PHYSICIAN'S BULLETIN

August 4, 2017: Vol. LIV, ISSUE 6

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT UPDATE

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been applied to the listed WCB specific fees for fiscal years 2015-16 and 2016-17.

Due to the increase in CPI for fiscal year April 1st, 2015 - March 31st, 2016 any of the WCB specific services listed below provided over this time will have their values retroactively increased by 1.74%. Physicians will be remunerated for the outstanding value of any services rendered over this period via a onetime payment on August 2, 2017.

Also due to the further increase in CPI for fiscal year April 1st, 2016- January 26th, 2017 any of the WCB specific services listed below provided over this time will have their values retroactively increased by a cumulative 2.137% (1.74% for 2015-2016, 0.39% for 2016-2017). Physicians will also be remunerated for the outstanding value of any services rendered over this period via a one-time payment on August 2, 2017.

CODE	DESCRIPTION	VALUE
WCB12	EPS physician assessment Service. Combined office visit and completion of Form 8/10 For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15 minute increments to a maximum of 1 additional hour	**Initial visit:** $174.93 + $51.11 per 15 minutes to a maximum 4x (RO=EPS1 and RP=INTL) **Subsequent visit:** $174.93 (RO=EPS1 and RP=SUBS)
WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable	GPs.....$42.72 per 15 min EPS(RO=EPS1)$51.11 per 15 min Specialists.....$57.49 per 15 min
WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable	GPs.....$42.72 per 15 min EPS(RO=EPS1)$51.11 per 15 min Specialists.....$57.49 per 15 min
WCB17	Photocopies of Chart Notes	10 pgs or less (ME=UP10)..$25.56 11-25 pgs (ME=UP25).....$51.11 26-50 pgs (ME=UP50)..... $102.17 Over 50 pgs (ME=OV50)...$153.25
WCB20	Carpal Tunnel Syndrome (CTS) Assessment Report	$65.56
WCB21	Follow-up visit report	$38.33
WCB22	Completed Mandatory Generic Exemption Request Form	$12.80 per form
WCB23	Completed Non-Opioid Special Authorization Request Form	$12.80 per form
WCB24	Completed Opioid Special Authorization Request Form	$42.96 per form
WCB25	Completed WCB Substance Abuse Assessment Form	$28.62
WCB26	Return to Work Report – Physician's Report Form 8/10	$65.56
WCB27	Eye Report	$57.49
WCB28	Comprehensive Visit for Work Related Injury or Illness	$65.96

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MEDICAL ASSISTANCE IN DYING (MAID)

The MAID fees are currently interim while data is gathered. They are categorized as independent consideration (IC) and have no automatic MSU value in the system. Each claim submitted is held by MSI and manually adjudicated based on the information provided by the submitter in the claim text. As this is an interim fee the collection of data is important in considering a permanent fee in the future.

Claims will be processed independently of other physicians involved in the MAID services. This means that health service codes for the first, second and prescribing physicians will be reviewed as received and not held waiting for other MAID claims. All other applicable billing guidelines will apply in the processing of these health service codes.

Fees New Fees and Highlighted Fees

NEW INTERIM FEES (2015-2019 MASTER AGREEMENT)

Mindfulness-Based Cognitive Therapy (MBCT)

Physicians are asked to hold these claims until notified that they may be submitted for payment.

PLEASE NOTE: **Physicians eligible to claim this code are restricted to PSYC trained in MBCT or GENP trained in group psychotherapy and MBCT.** Credentials must be submitted to MSI directly. Once MSI receives a physician's credentials and grants approval, the physician will be permitted to claim for this fee after the next system update. **Once the physician has contacted MSI with their credentials, the physician is advised to hold their claims until the next system update**.

