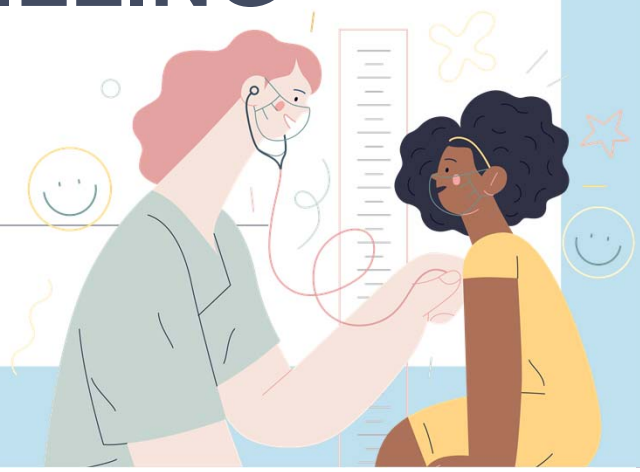
PHYSICIAN BILLING

in Nova Scotia

January 2022



PRESENTED BY

Doctors Nova Scotia

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FACULTY OF MEDICINE
Continuing Professional Development

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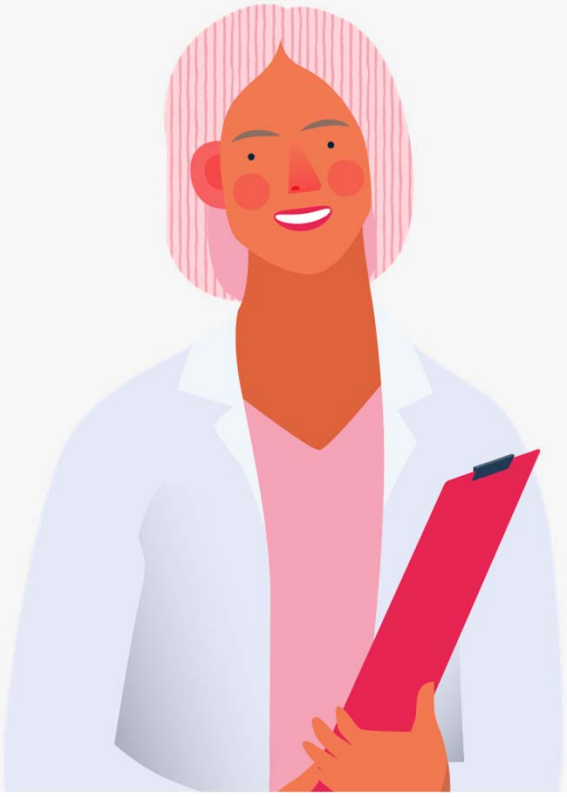


This one-credit-per-hour Group Learning program meets the certification criteria of the College of Family Physicians of Canada and has been certified by the Continuing Professional Development Office of Dalhousie University for up to 2.75 Mainpro+ credits.

Dal CPD will email you a certificate, allowing you to claim your hours for the session towards your annual CPD requirements…watch for a message from Deirdre Harvey or Dal CPD. Sometimes the emails land in your junk folder.

You are also required to complete an evaluation, which will be emailed to you next week.

Disclosures

Presenter Disclosures

- Employees of DNS
- Family Physician

Financial support

- None

Conflicts of Interest

- No conflicts of interest were identified by the speakers/presenters

Agenda

Health system explanation

Billing Basics

- Importance of Billing Correctly
- Billing Manual, preamble, MSI Bulletins
- Medical Services Unit (MSU)

GP specific billing

- Common billing codes and incentive programs
- Fee changes
- Audit and appeal
- DNS Contacts

Canadian Health Care System

Medicare

Canada's publicly funded health-care system

13 provincial/territorial health-care insurance plans

Roles and responsibilities for services are shared between provincial/territorial and federal governments.

Canadian residents have reasonable access to medically necessary hospital and physician services without paying out-of-pocket.

The physicians manual has a list of the different provincial insurance providers.

Canada's publicly funded health-care system
13 provincial and territorial health-care insurance plans
Roles and responsibilities for health-care services are shared between provincial and territorial governments and the federal government.
Canadian residents have reasonable access to medically necessary hospital & physician services without paying out-of-pocket.

Roles & Responsibilities

Provincial:

- Responsible for the management, organization and delivery of health care

Federal:

- Sets and administers national standards (Canada Health Act)
- Funds provinces/territories
- Supports service delivery to specific groups
- Provides other health-related functions

The provincial/territorial governments are responsible for the management, organization and delivery of health care services for their residents, with the exception of:

- First Nations people living on reservations
- Inuit
- Canadian Forces-serving members
- Eligible veterans
- Inmates in federal penitentiaries
- Some groups of refugee claimants

Federal funding serves these groups, however, services to these patients are billed through MSI.

Nova Scotia

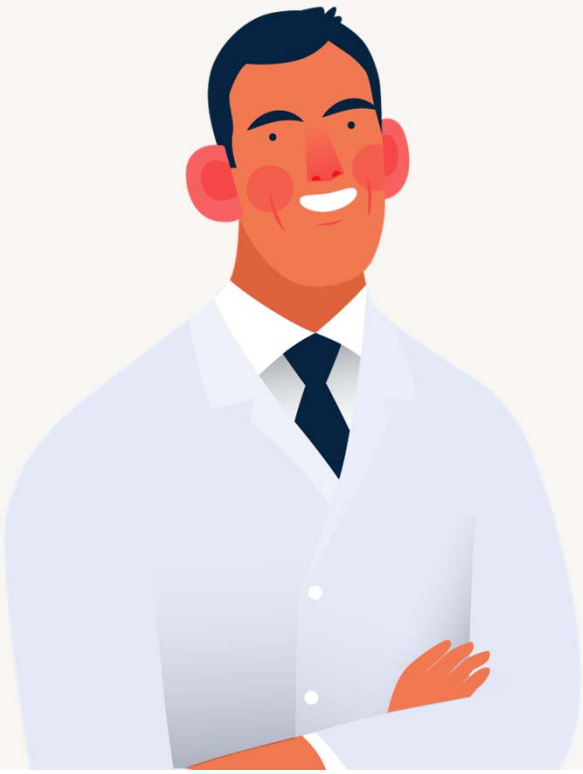
Department of Health and Wellness

Medical Services Insurance (MSI)

Nova Scotia Health

College of Physicians & Surgeons

Doctors Nova Scotia



Department of Health & Wellness (DHW)

Sets the policy for programs and services that protect and promote health and treat illness.

Responsible for funding medically insured services in Nova Scotia.

Medical Services Insurance (MSI)

Medavie Blue Cross/MSI administers physician & dentist payment for medically insured services on behalf of DHW. Also responsible for audit of physician payments.

The Hospital Insurance Program is administered directly by DHW. The cost is met through the general revenues of the province.

Nova Scotia Health (NSH)

The provincial health authority responsible for the planning and delivery of services

IWK Health is its own authority and provides care to children and women

NSH and IWK Health also provide specialized services to residents in the Atlantic region

NSH is the provincial health authority which, along with IWK (pediatric hospital and also stands as its own health authority), is responsible for the planning and delivery of primary, community and acute health care services in Nova Scotia.

