PHYSICIAN'S BULLETIN
October 18, 2017: Vol. LVII, ISSUE 10

NOVA SCOTIA MEDICAL SERVICES INSURANCE

CONTENTS

MSI News

1 – Introduction to New Fees

Fees

2 – Care Plan Oversight (CPO) Nursing Home, Residential Care Facility, or Hospice
3 – Subsequent Daily Hospital Visit
4 – Acute Care Hospital Discharge Day Management – Comprehensive
5 – First Visit after Acute Care In-Patient Hospital Discharge – Complex Care
6 – First Visit after Acute Care In-Patient Hospital Discharge – Maternal and Newborn Care
6 – Blended Mileage and travel detention for Home Visits

Billing Matters

7 – Fee Adjustments for Home Visits
7 – First Examination – Newborn Care Healthy Infant
8 – Fee Adjustments for Health Services provided by GENP only
- Suture of skin and subcutaneous tissue of other sites
- Suture of simple wounds or lacerations – child's face
- Other incision with drainage of skin and subcutaneous tissue

8 – Termed fees
- Suture minor laceration with removal of foreign body
- Suture minor lacerations or simple wounds

8 – Preamble changes

In Every Issue

10 – Updated Files
10 – Useful Links
10 – Contact Information

MSI News

This special bulletin is being issued in order to introduce the new Health Service Codes that will replace the Comprehensive Care Incentive Program (CCIP) which ends, as negotiated in the current Master Agreement, on October 31, 2017.

The purpose of the introduction of these new codes is to transition from an incentive based payment to a health service code based payment for primary care physicians.

Codes will be effective November 1, 2017, Physicians are asked to hold these claims until November 17, 2017 at which time the codes will be implemented into the MSI system and made available for billing.

In regard to the Health Service Codes with fee value adjustments, physicians are asked to continue billing these codes, and a retroactive payment will be provided at a later date for claims billed between November 1, 2017 and November 17, 2017.

BACK TO CONTENTS

NEW FEES

Effective November 17, 2017 the following health service codes will be available for billing:

Physicians are asked to hold these claims until November 17, 2017.

Category	Code	Description	Base Units
DEFT	CPO1	**Care Plan Oversight (CPO) Nursing Home, Residential Care Facility, or Hospice**	
		A) CPO 15 to 29 minutes within a calendar month	15 MSU
		B) CPO greater than 30 minutes within a calendar month	30 MSU
		Supervision of care for a nursing home, residential care facility, or hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by the physician most responsible for providing definitive or comprehensive care for that particular patient, review of subsequent reports of patient status, review of related laboratory and other studies not generated in a face to face encounter, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s) outside of that physician's practice, family member(s), surrogate decision maker(s) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; a) 15 to 29 minutes or b) 30 minutes or more.	
		Billing Guidelines • Reportable for the calendar month when greater than 15 minutes of physician time is spent on the duties listed above. Anything less than 15 minutes is considered to be included in the visit encounter service. • Maximum reporting six times per calendar year. • Only one physician may report for any given patient in a calendar month. • The physician claiming the service must be the most responsible physician who provides definitive or comprehensive care for that particular patient. • The physician must have seen the patient for a face to face visit at least once in the six months prior to reporting CPO. • The physician must personally document the date, the time spent and a brief description of the activities provided in the patient's health record. Given that this service may be reported when the physician is not physically present in the nursing home, RCF or hospice, the initial documentation should be made in either the physician's EMR or the patient's nursing home, RCF or hospice health record. This information **must** be documented in the nursing home, RCF or hospice health record when the physician next visits the nursing home, RCF or hospice. • For reporting purposes, activities must be documented in the Care Plan Oversight Reporting Table (or similar format that includes all of the same service elements, times and dates) in the patient health record. • Do not report with other telephone service or non face to face codes such as: o 13.99C Supervision of long-term anticoagulant therapy - in the same calendar month. o ENH1 Long Term Care Medication Review - in the same calendar year.	

