PHYSICIAN'S BULLETIN

May 18, 2017: Vol. LII, ISSUE 4

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

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.

INTERPROVINCIAL RECIPROCAL BILLING

Service providers may be required to render medical services to patients from other provinces within Canada who are visiting or travelling within Nova Scotia. Effective April 1, 1988, all provinces and territories, except Quebec, agreed to participate in a reciprocal billing agreement under which a service provider would submit service encounters directly to their own provincial medical plan for eligible Canadian patients. Attached is a sample of Valid Insured Health Services Plan Cards for Reciprocal Billing. Please see Preamble section 2.4.0 for detailed Reciprocal Billing Agreement information, including eligibility criteria.

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INTERIM FEES MADE PERMANENT

Effective May 18, 2017, the following interim fees have been made permanent.

Category	Code	Description	Base Units
CONS	03.09I	**Anatomic Pathology Consultation** **Diagnostic Consultation, with review of records and specimens, with report on referred material prepared elsewhere.**	45 MSU
CONS	03.09J	**Anatomic Pathology Consultation** **Special Diagnostic Consultation, with review of records and specimens, with report on referred material and requiring preparation of additional slides, and/or ordering and interpretation of special tests.**	60 MSU
VEDT	03.38B	**Exercise Induced Asthma Assessment, interpretation.** **Includes interpretation of all serial spirometry, flow/volume loops, bronchodilation responsiveness, and oximetry required to assess the patient.**	20 MSU
VEDT	03.38C	**Interpretation of Spirometry Pre and Post Bronchodilator** *(Revised March 31,2020 – See April 2020 Bulletin for updated information)*	10 MSU
VEDT	03.38D	**Six Minute Walk Test, interpretation, when this is the sole procedure.**	2 MSU
VEDT	05.99A	**Immunofluorescence, interpretation of any and all markers required for diagnosis; any method.**	30 MSU
VEDT	05.99B	**Molecular testing, interpretation of any and all analyses/tests required for diagnosis; any method.**	40 MSU

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NEW INTERIM FEES (2015-2019 MASTER AGREEMENT)

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New Health Service Codes for Non-Face to Face Services

Eligible services can now be submitted for dates of service April 1, 2017 onward. Physicians have 90 days from the date of this Bulletin to submit these claims. Please contact MSI directly for detailed instructions on how to submit these outdated eligible services.

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

The new non face-to-face HSCs will replace HSCs 03.03F, 03.03I, 03.09D, 03.09E and 03.09F and therefore physicians should, effective March 31, 2017, cease using them. Services that would have been submitted using these discontinued HSCs should be held and claimed using the new HSCs.

Category	Code	Description	Base Units
CONS	**03.09K**	**Specialist Telephone Advice – Consultant Physician – Providing Advice**	25 MSU
CONS	**03.09L**	**Specialist Telephone Advice – Referring Physician – Requesting Advice**	11.5 MSU

This health service code may be reported for a two-way telephone (or other synchronous electronic verbal communication) regarding the assessment and management of the patient but without the consulting physician seeing the patient.

The referring physician may be a family physician or other specialist seeking an expert opinion from the consulting physician due to the complexity and severity of the case and with the intent of continuing to provide the patient's care closer to home. The consultant specialist may also receive requests for advice from a nurse practitioner.

The referring physician (or NP) must submit a written request for an elective consultation to the specialist. The specialist will schedule a 15 minute telephone call with the referring provider. There must be by a two-way verbal communication discussing the clinical situation followed by a management decision and a written report from the specialist to the referring provider.

For urgent consultations that do not result in transfer of the patient, the telephone call and the written request to the specialist may occur on the same day.

The written referral and the formal consultation report must be available in the patient's medical record; both the referring physician (or NP) and the specialist must maintain copies of both documents. Both medical records must include the date and time of the service and any contemporaneous notes, in addition to the written documents.

The service is reportable by the specialist for a new patient or an established patient with a new condition or an exacerbation of an existing condition.

Billing Guidelines
The HSC includes a review of the patient's history, family history and history of present complaint, and a review of any laboratory data, PACS images, medical records or other data as needed to provide advice.

The health service includes a discussion of the physical findings as reported by the referring provider.

If subsequent phone calls are necessary within 14 days to complete the consultation they are considered included in the HSC for the telephone consultation.

The Consultant Physician HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.

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The Referring Physician HSC may be reported when the telephone call for an urgent consultation occurs on the same day as the patient visit that generated the consultation.

The HSC is not reportable when the purpose of the communication is to:

- Arrange transfer
- Arrange a hospital bed for the patient
- Arrange a telemedicine consultation
- Arrange an expedited face to face consultation
- Arrange a laboratory, other diagnostic test or procedure
- Inform the referring physician of the results of diagnostic investigations
- Decline the request for a consultation or transfer the request to another physician

The service is not reportable for other forms of communication such as:

- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another health professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student

The service is not reportable by the consulting physician if the patient has had a face to face visit with the consultant or any member of his/her call group within the previous 14 days for the same condition or if the telephone consultation results in a face to face service within the next 14 days or the next available appointment of the consultant.