College of Physicians & Surgeons Nova Scotia (CPSNS)

The regulatory body for the profession as per the Medical Act and its regulations

The duties of the College include:

- Licensing of physicians practicing in NS
- Investigating and resolving complaints
- Monitoring and maintaining standards of practice
- Developing professional standards and guidelines

The College of Physicians and Surgeons of Nova Scotia serves the public by regulating the province's medical profession in accordance with the *Medical Act* and its regulations.
All physicians in Nova Scotia must be licensed by the College in order to practise medicine in the province.

Licensing qualified and competent physicians to practise medicine
Investigating and resolving physician-related complaints on behalf of the public
Monitoring and maintaining standards of practice through peer assessment
Developing professional standards and guidelines to support high standards of medical practice and ethical conduct

Doctors Nova Scotia (DNS)

Negotiates physician remuneration

The medical profession’s united voice

Influences and supports policy development

Contract support (APP and C/AFP)

EMR support

Programs, services and comprehensive benefits

Billing Basics

Correct billing is important

Queries to MSI in writing

Retain MSI response for audit

MSI_Assessment@medavie.bluecross.ca

Physicians are responsible for claims even if the claims are being entered by someone else.

- Easy to miss billings opportunities (reduced income)
- Try to avoid audit as best you can (reduced risk)
- Questions about how to bill for an encounter should be sent in writing to MSI: MSI_Assessment@medavie.bluecross.ca
- A copy of their answer should be kept on file in case needed during a future audit.

Why it matters

For both FFS & APP physicians, billing correctly can:

- ↑ Income
- ↑ Accountability/proof of work
- ↓ Audit risk
- ↓ Intraprofessional strife

FFS physicians – Billing correctly affects income and reduces audit risk

APP physicians – Contractual commitment of 60% shadow billing. Not meeting or exceeding this threshold means:

- Accountability – without shadow billing, the system has no way to know what you are doing for the funding you receive

- Physicians who do not shadow bill place the funding model in jeopardy. While we know that most if not all APP physicians are doing really good work taking care of their patients, the system only sees that shadow billing for services provided is significantly lower than the funding would warrant. We lose our negotiating leverage when this happens.

It's also important to know that shadow billing for all services provided may actually lead to increased income:

- Shadow billing in excess of 80% of the contract amount = 5.6% bonus
- Shadow billing in excess of 100% of the contract amount = $ for $ for anything above contract amount

Why it matters

Continued lack of shadow billing by APP physicians will result in reduced negotiations leverage.

- Removal of APPs as an option
- Lack of rate increases, COLA or otherwise

We're not the experts!

Significant information gap regarding how to bill in Nova Scotia

MSI is the ultimate authority on how to bill

For specific claims questions relating to a provided patient service:

- Email MSI: MSI_Assessment@medavie.bluecross.ca

File their advice away for

- Subscribe: https://msi.medavie.bluecross.ca/billing-publications/

DNS recognizes there is an information gap and so while we are not the authority, we're happy to help provide some billing guidance.
MSI is the ultimate authority, if you have questions through your workday, we recommend you speak with MSI.
Email MSI so you have a written thread, you can save this information for audit purposes.

Billing Resources

Physician's manual

- Preamble - Overarching rules and guidelines
- Fee Codes – Codes and related information

MSI Physician's Bulletins

- Billing manual updates
- Subscribe: https://msi.medavie.bluecross.ca/billing-publications/

Bulletins are searchable (Control F)

Important Billing Timelines

After service date:

- 90 days to submit claims
- 185 days to correct claims

MSI responses should be reviewed regularly to correct claims that have been refused, reduced, paid at zero or changed in some other manner

Documentation

General requirements:

- 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) and the fee code claimed
- Working diagnosis and the treatment prescribed
- Start and stop times for time-based codes
- Where appropriate, name of referring or consulting physician, and reason for referral (diagnosis or treatment)
- Where appropriate, copy of consultant report

Some fee codes have additional documentation requirements in order to support a claim. Not meeting these requirements can increase your audit risk.

Medical Service Units (MSU)

MSU has both a value (effort) and a rate ($) to determine payment.

- MSU rate is negotiated in the Master Agreement and varies annually.
- MSU value represents the value of the service and is set by Fee Committee when a fee code is created or revised.

Example (as of April 1/21)

Office visit (with ME=CARE modifier):

16.96 (MSU value) x $2.63 (MSU rate) = $44.60

Medical Service Unit is the “value” of each service indicated in units. This amount is multiplied by the current MSU rate to determine the dollar amount that service pays.

Example:

Office visit (with ME=CARE modifier): 16.96 MSU x $2.63 (MSU value) = $44.60

The MSU rate is increased as negotiated in the Master Agreement, and varies from year to year.

Top 7 billing codes

These seven billing codes account for approximately 83% of the average family physician billings:

- Office visit
- Geriatric visit
- Hospital visit
- Chronic Disease Management
- Nursing home visits
- Immunizations
- Hospital comprehensive visits

Special note: Virtual care codes

Due to the pandemic, services that don't require a face-to-face visit can be done virtually.

Submit claims as usual, using your normal practice location, and include the following text, service provided by:

- Pandemic telephone
- Pandemic telehealth
- Pandemic virtual care

Virtual care codes are in effect until March 31, 2022 to complement face-to-face care.

Must also provide face-to-face care.

On March 24, 2020, DHW announced at all office based, non-procedural services normally rendered in a face-to-face setting could be done virtually.
Claims should be submitted as usual, using your normal practice location, and should include the following text on the claim:

Service provided via phone call: Pandemic telephone

Service provided via the telehealth network: Pandemic telehealth

Service provided via a virtual care platform: Pandemic virtual care

On March 30, 2021, DHW announced that these codes have been extended until March 31, 2022 to allow virtual care to continue to complement face-to-face care.

Office Visits

MSU value varies

There are many types of office visits for primary care physicians, including:

- Standard office visit (03.03)
- Geriatric (patients over the age of 65) (03.03A)
- Complex Care (03.03B)
- Adults with developmental disabilities (03.03E)
- Routine pre-natal
- Post natal care
- Well baby care

Standard Office Visit (03.03)

13MSU/$34.19 (with ME=CARE 16.96MSU/$44.60)

Must include a history of problem and an evaluation of relevant body systems.

Claim when you see the patient and:

- perform a limited assessment for a new condition, or
- monitor or provide treatment of an established condition

Walk-ins with patients who aren't yours or your collaborative practice are claimed at 13MSU.

The ME=CARE modifier can only be used when you have access to the medical record (your own patient or collaborative practice).

To bill the modifier you must sign an attestment letter.

An office visit may be claimed when you see the patient and perform a limited assessment for a new condition, or when monitoring or providing treatment of an established condition. It includes a history of the presenting problem and an evaluation of relevant body systems.
Walk in clinics/visits with patients who are not yours or that of your collaborative practice (episodic care) can only be claimed at 13MSU.
The ME=CARE modifier (enhanced rate of 16.96MSU) can only be used when caring for your own patient or a patient belonging to your collaborative practice, for whom you have access to the medical record. You must have filled out an attestment letter to be eligible to bill this modifier.

