PHYSICIAN'S BULLETIN

April 5, 2019: Vol. LXIV, ISSUE 5

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

UNIT VALUES AND PAYMENT RATES

MEDICAL SERVICE UNIT / ANAESTHESIA UNIT VALUE

Effective April 1, 2019 the Medical Service Unit (MSU) value is $2.48 and the Anaesthesia Unit (AU) Value is $21.07.

WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC UNIT VALUE

Effective April 1, 2019 the Workers' Compensation Board MSU Value is $2.76 and the Workers' Compensation Board Anaesthetic Unit Value is $23.41.

PSYCHIATRY FEES

Effective April 1, 2019 the hourly Psychiatry rate for General Practitioners is $113.33 and the hourly rate for Specialists is $153.67 as per the tariff agreement.

SESSIONAL PAYMENTS

Effective April 1, 2019 the hourly Sessional payment rate for General Practitioners is $148.80 and the hourly rate for Specialists is $173.60 as per the tariff agreement.

CHANGE TO BREAST REDUCTION CRITERIA

Effective immediately DHW has removed the criteria that patients have a BMI of 27 or less to qualify for MSI coverage for a breast reduction. All other requirements remain unchanged.

REISSUING REQUEST FOR PROPOSALS – MEDICAL CONSULTANT

The Department of Health and Wellness is reissuing the Request for Proposals (RFP) for part time services of a Medical Consultant to provide support and advice on a range of policy issues related to Physician Services, Pharmacare, Children's Oral Health Program, and other extended health benefit programs. It is anticipated that the RFP will be posted on the Government Procurement site the week of April 8, 2019 and will be posted for a period of 15 days. Please watch for it on the Government Procurement site at https://novascotia.ca/tenders/default.aspx

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PATIENT PANEL ENROLLMENT INCENTIVE

In March 2018 the Premier announced a number of new investments in Primary Care. This announcement included a one-time flat enrollment fee of $7.50 per current patient to enable family physicians to identify a panel of patients for whom they are providing comprehensive and continuing care.

As noted in the Physician's Bulletins posted on December 11, 2018 and January 14, 2019 the patient enrollment incentive is available to those family physicians who attest that they are providing comprehensive and continuous care to their patients by signing and returning the Physician Confirmation Letter provided by MSI, prior to February 1, 2019. Participation in the patient panel verification initiative is on a voluntary basis.

An initial patient panel has been created for each eligible physician based upon claims submitted to MSI over the past 3 years. A package containing instructions on how to access your panel online and verify your patients will be mailed to you on April 15, 2019. Your patient panel will be accessible via the link provided until May 23, 2019. Your patient panel will need to be updated and finalized during this time period. An incentive will only be paid to those physicians who completed the verification process and finalized their panel. Your incentive will be based upon the number of patients that appear on your final approved and validated panel. The payment will be issued on July 17, 2019. Additional details will be provided in the package.

If you have any questions regarding this upcoming verification process, please do not hesitate to contact us. We can be reached at msi_assessment@medavie.bluecross.ca or 902-496-7011/toll-free 1-866-553-0585.

★ Fees New Fees and Highlighted Fees

UPDATED FEES

Effective April 6, 2019 Health Service Code 02.02B has been updated to include patients starting hydroxychloroquine or chloroquine treatment.

Category	Code	Description	Base Units
VADT	**02.02B**	**Optic Nerve Imaging** Optic Nerve Imaging by any means (e.g. OCT, HRT) for patients with a diagnosis of glaucoma, wet AMD, retinal vein occlusion, diabetic macular edema, *and patients starting hydroxychloroquine or chloroquine treatment.* This fee is for the interpretation of scanning computerized ophthalmic diagnostic imaging, with interpretation and written report, unilateral or bilateral, of the optic nerve and/or retina regardless of the technology used to perform the imaging. Not to be used for glaucoma screening. **Billing Guidelines** • Glaucoma Diagnosis – once per patient per year. • Diabetic macular edema, retinal vein occlusion or wet age related macular degeneration having been treated once in the past year with intravitreal anti-VEGF drugs – up to 6 times per patient per year. • *One baseline OCT for patients starting treatment with hydroxychloroquine or*	**8 MSU**

