PHYSICIAN'S BULLETIN

March 24, 2017: Vol. LII, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

CONTENTS

MSI News

MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT/ANAESTHESIA UNIT CHANGE

Effective April 1, 2017, the Medical Service Unit (MSU) value will be increased from $2.42 to $2.44 and the Anaesthesia Unit (AU) value will be increased from $20.55 to $20.76.

PSYCHIATRY FEES

Effective April 1, 2017 the hourly Psychiatry rate for General Practitioners will increase to $111.66 while the hourly rate for Specialists increases to $151.40 as per the tariff agreement.

SESSIONAL PAYMENTS

Effective April 1, 2017 the hourly Sessional rate for General Practitioners will increase to $146.40 while the hourly rate for Specialists increases to $170.80 as per the tariff agreement.

WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC

Effective April 1, 2017 the Workers' Compensation Board MSU Value will increase from $2.69 to $2.71 and the Workers' Compensation Board Anaesthetic Unit Value will increase from $22.83 to $23.07.

WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT UPDATE

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been calculated to the listed WCB specific fees for fiscal year 2017-18.

Due to the increase in CPI for 2016, all of the WCB specific services listed below will have their values increased by 1.24% effective April 1st, 2017:

CODE	DESCRIPTION	NEW VALUE
WCB12	EPS physician assessment Service. Combined office visit and completion of Form 8/10 For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15 minute increments to a maximum of 1 additional hour	**Initial visit:** $177.10 + $51.76 per 15 minutes to a maximum 4x(RO=EPS1 and RP=INTL) **Subsequent visit:** $177.10 (RO=EPS1 and RP=SUBS)
WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable	GPs……$43.25 per 15 min EPS(RO=EPS1)……..$51.76 per 15 min Specialists……$58.21 per 15 min
WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable	GPs……$43.25 per 15 min EPS(RO=EPS1)……..$51.76 per 15 min Specialists……$58.21 per 15 min
WCB17	Photocopies of Chart Notes	10 pgs or less (ME=UP10)……....$25.88 11-25 pgs (ME=UP25)……$51.76 26-50 pgs (ME=UP50)……$103.44 Over 50 pgs (ME=OV50).....$155.15
WCB20	Carpal Tunnel Syndrome (CTS) Assessment Report	$66.37
WCB21	Follow-up visit report	$38.81
WCB22	Completed Mandatory Generic Exemption Request Form	$12.98 per form
WCB23	Completed Non-Opioid Special Authorization Request Form	$12.98 per form
WCB24	Completed Opioid Special Authorization Request Form	$43.50 per form
WCB25	Completed WCB Substance Abuse Assessment Form	$28.97
WCB26	Return to Work Report – Physician's Report Form 8/10	$66.37
WCB27	Eye Report	$58.21
WCB28	Comprehensive Visit for Work Related Injury or Illness	$66.80

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NEW FEES

Effective March 24, 2017 the following health service code will be available for billing:

Category	Code	Modifier	Description	Base Units
VADT	03.19H	**RO=INTP**	**Corneal Topography of both eyes for corneal disease (not refractive eye surgery)** Physician interpretation of computerised corneal topography for; • Central corneal ulcer • Corneal dystrophy, bullous keratopathy, and complications of transplanted cornea • Diagnosis and monitoring of keratoconus and pellucid marginal corneal degeneration • Corneal astigmatism **Billing Guidelines** • Post corneal transplant-maximum 6 per patient per year. • Fee includes both eyes, whether one at a time or on two separate visits • For keratoconus and pellucid degeneration where progressive changes greater than 1 diopter in a year has been documented this HSC is payable twice per year per patient. • Not payable for pre or postoperative cataract patients except where there is evidence of irregular astigmatism • Not payable when done in association with laser refractive surgery or the pre or postoperative care of these patients with laser refractive surgery **Specialty Restriction** OPHT With Fellowship in Corneal Disease **Location** LO=OFFC, LO=HOSP	5.8 MSU

Effective March 24, 2017 the following health service code will be available for billing:

