PHYSICIAN'S BULLETIN
September 25, 2026: Vol. LXXI, ISSUE 8

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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NEW FEES

CFP1A

In follow up to the July 17, 2026 Physician's Bulletin, it is recognized that, on occasion, a physician may complete all preparation and collaborative activities leading up to a scheduled meeting but be unable to attend due to unforeseen circumstances. In these situations, a one-time annual exception to the monthly meeting attendance requirement may be granted. A qualifier has been created to denote these exceptions.

Physicians should submit HSC **CFP1A** to allow an exception of the billing rule 'participation in structured team meetings at least once per month.' This HSC is billable once per year per provider.

As a reminder, any unplanned absence must be appropriately documented. This exception is intended only for circumstances in which the physician has completed the preparatory work associated with the meeting but is unexpectedly called away and unable to attend.

Effective September 25, 2026 the following health service code is available for billing:

Category	Code	Description	Base Units
DEFT	PPCB1	**Preauthorized Physician to Physician Mentorship:** Mentee Physician only – sessional fee for preapproved learning opportunity per 15 minutes of in person work with the mentor – not to exceed the preapproved maximum time limit as set by the Division/Department head. **Description** This fee is intended to compensate the mentee for time away from their practice spent in person (face-to-face) with a mentor in a Division/ Department head preapproved learning opportunity (with approval form sent directly to Medavie).	GENP: 15 MSU/15 min + MU SPEC: 17.5 MSU/15 min + MU

Category	Code	Description	Base Units

A mentee, in this context, is defined as a physician who is fully licensed by the College of Physicians and Surgeons of Nova Scotia and is not in a recognized training program, this excludes residents and fellows.

The mentee must maintain a logbook with the mentor's name, services provided with the mentor, patient(s) name and HCN(s), along with start and stop time of each learning session. The claim must have the mentor's name entered in the submission text field. The mentor will record the mentee's name in the health record of any patient having had services rendered with the mentee. This fee may not be claimed with any other fee for a service provided during the time in which the physician has attended in the role of mentee.

Division and/or Department heads will be aware of skills required in their respective zones and will be asked to provide preauthorization for the learning opportunity. The additional skills/training cannot exceed the scope of practice of the mentee physician's specialty (as determined by the Division/Department head). Approval documentation must include the names of mentor and mentee along with the maximum number of hours to be claimed for this learning opportunity.

Division/Department heads will determine the total number of hours permitted on the authorization form and provider access will be maintained for the rolling year or until the maximum approved hours are reached. In the case where a mentor and mentee are from different Divisions/Departments, both Division/Department heads must sign the form to show agreement.

The mentee will claim a sessional rate per 15 minutes of time spent with the mentor. The maximum number of hours billable per day is 12 hours.

The mentor will document the mentee's name in the health record for the service provided. This remuneration is intended for direct in person (face-to-face), physician-to-physician learning only. Preauthorization must be in place before the learning activities are undertaken – post-hoc approval will not be accepted.

Billing Guidelines:

- The learning activities must be preauthorized by the mentee's Division and/or Department Head. In the case where a mentor and mentee are from different Divisions/Departments, both Division/Department heads must authorize.
- Both mentor and mentee must keep documentation of the learning session.
- The mentee must keep a learning logbook documenting the mentor's name, services provided with the mentor, patient(s) name and HCN(s), along with start and stop times of each learning session.
- The mentee must submit the name of the mentor in the submission text field on the claim.
- The mentor must document the presence of the mentee, by name, in the service encounter note or operative report, as appropriate, in the patient's health record.
- The remuneration is intended for direct in person (face-to-face), physician-to-physician sessions only.
- The mentee will be paid the sessional rate 60 MSU/h GENP, or 70 MSU/h SPEC, paid in 15 minute multiples, up to a maximum of 12 hours per day.

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Category	Code	Description	Base Units
		• Access will be maintained for the rolling year or until the maximum approved hours are reached. • The mentee may not claim another fee code during the period that they are being mentored. The mentor will receive service payment for the services provided as usual. **Claims must be submitted to HCN: 0016813610, DOB April 1, 1969** Dx code: V68.9 (unspecific administrative purpose) **Multiples:** GENP: 15 units per 15 minutes to a maximum of 12 hours in any given day and overall maximum hours preapproved for the learning opportunity SPEC: 17.5 units per 15 minutes to a maximum of 12 hours in any given day and overall maximum hours preapproved for the learning opportunity **Approval Form**: Capacity Building Authorization form (to be submitted by Division and/or Department Head of the mentee)	

FEE UPDATES

CARE PLAN OVERSIGHT (CPO) NURSING HOME, RESIDENTIAL CARE FACILITY OR HOSPICE (CPO1)

As of September 25, 2026, the CPO1 health service code has been terminated.

INTERNAL MEDICNE OFFICE VISITS

In addition to the increases for office visits for NEUR, PHMD, INMD in January, the additional specialties below have been adjusted to the new value. Claims submitted for these added specialties with service dates from January 16, 2026 - September 24, 2026, will be identified and a retroactive payment will be sent to physicians once the 90-day submission window has elapsed.