Category	Code	Description	Base Units
PSYC	**08.44A**	**Mindfulness-Based Cognitive Therapy (MBCT)** **Group therapy fee per patient per two hour session (minimum 8 to maximum 12 patients per group)** MBCT is defined as a specific psychological intervention incorporating elements of cognitive behavioural therapy and mindfulness. This fee is for each two hour session of the eight week MBCT course provided for a group of 8 to 12 patients with recurrent episodes of depression. **Billing Guidelines** Fee is per patient, per two hour session. Session dates and start/stop times must be documented in the health record of each participant. One series of 8 sessions per patient per 365 days. Additional fees may be charged to the patient for non-billable services such as the provision of course materials and for the services of a privately paid non-MD therapist if applicable.	14.3MSU

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Category	Code	Description	Base Units
		Specialty restriction • GENP with approval from MSI. • PSYC with approval from MSI. Physicians approved to report this HSC will be required to provide proof that they have completed a minimum five day intensive training in MBCT for MBCT providers within the last five years (for example, a seven day retreat in Mind-Body Medicine from the Centre for Mindfulness in Medicine, Health Care and Society or equivalent), and attest to an ongoing personal mindfulness practice. GENP will, in addition to the above, need to provide evidence of training in the provision of group psychotherapy from a recognized training program and of ongoing practice in mental health and group therapy. PSYC are considered to have had training in the provision of group psychotherapy through their respective residency programs. Start and stop time to be documented in health record and also in the text field of the claim to MSI. However session outline and activities are standardized to be completed in 2 hours. **Location** LO=OFFC, HOSP, OTHR	

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BILLING CLARIFICATIONS

The following communication is to clarify information published in the May 18, 2017 MSI Physicians Bulletin regarding Ophthalmology Services. As a reminder, the Preamble and related MSI Physicians Bulletins are the authority for the proper interpretation of the fee schedule. All inquiries on appropriate billing should be directed to MSI.

Vision Screening for Type 2 Diabetes

As per the Canadian Diabetes Association guidelines for vision screening, effective April 1 2017, residents with type 2 diabetes will only be eligible for a complete eye examination every 2 years. Residents with type 1 diabetes and residents with type 2 diabetes and retinopathy will be eligible for a complete eye examination every year. Diagnosis must be confirmed in the resident's medical chart.

Clarification: The information posted was to bring awareness to the Canadian Diabetes Association's vision screening guidelines which will be applied to Nova Scotia's optometry benefits. The change to Nova Scotia's optometry benefits was done in consultation with the Nova Scotia Association of Optometrists, the Diabetes Care Program of Nova Scotia and an Ophthalmologist practicing in Nova Scotia. There have been no changes applied to the policy for vision screening provided by physicians; physicians should continue to provide vision screening as medically required.

Cataract Surgery

Ophthalmologic surgeons are reminded that monitoring of intraocular pressure is a part of the customary operative or post-operative care when providing cataract surgery. Health Service Code 03.12 should not be reported in addition.

Clarification: This would apply only to the day of surgery and not over the remainder of the postoperative period.

Trabeculectomy and Trabeculoplasty

Health service codes for Trabeculectomy (HSC 26.25, 26.25B, 26.25C and 26.25D) and trabeculoplasty (HSC 26.29D and 26.29E) are for invasive major surgical procedures and as such may only be claimed for services provided in an operating room.

Clarification: Physicians may continue to bill HSC 26.29D Trabeculoplasty in an office or hospital setting. The May bulletin reminder still applies to the Trabeculectomy codes. These procedures must be performed in an operating room.

BILLING REMINDERS

Complete care codes

As per Physician's Manual Preamble section 7.4.1, 'Complete care codes are minor surgical procedures, which include the visit the same day and related visits by the same physician for 14 days following the procedure'.
Counselling related to the procedure cannot be claimed during this period.

Other repair and plastic operations on trachea, tracheal splint, transthoracic

HSC 43.69 other repair and plastic operations on trachea, tracheal splint, transthoracic may only be claimed by GNSG and THSG.

Exploration of peripheral nerve

17.5A – Exploration of peripheral nerve transplant or nerve transposition with or without neurolysis (excluding median nerve at carpal tunnel) is only to be claimed when the surgery is performed on peripheral nerves. This code may not be used for operations on cranial nerves.