Geriatric Office Visit (03.03A)

16.5MSU/$43.40 (with ME=CARE 20.99MSU/$55.20)

Includes a history of problem and an evaluation of relevant body systems.

Claim when you see a patient who is 65+ years:

- perform a limited assessment for a new condition, or
- when monitoring or providing treatment of an established condition

Walk-ins with patients who aren't yours or your collaborative practice are claimed at 16.5MSU.

The ME=CARE modifier can only be used when you have access to the medical record (your own patient or your collaborative practice).

To bill the modifier you must sign a letter.

A geriatric office visit may be claimed when you see a patient who is 65+ years old and perform a limited assessment for a new condition, or when monitoring or providing treatment of an established condition. It includes a history of the presenting problem and an evaluation of relevant body systems.

Walk in clinics/visits with patients who are not yours or that of your collaborative practice (episodic care) can only be claimed at 16.5MSU.

The ME=CARE modifier (enhanced rate of 20.99MSU) can only be used when caring for your own patient or a patient belonging to your collaborative practice, for whom you have access to the medical record. You must have filled out an attestment letter to be eligible to bill this modifier.

Complex Care (03.03B)

21MSU/$55.23

Bill maximum four times per patient, per year for patients under active management for three or more eligible chronic diseases.

Patient must require ongoing monitoring, maintenance or intervention to control, limit progression, or palliate a chronic disease.

Requires at least 15 mins with patient and address at least one of the chronic diseases either directly or indirectly.

Start and finish times must be recorded in the patient's medical chart and on the billing claim.

- May be billed a maximum of 4 times per patient per year by the family physician and/or the practice providing ongoing comprehensive care to the patient who is under active management for three or more of the following chronic diseases: asthma, chronic obstructive pulmonary disease, diabetes, chronic liver disease, hypertension, chronic renal failure, congestive heart failure, ischemic heart disease, dementia, chronic neurological disorders, or cancer.
- The patient must require ongoing monitoring, maintenance or intervention to control, limit progression, or palliate a chronic disease.
- Must spend at least 15 mins in direct patient intervention and address at least one of the chronic diseases. **Start and finish times must be recorded**
- Documentation must indicate the three eligible chronic diseases, including date of onset when/if known by physician
- Cannot be claimed in walk in clinics

Complete Pregnancy Exam (03.04, RO=ANTL)

29.7MSU/$78.11

Billed once per pregnancy as a comprehensive visit which includes:

- Complete history and physical, incl. a gynaecologic exam
- Documenting full details on prenatal record form

Referred patient: Receiving physician can't claim comprehensive visit if one was claimed by referring family physician.

Includes:

- pregnancy related counselling or advice
- PAP (if medically necessary)
- venipuncture

Can only be billed once per pregnancy, and must meet Preamble requirements for a comprehensive visit which includes:

- Conducting a complete history and physical, incl. a gynaecologic exam
- Documenting full details of the history and physical on the standardized Nova Scotia prenatal record form.

When seeing a referred patient, the receiving physician who conducts and documents a complete history and physical cannot claim a comprehensive visit if one has been claimed by the regular family physician prior to referring the patient for obstetrical care.

Includes pregnancy related counselling or advice to the patient, a Pap smear if medically necessary, and venipuncture.

Routine Pre-Natal Care (03.03, RO=ANTL)

13MSU/$34.19 (with ME=CARE: 16.96MSU/$44.60)

Maximum 12 limited (routine) prenatal visits per patient amongst physicians

Must include:

- pregnancy related counselling or advice to the patient
- care for less serious complications

PAP is included, if medically necessary

For complicated pregnancies:

- Bill additional visits and include diagnostic code on service encounter
- Examples: toxaemia, extremely high blood pressure, diabetes, etc.

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No more than 12 limited (routine) prenatal visits may be claimed for one patient's pregnancy regardless of the number of physicians involved.

All routine prenatal visits include pregnancy related counselling or advice to the patient, and care for less serious obstetrical complications incidental to the pregnancy; e.g. cystitis and simple anaemia, false labour, mild hypertension, leucorrhea, vaginal discharge and obesity. Fees also include a Pap smear, if medically necessary.

Complicated pregnancies may require more than the limit of 12 prenatal visits. Prenatal care does not include services rendered for major complications related to pregnancy. If billing for additional visits for major complications of p pregnancy such as toxaemia, extremely high blood pressure, diabetes, etc. include the diagnostic code for the complication on the service encounter.

Postnatal Care Visit (03.03, RO=PTNT)

19MSU/$49.97

Billed only once by one physician

May include a pelvic examination with PAP

Not a postoperative visit

Fitting or inserting birth control device can be claimed in addition

- May include a pelvic examination with Pap smear.
- May be billed only once following delivery by one physician.
- Not considered a postoperative visit in the context of surgical procedural rules.
- A diaphragm fitting or insertion of an intrauterine device can be claimed with a post natal visit.

Well Baby

13MSU/$34.19
(03.03, RO=WBCR)

With ME=CARE
16.96MSU/$44.60

Once monthly for first six months

Once for each three-month period from 6 – 12 months

- 12-month visit has a four-week buffer on either side for billing

One visit at 18 months

- 18-months visit has a two-week buffer on either side for billing

Bill immunizations and tray fees separately

Note: Changes are coming – look for details in an upcoming MSI Physician's Bulletin.

- Payable as 1 per month during the first 6 months; 1 visit during each 3 month period up to 1 year of age; and 1 visit at 18 months of age.
- The visit fee at 12 months of age has a 4 week buffer on either side of the first birthday for billing.
- The visit fee at 18 months of age has a 2 week buffer on either side of the date of 18 months of age for billing.
- Immunizations and tray fees are commonly billed in addition to these visits.
- PAY ATTENTION TO MSI BULLETINS

Immunizations

Up to 6MSU/$15.78 per shot (ADON 13.59L) + tray fees: 1.5 MSU/$3.95 (up to 4 per encounter, ADON 13.59M)

When claiming an office visit and immunization (ie: well baby)

- The office visit and the first injection can be claimed at full fee
- All subsequent injections will be paid 50 percent of the specified MSU.

When claiming immunization only (ie: flu clinic)

- If two vaccines are given at the same visit but there is no associated office visit, a claim for each specific vaccine can be submitted at full fee
- All subsequent injections will be paid at 50% of the specified MSU

Bill tray fee for each immunization, maximum 4 per encounter

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- If one vaccine is administered but no associated office visit is billed, claim the full fee of 6.0MSU.
- If two vaccines are administered at the same visit but no associated office visit is billed, claim the full fee of 6.0MSU each.
- If one vaccine is administered in conjunction with a billed office visit, claim both the office visit and the immunization at full fee.
- If two vaccines are administered in conjunction with a billed office visit, the office visit and the first injection can be claimed at full fee. All subsequent injections will be paid at 50%.