When CPO has been reported, only one CGA1 (Long Term Care Geriatric Assessment) may be reported in the same calendar year. If a nursing home patient's condition is declining such that a second CGA1 is deemed necessary within a calendar year this may be reported. However it may not be reported in the same month that CPO is reported. In addition, text is required on the claim to indicate the reasons for a second CGA1 in the same year.

Specialty Restriction
GENP
Location
LO=NRHM, Residential Care Facility, or Hospice

Category	Code	Description	Base Units
VIST	03.03	**Subsequent Daily Hospital Visit (LO=HOSP, FN=INPT, DA= DA23 or DA=DA47)**	
		A) Days 2, 3, and first day out of ICU (DA=DA23)	23 MSU
		B) Days 4 – 7 (DA=DA47)	19 MSU

These adjusted MSU values apply to health service code 03.03 LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, a subsequent limited visit provided to patients admitted to hospital where the family doctor is the most responsible physician.

Billing Guidelines

- May only be claimed once per patient per day by the most responsible physician (MRP).

First day out of ICU should be considered equivalent to day 2 and subsequent inpatient days as 3,4,5,6,7 for the purpose of reporting these increased code values.

Specialty Restriction
GENP
Location
LO=HOSP, FN=INPT

Category	Code	Description	Base Units
VIST	03.04F	**Acute Care Hospital Discharge Day Management - Comprehensive** The comprehensive hospital discharge day management code is intended to be used when services provided on the day of discharge require greater than 30 minutes of the physician's time. This HSC includes all services provided to the patient on the day of discharge from the acute care hospital; the final examination of the patient, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms. Every effort is to be made by the discharge physician to communicate (direct, contact telephone, electronic) with the community physician who will be most responsible for the patient's care after discharge. It is recognized that for complex comprehensive discharges, the discharge process may occur over 2 days. For example the discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms may be completed on one day and the final examination of the patient and discharge order the following day. If this situation arises, the code must be reported on the date of discharge, the cumulative time spent must be greater than 30 minutes, the code may only be reported once by the MRP and may not be unbundled to accommodate splitting the workload • A visit is considered an integral part of this service and is not reportable in addition. • Documentation of the services provided and time spent must be documented in the health record. **Billing Guidelines** Preamble Rules 5.1.30 - 5.1.31 apply. Not reportable if the patient is admitted and discharged on the same day or 24 hour period. • Reportable by the Most Responsible Physician only. The Most Responsible Physician (MRP) is defined as the physician in charge of the patient's care for any given day (24 hour period). • Only once per patient per inpatient hospital admission. • The physician claiming this health service may not report any other visit service for the same patient, same day. In addition, HSC 03.02 (Hospital Discharge Free) A may not be claimed as the service is included in the Comprehensive Acute Care Discharge Day Management Health Service Code. • Efforts made to establish communication with the health care provider who will be most responsible for the patient's care after discharge must be documented in the health record. • Not reportable for hospital deaths. Do not count time for services performed outside of the patient's unit or floor e.g., calls to the receiving physician/facility made from the physician's private office) or services performed after the patient physically leaves the hospital. **Specialty Restriction** GENP **Location** LO=HOSP, FN=INPT	45 MSU

Category	Code	Description	Base Units
ADON	03.03S	**First Visit After Acute Care In-Patient Hospital Discharge – Complex Care** This is an additional fee for the first office visit of the patient requiring ongoing complex care within 14 days of acute care in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care. • The physician or their office staff must make every effort to communicate (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge. • Not reportable in the walk-in clinic setting. A complex care patient is defined as: • A patient with multiple (two or more) chronic conditions requiring active management expected to last at least 12 months, or until the death of the patient. • The chronic conditions must place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. **Billing Guidelines** ADON Restricted to: 03.03 Office visit 03.03A Geriatric Office Visit (for patients age 65+) 03.03E Adults with Developmental Disabilities • Reportable only if the visit occurs in the primary care physician's office or the patient's home within 14 calendar days after hospital discharge (consider discharge date as Day zero). • Hospital length of stay must be greater than or equal to 48 hours. • Communication (direct contact, telephone, electronic) with the patient and/or caregiver by the physician or their office staff within 2 business days of discharge must be documented in the health record. If unsuccessful, the reason must be documented in the health record. • Not reportable if the admission to hospital was for the purpose of performing elective surgery (major or minor) or fracture care (major or minor). • Not reportable if the admission to hospital was for the purpose of obstetrical delivery. • Not reportable if the admission to hospital was for the purpose of newborn care. • Not reportable for services rendered in other locations such as Nursing Homes, Residential Care Facilities, or Hospice. • The physician claiming the service must be the provider most responsible for the patient's ongoing complex care. • Claimable once per patient per inpatient admission. • Not reportable for any subsequent discharges within 30 days. • Not reportable in the same month as other monthly care fees - such as 13.99C – Supervision of long-term anticoagulant therapy. • Maximum of 4 claims per physician per patient per year. **Specialty Restriction** GENP **Location** LO=OFFC, HOME	10 MSU