Category	Code	Description	Base Units
		<u>*chloroquine*</u> • <u>*After five years of hydroxychloroquine or chloroquine treatment, one OCT per year will be considered medically necessary.*</u> • <u>*For patients on hydroxychloroquine or chloroquine who have suspicious visual fields, clinical findings on examination of the retina, or are at high risk (dosing in excess of 5mg/kilo per day), OCT will be considered medically necessary up to twice a year*</u>. **Eligible Diagnostic Codes** • 362.52 – Exudative Senile Macular Degeneration • 362.01 – Background Diabetic Retinopathy • 362.35 – Central Retinal Vein Occlusion • 362.36 – Venous Tributary Occlusion • 379.27 – Vitreomacular Adhesion • 365.9 – Unspecified Glaucoma • <u>*362.10 – Background Retinopathy Unspecified (this is to be used for patients on hydroxychloroquine/chloroquine as there is no specific ICD9 code- see note below)*</u> **Location** OFFC, HOSP **Note** Claims submitted with 362.10 ICD9 diagnostic code will require text stating the type of medication and any additional risk factors. These claims will be manually assessed.	

<u>Effective April 6, 2019 the modifier (US=UNOF) has been removed from (PT=EXPT) claims</u>.
By definition an urgent visit requires the physician to travel from one location to another in order to visit the patient, as outlined in Preamble 5.1.52. While an urgent visit is appropriate for the first patient seen at a facility, it does not apply to the second or subsequent patients seen at the same location as the physician is already physically in the facility and thus no travel occurred.

<u>13.59L RO=HPV9 PT=RISK Age Restriction</u>
High-Risk patients will only be eligible for this vaccination up to and including 45 years of age.

★ Fees New Fees and Highlighted Fees

NEW FEES

Effective April 6, 2019 the following health service code will be available for billing:

Category	Code	Description	Base Units
VEDT	**13.59O**	**Injection of onabotulinumtoxinA for the treatment of Chronic Migraine (Prior Approval)** This is a comprehensive code for the assessment and treatment of adults with a documented history of chronic migraine, defined as having greater than or equal to 15 headache days per month over at least a three month period, and who have not responded to at least three prior pharmacological prophylaxis therapies or for patients who are intolerant of pharmacological prophylaxis.	**70 MSU**

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Category	Code	Description	Base Units
		This code includes patient assessment and counselling, preparation of ONA injections, performing all injections using the appropriate protocol, and patient observation prior to discharge. The physician must request prior approval in writing. The request must include: • The patient's clinical history of Chronic Migraine • Documentation of previous attempts at pharmacological prophylaxis including the names of medication, duration of treatment and results. • If this is a subsequent request for continued treatment, documentation of treatment effect must be included. **Billing Guidelines** • Prior approval will be valid for treatment provided to that patient for a period of 24 months • No more than 8 service encounters for injection of ONA for Chronic Migraine may occur over that 24 month period • Services to be no more frequent than every 3 months • If treatment continues to be recommended after this time period, prior approval must be requested again Once a request for approval has been made to the MSI Medical Consultant, a response will be issued. If approval is granted you will be advised of a Preauthorization Number. To ensure payment of the service the Preauthorization Number must be entered in the appropriate field on the service encounter. **Specialty Restriction** NEUR **Location** OFFC	

Effective April 6, 2019 the following health service codes will be available for billing:

Category	Code	Description	Base Units
VEDT	**13.99F**	**Assessment and management of patient with Acute Stroke:** **From activation of Acute Stroke Protocol through completion of thrombolytic therapy (e.g. t-PA)** This HSC is specific for the assessment and management of a patient experiencing symptoms of acute stroke and for whom the Acute Stroke Protocol has been activated. The service includes ongoing evaluation, clinical monitoring, diagnostic evaluation, review of diagnostic imaging and completion of thrombolytic therapy (e.g. t-A) **Billing Guidelines** • Reportable by one physician per patient per day • Must complete thrombolytic therapy in order to report this HSC • If patient does not receive thrombolytic therapy, only the pertinent visit code is reportable **Location** HOSP (Provincial Stroke Centers only)	**130 MSU**
VEDT	**13.99G**	**Assessment and management of patient with Acute Stroke:** **From activation of Acute Stroke Protocol through receiving endovascular thrombectomy (EVT) with or without administration of thrombolytic therapy**	**170 MSU**