Health Service Code	New Value	Specialties
03.03 RP=SUBS	**17** MSU	SP=CARD, CLIA, ENME, GAST, GEMD, HAGY, INDI, MDON, MEMI, NEPH, RHEU, RSMD
03.03 RO=CNTC	**17** MSU	SP=CARD, CLIA, ENME, GAST, GEMD, HAGY, INDI, MDON, MEMI, NEPH, RHEU, RSMD
03.03 RO=CNTC AG=OV65	**21** MSU	SP=CARD, CLIA, ENME, GAST, GEMD, HAGY, INDI, MDON, MEMI, NEPH, RHEU, RSMD
03.03A	**21** MSU	SP=CARD, CLIA, ENME, GAST, GEMD, HAGY, INDI, MDON, MEMI, NEPH, RHEU, RSMD
03.03 RO=DIRC	**17** MSU	SP=CARD, CLIA, ENME, GAST, GEMD, HAGY, INDI, MDON, MEMI, NEPH, RHEU, RSMD
03.03 RO=DIRC AG=OV65	**21** MSU	SP=CARD, CLIA, ENME, GAST, GEMD, HAGY, INDI, MDON, MEMI, NEPH, RHEU, RSMD

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ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP) – Physician Declaration

ERCP is a specialized endoscopic procedure requiring appropriate training, demonstrated competency, specialized equipment, and suitable facility resources. Physicians are now required to request preapproval for providing ERCP related health service codes listed below, by completing and returning the ERCP declaration form.

ERCP-RELATED HEALTH SERVICE CODES

63.82A — Esophagogastroduodenoscopy – with papillotomy
63.89A — Esophagogastroduodenoscopy – with manometry of ampulla of Vater
63.95A — Esophagogastroduodenoscopy – with basket extraction of stones
63.95B — Esophagogastroduodenoscopy – with indwelling nasobiliary catheter
63.95C — Esophagogastroduodenoscopy – with biliary stents
64.91A — Esophagogastroduodenoscopy – with cannulation of pancreatic duct
64.96A — Esophagogastroduodenoscopy – with selective pancreatic duct cytology

Physicians are advised that Health Service Codes 66.98E, 66.98F and 66.98G are now permanent:

Category	Code	Description	Base Units
VEDT	66.98E	**Percutaneous Insertion of Tunneled Intraperitoneal Catheter for use in dialysis.** **Description** This is a comprehensive code for the percutaneous insertion of a tunneled intraperitoneal catheter, it includes all imaging guidance and injection of contrast as required to complete the procedure. **Specialty Restriction:** SP=NEPH **Location:** LO=HOSP (QEII only)	125 MSU
VEDT	66.98F	**Removal of Tunneled Intraperitoneal Catheter (for use in dialysis)** **Description** This is a comprehensive code for the removal of tunneled intraperitoneal catheter, it includes all services required to remove the device and close the wound. **Specialty Restriction:** SP=NEPH **Location:** LO=HOSP (QEII only)	75 MSU
VEDT	66.98G	**Repositioning of Tunneled Intraperitoneal Catheter for use in dialysis** **Description** This is a comprehensive code for the repositioning of a tunneled intraperitoneal catheter, it includes all imaging guidance and injection of contrast as required to complete the procedure. **Specialty Restriction:** SP=NEPH **Location:** LO=HOSP (QEII only)	75 MSU

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Effective September 25, 2026 the following health service codes have been updated:

Category	Code	Description	Base Units	Anae Units
MASG	67.3	**Partial Nephrectomy (Regions required)** **Description** Partial nephrectomy is procedure that may be done via an open technique, laparoscopically, or a robotically. This is a single comprehensive surgical code that includes all routine operative steps required expose the kidney, remove the tumour, repair the collecting system and parenchyma, secure haemostasis, a nephropexy if required, and immediate perioperative care. **Billing Guidelines:** The code is a comprehensive surgical code that includes all routine surgical steps. The following codes may not be billed with HSC 67.3: • 67.6 Nephropexy • 66.3 Excision or Destruction of Lesion or Tissue of Peritoneum • 67.29A Excision of Renal Cyst In unusual and exceptional circumstances, additional codes may be approved providing there is clear documentation of the specific issue in the OR report and supported by the surgical time in the OR record. **Specialty Restriction:** SP=UROL **Assistant:** RO=SRAS allowed **Regions:** RG=LEFT or RG=RIGHT **Location:** LO=HOSP	475 MSU	7 + T

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Billing Matters Billing Reminders, Updates, New Explanatory Codes

PHYSICIAN'S MANUAL

Applicable updates in the Physician's Bulletin's will be reflected in the Physician's Manual within 3 weeks; however, it may be necessary to refer to Physician's Bulletins for additional detailed information and any billing clarifications or reminders.

INTERIM FEE REFERENCE GUIDE

Physicians are reminded of the Interim Fee Reference Guide (PDF) available on the MSI website, which provides a comprehensive list of all current interim fees.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
MA077	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 67.3 MAY NOT BE CLAIMED AT THE SAME ENCOUNTER AS HSC 67.6, 66.3 OR 67.29A
PV005	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED CFP1A DURING THE CURRENT FISCAL YEAR
VA113	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST SUBMIT YOUR SIGNED DECLARATION OF SUBSPECIALTY TRAINING AND COMPETENCY IN ORDER TO CLAIM ERCP HEALTH SERVICE CODES

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday September 25, 2026. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

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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

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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