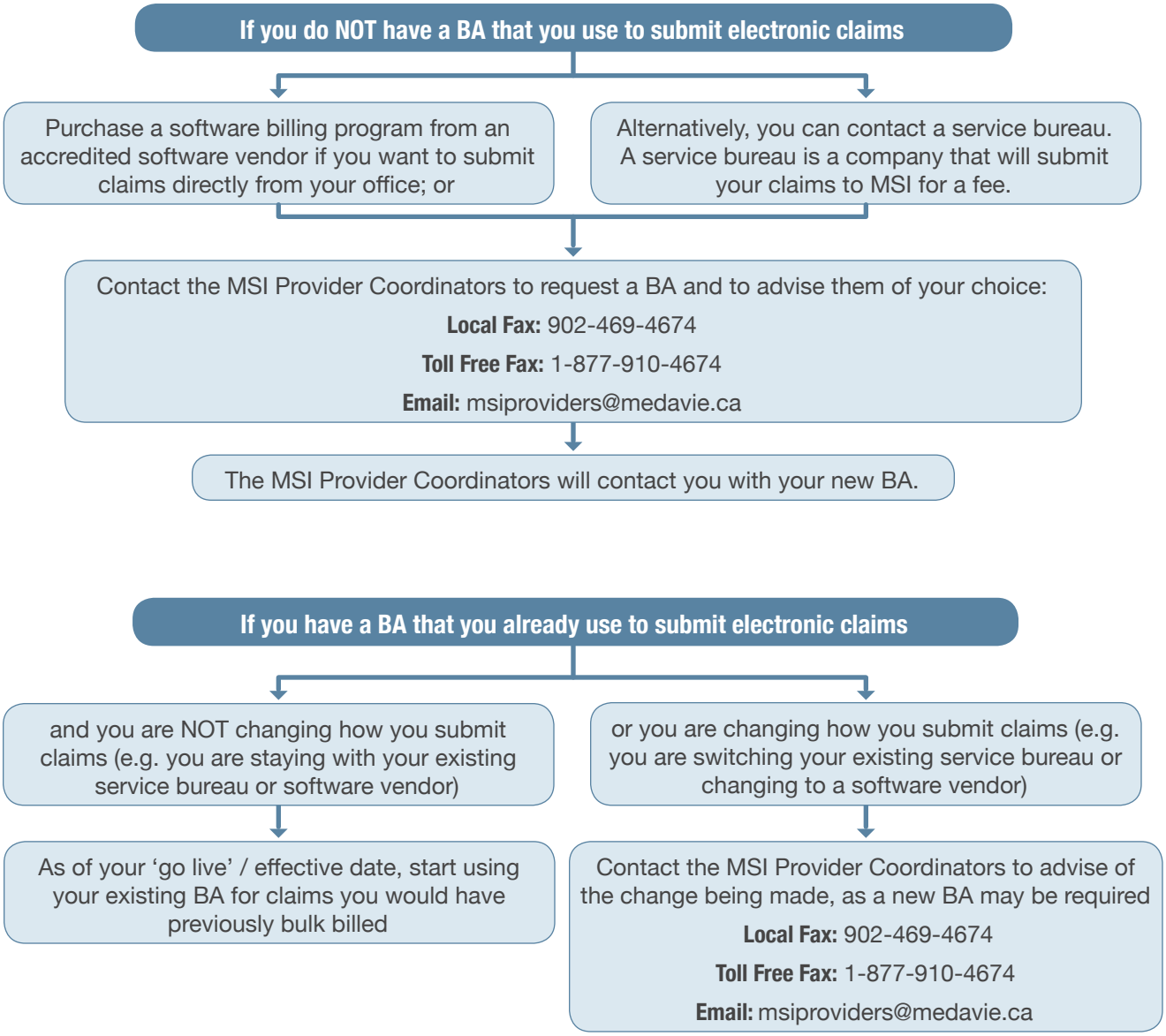
Available 8:00 am to 5:00pm Monday to Friday (excluding holidays)

Bulk Billing Flow Chart

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Am I ready to submit Patient Specific Electronic Claims?

MSI will use existing banking information when setting up a BA. If you wish for your banking information to be changed or updated, you must complete and submit an MSI Business Arrangement Form with a VOID cheque.



Note: MSI Business Arrangement Forms, Software Vendor Lists and Service Bureau Lists can all be found on the MSI Website at: www.medavie.bluecross.ca/msiprograms

Also, a list of Software Vendors and Service Bureaus have been provided in your package.

NOVA SCOTIA MEDICAL SERVICES INSURANCE

MSI Information System Service Bureaus

Current as of January 2015

Company	Contact	Location	Telephone
San T Claims Services	Sherry Gray	Bedford	902-832-2749
Personal Billing Services	Elizabeth Morgan, Terry Wagner	Halifax	902-479-0046
Office Services	Pam Patterson	Kingston	902-847-0061
MacNeil Claims Management	Daniel C. MacNeil	Sydney	902-539-6519
Hopper	Janice Hopper	Eastern Passage	902-497-0422 902-431-1800
Sandra Langthorne	Sandra Langthorne	Fall River	902-233-1825 902-473-6238
Medex	Connie Tone	Halifax	902-868-2170
By the Bay Admin Services	Melissa Hiltz	Mahone Bay	902-624-0191
Proactive HealthCare Recruiting Inc	Barkaat Ahmad	Sydney	902-578-6568