PHYSICIAN'S BULLETIN
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NOVA SCOTIA MEDICAL SERVICES INSURANCE

CONTENTS

MSI News

PRESCRIBING MEDICATION

AN ARTICLE BY DR. RHONDA CHURCH

It's a weekday afternoon. It's flu season. You have a waiting room full of patients and your assistant and two of the other physicians in your clinic are out sick. You're running almost an hour behind and have been fielding calls from the local nursing home about a number of ill residents there. You missed your son's last few basketball games because of work issues and you promised him you'd get to the one later today.

As you are attempting to sort out a complex, confused, and slightly hard of hearing elderly man who is short of breath, there is a knock at the exam room door.

"Call from the pharmacy on line 2. Question about a prescription you wrote this morning."

Sound familiar?

In addition to managing payments to physicians, Medavie Blue Cross also administers payments to pharmacists under the provincial Pharmacare Program. Recently, I met with members of our Pharmacare team who told me that one of the most frustrating aspects of a community pharmacist's job is having to call a physician for clarification on a busy day.

A great pharmacist is like a living, breathing CPS, with a tremendous depth of knowledge about medications we prescribe. Like physicians, they run small businesses, often employ staff and have practice standards in place to ensure safe and effective care of the people they serve. If they fill a prescription that contains incomplete information, there is a risk that they will fill the script in a way other than the physician intended. Not only can this lead to increased risk to the patient, filling such prescriptions can have significant financial implications for these small businesses as third party payers may not honour their fees.

MSI News continued

Here are the suggestions they had to reduce the number of calls:

- Include the patient's full name i.e. Walter White rather than Mr. White
- Include the name of the medication or product being prescribed rather than using nonspecific terms such as "ostomy supplies x 1 year"
- Include the dosage of the medication prescribed as well as the total number to dispense i.e. furosemide 20 mg once daily (90 tabs) rather than "furosemide as before" For individuals whose conditions are stable, three months' supply is generally the most cost effective option but if finances are tight, or the medication is new, a shorter duration may be appropriate.
- Include the size of the bottle or tube for liquids, ointments, etc. The pharmacist will only be able to fill this without clarifying it with you if the product comes in just one size.
- Include specific refill instructions i.e. "3 refills" rather than "as necessary" or "release with methadone."
- Sign the prescription.

A few extra seconds when prescribing can make a difference in the flow of you and your pharmacist's day and get you out the door and onto the bleachers.

★ Fees New Fees and Highlighted Fees

HIGHLIGHTED FEES

Effective November 30th, 2018 the adjusted MSU values apply to the following health service codes:

Category	Code	Description	Base Units
VIST	03.03	**Post-Partum Visit (LO=HOSP, FN=INPT, RO=PTPP)**	
		Days 2, 3 (DA=DA23)	23 MSU
		Days 4-7 (DA=DA47)	19 MSU
		Subsequent Care – Newborn Healthy Infant (LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS)	
		Days 2, 3 and (DA=DA23)	23 MSU
		Days 4-5 (DA=DA45)	19 MSU
		Description These adjusted MSU values apply to the following health service codes: 03.03 LO=HOSP, FN=INPT, RO=PTPP – Post-Partum Visit 03.03 LO=HOSP, FN=INPT, RO-NBCR, RP=SUBS – Subsequent Care, Newborn Healthy Infant. When the visit is provided to patients admitted to hospital where the family doctor is the most responsible physician. **Billing Guidelines** May only be claimed once per patient per day by the most responsible physician (MRP). **Specialty Restriction** SP=GENP **Location** LO=HOSP, FN=INPT	

As per the October 18th, 2017 bulletin, if a home visit occurs for a patient that is not considered homebound, then the visit is considered to be rendered at the home for convenience and may be claimed at the normal office rate. To facilitate this use, the new modifier ME=CONV (visit of convenience) has been added to the 03.03 home visit fee (effective November 30th, 2018), and will now pay at the correct normal office rate.

