PHYSICIAN'S BULLETIN

December 13th, 2019: Vol. LXIV, ISSUE 17

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT

Effective April 1, 2019, the Medical Service Unit (MSU) value will be increased from $2.48 to $2.53.

Note: This increase was automatically implemented on any claims made with a date of service on or after November 29, 2019. Claims made with service dates from April 1, 2019 – November 28, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window for these services has elapsed.

ANAESTHESIA UNIT

Effective April 1, 2019, the Anaesthesia Unit (AU) value will be increased from $21.07 to $21.50, followed by an additional increase to $21.56 effective October 25, 2019.

Note: The current $21.56 value was automatically implemented on any claims made with a service date on or after November 29, 2019. Claims made with service dates from April 1, 2019 – November 28, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window for these services has elapsed.

PSYCHIATRY FEES

Effective April 1, 2019 the hourly Psychiatry rate for General Practitioners has increased to $115.60 while the hourly rate for Specialists increased to $156.74 as per the tariff agreement. An additional increase effective October 25, 2019 has raised the hourly Psychiatry rate for General Practitioners to $137.85 and the hourly rate for Specialists increased to $186.91.

Note: These rates will automatically take effect on any claims made as of December 13th. Claims made with service dates from April 1, 2019 – December 12, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window for these services has elapsed.

WORKERS COMPENSATION BOARD MEDICAL SERVICE UNIT

Effective April 1, 2019, the Workers Compensation Board Medical Service Unit (WCB MSU) value will be increased from $2.76 to $2.81.
Note: This increase was automatically implemented on any claims made with a date of service on or after December 13, 2019. Claims made with service dates from April 1, 2019 – December 12, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window for these services has elapsed.

WORKERS COMPENSATION BOARD ANAESTHESIA UNIT

Effective April 1, 2019, the Workers Compensation Board Anaesthesia Unit (WCB AU) value will be increased from $23.41 to $23.89, followed by an additional increase to $23.96 effective October 25, 2019.
Note: The current $23.96 value was automatically implemented on any claims made with a service date on or after December 13, 2019. Claims made with service dates from April 1, 2019 – December 12, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window for these services has elapsed.

PROVIDER PROFILE CHANGES

This year Provider Profiles will only be sent out by request. If you would like to receive your Provider Profile for 2018/19 please send your request by email to: MSI_Assessment@Medavie.Bluecross.ca
In the email please include: your name, your provider number, and the profile will be mailed to the address on file.

★ Fees New Fees and Fee Revisions

NEW FEES

Effective November 1, 2019 the following code is available for billing:

Category	Code	Description	Base Units
ADON	13.34A	**Rotavirus Immunization** **Description** Rotavirus vaccine, administered orally. Immunization to occur at 2, 4, and 6 months of age. **Billing Guidelines** • Maximum three claims of rotavirus immunization per patient per lifetime. • May only be claimed for patients born on or after November 1, 2019. • May not be claimed for patients greater than 8 months old. • Follows normal provincial immunization billing guidelines with one exception – a tray fee may not be claimed for this immunization.	6 MSU

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Effective December 13, 2019 the following codes are available for billing:

Category	Code	Description	Base Units
MASG	98.99H	**MOHS Micrographic surgery (MMS) for the Removal of a Histologically Confirmed Cutaneous Malignancy – Initial Level and Debulking** **Description** This HSC is specific to the Mohs micrographic surgery (MMS) technique for the removal of a histologically confirmed cutaneous malignancy. Reportable only when the preparation of slides is rendered or supervised by the Mohs surgeon claiming the MMS code(s) and all microscopic tissue sections are personally reviewed and interpreted by the Mohs surgeon. If a pathologist reviews the slides and claims for service, the Mohs physician may not report using these codes. Closure of the wound by undermining or advancement flaps is included in this service. When a more complex closure is required, such as rotation flaps, transposition or skin grafting, it may be reported and paid in full (100%) for the first HSC reported followed by the usual rates for multiples. Other lesions addressed by the same surgeon, same day will be paid according to rules of multiples. **Billing Guidelines** • Payable once per surgeon per lesion – even if the service extends more than one day. • May not be reported if there is a pathology claim for the same patient same day. • Complex closure may be reported at 100% for the first HSC once per MMS lesion. • If additional closure HSC is reported, the usual rules of multiples apply. • May be reported with: ○ 98.51B Local tissue shifts with free skin graft to secondary defect - single ○ 98.51C Local tissue shifts – advancements, rotations, transpositions, 'Z' plasty - single ○ 98.51D Local tissue shifts– advancements, rotations, transpositions, 'Z' plasty - multiple ○ 98.51E Local tissue shifts with free skin graft to secondary defect - multiple ○ 98.53A Local tissue shifts, advancements, rotations, transpositions, 'Z' plasty, etc., eyebrow, eyelid, lip, ear, nose – single ○ 98.53B Local tissue shifts, advancements, rotations, transpositions, 'Z' plasty, etc., eyebrow, eyelid, lip, ear, nose – two stages • Other non-MMS lesions same patient, same day are subject to the rules of multiples. **Specialty Restriction:** SP=DERM SP=PLAS (with proof of Mohs Micrographic surgery fellowship in keeping with the standards of the American College of Mohs Surgery (ACMS)	155 MSU
ADON	98.99I	**Additional Levels (Comprehensive of all additional levels required for complete excision)** **Billing Guidelines** Payable once per surgeon per lesion **Specialty Restriction:** SP=DERM SP=PLAS (with proof of Mohs Micrographic surgery fellowship in keeping with the standards of the American College of Mohs Surgery (ACMS)	135 MSU

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NEW FEES (CONTINUED)

Effective October 25, 2019 the following code is available for billing:

Category	Code	Description	Base Units
ADON	87.98A	**Detention During Obstetrical Delivery (for attendance beyond three hours) RO=DETE** **Description** Detention time for obstetrical delivery performed by a family physician when the physician is required to be in attendance beyond three hours, notwithstanding clause 5.2.75 *(see below)* of the Physicians Manual (2014). Each 15 minute time increment beyond three hours has a rate of 12.5 MSU to a maximum of 8 hours. **Billing Guidelines** May only be claimed as an add-on for HSC 87.98 Delivery NEC. 1 multiple = 3 hours with patient 2 multiples = 3 hours, 15 minutes 3 multiples = 3.5 hours 4 multiples = 3.75 hours 5 multiples – 4 hours etc. to a maximum of: 21 multiples = 8 hours **Specialty Restriction** SP=GENP {ATTENDANCE AT LABOUR AND DELIVERY*(5.2.75)* This is a service involving constant or periodic attendance on a patient during the period of labour to provide all aspects of care. This includes the initial assessment, and such subsequent assessment as may be indicated, including ongoing monitoring of the patient's condition. Obstetrical delivery covers services rendered during delivery, including medical or surgical inductions by the attending physician, suturing of minor lacerations, hypnosis, detention time during labour, local or regional anesthesia and manual removal of placenta by the attending physician, and all obstetrical manoeuvers that may be required, e.g. use of forceps.}	12.5 MSU /15 mins