Adults with Developmental Disabilities (03.03E)

- Visit: 19.5MSU/$51.29 Complete Exam: 36MSU/$94.68

Diagnostic Code	Description	Diagnostic Code	Description
29900	Autism	7583	Velo-cardiofacial syndrome
29980	Retts Disorder, Pervasive Developmental Disorder, Aspergers Disorder	7595	Tuberous sclerosis
3155	Mixed Developmental Disorder	75989	Noonan Syndrome
3430	Cerebral Palsy (paraplegic, congenital)	75981	Prader Willi
3431	Cerebral Palsy (hemiplegic, congenital)	75983	Fragile X
7580	Chromosomal Abnormalities	75989	Angelman's Syndrome
7580	Down's Syndrome	76071	Fetal Alcohol Syndrome
7583	Cri du Chat syndrome		

Under 758: Williams Syndrome, Deletion22q11.2, Smith-Magenis Syndrome(17pdeletion), Charge(Hall Hittner) Syndrome
Under 3155: may include conditions such as: Cerebral Palsy, Neurofibromatosis, Deletion22q11.2, Chronic Brain injury (traumatic or hypoxic). Record the ICD code if available and add "with Developmental Disability" or "with DD" in text.

Applies to the care of adults with developmental disabilities. The following diagnostic codes are eligible:

To include those not specifically coded: Under 758: Williams Syndrome, Deletion22q11.2, Smith-Magenis Syndrome(17pdeletion), Charge(Hall Hittner) Syndrome, Under 3155: May include conditions that are frequently but not always associated with developmental or cognitive disability, such as: Cerebral Palsy, Neurofibromatosis, Deletion22q11.2, Chronic Brain injury (traumatic or hypoxic). In these cases record the ICD code if available, and add "with Developmental Disability" or "with DD" in text.

Chronic Disease Management (CDM1)

Up to $225 per year ($100 if one CD, +$75 if two CD, +$50 if three CD)

Claim once per fiscal year (April 1 to March 31) if:

Patient is seen by the physician about their CD(s) at least once in the previous 12 months;

Patient has had at least one other appointment with either the physician or another licensed provider about their CD(s) in the previous 12 months; and,

The CDM indicators required have been addressed at the required frequency and documented at or before the time of billing.

You may or may not provide care directly and aren't responsible if patients do not follow your recommendations

MAY 23, 2014 MSI BULLETIN

Can be claimed once per fiscal year (April 1 to March 31 inclusive) if:

- The patient is seen by the physician in relation to their CD(s) at least once in the fiscal year for which the CDM incentive is being claimed;
- The patient has had at least one other appointment with the physician or another licensed health care provider in relation to their CD(s) in the previous 12 months; and,
- The CDM indicators required have been addressed at the required frequency and documented at or before the time of billing.

The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations, including for investigations, follow-up visits and/or referrals.

CDM (cont'd)

The qualifying chronic diseases :

- Diabetes (Type 1 and 2)
- Ischaemic heart disease
- Chronic Obstructive Pulmonary Disease (COPD)
  - Action plan completed annually – copy to patient and on record

CDM indicators are in the May 23, 2014 MSI Physician's Bulletin.

Before claiming incentive, all indicators must be addressed as outlined

Note: Will transition to fees. Bill incentive soon after care cycle has been completed.

The qualifying chronic diseases eligible for CDM are:

- Type 1 and Type 2 Diabetes
- Ischaemic Heart Disease
- Chronic Obstructive Pulmonary Disease (COPD)
  - A COPD Action Plan must be developed and then reviewed/completed annually, with a copy given to the patient and available in the clinical record.

CDM indicators for these conditions can be found in the May 23, 2014 MSI Physicians' Bulletin. All indicators must be addressed at the frequency indicated in the Bulletin before claiming the CDM incentive.

As this program is slated to eventually transition to fees, this incentive should be billed as soon as the care cycle is completed.

Nursing home visits (03.03, LO=NRHM)

21.3+MSU/$56.02+ for first patient,

15.8+MSU/$41.55+ for extra patient

Can be billed when the physician visits and provides care to a nursing home resident at the request of nursing home staff/providers, the patient or patient's family or guardian.

Additional patients seen at the same visit should be claimed at the extra patient fee.

When prearranged routine trips are made to an institution, fees can only be claimed when there is medical necessity for the visit.

Can be billed when the physician visits and provides patient care to a nursing home patient at the request of nursing home staff/providers, the patient or patient's family or guardian.

Additional patients seen at the same visit should be claimed at the extra patient fee, not the initial visit fee.

When prearranged routine trips are made to an institution, fees can only be claimed when there is medical necessity for the visit.

LTC Geriatric Assessment (CGA1)

26.32MSU/$69.22

Claim only for residents of publicly funded facilities

Must complete the following sections:

- The medication list
- Diagnostic categories
- Cognition
- Emotional
- Behavior
- and provide the final opinion of frailty once other disciplines have completed assessments. Other sections may be completed by you or other licensed providers.

- Can only be claimed for residents of licensed Nursing Homes and Residential Care Facilities (RCF's) funded by DHW.

- The physician is directly responsible for completing the following sections:
  - The medication list
  - Diagnostic categories
  - Cognition
  - Emotional
  - Behavior

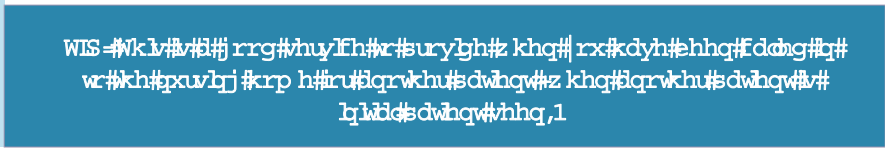
and provides the final overall opinion of the frailty level once the other disciplines have completed their assessments. Other sections may be completed by the physician or by other licensed healthcare providers.

CGA cont'd

Complete soon after admission, once patient is known and attach to applicable transfer forms

Includes one direct service encounter on the date CGA form is completed and signed.

Additional service encounters are paid separately. Track the dates associated with the completion of the CGA on the form.



- Should be completed as soon as possible following Nursing Home or RCF admission, once the physician and clinical team have had time to become familiar with the resident/patient, and should be attached to any applicable transfer forms, including inter facility transfers whenever possible.

- Requires one direct service encounter on the date of the final completion and signing of the CGA form. This service encounter is included in the CGA fee.

- May involve additional service encounters which would be paid separately. The dates of these service encounters associated with the completion of the CGA must be tracked on the CGA form.

THE ORDER YOU BILL THIS SERVICE IS IMPORTANT. If asked at visit, bill regular visit first patient, then the CGA.

CGA cont'd

Must review, complete and sign form in the facility on the date of the final CGA service encounter. Include a note in the resident's record corroborating CGA is completed

Date when the final CGA service encounter occurs, form is completed and signed is the service date

May bill twice per fiscal year (April 1 – March 31), per resident.

- Must review, complete and sign the CGA form in the long-term care facility on the date of the final CGA service encounter and place a note in the resident's clinical record corroborating that the CGA has been completed.
- The date of service is the date when the final CGA service encounter occurs and the CGA form is completed and signed by the physician.
- May be billed twice per fiscal year (April 1 – March 31), per resident.
- Eligible APP Physicians will be required to shadow bill the fee in order to receive payment.