Category	Code	Description	Base Units
VIST	03.03	**ME=CONV, PT=FTPT, LO=HOME** **AG=OV65, ME=CONV, PT=FTPT, LO=HOME** **Description** This modifier is to be used when a visit outside of the office occurs for the convenience of either the patient or general practitioner. **Billing Guidelines** The modifier should be added to 03.03 home visit services for the first patient and the visit is for convenience. The modifier should also be added for 03.03 home visits for the first patient if they are 65 years of age or older and the visit is for convenience. If a home visit for convenience is claimed, the physician may not claim for mileage (HSC HOVM1). **Specialty Restriction** SP=GENP **Location** LO=HOME	13 MSU 16.5 MSU

NEW FEES

Effective November 30th, 2018 the following health service codes will be available for billing:

Category	Code	Description	Base Units	Anaes Units
MAAS IC	66.99B	**Cytoreductive Surgery with or without perioperative intraperitoneal chemotherapy (Sugarbaker Procedure)** This is a comprehensive fee based on the "skin to skin" operative time required to perform cytoreductive surgery with or without intraperitoneal chemotherapy (Sugarbaker). This procedure may include, but is not limited to, peritonectomy and multivisceral resections and may be followed by the infusion of intraperitoneal chemotherapy. **Billing Guidelines** • Surgical start and stop times must be reported in text with the claim and be verifiable by the record of operation in the patient's health record. • No other health service codes may be reported by the same physician, same patient, same service encounter, same day. **Specialty Restriction** SP=GNSG **Location** LO=HOSP	175MSU/Hour	12+T

Category	Code	Description	Base Units	Anaes Units
MASG	47.25A	**Aortic valve and ascending aorta replacement with reimplantation of coronary arteries (Bio-Bentall or Mechanical Bentall repair)** This is a comprehensive code for aortic root replacement with ascending aorta graft and valve conduit including coronary reimplantation. **Billing Guidelines** • Not reportable with: - 47.25 Other replacement of Aortic valve - 50.34B Excision of thoracic aorta aneurysm - 48.13 Aortocoronary bypass of two coronary vessels • May report, where clinically indicated, with: - ADON 51.61 Extracorporeal Circulation auxiliary to open heart surgery - ADON 49.99C Repeat open heart surgery **Specialty Restriction** SP=CASG **Location** LO=HOSP	1105MSU	35+T

Category	Code	Description	Base Units	Anaes Units
MASG	47.25B	**Valve sparing aortic root replacement or remodeling (David or Yacoub) with reimplantation of coronary arteries (VSR)** This is a comprehensive code for valve sparing aortic root replacement with graft, aortic valve suspension or remodeling, and coronary artery reimplantation. **Billing Guidelines** • Not reportable with: - 47.25 Other replacement of Aortic valve - 50.34B Excision of thoracic aorta aneurysm - 48.13 Aortocoronary bypass of two coronary vessels • May report, where clinically indicated, with: - ADON 51.61 Extracorporeal Circulation auxiliary to open heart surgery - ADON 49.99C Repeat open heart surgery **Specialty Restriction** SP=CASG **Location** LO=HOSP	1105 MSU	35+T

FEE REVISIONS

During the Province's March 2018 announcement of its $39.6 million investment in Primary Care simplification of the existing telephone health service codes was promised. The work of simplifying the documentation and billing guidelines has now finished and the following are the result of that work. Click here to go to the billing reminder in the September, 2018 bulletin

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

Description

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 communicate to the specialist the reason for the consultation and relevant patient information through verbal, written or electronic communication, either before or within four business days after the telephone call. The referring physician must document that this information was supplied to the specialist. There must be 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.

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 this document, 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 relevant history, relevant family history and relevant 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 relevant 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.

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

- The referring physician must document that s/he has communicated the reason for the consultation and relevant patient information to the specialist
- Both the specialist consultant and the referring provider must document the patient name, identifying data, 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 claim.
- Both physicians must submit the start and stop time of the call in the text field on the MSI service report.