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Category	Code	Description	Base Units
		This HSC is specific for the assessment and management of a patient experiencing symptoms of acute stroke and for whom the Acute Stroke Protocol has been activated. The service includes ongoing evaluation, clinical monitoring, diagnostic evaluation, review of diagnostic imaging, with or without thrombolytic therapy, and supervision of patient receiving EVT. **Billing Guidelines** • Reportable by one physician per patient per day • Patient must undergo EVT in order to report this HSC **Specialty Restriction** NEUR **Location** HOSP (Halifax Infirmary only)	

NEW INTERIM FEES

Effective April 6, 2019 the following interim health service codes will be available for billing:

Category	Code	Description	Base Units
VADT	**13.59P**	**Insertion of Buprenorphine Implant (e.g. Probuphine) for the treatment of opioid use disorder** This HSC is for the insertion of the non-biodegradable buprenorphine delivery implant for the treatment of opioid use disorder	**20 MSU**
VADT	**13.59Q**	**Removal of Buprenorphine Implant (e.g. Probuphine)** This HSC is for the removal of the non-biodegradable buprenorphine delivery implant For removal and reinsertion of the non-biodegradable buprenorphine delivery implant, report the removal code at 100% and the insertion code at LV50. **Billing Guidelines** May not be claimed in addition to OAT1 or OAT2 by any physician for the same patient for 6 months following implantation. If the implant is removed early or there are special circumstances to consider the physician should add text to the OAT management claim explaining the circumstances.	**20 MSU**

Effective April 6, 2019 the following interim health service code will be available for billing:

Category	Code	Description	Base Units
VEDT	**50.0B**	**Endovascular Thrombectomy-Intracranial** Endovascular Thrombectomy for the purpose of revascularization of a thrombotic or embolic occlusion of one or more intracranial vessels. This comprehensive health service code includes: Selective catheterization, diagnostic angiography and all selective angiography required to perform the procedure within the vascular territory. **Specialty Restriction** Neuroradiology (DIRD with subspecialty in neuroradiology) **Location** HOSP (QEII only)	**300 MSU**

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NEW INTERIM FEES (CONTINUED)

Effective April 6, 2019 the following interim health service code will be available for billing:

<table>
<tr><th>Category</th><th>Code</th><th>Description</th><th>Base Units</th></tr>
<tr><td>VIST</td><td>03.04I</td><td>PSP Mental Health Comprehensive Visit to establish the PSP Mental Health Plan (PSP= Practice Support Program)
This code is for the complete assessment of the patient with a confirmed mental illness meeting the diagnostic criteria in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of sufficient severity and acuity to cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and warrant the development of a Mental Health care plan. This is not intended for patients with self-limited or short lived mental health symptoms. The assessment is to be performed by the PSP trained family physician most responsible for the patient's mental health care. The Mental Health Plan and start and stop times must be documented in the health record.
This complete assessment is to include all of the following elements and be documented in the health record:
• The patient's DSM diagnosis, psychiatric history and current mental state including suicide risk assessment as appropriate
• Obtaining collateral history and information from caregivers as required
• Performance of a complete medication review to include collateral information from pharmacy and assisted living facility as appropriate
• Reviewing and documenting results of relevant validated assessment tools, laboratory, and other test results
• Documentation of a clinical plan for the patient's care over the next year. Includes advanced care planning where appropriate
• Outline of expected outcomes as a result of the treatment plan
• Outline of linkages with other health care providers and community resources who will be involved in the patients care.
• Confirmation that the plan has been created jointly and shared with the patient or their medical representative. The plan is to be shared with other care providers as appropriate
• A documented care plan must be in place before access to additional counselling hours is provided
It is recognized that the required elements may require more than one visit to complete. This health service code may be claimed at the final visit only when all of the information is complete and documented in the health record; other visits may be reported at the usual rate.

All elements must be documented in the health record before reporting this PSP MHP visit service.