Comprehensive Visit (03.04)

24MSU/$63.12

In-depth evaluation necessitated by the seriousness, complexity, or obscurity of the patient's complaints or medical condition

This service includes:

- Recording a complete history in the record (medical school style documentation)
- Performing a physical exam appropriate to the physician's specialty and the working diagnosis

Do not claim within 30 days of a comprehensive consultation on the same patient, same condition

- An in-depth evaluation of a patient necessitated by the seriousness, complexity, or obscurity of the patient's complaints or medical condition.
- This service includes:
  - Ensuring a complete history is recorded in the medical record
  - Performing a physical examination **appropriate to the physician's specialty and the working diagnosis**
- May not be claimed within 30 days of a comprehensive consultation on the same patient for the same condition

Counselling, lifestyle counselling, and psychotherapy

What do I claim when?

Service	Details	Value
Counselling (08.49A)	Claimed when patient has an underlying mental health disorder, acute adjustment disorder or bereavement.	**15MSU/$39.45 per 15 minute interval**
Lifestyle counselling (08.49C)	Claimed when providing advice on lifestyle items such as lipid or dietary counselling, smoking cessation, etc.	**15MSU/$39.45 per 15 minute interval**
Psychotherapy (08.49B)	Claimed when the physician works to remove modify or retard symptoms, lessen or reverse patterns of behaviour and promote positive personality growth and development.	**30MSU/$78.90 per 30 min** Claimed in 15 min intervals, a minimum of two intervals must be claimed per visit.

Start and stop times must be documented in the rec…put the time on the clinical record part of the EMR.

This code cannot be billed on top of an office visit.

80% of the time claimed must be time spent with the patient. For example, if claiming 30 Minutes, 24 minutes must be in face-to-face counseling, the remaining time claimed is for documentation. Chart start and stop times of the time spent with the patient and separately note time documentation is completed.

What's the difference?

Service	What's different?	What's the same?
Counselling (08.49A)	Can't claim for: • More than 5 hours/patient, per physician/year • More than 1 hour/patient/day	Must spend at least 80% of the time claimed with the patient. Can't be claimed for children under the age of 4. Must document the details of the discussion, not just state "long discussion," "counselled" etc. Start and stop times must be noted in the patient's medical record **and** the billing claim.
Lifestyle counselling (08.49C)	Can't claim for: • More than 2 hours/patient, per physician/year • More than 30 minutes/patient, per day	
Psychotherapy (08.49B)	Can't claim for: • More than 20 hours/patient/family/group per physician/year • More than 90 continuous mins/patient/day	

- Treatment for medical complaints, acute adjustment reactions or bereavement reactions do not qualify as psychotherapy. They should more appropriately be claimed as counselling.

- Annual maximum of 20 hours per patient/family/group per physician per year.

- Except in unusual clinical circumstances, cannot be claimed for the following:
    - More than 90 continuous minutes or six continuous 15 min intervals per patient per day.
    - A patient younger than four years old.
    - More than one general practitioner treating the same illness for a particular patient.

Psychotherapy: special note

Documentation should:

Be evident that 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.”

Show evidence of discussions taking place between you and the patient, patient’s response, and subsequent advice given to improve emotional wellbeing

- Treatment for medical complaints, acute adjustment reactions or bereavement reactions do not qualify as psychotherapy. They should more appropriately be claimed as counselling.

- Annual maximum of 20 hours per patient/family/group per physician per year.

- Except in unusual clinical circumstances, cannot be claimed for the following:
    - More than 90 continuous minutes or six continuous 15 min intervals per patient per day.
    - A patient younger than four years old.
    - More than one general practitioner treating the same illness for a particular patient.

Add ons, modifiers and premiums

ME=CARE (modifier)

JUNE 15 2018 MSI BULLETIN

Comprehensive and continuous care to your patients or those in your shared collaborative practice

- Office visits, including:
  - Standard
  - Geriatric
  - Prenatal
  - Well baby
  - Post natal
- Opioid Agonist Treatment

- Increase to the fees paid for:
  - Office visits, including:
    - Standard
    - Geriatric
    - Prenatal
    - Well baby
    - Postnatal
  - Opioid Agonist Treatment

Available only when providing delivering comprehensive and continuous care to their patients or the patients of your shared collaborative practice. This increase is not available for episodic care provided to walk-in patients.

- Use modifier ME=CARE.

GP Enhanced Hours Premium (TI=GPEW)

25% increase in claim value

Expanded access to comprehensive primary care for your patients and those in your shared collaborative practice.

- Weekdays from 6 to 8 a.m. and 5 to 10 p.m.
- Weekends/holidays from 9 a.m. to 10 p.m.

Can't be used in a walk-in clinic or if you "run late"

Must maintain documentation that the patient was booked in a premium-eligible appointment.

- Intended to promote enhanced patient access to comprehensive primary care outside of traditional office hours. Eligible time periods are weekdays from 6 – 8 a.m. and 5 – 10 p.m, weekends & holidays from 9 a.m. to 10 p.m.
- Available to physicians providing comprehensive and continuous primary care to their patients (eligible for ME=CARE)
- Should offer and book appointments during these time periods.
- Can also be claimed for patients from the same practice, as long as the health record can be accessed and the encounter is recorded.
- Not for unattached patients or for walk-in clinics
- Only one incentive can be claimed per patient encounter
- Cannot be claimed when you "run late" or when the patient doesn't answer the phone (for a virtual appointment)

PAP

PAP (VADT 03.26A): 10.5MSU/$27.62
Tray fee (ADON 03.26B): 2MSU/$5.26

Cannot be claimed as:

- addition to a visit, consultation or procedure for a gynaecologic or obstetrical diagnosis
- addition to a complete physical examination

For a PAP and an unrelated, non-gynaecologic medical condition claim office visit, PAP and tray fee

Remember to claim your tray fee

Do not charge patient for supplies

- Cannot be claimed in addition to a visit, consultation or procedure for a gynaecologic or obstetrical diagnosis, or in addition to a complete physical examination.
- A visit for a Pap and an unrelated, non-gynaecologic medical condition can include a claim for the office visit, Pap and Pap tray fee.
- When cost of supplies when performing a Pap, a tray fee can be claimed. There will be no charge to the patient for any supplies, equipment or disposables associated with the performance of a Pap.
- Tray fee can be claimed when a Pap is performed alone or as part of a comprehensive examination, an office visit, or a gynaecological procedure.

Speculum Exam (no PAP, VADT 03.26C)

10.5MSU = $27.62

Comprehensive pelvic examination:

- Symptomatic patient
- STI screening

Document in the health record:

- Visual inspection of the vulva and perineum
- Speculum insertion to inspect the vault/cervix
- Bimanual examination of the pelvis
- Pelvi-rectal examination where indicated

May be billed in addition to a visit

Not billable with PAP smear VADT 03.26A, or ADON 03.26B

- Comprehensive pelvic examination in either a symptomatic female patient or when screening for sexually transmitted infections.
- The following elements are to be documented in the health record:
  - Visual inspection of the vulva and perineum
  - Insertion of the speculum into the vagina to inspect the vault/cervix
  - Bimanual examination of the pelvis
  - Conduction of a pelvi-rectal examination where indicated.
- Can be billed in addition to a visit.
- Not billable with PAP smear VADT 03.26A, or ADON 03.26B

First Visit after Discharge, mom & baby (ADON 03.03P)

10MSU/$26.30
(restricted to Standard and Well Baby Care office visits)

JULY 27, 2018 MSI BULLETIN

Within 14 days discharge to the primary care provider

Communicate with the patient/caregiver within two business days of discharge

Claimable once per physician, per patient, per admission

Not reportable for subsequent discharges within 30 days, or in a walk-in

One claim per pregnancy and one claim per infant

- First maternal/newborn office visit must take place within 14 days of discharge to the primary care provider responsible for the patient's ongoing care.
- Every effort should be made to communicate with the patient and/or caregiver within 2 business days of discharge.
- Claimable once per physician per patient per inpatient admission for obstetrical delivery.
- Not reportable for any subsequent discharges within 30 days, or in a walk-in setting.
- Maximum of 1 claim per pregnancy (mother) and 1 claim per infant.