Category	Code	Description	Base Units	ANAES Units
MASG	97.79A	**Masculinization of the Female Chest** Complete masculinization of the chest wall for the surgical treatment of gender dysphoria to include bilateral subcutaneous mastectomy, nipple-areolar repositioning, chest contouring and initial scar camouflage as required. **Billing Guidelines** • Must have prior approval by MSI. • Not to be billed with any other mastectomy, nipple or breast reconstruction or tissue shift codes. **Specialty Restriction** PLAS **Location** LO=HOSP	IC at 110MSU/hr	4+T

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Effective March 24, 2017 the following health service code will be available for billing:

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

Category	Code	Modifier	Description	Base Units	ANAES Units
MASG	57.6D	**RO=FPHN** **RO=SPHN**	**Total proctocolectomy with ileostomy and abdominal perineal resection** This fee is for the complete resection of the entire colon, rectum, and anus with perineal dissection to remove the anal sphincter, and the creation of an ileostomy. Includes mobilization of colon, identification of ureter, dissection of mesocolic vessels, division and suture of bowel, excision of rectum and anus, omental flap for repair as required. To bill as SPHN, the second surgeon must actively participate for 75% of the procedure time. When the second surgeon fee is billed no other assistant fee may be billed. * This fee is replacing health service code 57.6A - Enterectomy with colostomy, caecostomy or ileostomy, which was termed for March 23, 2017. **Billing Guidelines** Not to be billed with any other fees for resection or suture of bowel or formation of ileostomy on the same patient same day i.e.,HSC's: • 57.04 (A or B) Enterotomy or colostomy or multiple Colostomy • 57.42 (A or B) Enterectomy with anastomosis • 58.52 Closure enterostomy plus resection • 58.53 Closure of colostomy • 58.73 Other suture of intestine Not to be billed with: • 1.24C Sigmoidoscopy • 58.21 Ileostomy for ulcerative colitis • 58.39A Ileostomy with tube • 66.64 (A or B) Omental flap to repair extra-abdominal defect If reported with Vaginectomy or vaginal reconstruction the operative report and record of operation must be submitted for manual assessment i.e.,HSC's: • 82.23 Excision of lesion of vagina • 82.3 (also A, B, C) Obliteration of vagina • 82.52 Vaginal reconstruction • 82.62 Repair of Fistula of Vagina • 82.69 (A or B) Vaginoplasty **Premium** No – but may submit OR Report and Record of Operation for manual assessment if service is provided in premium time for medical necessity **Assistant** Reportable only when RO=SPHN is not reported **Specialty Restriction** GNSG, RO=SPHN also restricted to GNSG **Location** LO=HOSP	550MSU 400MSU	8+T

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NEW INTERIM FEES (2015-2019 MASTER AGREEMENT)

New Health Service Codes for Non-Face to Face Services

In the coming weeks, a number of new Health Service Codes will be available to physicians for select non-face to face services rendered on or after April 1, 2017. Physicians are asked to hold these claims until notified that they may be submitted for payment. An update regarding submission dates will be published in the next MSI Physician's Bulletin on May 18, 2017.

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
VIST	**03.09K**	**Specialist Telephone Advice – Consultant Physician – Providing Advice**	25 MSU
VIST	**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 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. • 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.	11.5 MSU

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Category	Code	Description	Base Units
VIST	**03.03R**	**Scheduled Family Physician Telephone Management/Follow-Up with Patient**	11.5 MSU

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.

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.
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.

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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.

Location
LO=OFFC

Billing Matters Billing Reminders, New Explanatory Codes

BILLING REMINDERS

Complete Hearing Tests
Physicians are reminded that health service code 09.41D complete hearing testing includes pure tone audiometry (air and bone), tympanometry, and a speech test, and all components must be performed to claim this fee.

Laser Treatment of Malignant Neoplasms of Esophagus, Bronchi, etc. in Addition to Scope
Physicians are reminded that health service code 44.0A laser treatment of malignant neoplasms of esophagus, bronchi, etc. in addition to scope is an add-on fee and should only be claimed after an appropriate base fee for bronchoscopy or esophagoscopy is paid.

Pap Smears
Physicians are reminded that health service code 03.26A pap smear may not be claimed in addition to a visit, consultation or procedure for a gynaecological or obstetrical diagnosis, nor is it payable in addition to a complete physical exam.

