PHYSICIAN'S BULLETIN

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NEW INTERIM FEES

The following interim health service codes are effective May 1, 2022 however will not be available for billing until the next system update. Notification will be provided in a future bulletin when physicians may start claiming.

Category	Code	Description	Base Units
VADT	TBA	**Ophthalmic Ultrasound of the anterior segment by High Resolution Biomicroscopy or immersion B-scan (water bath) for the assessment of the anterior chamber, unilateral or bilateral.** **Description** Assessment of one or both anterior chambers by high resolution ultrasound. If a complete ophthalmic US (A-scan or B-scan) is provided by the same physician, claim for only one or the other but not both. Not to be used for glaucoma screening. May be claimed only when the service is personally rendered by the physician. **Billing Guidelines** Not billable with: • 09.13A real time (eye) ultrasound **Specialty Restriction:** SP=OPHT with training in ocular oncology **Location:** LO=OFFC	38.7 MSU

NEW INTERIM FEES (CONTINUED)

Category	Code	Description	Base Units
VADT	TBA	**Ophthalmic Biometry by partial coherence interferometry with IOL (intraocular lens) power calculation, unilateral or bilateral.** **Description** Ophthalmic biometry measurements by partial interferometry with IOL power calculation in one or both eyes. If ophthalmic biometry by ophthalmic US (A-scan) is also used for the same patient, claim for only one or the other but not both. May be claimed only when the service is personally rendered by the physician. **Billing Guidelines** Not billable with: • 03.12 Tonometry • 09.13A real time (eye) ultrasound • 09.13B Axial length measurement by ultrasound **Specialty Restriction:** SP=OPHT **Location:** LO=OFFC	25.44 MSU

Billing Clarifications:

09.13A Real time (eye) ultrasound – may be claimed only when a complete ophthalmic ultrasound, defined as a diagnostic B-scan personally rendered by the physician with or without a quantitative A-scan, is performed on one or both eyes. Images must be captured and stored, a report must be generated and incorporated into the health record. May not be claimed with 09.13B or either of the new interim fees.

09.13B Axial length measurement by ultrasound - should be used to report ophthalmic biometry by ultrasound A-scan, with or without IOL power calculation. The prescription for the IOL must be recorded in the patients' health record.

A-mode one dimensional ultrasonic measurement procedure
B-scan implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display.
Real time scan implies a two-dimensional ultrasonic scanning procedure with a display of both two-dimensional structure and motion with time.

NEW FEES

The following health service codes are effective May 11, 2022 however will not be available for billing until the next system update. Physicians are asked to hold their claims for the following services until notification is provided in a future bulletin when physicians may start claiming.

Category	Code	Description	Base Units	Anae Units

MASG	TBA	**Masculinization of the female chest**
		Prior Approval/Preauthorization required (PA)
		
		Description
		Complete masculinization of the chest wall for surgical treatment of well documented persistent gender dysphoria to include bilateral subcutaneous mastectomy, nipple and or areolar reduction or transposition, nipple areolar flap or free graft, chest contouring, complex wound closure and initial scar camouflage as required. No additional uninsured services may be performed or charged to the patient during this encounter. Insertion of pectoral implants is not an insured service.
		
		Billing Guidelines
		• Must have prior approval from MSI for gender affirming surgery (GAS) based on a complete and approved GAS application which is available online: https://novascotia.ca/dhw/gender-affirming-surgery/
		• May not be claimed with:
		  o Mastectomy HSC's: 97.12, 97.13, 97.14, 97.15, 97.31A, 97.31C, 97.32, 97.32B
		  o Reconstruction of nipple HSC: 97.77
		  o Tissue shift/graft HSC's to include, but not limited to: 98.51B, 98.51C, 98.51D, 98.51E
		• Once per patient per lifetime
		
		RO=SRAS applicable
		
		Specialty Restriction:
		SP=PLAS (non fee for service)
		
		Location:
		LO=HOSP
			425 MSU	4+T

NEW FEES (CONTINUED)

<table>
<tr><th>Category</th><th>Code</th><th>Description</th><th>Base Units</th><th>Anae Units</th></tr>
<tr><td>MASG</td><td>TBA</td><td>Feminization of male chest
Prior Approval/Preauthorization required (PA)

Description
Complete feminization of the chest wall for the surgical treatment of well documented persistent gender dysphoria to include bilateral augmentation mammoplasty with insertion of prosthesis or prostheses, nipple-areolar reconstruction, advancement flaps, tissue shifts, complex wound closure and initial scar camouflage as required. No additional uninsured services may be performed or charged to the patient during this surgical encounter.

