PHYSICIAN'S BULLETIN

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NOVA SCOTIA MEDICAL SERVICES INSURANCE

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NEW FEES

Effective in the coming months, the following changes will be made to the Provincial Immunization Schedule:

HSC	Modifier	Description
13.59L	RO=HPV9	Human Papillomavirus - Requires PT=RISK when third dose is given - Requires text when claiming PT=RISK - **Available September 1st, 2018**
	RO=HDIN	High-dose-Influenza – Inactivated - Patient to be equal to or greater than 65 years of age. - Location Restricted to Long-Term Care Facility (i.e. Nursing Home or Residential Care Facility) only - **Available October 1st, 2018**

Please note as of August 1st, 2018 RO=TDAP (Tetanus Toxoid, Diphtheria, Acellular Pertussis) is available to female patients with each pregnancy. Physicians are reminded to bill as EC with explanatory text if the patient was previously incompletely immunized or pregnant.

FEE REVISIONS

Effective July 27th, 2018 the following billing guidelines changed to allow more than one physician to claim per patient (see underlined below). Physicians are asked that if they bill this health service code and receive explanation code AD068, they should rebill the claim as an EC for it to be manually processed. MSI will make the following billing changes in the near future.

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

Category	Code	Description
ADON	03.03P	**First Visit after In-Patient Hospital Discharge – Maternal and Newborn Care** This is an additional fee for the first maternal/newborn office visit within 14 days of in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care. • The primary care physician or their office staff should make every effort to communicate with the patient and/or caregiver within 2 business days of discharge to better facilitate the patient being seen within 14 days of discharge. • Not reportable in the walk-in clinic setting. **Billing Guidelines** ADON Restricted to: 03.03 Office visit 03.03 Well Baby Care • Reportable only if the visit occurs in the primary care physician's office or the patient's home within 14 calendar days after hospital discharge (consider discharge date as Day zero). • Only reportable if the reason for admission to hospital was for the purpose of obstetrical delivery. • Physician must be the provider most responsible for the mother and child's ongoing care. • Claimable once per physician per patient per inpatient admission for obstetrical delivery. • Not reportable for any subsequent discharges within 30 days. • Maximum of 1 claim per pregnancy (mother) • Maximum 1 claim per infant **Specialty Restriction** SP=GENP **Location** LO=OFFC, HOME

Effective July 27th, 2018 the following billing guidelines for 03.03R have changed from requiring two or more chronic diseases, to at least one chronic disease. Please see the underlined change below.

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

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

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
- 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.
- There must be text on the MSI service report to indicate whether or not this service replaced a face to face service.

Location

LO=OFFC

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Effective July 27th, 2018 the below billing guidelines have been updated. Please note: work is continuing with the Nova Scotia Health Authority and the Fee Committee to review travel time compensation. Details to follow in a future MSI Physicians bulletin.

Category	Code	Description	Base Units
VIST	03.03M	**Medical assistance in dying – First physician assessor (first 15 minutes)** 30 MSU for first 15 minutes, 15 MSU for each additional 15 minutes up to a maximum of 4 hours Service may be provided via PHIA compliant, synchronous, virtual care platform. Modifier ME=VTCR is available for this service **Description** This fee is to compensate the first physician assessor for time spent providing MAiD services outlined in the College of Physicians and Surgeons of Nova Scotia Professional Standard Regarding Medical Assistance in Dying. It includes, but is not limited to, the time spent engaging the patient in a discussion of their diagnosis, prognosis, and treatment options, discussing the availability of palliative care for terminally ill patients, assessment of patient for MAiD criteria and arrangement for a second physician to assess the patient. **Billing Guidelines** Start and stop times must be recorded in the patient's medical record and on the MSI claim. Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family as required. Total duration of all components may be claimed. If the physician is a specialist and the patient has been formally referred the physician may bill the appropriate specialist prolonged consult fee with the same time documentation requirements as noted above. MAiD must be noted in the text on the MSI claim. **Premium** TI=MDNT for the hours of 0000-0800 TI=EVWH for evenings after 1800, weekends, and holidays **Location** OFFC, HOSP, HOME, CCNT, NRHM	30 MSU +MU

Category	Code	Description	Base Units
VIST	03.03O	**Medical assistance in dying – Second physician assessor (first 15 minutes)** 30 MSU for first 15 minutes, 15 MSU for each additional 15 minutes up to a maximum of 4 hours Service may be provided via PHIA compliant, synchronous, virtual care platform. Modifier ME=VTCR is available for this service **Description** This fee is to compensate the second physician assessor for time spent providing MAiD services outlined in the College of Physicians and Surgeons of Nova Scotia Professional Standard Regarding Medical Assistance in Dying. It includes, but is not limited to; the time spent conducting the subsequent assessment of the patient for MAiD criteria. **Billing Guidelines** Start and stop times must be recorded in the patient's medical record and on the MSI claim. Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family as required. Total Duration of all components may be claimed. **Premium** TI=MDNT for the hours of 0000-0800 TI=EVWH for evenings after 1800, weekends, and holidays **Location** OFFC, HOSP, HOME, CCNT, NRHM	30 MSU +MU