Billing Guidelines
• Reportable by the patient's PSP trained physician only
• Not reportable with any other visit fee for the same physician, same patient, same day
• Not reportable for services provided at walk-in clinics
• Not to be used for patients living in nursing homes, residential care facilities or hospices
• Reportable only once per patient per year
• 50 MSU for first 30 minutes, 25 MSU for each additional 15 minutes, up to a maximum of 1 hour (5 multiples)
• Start and stop times must be reported in the text field of the claim to MSI, as well as in the clinical record

Specialty Restriction
GENP with PSP Training

Location
OFFC, HOME</td><td>50 MSU +MU</td></tr>
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PREAMBLE CHANGES

Counselling- Preamble 5.2.151

Current Definition	New Definition
The following services and restrictions apply to general practitioners only. *(5.2.152)* Counselling is a prolonged discussion directed at addressing problems associated with acute adjustment reactions or bereavement reactions. *(5.2.153)* Counselling may be claimed in 15 minute intervals. At least 80 percent of the time claimed must be spent in direct patient intervention. *(5.2.154)* Restrictions: Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, counselling may not be claimed for the following: – More than five hours per patient per physician per year. – More than one hour per patient per day. – A patient younger than four years old. – More than one general practitioner providing counselling to a particular patient. *(5.2.155)*	The following services and restrictions apply to general practitioners only. *(5.2.152)* Counselling is a prolonged discussion directed at addressing issues pertaining to the patient's underlying mental illness, acute adjustment disorder or bereavement. Counselling may be claimed by family physicians for patients who meet the current DSM (Diagnosis and Statistical Manual of Mental Disorders) diagnostic criteria for the diagnosis of a mental health disorder *(5.2.153)* Counselling may be claimed in 15 minute intervals. At least 80 percent of the time claimed must be spent in direct patient intervention. *(5.2.154)* Restrictions: Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, counselling may not be claimed for the following: – More than five hours per patient per physician per year. – More than one hour per patient per day. – A patient younger than four years old. – More than one general practitioner providing counselling to a particular patient. – Physicians who have completed training in the Practice Support Program Adult Mental Health Module may have access to an additional 4 hours of counselling per patient per year. The physician's name must be in the Nova Scotia Health Authority database confirming completion of training. *(5.2.155)*[1]
PSYC 08.49A Counselling.....................................12.7 per 15 min TI=GPEW..15.88 per 15 min	PSYC 08.49A Counselling.....................................25.4 per 30 min. (12.7 units per 15 min. thereafter) TI=GPEW......................................15.88 per 15 min.

[1] PSP Physicians who are billing above the 5 hour maximum per patient per year GP restriction must indicate in the text field of the claim that they are a PSP qualified physician. These physicians must be in the NSHA database to confirm completion of training.

BILLING REMINDERS

Meet and Greet

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" encounter with a new patient unless a health related concern/complaint has been addressed during the encounter and the Preamble requirements for medically necessary visits have been satisfied.

Unattached Patient Bonus Incentive (UPB1)

Physicians are reminded that this incentive may only be claimed for individuals they have agreed to take on as regular patients. The incentive may be claimed at the time of the first visit to the physician's office. The fee cannot be claimed in other circumstances such as placing the patient on a waiting list for the practice, when the patient is not being accepted into the practice, or is being directed to another physician for care.

The current guidelines for UPB1 were effective April 1, 2018

Category	Code	Description	Value
DEFT	UPB1	**Unattached Patient Bonus** This incentive is available for eligible general practitioners who take on a patient who does not have a family physician and meets the criteria indicated below **Billing Guidelines** • The GP has to have had at least one visit service with the patient prior to claiming the UPB1 fee. The UPB1 fee is billable in addition to the associated visit fee. • A GP can only claim UPB1 once per patient per lifetime. A physician cannot claim the unattached patient bonus more than once for the same patient. • An unattached patient is described as: patients taken from the 811 list, referred from an emergency department, patients who do not have a family physician, newborns and patients whose family physician is about to retire or relocate and does not have a new family physician to assume their practice. • The GP keeps the Unattached Patient in his/her practice and maintains an open chart for the patient for a minimum of one year. • The UPB1 cannot be claimed for walk-in clinics, for patients who already appear on a physician's patient list (physician validated), for patients who were taken off the 811 list before the establishment of this fee enhancement, or for new physicians who are building their practices until that point when their patient panel reaches 1350. • New Physicians must be practicing in the community for a minimum of two years, or have reached a patient panel of 1350 prior to claiming the UPB1. • Locum physicians are not eligible for this incentive. **Documentation** The GP must confirm and document at the initial visit with the Unattached Patient that the patient is unattached (i.e., does not already have a regular family physician). Information about the encounter that resulted in the GP taking the Unattached Patient into his/her practice must also be recorded in the patient's record. This can be a patient from the 811 list, referral from the hospital emergency department, for enrolling patients who do not have a physician or are unattached at time of enrolment, for enrolling patients for whom un-attachment is imminent because their family practitioner is retiring/relocating and no new family physician is taking over the practice, an inpatient hospital report or other documentation. (Other documentation may include a note by the physician, documenting their discussion with the patient, confirming the prior hospital encounter.) **Specialty Restriction** GENP **Location** All Locations	**$150.00** (one time per patient)