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Surgical access

Physicians are reminded that procedures used to provide the surgical exposure (e.g.-laparoscopy, sinusoscopy, cystoscopy, etc.) necessary to perform a definitive procedure are included in the surgical HSC and may not be claimed separately. As per Physician's Manual Preamble section 5.3.71, 'When one physician performs a definitive procedure on an organ or within a body cavity, only that service should be claimed. The procedure used to provide surgical exposure should not be claimed; e.g. a laparotomy is not to be claimed to provide access to the abdominal cavity except when no definitive procedure is performed within the abdomen. When one physician provides surgical exposure for a procedure performed by a physician in another specialty, the exposure and definitive procedures may be claimed separately by the respective physicians.'

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Surgical procedure claims

Physicians are reminded that it is not appropriate to claim for parts of a procedure that would normally be considered the defined technique. Procedures such as ligation of blood vessels to prevent hemorrhage, that are performed as preventative measures are considered to be part of the defined technique. As per Physician's Manual Preamble section 5.3.68, 'Procedural codes and their associated tariff are intended to remunerate the physician for all parts of the procedure that would normally be considered the defined technique for that procedure. It is not appropriate to deconstruct (unbundle) the procedure into constituent parts and bill MSI for these codes in addition to the procedural codes.'

Composite fee

Physicians are reminded to use composite fees that were devised to encompass several procedures that are commonly performed together rather than claiming the procedures separately. As per Physician's Manual Preamble section 5.3.68, 'Procedural codes and their associated tariff are intended to remunerate the physician for all parts of the procedure that would normally be considered the defined technique for that procedure. It is not appropriate to deconstruct (unbundle) the procedure into constituent parts and bill MSI for these codes in addition to the procedural codes.'

Example:

When a partial glossectomy is accompanied by a radical neck dissection the code that should be claimed is 37.1A-hemiglossectomy plus radical neck dissection.

It is not appropriate to claim code 37.1 and in addition claim one of the following codes; 52.32, 52.32A, 52.33, 52.33A.

Comprehensive visits

Comprehensive Visits (HSC 03.04) may be claimed when medical necessity exists for a physician to conduct an in-depth evaluation of a patient due to the seriousness, complexity or obscurity of the patient's complaints or medical condition. It includes ensuring a complete history is recorded in the medical record and performing a physical examination appropriate to the physician's specialty and the working diagnosis.

As has been outlined in previous Bulletins, documentation of **all** of the following provides a clear indication that a comprehensive visit has taken place:

1. 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

2. A complete 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 i.e. HSC 03.03.

Preamble rules also stipulate that a comprehensive visit may not be claimed within 30 days of a previous limited or comprehensive visit. However, a subsequent comprehensive visit service may be claimed by the specialties of internal medicine, neurology, and paediatrics.

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These three specialties – internal medicine, neurology and paediatrics – have two types of comprehensive visits available to them for services provided in the office i.e. Initial and Subsequent. An Initial Comprehensive Visit may be claimed provided **all** of the above requirements above are met, **and** the patient is being seen for a new condition or complication of an existing condition. If the patient is not being seen for a new condition or complication of an existing condition, an initial visit may not be claimed and either a subsequent 03.04 or 03.03 should be claimed, depending on whether the requirements above have been satisfied.

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It is not appropriate to claim either an initial or subsequent 03.04 for all follow-up visits after 30 days have passed; the requirements noted above must be satisfied

Non-Face to Face Health Service Codes (HSCs 03.09K, 03.09L, 03.03Q, 03.03R)

Upon review of the new non-face to face HSCs which were implemented April 1, 2017 MSI has noted that some claims were for services ineligible to be claimed using these HSCs. Common errors included the following:

- The telephone call was not scheduled;
- The purpose of the call was to provide a prescription renewal;
- The purpose of the call was to inform the patient of the results of diagnostic investigations with no change in management plan.
- The service was claimed when the decision is to see the patient at the next available appointment in the office.