Billing Guidelines
• Must have prior approval from MSI for gender affirming surgery (GAS) based on a complete and approved GAS application which is available online: https://novascotia.ca/dhw/gender-affirming-surgery/
• May not be claimed with:
  o Augmentation Mammoplasty HSC's: 97.43, 97.44
  o Insertion of tissue expander HSC: 98.98
  o Breast Reconstruction HSC's: 97.6B, 97.6C, 97.6D, 97.75A
  o Reconstruction of nipple HSC: 97.77
  o Tissue shift/graft HSC's to include, but not limited to: 98.51B, 98.51C, 98.51D, 98.51E
• Once per patient per lifetime

RO=SRAS applicable

Specialty Restriction:
SP=PLAS (non fee for service)

Location:
LO=HOSP</td><td>350 MSU</td><td>4+T</td></tr>
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NEW FEES (CONTINUED)

Category	Code	Description	Base Units	Anae Units

MISG	TBA	**Revision of gender affirming chest surgery**
		Prior Approval/Preauthorization required (PA)
		
		Description
		Revision of chest surgery performed within 18 months of MSI approved gender affirming chest surgery to address complications and functional impairment only. This comprehensive service includes any unilateral or bilateral scar revision, re-contouring of the chest wall, revision of nipple, and areolar reconstruction as required. The physician will submit a written request documenting the reason for the proposed revision to MSI for PA. Photographs of the affected area may be requested to support the request. No additional uninsured services may be performed or charged to the patient during this surgical encounter.
		
		Billing Guidelines
		• Original chest surgery must have had prior approval from MSI for gender affirming surgery based on a complete and approved GAS application.
		• Only one per patient per lifetime
		• Requires a formal request for prior approval/ preauthorization from MSI by the physician proposing the procedure.
		• May not be claimed with:
		  o Reconstruction of nipple HSC: 97.77
		  o Tissue shift/graft HSC's to include, but not limited to: 98.51B, 98.51C, 98.51D, 98.51E
		
		RO=SRAS applicable
		
		Specialty Restriction:
		SP=PLAS (non fee for service)
		
		Location:
		LO=HOSP
			150 MSU	4+T

Category	Code	Description	Base Units
CONS	TBA	**Preoperative comprehensive assessment for gender affirming surgery** **Description** This health service code is for the comprehensive assessment of the patient with a confirmed diagnosis of persistent gender dysphoria by the plastic surgeon intending to perform the surgery. The patient's MSI approval for gender affirming surgery should be in place prior to the consultation. The assessment must be documented in the health record and include, but is not limited to: • History and physical examination • Discussion of surgical care • Documentation that the current WPATH (World Professional Association for Transgendered Health) standards for care for surgical readiness have been met • Review of psychological assessment to ensure patient is a candidate for reconstructive surgery and discussion with other health professionals concerning patient eligibility as required • Discussion with patient support person(s) as required **Billing Guidelines** Once per patient per lifetime **Specialty Restriction:** SP=PLAS (non fee for service) **Location:** LO=OFFC	62 MSU

Category	Code	Description	Base Units
VIST	TBA	**Post operative care – gender affirming chest surgery** **Description** This health service code is for the post operative assessment of the patient who has undergone MSI approved gender affirming chest surgery in the previous 18 months. May be claimed once in the 18 months after gender affirming chest surgery by the surgeon who performed the surgery. **Billing Guidelines** May be claimed once per patient within 18 months post gender affirming surgery by the physician who claimed the original gender affirming surgery. **Specialty Restriction:** SP=PLAS (non fee for service) **Location:** LO=OFFC	36 MSU

NEW MODIFIERS

Effective May 27, 2022, new modifiers for Virtual Care and Telephone encounters are available for billing to denote when the service was conducted via either telephone or PHIA compliant virtual care video platform. These services will be paid at the same rate as they would if delivered face-to-face.
The new explicit modifiers:

- **AP=PHON** – Encounter occurred via telephone
- **AP=VIRC** – Encounter occurred via virtual care video platform

Applies to office based non-procedural services.