Hemodialysis
Physicians providing dialysis services are reminded that only one claim per patient may be made for initial hemodialysis i.e. HSC 51.95 RP=INTL

Clinical Records Supporting Claims to MSI
On occasion, MSI requires physicians to provide supporting clinical documentation to verify claims made to MSI. 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."

Medical Assistance in Dying (MAID)
Physicians are reminded that time spent discussing MAID with legal representatives, the College of Physicians and Surgeons of Nova Scotia, the Canadian Medical Protective Association or other associations not involved in direct patient care cannot be claimed.

The health service code for the second physician (03.03O) cannot be processed if a claim has not been submitted for the role of first physician (03.03M).

The health service code for the prescribing physician (03.03N) cannot be processed if claims have not been made for first and second physician.

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Canadian Medical Protective Association ("CMPA") Assistance Payment and other eligible Master Agreement related payments

*****If you have already taken action, please disregard this communication*****

The 2015-2019 Physician Master Agreement provides funding for reimbursement of eligible physician fees paid to The Canadian Medical Protective Association. As of September 9, 2016, the Department of Health and Wellness (through MSI) will provide compensation directly to all eligible physicians. This is a new process, as in the past, reimbursement was provided from Doctors Nova Scotia. All physicians registered with MSI have been mailed a package on February 15, 2017 to coordinate this process.

To ensure receipt of eligible reimbursement, all physicians are required to complete and submit the business arrangement form. The original deadline was March 17, 2017, but if you have not submitted, please submit as soon as possible. This new business arrangement will be used to process your CMPA payments as well as all other contractual incentive payments under the current Master Agreement. This new process, including the submission of required information to MSI, will allow for a transition away from a cheque based payment to an electronic funds transfer in the near future. You will continue to receive any/all eligible incentive based payments by cheque while we transition to electronic funds transfer.

Should you have any questions, please contact the MSI Provider Coordinators at msiproviders@medavie.bluecross.ca or by telephone 902-496-7011 (toll free: 1-866-553-0585).

Documentation Reminder

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribed, and start and stop times for time based codes.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptions, or emotional problems, the physician "deliberately established a professional relationship with the patient for the purposes of removing, modifying or alleviating existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional well being of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy," etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service on that date, then the service is not paid for or a lesser benefit is given. When the clinical record does not support the service claimed, there will be a recovery to MSI at the time of audit. Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

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NEW EXPLANATORY CODES

Code	Description
AD067	SERVICE ENCOUNTER HAS BEEN REFUSED. RESUBMIT USING THE APPROPRIATE HEALTH SERVICE CODE AND MODIFIER COMBINATION WITH THE PT=RISK MODIFIER AND TEXT EXPLAINING HIGH RISK.
BK060	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE FOLLOWING HSCS I1310, I1312, AND I1313 MAY ONLY BE BILLED ONCE PER PATIENT PER DAY.
GN028	SERVICE ENCOUNTER HAS BEEN DISALLOWED. RESUBMIT INDICATING DURATION OF SERVICE.
GN043	SERVICE ENCOUNTER HAS BEEN DISALLOWED. RESUBMIT INDICATING THE START AND FINISH TIME FOR THE PROCEDURE PERFORMED.
GN088	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR HSC 57.6D HAS BEEN APPROVED ON THIS DAY.
GN089	SERVICE ENCOUNTER HAS BEEN DISALLOWED. PLEASE RESUBMIT WITH TEXT INDICATING SPECIFIC AREAS INVOLVED.
GN090	SERVICE ENCOUNTER HAS BEEN DISALLOWED BECAUSE THE PROCEDURE IS NECESSARY TO ALLOW ACCESS/VISUALIZATION TO PERFORM THE SURGERY.
GN091	SERVICE ENCOUNTER HAS BEEN REFUSED. PLEASE RESUBMIT USING THE APPROPRIATE MODIFIER(S).
MI007	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 03.03, 09.02C OR 09.02F ON THIS DAY.
MJ018	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THIS SERVICE REQUIRES ELECTRONIC TEXT OR A PRIOR APPROVAL NUMBER.
MJ021	SERVICE ENCOUNTER HAS BEEN DISALLOWED. RESUBMIT WITH A COPY OF THE OUT PATIENT REPORT TO AID IN THE ADJUDICATION OF YOUR SERVICE ENCOUNTER.
MJ058	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 29.94A, 29.94B AND 29.94C MAY NOT BE CLAIMED TOGETHER AT THE SAME ENCOUNTER.
MJ059	DATE OF SERVICE ON CLAIM DOES NOT MATCH DATE OF SERVICE ON OPERATIVE REPORT.
NR006	SERVICE ENCOUNTER HAS BEEN DISALLOWED. INDICATE ACTUAL PROCEDURE PERFORMED WHEN RESUBMITTING.
NR014	SERVICE ENCOUNTER HAS BEEN DISALLOWED. RESUBMIT WITH A COPY OF THE PATHOLOGY REPORT TO AID IN THE ADJUDICATION OF YOUR SERVICE ENCOUNTER.
NR085	SERVICE ENCOUNTER HAS BEEN PAID AS THE RESULT OF A PRE-PAYMENT ASSESSMENT REVIEW.
OP033	SERVICE ENCOUNTER HAS BEEN REFUSED AS ONE OF THE REQUIRED DIAGNOSTIC CODES (37160,37148,37171,V425) WAS NOT INCLUDED ON THE SERVICE ENCOUNTER.
OP042	SERVICE ENCOUNTER HAS BEEN REFUSED AS AN INITIAL VISIT HAS ALREADY BEEN CLAIMED FOR THIS DIAGNOSIS.
OP043	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS AN ADDITIONAL COMPLETE EXAM HAS ALREADY BEEN APPROVED IN THE PAST YEAR.
OP044	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THIS FEE IS ONLY PAYABLE ONCE EVERY 2 YEARS FOR THE DIAGNOSIS SPECIFIED.