Consultations with unknown medical necessity

As outlined in Preamble 2.2.9, MSI will pay for a visit or consultation to determine if a treatment method is insured. This applies in circumstances in which the proposed procedure is sometimes, but not always insured. If the proposed procedure or treatment method is always uninsured, a visit or consultation may not be claimed.

Health Service Code 13.59N (Intravenous Infusion of Local Anaesthetic/Adrenergic Drugs for Chronic Pain Management)

The protocol required in order to claim Health Service Code 13.59N was originally outlined in the submission to the Fee Committee. In the performance of this procedure, patients are to be monitored with both an electrocardiogram and a pulse oximeter. An intravenous line is established and an infusion pump is used to deliver the drug. The physician must be in attendance or readily available to intervene to ensure that side effects do not occur and to make the necessary adjustments in the dosage of the medication. The patient also must be monitored for 10-15 minutes after the infusion is completed and then transferred to a 'post-recovery area' where they are continued to be monitored for a further 30 minutes before being discharged.

Imaging Studies Ordered by Chiropractors

Radiologists are reminded that they may only claim for imaging studies requested by physicians and nurse practitioners. They may not claim for studies requested by other health care providers, including chiropractors.

NEW EXPLANATORY CODES

Code	Description
AD083	SERVICE ENCOUNTER HAS BEEN REFUSED BASED ON THE AGE OF THE RECIPIENT
DE035	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS OAT1 AND OAT2 MAY NOT BE CLAIMED IN THE 6 MONTHS FOLLOWING AN INSERTION OF BUPRENOPHRINE IMPLANT FOR THE TREATMENT OF OPIOID USE DISORDER
MA076	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU ARE NOT PERMITTED TO CLAIM THIS FEE
VA094	SERVCE ENCOUNTER HAS BEEN REFUSED AS ELECTRONIC TEXT IS REQUIRED ON THE CLAIM STATING TYPE OF MEDICATION AND ANY ADDITIONAL RISK FACTORS
VA095	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF OCT FEES PER YEAR FOR THIS DIAGNOSIS HAVE PREVIOUSLY BEEN CLAIMED IN THE PAST YEAR
VE020	SERVICE ENCOUNTER HAS BEEN REFUSED AS AN INJECTION OF ONA FOR CHRONIC MIGRAINE HAS ALREADY BEEN APPROVED IN THE PREVIOUS 3 MONTHS
VE021	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 8 INJECTIONS OF ONA FOR CHRONIC MIGRAINE MAY BE CLAIMED OVER A 24 MONTH PERIOD. IF TREATMENT CONTINUES TO BE RECOMMENDED AFTER THIS TIME PERIOD, PRIOR APPROVAL MUST BE REQUESTED AGAIN
VE022	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR ASSESSMENT AND MANAGEMENT OF A PATIENT WITH ACUTE STROKE WAS PREVIOUSLY MADE FOR THIS PATIENT ON THIS DAY
VE023	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS FACILITY IS NOT AUTHORIZED TO CLAIM THE ACUTE STROKE PROTOCOL FEE
VE024	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE MAY ONLY BE CLAIMED FROM THE QEII

Code	Description
VT166	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS TEXT INDICATING THE STOP AND START TIMES FOR THIS SERVICE IS REQUIRED
VT167	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.04I IS NOT REPORTABLE WITH ANY OTHER VISIT FEES ON THE SAME DAY
VT168	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.04I MAY ONLY BE REPORTED ONCE PER PATIENT PER YEAR

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

UPDATED FILES

Updated files reflecting changes are available for download on Saturday April 6, 2019. The files to download are health service (SERVICES.DAT), health service description (SERV_DSC.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

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