The requirements for claiming these HSCs were outlined in previous MSI Bulletins. Once again, physicians are asked to carefully review these requirements to be sure they are in compliance. If services have been claimed that are not in compliance, please delete these claims.

Physicians and their billing clerks are asked to carefully review the requirements for these new Health Service codes before submitting them.

QUESTION AND ANSWER

New Non-Face to Face Health Service Codes (HSCs 03.09K, 03.09L, 03.03Q, 03.03R)

Q: I am a specialist in a tertiary care centre. A family physician phones me to discuss a patient with an urgent problem but there was no written request. Does this mean I cannot claim HSC 03.09K Specialist Telephone Advice (Consultant Physician)?

A: Provided the family physician sends the written request before or on the day of the call – including after the telephone call – you may claim this service using HSC 03.09K. As a reminder, the telephone call needs to be scheduled.

Q: I regularly speak by telephone with the radiologists at my local hospital to discuss my patients' imaging results and obtain advice on planning future imaging studies. Can HSCs 03.09K/03.09L be used for these calls?

A: Telephone calls with radiologists may not be claimed using these HSCs. The intent of the telephone consultation HSCs is to replace an in-person consultation with the specialist and calls to relay the results of imaging studies or plan future studies do not satisfy that intent.

Q: Can I claim HSC 03.09K/03.09L for providing advice to a psychologist or if I ask a psychologist for advice?

A: HSCs 03.09K and 03.09L are for telephone consultations between physicians. The only exception is that a Nurse Practitioner may also request consultation advice from a specialist physician. Telephone consultations with psychologists may not be claimed.

Q: When claiming HSC 03.03Q Scheduled Specialist Telephone Management/Follow-up with Patient or 03.03R Scheduled Family Physician Telephone Management/Follow-Up with Patient do I need to inform the patient of the scheduled time of the call?

A: Yes, you need to schedule the call with the patient and advise them of the time of the call just as you would for an in-person appointment.

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Q: I am a specialist in a tertiary care centre. Because of the nature of my subspecialty, I look after patients from other Maritime provinces. Can I claim HSCs 03.09K and 03.03Q for these patients?

A: Yes, you may claim these HSCs for these patients. However, in the case of the consultation codes, the referring physician or Nurse Practitioner in the other province cannot claim the referring practitioner code i.e. HSC 03.09L.

Q: A referral arrived from a family physician asking me to see a patient. After reviewing the referral, I was certain that I could sort out the questions the family physician had over the phone, saving the patient a two hour drive. Can I claim 03.09K in these circumstances or does the family physician have to have requested a telephone rather than an in-person consultation?

A: You may claim 03.09K under these circumstances, provided you've met the other requirements for the HSC, including scheduling the call with the family physician.

Q: I am a family physician. I referred my patient to a specialist several months ago. However, his clinical condition has worsened and he needs to be seen by the specialist urgently. Can I claim 03.09L if I call the specialist to ask for a sooner appointment?

A: HSCs 03.09K and 03.09L cannot be claimed when the purpose of the call is to expedite an in-person assessment; the intent of the telephone consultation is to replace an in-person consultation.

Q: I am a billing clerk for a family doctor. How do I claim for calling a patient with their test results?

A: When calling patients concerning the results of diagnostic investigations HSC 03.09R (and 03.09Q for specialists) may only be claimed when there is a change in the management plan for the patient. As a reminder, the call must be made by the physician personally and not delegated to neither office staff nor medical trainees such as residents.

Q: Can 03.09K be used when a specialist is requesting advice from a GP?

A: HSC 03.09K requires the physician providing the advice to be a specialist. A specialist is defined as one whose name appears in the specialist register of the College of Physicians & Surgeons of Nova Scotia.

Q: As a family physician, can I claim both 03.03 and 03.09L on the same day for the same patient?

A: Yes, it's recognized that in some circumstances you will see a patient with an urgent problem who requires a consultation with a specialist the same day. In those circumstances, you may claim for your visit with the patient and additionally for a scheduled telephone consultation with the specialist that day. As a reminder, you are required to send a written referral to the specialist for the consultation service.

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HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

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