First Visit after Discharge – Complex Care (ADON 03.03S)

10MSU/$26.30
(restricted to Standard, Geriatric and Adults with Developmental Disabilities office visits)

Defined as:

- Two or more chronic long-term conditions requiring active management
- Patient at significant risk of death, acute exacerbation/decompensation, or functional decline

Communicate with the patient/caregiver within two business days of discharge

Visit must occur in your office or patient's home within 14 calendar days after discharge (day zero)

- A complex care patient is defined as:
  - A patient with multiple (two or more) chronic conditions requiring active management expected to last at least 12 months, or until the death of the patient.
  - The chronic conditions must place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
- Every effort should be made to communicate with the patient and/or caregiver within 2 business days of discharge.
- Can be claimed 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).

First Visit after Discharge – Complex Care (cont'd)

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Hospital stay greater than 48 hours

Claiming physician must be the provider most responsible for the patient's ongoing complex care

Claimable once per physician, per patient, per inpatient admission

Maximum of four claims per physician, per patient, per year

- Hospital stay must be greater than 48 hours.
- The physician claiming the service must be the provider most responsible for the patient's ongoing complex care.
- Claimable once per physician per patient per inpatient admission.
- Maximum of 4 claims per physician per patient per year.

First Visit after Discharge – Complex Care (cont'd)

Not reportable if hospital admission was for elective surgery, fracture care, obstetrical delivery or newborn care.

Not reportable in the same month as other monthly care fees - such as 13.99C anticoagulant monitoring

- Not reportable for any subsequent discharges within 30 days.
- Not reportable in the walk-in clinic setting.
- Not reportable if the admission to hospital was for the purpose of performing elective surgery (major or minor), fracture care (major or minor), obstetrical delivery, or newborn care.
- Not reportable in the same month as other monthly care fees - such as 13.99C

Use of an Interpreter (ADON OFI1)

5MSU/$13.15

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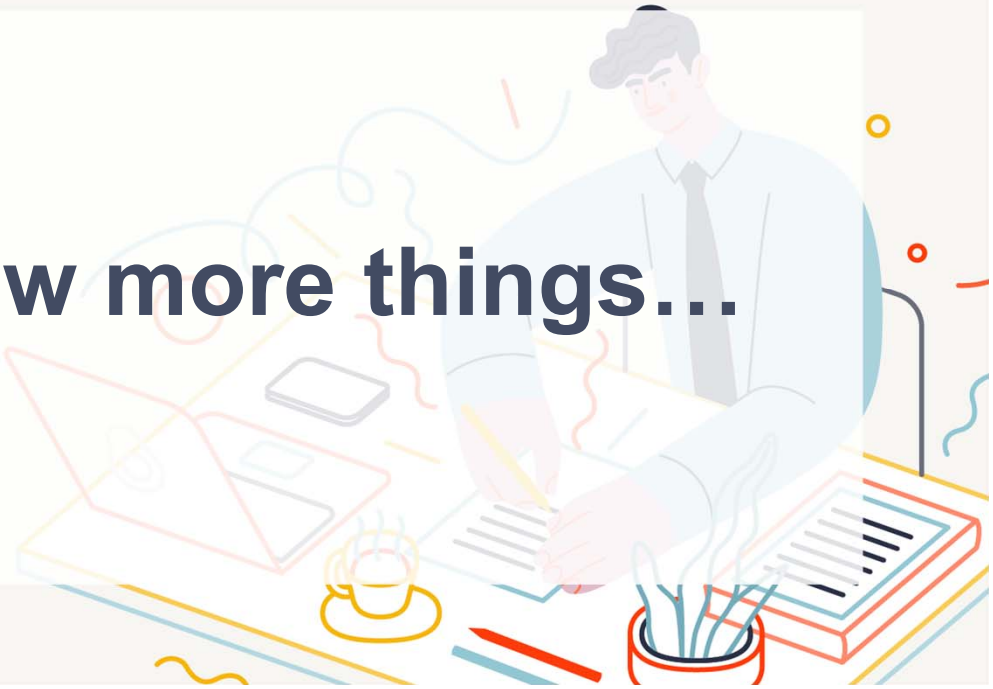
When an official interpreter is needed
Contact in person or via virtual care
Must document interpreter in record

- Can be claimed when the services of an official interpreter, as designated by the NSHA or IWK, are used when providing care to a patient of Limited English Proficiency (LEP) or who are deaf or hearing impaired and communicate using American Sign Language.
- Contact with the interpreter may be in person or via real time PHIA compliant technology.
- The interpreter's official identification must be documented in the patient's health record.

A few more things…



Long-term Anticoagulant Therapy (VADT 13.99C)

10MSU/$26.30

Can be billed once per month

Does not require a face-to-face interaction with the patient, provided the patient's treatment is managed by phone, fax or email advice

Cannot be claimed for any month in which a patient has been hospitalized for the complete month

TIP: Develop an in-office system where office staff automatically submits billing claims for all patients whose long-term anticoagulant therapy is being actively supervised.

This is a monthly management fee that does not require you to see the patient in office.

Same Day Same Patient

Claim if the visit is for:

- A different condition/diagnosis, or
- An exacerbation of the condition from first visit

Same applies if patient seen by another physician on the same day

Justification for extra visits must be recorded

Time of service required of second and subsequent visits

- A second visit can be claimed for a patient if seen in the same day as long as the visit is:
    - For a different condition/diagnosis, or
    - For an exacerbation of the condition presented at the first visit.
- This is also true for patients who have been seen by a different family physician on the same day.
- Documentation of the necessity for the extra visits must be recorded on the chart.
- Time of service occurrence must be provided on second and subsequent visits.

Services provided by a nurse

Nurse must be employed by you or practice (not NSH)

Physician must be on the premises (with or without interacting with patient) to bill:

- PAPs
- Immunizations
- Injections

To bill an office visit code for a visit the nurse participates in, you must participate too and meet preamble requirements. Must be noted in chart.

- Nurse must be employed by the physician or practice, not by the NSHA.
- Physician must be on the premises (but doesn't have to interact with the patient) to bill for:
    - PAPs
    - Immunizations
    - Injections
- Physician must personally participate in the visit and meet preamble visit requirements to bill for visits in which the nurse participates. **The chart note must reflect this**.