Category	Code	Description	Base Units
ADON	03.03P	**First Visit after In-Patient Hospital Discharge – Maternal and Newborn Care** This is an additional fee for the first maternal/newborn office visit within 14 days of in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care. • The primary care physician or their office staff must make every effort to communicate (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge. • Not reportable in the walk-in clinic setting. **Billing Guidelines** ADON Restricted to: • 03.03 Office visit • 03.03 Well Baby Care Reportable only if the visit occurs in the primary care physician's office or the patient's home within 14 calendar days after hospital discharge (consider discharge date as Day zero). Every effort to establish communication with the patient and/or caregiver by the physician or their office staff (direct contact, telephone, electronic) within 2 business days of discharge must be documented in the health record. If unsuccessful, the reason must be documented in the health record. Only reportable if the reason for admission to hospital was for the purpose of obstetrical delivery. Physician must be the provider most responsible for the mother and child's ongoing care. Claimable once per patient per inpatient admission for obstetrical delivery. Not reportable for any subsequent discharges within 30 days. Maximum of 1 claim per pregnancy (mother) Maximum 1 claim per infant **Specialty Restriction** GENP **Location** LO=OFFC, HOME	10 MSU

Category	Code	Description	Base Units
ADON	HOVM1	**Blended Mileage and travel detention for Home Visits (1 multiple = 1 km)** This health service code is added on to a home visit health service code when the physician must travel to the patient's home in order to provide clinical services to a homebound patient. **Billing Guidelines** Text for the claim must include: • the start and finish time of the visit • point of origin • destination address • the distance in kilometers maximum MU=70 **Specialty Restriction** GENP **Multiples** 1 MU = 1 km, maximum multiples = 70 **Location** LO=HOME	0.46 MSU + MU

*Refer to preamble change in relation to the definition of homebound patients and home visit travel fee

FEE ADJUSTMENTS

Physicians are asked to continue billing these codes, and a retroactive payment will be provided at a later date for claims billed between November 1, 2017 and November 17, 2017.

Category	Code	Description	Base Units
VIST	Select 03.03 and 03.04 codes	**Fee Adjustments for Home Visits** These adjusted health service code values apply to a homebound patient where the physician must travel to the patient's home in order to provide the clinical service. **Adjusted Fee Values** 03.03 - Home Visit 0800-1700 03.03 - Home Visit 1701-2359, weekends and holidays 03.03 - Home Visit 0000-0800 03.03 - Home Visit emergency 03.03 - Home Visit extra patient 03.03 - Home Visit extra patient aged 65 years and older 03.04 - Home Complete examination **Specialty Restriction** GENP **Location** LO=HOME	 36 MSU 47.8 MSU 64.7 MSU 59.5 MSU 13 MSU 16.5 MSU 40.6 MSU

*Refer to preamble change in relation to the definition of homebound patients and home visit travel fee

Category	Code	Description	Base Units
VIST	03.04	**First Examination – Newborn Care Healthy Infant** This adjusted fee applies to health service code 03.04 LO=HOSP, FN=INPT, RO=NBCR, RP=INTL, an initial comprehensive visit provided to a healthy newborn in hospital by the family doctor. **Specialty Restriction** GENP **Location** LO=HOSP, FN=INPT	24 MSU