The service is not reportable for telephone calls of less than 5 minutes of two way medical discussion.

The service is not reportable for calls between a referring provider and specialist in the same institution or practice location.

Documentation Requirements

- A written referral must be sent to the specialist and be available in the patient's medical record.
- Both the specialist consultant and the referring provider must document the patient name, identifying data and date and start and stop time of the call in their respective charts or EMRs.
- The names of the referring physician (or NP) and the consultant physician must be documented by both physicians.
- The diagnosis, reason for referral, elements of the history and physical as relayed by the referring provider, the opinion of the consultant physician and the plan for future management must be documented.
- A written report must be sent to the referring provider by the specialist consultant.
- The referring physician's billing number must be noted on the electronic MSI service Report (claim).
- The specialist must enter the date of the receipt of the referral in the text field on the MSI service report (claim).
- Both physicians must submit the start and stop time of the call in the text field on the MSI service report (claim).
- There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service.

Location
LO=OFFC

Note
As these codes replace HSCs 03.09E, 03.09F, 03.09D these three codes will be termed on implementation of these health services codes.

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Category	Code	Description	Base Units
VIST	**03.03Q**	**Scheduled Specialist Telephone Management/Follow-up with Patient** This health service code may be reported for a scheduled 15 minute telephone communication between the specialist physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face consultation, visit or procedure by the same physician within the last 9 months and has not been seen within the last 7 days. This service is not reported if the outcome of the scheduled call is to see the patient at the next available appointment in the office. This communication is intended to take the place of an office follow up visit that would have otherwise been scheduled, when a physical examination of the patient is not required. **Billing Guidelines** This health service is reportable for a scheduled telephone (or synchronous electronic verbal communication) between the specialist physician and the patient (or the patient's parent, guardian or proxy as established by written consent). Telephone management requires communication between the patient and physician on a clinical level; the HSC is not reportable for administrative tasks. The call must include a discussion of the clinical problem and a management decision. The HSC is reportable for scheduled telephone appointments only. The specialist physician must have seen and examined the patient within the preceding 9 months. The HSC is reportable a maximum of 4 times per patient per physician per year. The HSC is not reportable for facility based patients. The HSC is not reportable in addition to any other service for the same patient by the same physician on the same day. The service is not reportable when the purpose of the communication is to: • Arrange a face to face appointment • Notify the patient of an appointment • Provide a prescription renewal • Arrange a laboratory, other diagnostic test or procedure • Inform the patient of the results of diagnostic investigations with no change in management plan. The service is not reportable for other forms of communication such as: • Written, e-mail or fax communication • Electronic verbal forms of communication that are not PHIA compliant The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another professional such as: • Nurse practitioner • Resident in training • Clinical fellow • Medical student • Clerical staff The service is not reportable for telephone calls of less than 5 minutes of two way medical discussion. **Documentation requirements** • The date, start and stop times of the conversation must be noted in the medical record. • The medical record must indicate the content of the discussion, the management plan and that the patient understands and acknowledges the information provided.	11.5 MSU

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Category	Code	Description	Base Units
		• A written report must be sent to the referring physician or family physician by the specialist consultant. • The start and stop time of the call must be included in the text field on the MSI service report (claim). • There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service. **Location** LO=OFFC **Note** As this HSC replaces HSCs 03.03F and 03.03I these will be termed on implementation of this health service code.	

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Revised March 31, 2020 – See April 2020 Bulletin for updated information

Category	Code	Description	Base Units
VIST	**03.03R**	**Scheduled Family Physician Telephone Management/Follow-Up with Patient** This health service code may be reported for a scheduled 15 minute telephone communication between the family physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face visit by the same physician within the last 9 months and has not been seen within the last 7 days for the same condition. This telephone communication is intended to take the place of an office visit initiated by the patient (or the patient's parent, guardian or proxy as established by written consent) for a new condition or an exacerbation of an existing condition, or a follow up visit that would have otherwise been scheduled by either the physician or the patient, when a physical examination of the patient is not required. The patient population eligible must be either 65 years and older or be suffering from mental illness or multiple (two or more) chronic diseases. Chronic disease is defined as: Mental illness is defined as: • A condition that meets criteria for a DSM diagnosis The service is not reported if the decision is to see the patient at the next available appointment in the office. **Billing Guidelines** This health service is reportable for a scheduled telephone (or synchronous electronic verbal communication) between the family physician and the patient (or the patient's parent, guardian or proxy as established by written consent). Telephone management requires communication between the patient and physician on a clinical level; the HSC is not reportable for administrative tasks. The call must include a discussion of the clinical problem and a management decision. The HSC is reportable for scheduled telephone appointments only. The family physician must have seen and examined the patient within the preceding 9 months. The HSC is reportable a maximum of 4 times per patient per physician per year by the family physician and/or the practice providing ongoing comprehensive care to the patient. The HSC is not reportable by walk in clinics. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no requirement for an appointment, and episodic care with little or no follow-up. There is no standard patient roster and the patient list is constantly changing.	11.5 MSU

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Category	Code	Description	Base Units

The HSC is not reportable for facility based patients.

The HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.

The service is not reportable when the purpose of the communication is to:

- Arrange a face to face appointment
- Notify the patient of an appointment
- Prescription renewal
- Arranging to provide a sick note
- Arrange a laboratory, other diagnostic test or procedure
- Inform the patient of the results of diagnostic investigations with no change in management plan.

The service is not reportable for other forms of communication such as:

- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant
-

The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student
- Clerical staff

The service is not reportable for telephone calls of less than 5 minutes of medical discussion.

Documentation requirements

- The date, start and stop times of the conversation must be noted in the medical record.
- The medical record must indicate the content of the discussion, the management plan and that the patient (or the patient's parent, guardian or proxy as established by written consent) understands and acknowledges the information provided.
- For patient initiated appointment requests that result in a telephone management service on the same day, the following text should be entered in the MSI text field:
  Same day access
- The start and stop time of the call must be included in the text field on the MSI service report (claim).
- There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service.

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BILLING REMINDERS

Methadone Management Health Service Codes

Physicians are reminded that methadone treatment and management health service codes are reportable only by the physician most responsible for the ongoing care of the patient inclusive of the patient's substance use disorder and concurrent medical conditions. These health service codes are not reportable by physicians providing methadone management alone.

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.

Percutaneous Ureteroscopy with ultrasonic lithotripsy and/or ureteroscopy with electrohydraulic lithrotripsy (HSC 68.95B)

Procedural codes remunerate physicians for all aspects of the procedure that would normally be considered part of the defined technique for that procedure. Preamble rules prohibit unbundling procedural codes into constituent parts and claiming for them separately.

HSC 68.95B Percutaneous ureteroscopy with ultrasonic lithotripsy and/or ureteroscopy with electrohydraulic lithotripsy should not be claimed with any of the following as all are inherent parts of this procedure:

- HSC 68.95C ureteroscopy plus basket,
- HSC 68.99A removal of J-stent including cystoscopy, or
- HSC 68.99C calibration and/or dilation of ureter – one/both sides

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.

Suture of Lacerations (HSC's 98.22, 98.22A, 98.22B, 98.22D and 98.22E)

These health service codes may be claimed when suturing of lacerations is provided as a stand-alone procedure. These HSCs may not be claimed where skin suturing is an integral aspect of another procedure such as removal of a cutaneous lesion.

Multiples for these HSCs may only be claimed when multiple lacerations are sutured. It is not appropriate to claim multiples for each suture.

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NEW AND UPDATED EXPLANATORY CODES

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Code	Description
GN092	SERVICE ENCOUNTER HAS BEEN REFUSED AS TEXT IS REQUIRED FOR NON FACE TO FACE SERVICES.
GN093	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY BILLED A NON FACE TO FACE SERVICE FOR THIS PATIENT ON THE SAME DAY.
GN094	YOU HAVE BILLED FOR A NON FACE TO FACE SERVICE AND WE ARE REQUESTING THE SUPPORTING DOCUMENTATION TO AID IN THE EVALUATION OF THIS CLAIM.
GN095	SERVICE ENCOUNTER HAS BEEN REDUCED TO THE APPROPRIATE FEE FOR THE SERVICE PROVIDED.
MA072	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 27.72, 27.72B, 27.73, 27.73A, OR 27.73B HAS ALREADY BEEN BILLED AT THE SAME ENCOUNTER AND IS A COMPONENT OF THIS PROCEDURE.
VA080	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.12 IS A COMPONENT OF THIS PROCEDURE.
VT147	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE PATIENT MUST HAVE PREVIOUSLY BEEN SEEN FOR A FACE TO FACE ENCOUNTER BY THIS PROVIDER WITHIN THE LAST 9 MONTHS.
VT148	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.09K MAY NOT BE BILLED IN ADDITION TO ANY OTHER SERVICE FOR THIS PATIENT ON THE SAME DAY.
VT149	SERVICE ENCOUNTER HAS BEEN REFUSED AS CALLS BETWEEN A REFERRING PROVIDER AND SPECIALIST IN THE SAME INSTITUTION OR PRACTICE LOCATION ARE NOT PERMITTED FOR THIS SERVICE.
VT150	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED FOR SPECIALIST TELEPHONE ADVICE FOR THIS PATIENT WITHIN THE PREVIOUS 14 DAYS WHICH INCLUDES ANY SUBSEQUENT CALLS NECESSARY TO COMPLETE THE CONSULTATION.
VT151	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE ALREADY BILLED A FACE TO FACE VISIT FOR THIS PATIENT IN THE PREVIOUS 14 DAYS.

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UPDATED FILES

Updated files reflecting changes are available for download on Thursday May 18, 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

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