Palliative Care Med Chart Review and/or Call, Fax or E-mail (03.03, RO=CRTC)

11.5MSU/$30.25

Eligible only if initiated by providers involved in care

Telephone calls, fax or e-mails initiated by patient/family are not eligible

Keep detailed record of telephone calls, fax or e- mails

Includes up to three telephone calls, faxes or e-mails, per day, per patient. Each additional group of 3 can be claimed at 11.5MSU

- Only eligible for payment if initiated by health care professionals involved with the care of the palliative care patient.
- Telephone calls, fax or e-mails initiated by the palliative patient or their family members are not eligible.
- Physicians and health care professionals involved should keep a detailed record of telephone calls, fax or e- mails.
- Includes up to three telephone calls, faxes or e-mails/per day/per patient. Each additional group of three can be claimed at 11.5 units

NFTF–Advice

Consulting physician (03.09K): 25MSU/$65.75

Referring physician (03.09L): 11.5MSU/$30.25

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Two-way telephone call regarding assessment and management of patient

Referring physician (or NP) seeks expert opinion with intention of continuing to provide care closer to home

- Must communicate reason and relevant patient information before or within four business days after call
- Must document required information was supplied. Discussion must include clinical situation and management decision.

These Non-Face-to-Face (NFTF) fee codes may be reported for a two-way telephone call regarding the assessment and management of the patient but without the consulting physician seeing the patient.

The referring physician (or NP) is seeking an expert opinion 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 referring physician (or NP) must communicate 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 required information was supplied. Discussion must include the clinical situation followed by a management decision.

November 30, 2018 MSI Bulletin

Want to see a change?

The Fee Committee introduces new fees; revisions or deletions to existing fee codes; changes to the Preamble

Submit an application when:

- Code does not reflect current practice/standard of care
- Code is no longer not adequately valued
- No code exists for a procedure/service

- The Fee Committee is a decision making group that is responsible for the introduction of new fees; revisions or deletions of existing fee codes; additions, revisions or clarifications of the Preamble to the MSI Physician's Manual.

- There are numerous reasons an application may be submitted:
  - An existing code does not adequately reflect current practice/standard of care
  - An existing code is not adequately valued due to a change in circumstances since its inception.
  - There is no existing fee code for a procedure/service.

MSI audit and appeals

First audit on any given code should be for educational purposes only

On subsequent audits, the two-tier appeal process has strict timelines, missing a deadline forfeits your right to appeal

DNS can help you navigate the process

Audits
Usually based on either one or a few codes, not a full practice. Auditors will take a sample of 105 records associated with the codes they're looking at to check to see if the documentation supports the billing claim.

MSI audit and appeals
Schedule E of the Master Agreement is an appeal process that physicians may use to resolve issues relating to interpretation of fee codes listed in the MSI Physician's Manual and MSI Physicians' Bulletins. Doctors Nova Scotia may refer issues that require a policy or billing rule change to other committees for resolution.

Time is of the essence
Each phase of the appeal process has strict timelines. If you miss a deadline, you will forfeit your right to appeal. You are responsible for reviewing claim submissions in a timely manner to ensure adherence to these timelines.

Two teir appeal process:
Pre-payment assessment : If your pre-payment assessment claims have been rejected or adjusted by MSI, you have the right to appeal MSI's decision.

Post-payment audit review: When MSI identifies billing issues through the audit process, they provide you with written notice. If you disagree with the audit result, you have the right to ask for a review.

Audit appeals continued

Two-tiered appeal process for both pre-payment assessment and post-payment audits

- Facilitated resolution aims to resolve the issue through conversation and education
  - Legal counsel not permitted to attend
  - 30-business days to give notice to move to arbitration
- Arbitration by resolution panel makes binding decision
  - Legal representation may be present
  - Decision rendered within 10 days
  - Amounts owed are due and payable on decision date with interest

Physicians are responsible for billings even if someone else is entering the claims on their behalf

Two-tiered appeal process

If you have claims that have been rejected or adjusted by MSI, you may have the right to appeal. Both pre-payment assessment and post-payment audit disputes will proceed through this process.

Facilitated resolution

Facilitated resolution proceeds in accordance with Schedule C of the Commercial Arbitration Act (except for clauses 2, 15 and 16). You will meet with the DHW medical consultant, the DNS medical consultant, MSI audit personnel and a facilitator, with a goal to resolve the issue through conversation and education. Legal counsel is not permitted to attend facilitated resolution.

If an agreement is not reached, you have 30 business days to provide file a Notice of Intent to Proceed to Arbitration.

Arbitration by resolution panel

Cases that proceed to arbitration by resolution panel will be heard by a panel made up of a physician, a lawyer and a member of the public. You may have legal representation present at the arbitration. The panel will review the dispute and make a final binding decision by majority vote. The official decision will be rendered within 10 days.

Amounts owed by you or the DHW will be due and payable on the date of the decision and will bear interest of prime + 2% from that day.

Contacts

Want to submit an application, get advice on an audit, or ask other questions?

Jessica Moore, Compensation Manager,
Master Agreement and Fee Schedule
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(902) 481-4922

Derek Law, Compensation Manager,
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Dr. Ken Wilson, Medical Consultant
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(902) 481-4925

Questions?

Doctors Nova Scotia

DALHOUSIE UNIVERSITY
FACULTY OF MEDICINE
Continuing Professional Development

Additional slides if needed

Home visits

- For homebound patients, when the patient/delegate requests a visit
- Claim only when homebound patient's condition or situation justifies the service
- For non-homebound or convenience visits, claim normal office visit rate and don't claim travel
- A patient is homebound when one or more conditions are met and documented in the record:
  - Leaving home isn't recommended due to their condition
  - Without help (equipment, special transportation, help of another person) their condition keeps them home
  - Leaving home takes considerable effort

- For service provided to homebound patients, when the patient or patient's representative has requested a visit.
- Can only be claimed when the patient's condition or situation justifies the service and the patient is homebound.
- If the patient is not considered homebound, the visit is considered to be rendered at home for convenience. In this situation, the visit may be claimed at the normal office visit rate and travel may not be claimed.

Home visits

Description	MSU value	Dollar value
0800-1700	36	$94.68
1701-2350, weekends & holidays	47.8	$125.71
0000-0759	64.7	$170.16
Emergency	59.5	$156.49
Extra patient	13	$34.19
Extra patient 65+	16.5	$43.40
Complete Examination	40.6	$106.78

Home visits – Travel

0.46 per KM + MU

When travel is required to the homebound patient's home claim

Text for the claim must include:

- the start and finish time of the visit
- point of origin
- destination address
- the distance in kilometers maximum MU=70

1 multiple = 1 KM

- ADON to a home visit health service code when the physician must travel to the patient's home in order to provide clinical services to a homebound patient.

- Text for the claim must include:
  - the start and finish time of the visit
  - point of origin
  - destination address
  - the distance in kilometers maximum MU=70

- 1 multiple = 1 KM

Detention

12.5MSU ($32.88) per 15 minutes increment (starts after 30 min)

- When time is given exclusively to one patient for active treatment and/or monitoring
- Emergency care and/or treatment provided outside office
- Bill first 30 minutes with appropriate visit fee
- When claimed with Comprehensive or Limited Consult, claim after first hour
- Includes travel time between locations
- Claim **either** service or detention time, **not both**
- Document the circumstances in each case **and** the start and stop times

- When time is given exclusively to one patient for active treatment and/or monitoring of that patient at the sacrifice of all other work.
- For emergency care and/or treatment provided outside of the office.
- Starts after 30 min; claimed in 15 min increments. The first 30 min is billed with the appropriate visit fee.
- When claimed with Comprehensive or Limited Consult, starts after 1 hour.
- Can include travel time spent with the patient travelling from one location to another.
- Where any service is performed during the time spent with the patient, claim **either** the service **or** the detention time, but **not both**.
- The circumstances in each case **and** the start and stop times must be documented.