Category	Code	Description	Base Units
MISG		These 3 adjusted fee values apply to health services provided by GENP only:	
	98.22	**Suture of skin and subcutaneous tissue of other sites**	20 MSU
	98.22A	**Suture of simple wounds or lacerations – child`s face**	25 MSU
	98.03	**Other incision with drainage of skin and subcutaneous tissue (AN = LOCL)**	10 MSU
		These 2 HSCs will be termed and other pre-existing HSC used:	
	98.04A	**Suture minor laceration with removal of foreign body**	Term
	98.22E	**Suture minor lacerations or simple wounds**	Term
		98.04A and 98.22E are replaced by: 98.22D Suture minor laceration or foreign body wound 20 MSU **Specialty Restriction** GENP	

PREAMBLE CHANGES

Definition of a Homebound Patient

Current Definition	New Definition
Rules Specific to Location (5.1.44) c) A Home Visit: Is a service rendered by a physician to a patient or patients following travel to the patient's home. The patient or patient's representative must request the physician to visit. A home visit may only be claimed when the patient's condition or situation justifies the service. If the nature of the patient's condition requires periodic scheduled home visits, a daily home visit can be claimed. (5.1.48)	**Rules Specific to Location (5.1.44)** c) A Home Visit: Is a service rendered by a physician to a **homebound** patient or patients following travel to the patient's home. The patient or patient's representative has requested a visit with the physician. A home visit may only be claimed when the patient's condition or situation justifies the service and the patient is homebound. A patient is considered to be homebound when one or more of the following conditions are met and documented in the health record: I. Leaving the home isn't recommended because of the patient's condition; II. The patient's condition keeps him or her from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person); III. Leaving home takes a considerable and taxing effort. If the patient is not considered homebound, the visit is considered to be rendered at home for convenience. In this situation, the visit may be claimed at the normal office visit rate and travel may not be claimed.

As per Preamble 1.1.36 "All claims submitted to MSI must be verifiable from the patient records associated with the services claimed and be billed in accordance with the Preamble." Therefore, physicians must document within the clinical record, e.g. in the CPP/Problem List the specific circumstances that have led to the patient being deemed homebound.

Home Visit Travel Fee

Current Definition	New Definition
Services, supplies and other materials provided through the physician's office when such supplies are not normally considered part of office overhead (2.2.37) • Mileage or travelling time except as defined in (See Section 5(5.1.67)) relating to detention time or blended mileage/travel detention for acute home care home visits. (2.2.43) • For patients registered in acute home care, physicians may claim blended mileage/travel detention to compensate for travel expenses and time incurred for home visits. This fee does not apply to patients registered in the chronic home care program. Blended mileage/travel detention will be reimbursed only for those home visits initiated by the care coordinator or health care professionals of Home Care Nova Scotia. The mileage/travel detention fee is a blended rate based on kilometers travelled for the round trip. The distance in kilometers should be entered in the multiple field of the service encounter. A record should be kept in your office of the starting and destination points. (2.2.44)	• Mileage or travelling time except as defined in (See Section 5(5.1.67)) relating to detention time or blended mileage/travel detention for acute home care home visits, or for home visits. (2.2.43) • For patients registered in acute home care, physicians may claim blended mileage/travel detention to compensate for travel expenses and time incurred for home visits. This fee does not apply to patients registered in the chronic home care program. Blended mileage/travel detention will be reimbursed only for those home visits initiated by the care coordinator or health care professionals of Home Care Nova Scotia. • Mileage for home visits will be reimbursed only when a visit has been requested by the patient or patient's representative and the patient is considered homebound. The mileage/travel detention fee is a blended rate based on kilometers travelled for the round trip. Text for the claim must include: the start and finish time of the visit, point of origin, destination address, and the distance in kilometers. The distance in kilometers should be entered in the multiple field of the service encounter. A record should be kept in the physician's office of the starting and destination points. (2.2.44)

BACK TO CONTENTS

BACK TO CONTENTS

UPDATED FILES

Updated files reflecting changes are available for download on Friday November 17, 2017. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT) and, explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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

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

In partnership with

NOVA SCOTIA