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Category	Code	Description	Base Units
VIST	03.03N	**Medical assistance in dying – Prescribing physician** **RO=FPHN** (30 MSU for the first 15 minutes, 15 MSU for each additional 15 minutes up to a maximum of 4 hours) **RO=SPHN** **Description** This fee is to compensate the prescribing physician for time spent providing MAiD services outlined in the College of Physicians and Surgeons of Nova Scotia Professional Standard Regarding Medical Assistance in Dying. It includes, but is not limited to, procuring the medication and administration at the patient's request. This physician must also be either the first physician or second physician assessor. **Billing Guidelines** Start and stop times must be recorded in the patient's medical record and on the MSI claim. Non face to face components include all documentation required by the pharmacist and the administration process. Total duration of all components may be claimed. FPHN must have previously claimed for a MAiD service with the same patient. When a second physician assists at the time of administering the medication, RO=SPHN may be claimed. This fee is not intended to compensate a second physician for administrative duties or procurement/return of medications as these activities are considered to be the responsibility of FPHN. **Premium** TI=MDNT for the hours of 0000-0800 TI=EVWH for evenings after 1800, weekends, and holidays **Specialty Restriction** None	30 MSU +MU 56 MSU

Billing Matters Billing Reminders, Updates, New Explanatory Codes

BILLING REMINDERS

Claiming for a General Anesthetic for Dental Surgery

If a general anesthetic is deemed medically necessary when providing a dental service, the anesthetic fee is payable whether the dental surgery is an insured or uninsured service. The anesthetist must indicate the medical necessity in the text segment of the service encounter. Examples of conditions where a general anesthetic might be medically necessary include, for example, an individual with a developmental delay or significant mental health issues.

Chronic Disease Management Incentive Program

Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year. The claim **must** be submitted to MSI no later than March 31st of that year in order to receive payment for that fiscal year.

Outdated Policy

All original claims must be submitted to MSI within 90 days from the date of service. Claims that are outside of the specified time limitations will only be considered if extenuating circumstances can be demonstrated for a late submission and are within a reasonable time frame past the 90 day limit. Request for an extension must be made to MSI in writing and will be approved on a case by case basis.

The time frame for submitting the request to MSI for late submission should be within one month following the 90 day limit. Examples of extenuating circumstances may include physical damage to office such as fire or flood and or a serious technical issue.

Service encounters submitted over the 90-day limitation will be adjudicated to pay "zero" with the following exceptions

- Reciprocal billing claims (out of province) must be submitted within 12 months of the date(s) of service.

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- Resubmission of refused claims or incorrect billings. These claims must be resubmitted to MSI within 185 days of the date of service. Each resubmission must contain an annotation in the text field of the service encounter submission referencing the previous service encounter number.

Circumstances relating to staffing issues/shortages and mislaid, misfiled, or lost claims cannot be accepted by MSI as valid explanations for a late submission.
Claims for registered hospital in-patients must also be submitted within the 90 day time limitation regardless if the patient has been discharged or continues on an in-patient basis. It is incumbent on the physician to obtain the required billing information for these patients and submit claims within the prescribed time limitations. Explanations relating to late discharge summaries, or facilities not consolidating the required information for the physician, cannot be accepted as a valid explanation for a late submission.
Please note: Failure to use a preauthorization code given by MSI and annotate the text field with the previous service encounter number will result in an adjudication paid at "zero".

Unbundling of claims
Preamble rules prohibit unbundling procedural codes into constituent parts and claiming for them separately as well as claiming for the means used to access the procedural or surgical site. Please note that payment rules are inserted into the MSI system periodically to allow MSI to confirm adherence to Preamble rules. In some circumstances, physicians may be requested to provide a copy of the clinical record in order to substantiate the claim for payment.
As per the Preamble:

- Procedural codes and their associated tariff are intended to remunerate the physician for all parts of the procedure that would normally be considered the defined technique for that procedure. It is not appropriate to deconstruct (unbundle) the procedure into constituent parts and bill MSI for these codes in addition to the procedural codes. (5.3.68).

NEW AND UPDATED EXPLANATORY CODES

Code	Description
AD077	SERVICE ENCOUNTER HAS BEEN REFUSED AS A THIRD INJECTION FOR RO=HPV9 REQUIRES PT=RISK. PLEASE RESUBMIT WITH THE APPROPRIATE MODIFIERS.
AD078	SERVICE ENCOUNTER HAS BEEN REFUSED AS PATIENT IS NOT 65 YEARS OF AGE OR OLDER.
AD079	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS RO=HDIN MAY ONLY BE CLAIMED FROM A LONG TERM CARE/RESIDENTIAL CARE FACILITY.
AD080	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF HPV9 INJECTIONS HAS BEEN REACHED.
VA089	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS HSC 50.99A REQUIRES TEXT INDICATING THE INTRAVENOUS WAS PERFORMED BY THE PHYSICIAN.
VA045	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS HSC 69.94 REQUIRES TEXT INDICATING WHY THE CATHETER INSERTION WAS PERFORMED BY THE PHYSICIAN.
VT164	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS MEDICAL ASSISTANCE IN DYING CLAIMS REQUIRE START AND STOP TIMES.
VT165	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.03N CANNOT BE CLAIMED UNLESS THE PROVIDER HAS PREVIOUSLY CLAIMED HSC 03.03M OR 03.03O FOR THIS PATIENT.

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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 July 27th, 2018. The files to download are health service (SERVICES.DAT), modifier values (MODVALS.DAT), health service description (SERV_DESC.DAT), diagnostic codes (DIAG_CD.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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Toll-Free: 1-866-553-0585
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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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