Detention cont'd

Cannot be claimed for:

- Waiting for operating room, x-rays, laboratory results or admin duties
- Counselling or psychotherapy
- Advice given to the patient/family/representatives
- Waiting for patient's arrival
- Waiting time for attendance by another provider
- Return trip if the physician is not in attendance with a patient
- Time spent in completing or reviewing patient charts
- More than one patient at a time

Cannot be billed for an office visit or in addition to a) Intensive care or critical care b) Diagnostic and therapeutic procedures c) Obstetrical delivery fee codes for the same patient, same day

- Waiting time for an operating room, x-rays, laboratory results or admin duties
- Counselling or psychotherapy
- Advice given to the patient or patient's family or representatives
- Waiting time for a patient's arrival for assessment or treatment
- Waiting time for attendance by another medical practitioner or consultant
- Return trip if the physician is not in attendance with a patient
- Time spent in completing or reviewing patient charts
- More than one patient at a time

Cannot be billed for an office visit or in addition to a) Intensive care or critical care b) Diagnostic and therapeutic procedures c) Obstetrical delivery fee codes for the same patient on the same day.

Urgent Care Codes

- Claim if required to respond immediately outside regular or scheduled office hours
- Personal choice or availability doesn't apply
- If travel required, use **appropriate explicit modifier** on the service encounter

- Can be claimed when the patient's condition and/or the physician interpretation of that condition, requires the physician to respond immediately.
- Immediate attendance because of personal choice or availability does not constitute an urgent visit.
- If an urgent care visit interrupts regular office hours (0800 to 1700 Monday to Friday or during other scheduled office hours) and requires travel from one location to another, the appropriate explicit modifier must be entered on the service encounter to ensure proper payment.
- An urgent care visit does not apply to a patient attending the office during scheduled office hours regardless of the patient's condition.

Urgent Care cont'd

Urgent Care in Office Request by patient (28.3 – 38.3MSU/$74.43 – $100.73):

- When you are called to see patient and must travel to your office outside scheduled hours
- If additional patients are seen, a limited visit applies for those additional patients.

- Applies when the physician is called to see the patient and must travel to his or her office outside the hours of 0800 to 1700 Monday to Friday or during other scheduled office hours.
- An urgent care visit does not apply to a patient attending the office during scheduled office hours regardless of the patient's condition.
- If additional patients are seen at the same time, a limited visit applies.

Urgent Care cont'd

Urgent Visit Hospital Inpatient (35.2MSU/$92.58):

- Request made by hospital staff for an inpatient
- Travel required

Urgent Visit Sacrifice of Office Hours (35.2MSU/$92.58):

- Used for all non-hospital visits
- Interrupts regular office hours and travel required

Urgent Visit Hospital Inpatient (35.2MSU/$87.30):

- Must be at the request of hospital staff for a registered inpatient.
- Applies only when called to see the patient and must travel to do so.

Urgent Visit Sacrifice of Office Hours (35.2MSU/$87.30):

- Used for all other locations.
- An urgent visit may be applied when the physician is called to see a patient and interrupts his or her regular office hours and travels from one location to another to attend the patient.

Complete Care Codes

Cannot be claimed on the same day for the same patient. Complete Care codes include insertion of:

- IUD– **45.16MSU/$118.77**
- Diaphragm – **15MSU/$39.45**

Exception:

- Section 5.2.86 of the Preamble states:
- *"…can be claimed with a post natal visit."*

Complete care means that a visit cannot be claimed on the same day for the same patient and includes:

Insertion of Intrauterine Contraceptive Device – 32MSU/$79.36

Insertion of vaginal diaphragm – 15MSU/$37.20

Exception:
Section 5.2.86 of the preamble states:

A diaphragm fitting or insertion of an intrauterine device can be claimed with a post natal visit.

GP Consult

Comprehensive: 30MSU/$78.90
Repeat: 13MSU/$34.19

Formal request is received from the patient's physician, nurse practitioner, midwife, optometrist or dentist

Use when the complexity, obscurity or seriousness condition requires further opinion, requires access to specialized diagnostic or therapeutic services, or when another opinion is requested

Bill to determine if a treatment is insured if the proposed procedure is sometimes uninsured

- Can be billed when a formal request is received from the patient's physician, nurse practitioner, midwife (include the MSI midwife number when billing), optometrist or dentist.
- Is used when the complexity, obscurity or seriousness of the patient's condition demands a further opinion, when the patient requires access to specialized diagnostic or therapeutic services, or when the patient, or an authorized person acting on the patient's behalf, requests another opinion.
- Can be billed to determine if a treatment is insured if the proposed procedure is sometimes, but not always insured. If it is always uninsured, it cannot be claimed.

GP consult cont'd

A comprehensive consult requires:

- Complete medical history
- Complete physical exam, appropriate to the physician's specialty and relevant to the presenting complaint. Must document positive and negative findings.
- Written report must be sent to referring practitioner including an evaluation of relevant body systems and findings, and advice to patient

A prolonged consult cannot be claimed by family physicians

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- A comprehensive consult must be supported by:
- A complete medical history, including relevant history of presenting complaint, past medical and surgical histories, medication list, allergies, and, as appropriate, family and social history.
- A complete physical exam, appropriate to the physician's specialty and relevant to the presenting complaint. Documentation must include the positive and negative findings of the physical exam. It is not adequate to indicate that the "physical exam is normal."
- A written report must be sent to the referring practitioner including an evaluation of relevant body systems and findings, as well as advice to the patient.

- A prolonged consult cannot be claimed by family physicians.

GP consult cont'd

Repeat consult applies between same consultant and same provider as previous referral for the same issue within 30 days of first consult

Requires:

- A history of the presenting problem, and
- An examination limited to relevant body systems

It implies interval care by another physician.

- A repeat consult applies only where there has been a re-referral of the patient by the same physician, nurse practitioner, midwife, optometrist or dentist to the same consultant for the same condition or complication thereof within 30 days of the initial consultation. A repeat consult requires:

- A history limited to and related to the presenting problem, and
- An examination that is limited to relevant body systems

- and implies interval care by another physician. The situation where the consulting physician requests the patient to return for a later examination is not a repeat consultation.

Palliative Care Support

30MSU per 30 min/$78.90

Time-based all-inclusive visit for providing pain and symptom management, emotional support and counseling

You must spend 80%+ of the time claimed with patient

Claim a maximum of 60 minutes per patient, per day

Do not claim for other visits with patient on the same day

- Time-based all-inclusive visit for the purpose of providing pain and symptom management, emotional support and counseling to patients with terminal disease.
- The physician must spend at least 80% of the time claimed with the patient.
- Can claim a maximum of 60 minutes per patient per day.
- Cannot claim for any other visits with the patient on the same day.