Specialty Restriction
N/A

Location
LO=OFFC

Category	Code	Description	Base Units
VIST	03.03Q	**Specialist Telephone Management/Follow Up with Patient** **Description** This health service code may be reported for a 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 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.	11.5 MSU

Billing Guidelines
This health service is reportable for a telephone (or synchronous electronic verbal communication) between the specialist physician and the patient, or 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 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
- 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 (or the patient's parent, guardian or proxy as established by written content) 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

Specialty Restriction
N/A

Location
LO=OFFC

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

Description

This health service code may be reported for a 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 lace 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 suffering from at least one chronic disease.

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 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 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.

This 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 not 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 (or the patient's parent, guardian or proxy as established by written content) understands and acknowledges the information provided.
- The start and stop time of the call must be included in the text field on the MSI service report

Specialty Restriction
N/A

Location
LO=OFFC

UPCOMING FEE REVISION

Physicians are advised that health service **code 78.39A – Interruption or removal of fallopian tubes for purposes of sterilization: abdominal, vaginal, laparoscopic-not hysteroscopic (unilateral or bilateral)** – will be revised to permit surgical assist claims as of November 30th, 2018. Any physicians providing surgical assistance should hold their claims for this procedure until MSI can update the billing system in early 2019.

Billing Matters Billing Reminders, Updates, New Explanatory Codes

BILLING REMINDERS

Facility Numbers
Physicians are reminded to ensure that when submitting claims they are using the correct facility number.

Pacemaker battery/leads replacement
Physicians are reminded that the health service codes for pacemaker battery change and leads replacement/adjustment include any necessary programming. It is not appropriate to make a separate claim for pacemaker programming.

After Hours Visits
When a physician is called urgently to a hospital, nursing home or the patient's home after hours, responds immediately because of the patient's condition, and travels to see the patient, the service may be claimed using an urgent modifier (US=UIOH and US=UNOF). As a reminder, use of an urgent modifier requires that the physician travel to see the patient and movement within a hospital or nursing home is not considered travel. Therefore, if additional patients are seen during the same trip, the visit must be claimed as an extra patient without an urgent modifier.

Confirmation Letter Notice
A reminder that to be eligible to use the modifier ME= CARE you must have submitted a Confirmation Letter attesting to your status as a primary care provider providing continuity care in the context of an ongoing relationship with your patients (see original notification here). Only physicians who have submitted said Confirmation Letter will have claims with the ME=CARE modifier processed. If you have not submitted the Confirmation Letter your claim should be submitted as an otherwise unmodified visit.

Click here to be taken to the updated FAQ on the Primary Care Investments.

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NEW AND UPDATED EXPLANATORY CODES

Code	Description
MJ065	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR PROGRAMMING TO A PACEMAKER WHICH IS PART OF THIS SERVICE HAS ALREADY BEEN CLAIMED ON THIS DAY.
NR089	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS PROCEDURE SHOULD ONLY BE BILLED FROM A HOSPITAL LOCATION. IF A VALID REASON EXISTS FOR BILLING THIS PROCEDURE FROM A LOCATION OTHER THAN HOSPITAL PLEASE RESUBMIT WITH SUPPORTING DOCUMENTATION.
VA092	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR EITHER BATTERY OR LEADS REPLACEMENT/ADJUSTMENT HAS ALREADY BEEN CLAIMED ON THIS DAY WHICH INCLUDES ANY NECESSARY PROGRAMMING.
MJ066	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR HEALTH SERVICE CODE 47.25, 48.13 OR 50.34B AT THE SAME ENCOUNTER.
MJ067	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED FOR HEALTH SERVICE CODE 47.25A OR B AT THE SAME ENCOUNTER.
AD081	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC HOVM1 CANNOT BE CLAIMED ON HOME VISITS THAT OCCUR FOR PATIENT OR PHYSICIAN CONVENIENCE.
WBHUJ	FILE IS BEING ADJUDICATED FOR WORKERS COMPENSATION WITH A PROVINCE OTHER THAN NS.
WBHSD	SERVICE DATE NOT WITHIN WCB COVERAGE PERIOD.
WBHNC	INDIVIDUAL HAS NO WCB COVERAGE
WBHLT	HSC INVALID FOR WCB LTB CLAIM
WBHRT	HSC INVALID FOR WCB RTW CLAIM

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday November 30th, 2018. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT), modifiers (MODVALS.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/

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