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Code	Description
OP045	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED CORNEAL TOPOGRAPHY THE MAXIMUM OF SIX TIMES FOR THIS PATIENT WITHIN THE PAST YEAR.
OP046	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A PREVIOUS OPTOMETRIC VISION ANALYSIS HAS BEEN APPROVED WITHIN THE PREVIOUS 2 YEARS.
OP047	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED CORNEAL TOPOGRAPHY FOR KERATOCONUS AND PELLUCID DEGENERATION THE MAXIMUM OF TWO TIMES FOR THIS PATIENT WITHIN THE PAST YEAR.
VA047	SERVICE ENCOUNTER HAS BEEN REFUSED. HSC 03.26A AND 03.26C ARE INCLUDED IN THE COMPLETE CARE CODE 81.8 WHICH WAS PREVIOUSLY BILLED FOR THIS PATIENT ON THIS DAY.
VA077	SERVICE ENCOUNTER HAS BEEN DISALLOWED, PLEASE RESUBMIT WITH DOCUMENTATION INDICATING THAT THE SERVICE WAS PROVIDED BY THE PHYSICIAN, NOT ANOTHER PROFESSIONAL.
VA078	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY BILLED AN ESOPHAGOGASTRODUODENOSCOPY CODE AT THE SAME ENCOUNTER.
VA079	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST BILL THE APPROPRIATE BASE FEE FOR BRONCHOSCOPY OR ESOPHAGOSCOPY
VT100	SERVICE ENCOUNTER HS BEEN REFUSED AS A 03.26A OR 03.26C HAS PREVIOUSLY BEEN BILLED FOR THIS PATIENT ON THE SAME DAY.
VT138	SERVICE ENCOUNTER HAS BEEN REFUSED AND CANNOT BE PROCESSED UNTIL AFTER THE FIRST PHYSICIAN CLAIM HAS BEEN RECEIVED AND PROCESSED.
VT139	SERVICE ENCOUNTER HAS BEEN REFUSED AS MSI REQUIRES FIRST AND SECOND PHYSICIAN CLAIMS TO PROCESS THE PRESCRIBING PHYSICIAN CLAIM.
VT140	SERVICE ENCOUNTER HAS BEEN REFUSED AS A MINIMUM OF ONE HALF HOUR MUST BE SPENT FOR MAID FEES TO BE PAYABLE.
VT141	SERVICE ENCOUNTER HAS BEEN REDUCED AS A MAXIMUM OF 2 HOURS IS PAYABLE PER PATIENT FOR THIS HEALTH SERVICE CODE.

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UPDATED FILES

Updated files reflecting changes are available for download on Friday March 24, 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

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