By utilizing the modifiers, it is not required to enter manual text on each claim to denote the mode of virtual care.

It is recognized that due to extenuating circumstances of these difficult times, the ability to perform a comprehensive physical examination using these platforms may be limited, otherwise the usual preamble requirements apply to all services.

Not reportable for other forms of communication such as:

- Written email 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

The service is not reportable if the decision is to see the patient at the next available appointment in the office or outpatient clinic. Reportable for Health Authority supported clinics.

All encounters must be recorded in the patient's health record. It is recognized that the health record may not be available at the time of the call, but a note should be made and placed in the health record as soon as feasible. This should include the location of the provider (if other than office) and the technology used to render the service. Physicians should offer and book their telephone, telehealth, and virtual appointments during the same time periods in the same manner as they would for face-to-face encounters.

FEE UPDATES

The following interim health service code has been extended to November 30, 2023:

Category	Code	Description	Base Units
VEDT	15.93D	**Removal or Revision of Intracranial Neurostimulator Electrodes (SEEG)** **Description** This is a comprehensive code for the removal of neurostimulator electrodes such as stereoelectroencephalography (SEEG) electrodes. **Specialty Restriction:** SP=NUSG, SP=PEDI **Location:** LO=HOSP (QEII & IWK only)	124 MSU

Effective May 27, 2022, the following health service code has been terminated:

Category	Code	Description	Base Units
PSYCH	08.5A	**Clinical Psychiatry**	63.11 MSU

Billing Matters Billing Reminders, Updates, New Explanatory Codes

REMINDERS

Unbundling of Claims

Preamble rules prohibit unbundling of procedural codes into constituent parts and claiming for them separately as well as claiming for the means 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)

Facility On-Call

Physicians are reminded Facility On-Call payments transitioned to electronic billing effective July 1, 2021. Claims for Facility On-Call are to be submitted as Fee-for-Service (FFS) using the appropriate health service code.

Physicians are reminded to use caution when submitting Facility On-Call claims, particularly when selecting the appropriate health service code (HSC) for the completed call shift. Selecting the wrong HSC can prevent another provider from successfully claiming their on-call service; it is advisable to double check the selected HSC before submitting your claim for payment. The complete list of applicable health service codes and their descriptions, as well as FAQ are outlined in the July 2, 2021, Physician's Bulletin

NEW AND UPDATED EXPLANATORY CODES

Code	Description
MJ069	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVOUSLY BILLED HSC 33.59A AT THE SAME ENCOUNTER
MJ070	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 34.32 AT THE SAME ENCOUNTER
MJ071	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HAS 34.31 AT THE SAME ENCOUNTER
MJ072	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 34.42 AT THE SAME ENCOUNTER
MJ073	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 34.42A, 34.54A OR 34.54B AT THE SAME ENCOUNTER
MJ074	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 34.42A AT THE SAME ENCOUNTER
MJ075	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 34.54A OR 34.54B AT THE SAME ENCOUNTER
MJ076	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 34.43A AT THE SAME ENCOUNTER
MJ077	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 34.55 OR 34.54A AT THE SAME ENCOUNTER
MJ078	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 34.54A AND 34.54B MAY NOT BE CLAIMED TOGETHER AT THE SAME ENCOUNTER
MJ079	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 34.55 AND 34.54A MAY NOT BE CLAMED TOGETHER AT THE SAME ENCOUNTER
MJ080	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE ALREADY CLAIMED HSC 33.22A OR 34.0A AT THE SAME ENCOUNTER WHICH IS CONSIDERED TO BE AN INCLUDED PART OF THE PROCEDURE
MN017	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 34.31, 34.32, 34.54A, 34.54B OR 34.55 AT THE SAME ENCOUNTER
MN018	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS PROCEDURE IS CONSIDERED PART OF THE SURGERY PERFORMED AT THE SAME ENCOUNTER

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday May 27, 2022. The files to download are:
Health Service (SERVICES.DAT), Modifiers (MODVALS.DAT) and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

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Phone: 902-496-7011
Toll-Free: 1-866-553-0585
Fax: 902-490-2275
Email:
MSI_Assessment@medavie.bluecross.ca

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

Phone: 902-424-5818
Toll-Free: 1-800-387-6665
(In Nova Scotia)
TTY/TDD: 1-800-670-8888

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)
http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS
www.novascotia.ca/dhw/

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