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PREAMBLE CHANGE

Current Definition	New Definition
Detention Time *(5.1.75)*	**Detention Time *(5.1.75)***
Medical Detention occurs when a service provider's time is given exclusively to one patient for active treatment and/or monitoring of that patient at the sacrifice of all other work. Detention time is not payable when provided in the office. *(5.1.76)* Detention (see section 6 (6.0.23)) commences 30 minutes after the practitioner is first in attendance and may be claimed in 15 minute increments thereafter. When claimed with a Comprehensive or Limited consultation, detention time commences after 1 hour. This may include time spent with the patient travelling from one location to another. However, travel time to transport donor organs from a donor site to the recipient site for transplantation begins at the time the retrieving surgeon accompanied by the donor organs leave the donor site. Where any service is performed during the time spent with the patient, either the service or the detention time, but not both, should be claimed. The circumstances in each case, and the time involved, should be documented with the service encounter. *(5.1.77)* The first 30 minutes is the appropriate visit fee. The fee for detention is 12.5 units per 15 minutes. The detention modifier RO=DETE must be indicated on the service encounter. *(5.1.78)* Detention time does not apply to: a) Waiting time for an operating room, x-rays, laboratory results or administrative duties b) Counselling or psychotherapy c) Advice given to the patient or patient's family or representatives d) Waiting time for a patient's arrival for assessment or treatment e) Waiting time for attendance by another medical practitioner or consultant f) Return trip if the physician is not in attendance with the patient g) Time spent in completing or reviewing patient charts h) More than one patient at a time i) Office visits *(5.1.79)* Detention time is not payable in conjunction with fees paid for the following on the same day: a) Intensive care or critical care (section 5 (5.1.112 and 5.1.123)) b) Diagnostic and therapeutic procedures c) Obstetrical delivery *(5.1.80)*	Medical Detention occurs when a service provider's time is given exclusively to one patient for active treatment and/or monitoring of that patient at the sacrifice of all other work. Detention time is not payable when provided in the office. (See section 6 (6.0.23)). *(5.1.76)* Visits: When detention is claimed with limited or comprehensive visit services, detention commences 30 minutes after the practitioner is first in attendance and may be claimed in 15 minute increments thereafter. The first 30 minutes is the appropriate visit fee. Consultations: When claimed with a Comprehensive or Limited consultation, detention time commences after 1 hour. Obstetrical Delivery: When claimed with an obstetric delivery provided by a general practitioner, detention time commences after 3 hours. This may include time spent with the patient travelling from one location to another. However, travel time to transport donor organs from a donor site to the recipient site for transplantation begins at the time the retrieving surgeon accompanied by the donor organs leave the donor site. Where any service is performed during the time spent with the patient, either the service or the detention time, but not both, should be claimed. The circumstances in each case, and the time involved, should be documented with the service encounter. *(5.1.77)* The fee for detention is 12.5 units per 15 minutes. The detention modifier RO=DETE must be indicated on the service encounter. *(5.1.78)* Detention time does not apply to: a) Waiting time for an operating room, x-rays, laboratory results or administrative duties b) Counselling or psychotherapy c) Advice given to the patient or patient's family or representatives d) Waiting time for a patient's arrival for assessment or treatment e) Waiting time for attendance by another medical practitioner or consultant f) Return trip if the physician is not in attendance with the patient g) Time spent in completing or reviewing patient charts h) More than one patient at a time i) Office visits *(5.1.79)* Detention time is not payable in conjunction with fees paid for the following on the same day: a) Intensive care or critical care (section 5 (5.1.112 and 5.1.123)) b) Diagnostic and therapeutic procedures c) Obstetrical delivery by specialties other than general practitioner *(5.1.80)*

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PREAMBLE CHANGE

Upcoming increases to bilateral and multiple surgical procedures:

Current Definition	New Definition
Surgical Services Major or Minor *(5.3.66)* k) Bilateral Procedures i. Unless otherwise specified, bilateral procedures are claimed at an additional 50 percent of the unilateral procedure. ii. When bilateral procedures are performed subsequent to a major procedure through the same incision they should be claimed at 50 percent and 25 percent. iii. When bilateral procedures are performed subsequent to a major procedure through a separate incision, they should be claimed at 65 percent and 32.5 percent. iv. When performed under separate anesthetics at an interval, the full fee will be charged for each procedure. *(5.3.78)* l) Multiple Procedures Same Physician i. When multiple operative procedures are performed through a single incision in the course of an abdominal operation or on any one organ or cavity, the principle procedure will be claimed plus 50 percent for the secondary procedures (secondary incidental procedures, such as appendectomy which are not indicated by pathology, shall not be claimed). ii. A physician who performs multiple operative procedures simultaneously in different areas and through different incisions shall claim for the major procedure plus an additional 65 percent for each of the lesser procedures. Laparoscopic operations are considered to utilize a single incision regardless of the number of incisions. iii. When an appendectomy is claimed with another abdominal surgery, a pathology report must be forwarded to MSI. *(5.3.79)*	Surgical Services Major or Minor *(5.3.66)* k) Bilateral Procedures i. Unless otherwise specified, bilateral procedures are claimed at an additional 70 percent of the unilateral procedure. ii. When bilateral procedures are performed subsequent to a major procedure through the same incision they should be claimed at 70 percent and 35 percent. iii. When bilateral procedures are performed subsequent to a major procedure through a separate incision, they should be claimed at 70 percent and 35 percent. iv. When performed under separate anesthetics at an interval, the full fee will be charged for each procedure. *(5.3.78)* l) Multiple Procedures Same Physician i. When multiple operative procedures are performed through a single incision in the course of an abdominal operation or on any one organ or cavity, the principle procedure will be claimed plus 70 percent for the secondary procedures (secondary incidental procedures, such as appendectomy which are not indicated by pathology, shall not be claimed). ii. A physician who performs multiple operative procedures simultaneously in different areas and through different incisions shall claim for the major procedure plus an additional 70 percent for each of the lesser procedures. Laparoscopic operations are considered to utilize a single incision regardless of the number of incisions. iii. When an appendectomy is claimed with another abdominal surgery, a pathology report must be forwarded to MSI. *(5.3.79)*

Note: This change applies only to MASG and MISG procedures.
It does not apply to Diagnostic and Therapeutic procedures.

*These fee increases will take effect January 1, 2020. At that time, the LV=LV50 and LV=LV65 modifiers previously used to denote multiple procedures will no longer be applicable to major or minor surgical category procedures. These will be replaced with the following new modifiers to facilitate payment at the increased rate:
LV=DIFF – Indicates the surgical procedure done through a separate approach.
LV=SAME – The second or subsequent surgical procedure done through the same approach.

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FEE REVISIONS

INCREASES IN COMPREHENSIVE PRIMARY CARE FEE CODES

As per the master agreement, the following fees shall have their values increased for family physicians.
(New Value is the value effective October 25, 2019)

	Old Value	New Value
Description	**MSU**	**MSU**
Office Visit (ME=CARE)	14.76	15.28
Geriatric Office Visit (ME=CARE)	18.26	18.90
Office Visit After-Hours (ME=CARE)	18.45	19.10
Geriatric Office Visit After-Hours (ME=CARE)	22.83	23.63
Office Visit – Well Baby Care (ME=CARE)	14.76	15.28
Office Visit Well Baby Care After-Hours (ME=CARE)	18.45	19.10
Office Visit Prenatal Care (ME=CARE)	14.76	15.28
Office Visit Prenatal Care After-Hours (ME=CARE)	18.45	19.10
Office Visit Postnatal Care After-Hours (ME=CARE)	23.76	24.58
Subsq. Inpatient Care Visit (Days 2, 3)	23	23.81
Subsq. Inpatient Care Visit – Newborn (Days 2, 3)	23	23.81
Subsq. Inpatient Care Visit – Post-Partum (Days 2, 3)	23	23.81
Subsq. Inpatient Care Visit (Days 4-7)	19	19.67
Subsq. Inpatient Care Visit – Post-Partum (Days 4-7)	19	19.67
Subsq. Inpatient Care Visit (Daily to 56 days)	16	16.56
Subsq. Inpatient Care Visit (Weekly after Day 56)	16	16.56

*The effective date of these increases is October 25, 2019 however the fees in the system will only display the correct values as of December 13, 2019.
Claims made for these services from October 25 – December 12, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window has elapsed.

INCREASES IN PSYCHIATRY FEE CODES

As per the master agreement, the following fees shall have their values increased for psychiatrists.
(New Value is the value effective October 25, 2019)
Note: these increases are for psychiatrists only)

	Old Value	New Value
Description	**MSU**	**MSU**
Routine Psychiatric Visit (08.5B)	35.8	38.16
Psychotherapy (08.49B)	35.8	38.32
Comprehensive Consultation (03.08)	75	82.30
Child Psychiatric Assessment (08.19A)	39.32	42.08
Group Therapy (08.44)	9	9.63
Therapeutic/Diagnostic Interview Relating to a child (08.19B)	35.78	38.30

*The effective date of these increases is October 25, 2019 however the fees in the system will only display the correct values as of December 13, 2019.
Claims made for these services from October 25 – December 12, 2019 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window has elapsed.

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UPDATES

Youth Clinic Sessional

Sessional arrangements are established for clinical services. With the exception of a few unique clinics, submission of claim forms without associated shadow billing will not be paid. If a clinic is cancelled due to inclement weather, closure of a facility, etc., the physician may reschedule that clinic for a later date and claim for those services. When submitting such claims, they should provide a summary on the claim form.

In cases where patients do not present for scheduled clinics and there is no shadow billing for a particular date, the physician should provide a summary of the unbillable services they provided for consideration and approval of payment. Physicians should expect to provide additional information to Medavie upon request where necessary to make an assessment.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
MJ068	SERVICE ENCOUNTER HAS BEEN REDUCED TO 70%. WHEN MULTIPLE SURGICAL PROCEDURES ARE PERFORMED AT THE SAME TIME, ONLY ONE IS APPROVED AT 100%.
GN103	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THIS SERVICE MAY NOT BE BILLED IF A PATHOLOGIST HAS REVIEWED THE SLIDES AND CLAIMED FOR THE SERVICE.
AD086	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST CLAIM THE BASE DELIVERY FEE (HSC 87.98) PRIOR TO CLAIMING DETENTION DURING OBSTETRICAL DELIVERY.
AD085	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF ROTAVIRUS IMMUNIZATIONS HAS BEEN REACHED.
AD028	SERVICE ENCOUNTER HAS BEEN REDUCED TO 50%. ONLY ONE IMMUNIZATION AT FULL FEE IS PAYABLE WHEN A VISIT IS CLAIMED
BK061	SERVICE ENCOUNTER HAS BEEN DISALLOWED. PLEASE SUBMIT A COPY OF THE FIRST AND SUBSEQUENT ECHO REPORTS ALONG WITH THE CLINICAL DOCUMENTATION BEFORE REQUESTING REASSESSMENT FOR THIS CLAIM.

Note: BK061 was introduced and available for download on October 4, 2019.

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Claiming for Referred Services

A consultation is a service that results from a formal referral from the patient's physician, nurse practitioner, midwife, optometrist or dentist for an evaluation by a physician qualified to furnish advice. In addition to a formal (i.e. written) referral, a consultation also requires a written report to the referring provider.

A comprehensive consultation (Health Service Code 03.08) is a comprehensive visit. It requires a complete history and physician examination appropriate to the physician's specialty and the working diagnosis. The elements of a comprehensive visit have been outlined in previous MSI Bulletins. (August 2017)

In instances in which a comprehensive assessment is not medically necessary for a referred patient, a limited consultation (Health Service Code 03.07) may be claimed. This is an assessment that is focused on the problem that has led to the referral.

Both comprehensive and limited consultations require a physical examination by the physician.

Here are common questions we receive at MSI with respect to consultation services:

Q: Another physician in my specialty is retiring. If she sends me a written referral, may I claim for a consultation the first time I see one of her patients?
A: The situation you describe represents transferral of care. In this situation, where care is transferred either temporarily or permanently from one physician to another, the receiving physician may not claim either a consultation or comprehensive visit.

Q: I am a family doctor who works in a clinic with several other family doctors. Recently, we were discussing the fact that a specialist in town follows our patients for some chronic conditions. However, if it has been longer than six months since he last saw them, he insists that we send a new referral before he will see them again. This is extra paperwork that I don't need. Does MSI require that a new referral be sent after six months?
A: MSI has no such requirement. In situations where the specialist wishes to review the patient, the visit should be claimed as a follow-up visit (normally continuing care or directive care) and not as a new consultation.

Q: I am a specialist. Can I claim a new consultation without a new referral if considerable time has passed since I last saw them?
A: A valid referral is required each time you claim a new consultation. The referring provider must have assessed the patient and deemed that he/she requires a new opinion from you. If a patient is seen for a new or worsening condition in the absence of a new referral, and a new comprehensive visit is medically necessary and carried out, claim an initial visit with complete examination (HSC 03.04). If there is no new or worsening condition, claim as a limited visit (HSC 03.03).

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday December 13th, 2019. The files to download are:
Health Service (SERVICES.DAT),
Health Service Description (SERV_DSC.DAT),
Modifiers (MODVALS.DAT) and,
Explanatory Codes (EXPLAIN.DAT).

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

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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