Medical Services Insurance Billing Information Session Welcome Collaborative

2026

Learning Objectives

At the conclusion of this presentation, participants will be able to:

- Recognize the available resources and how to utilize them to bill accurately
- Acquire a basic level of knowledge surrounding health service codes used to bill for common services provided by Family Physicians.
- Gain an awareness of general billing rules
- Deepen their knowledge base, support their own billing and seek support when needed

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Declaration of Conflict

We are presenting today with no conflicts to declare

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Relationships

Department of Health and Wellness:

- Sets Health Policy

Doctors Nova Scotia:

- Negotiates fees with DHW via the Fee Committee

Medavie Blue Cross:

- Administers the MSI program/policy

Overview of MSI

- Medavie Blue Cross has administered the MSI program since 1969
- More than 8M claims submitted annually to MSI
  - Of those, approximately 300k claims are manually processed/assessed
- Claims for out of province and out of country services are also submitted by physicians and patients
- Approximately 80 calls per day in Medicare from providers and residents
- Bi-weekly payments are made to physicians, optometrists, ancillary providers
- Support DHW and DNS business initiatives i.e., physician tariff and billing education

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Billing Fundamentals

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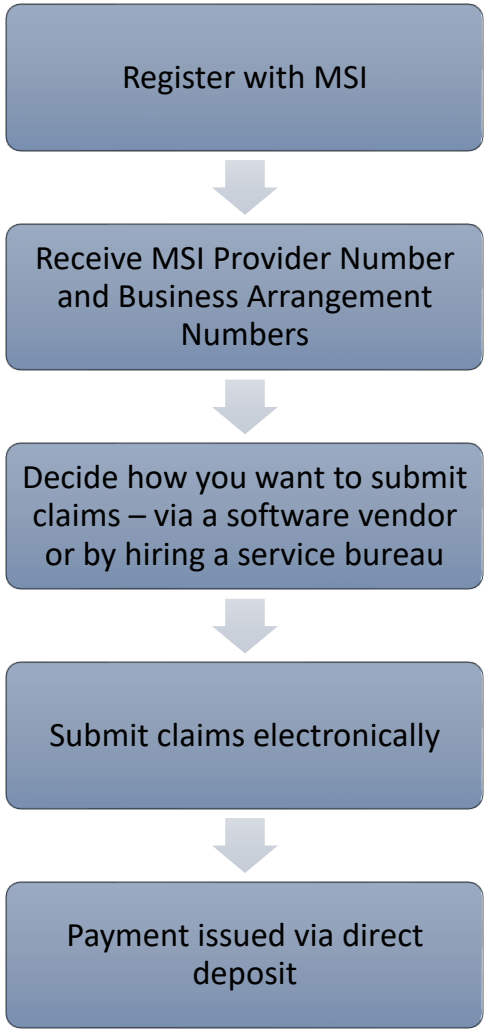
Important Documents

Physician's Manual	Preamble – authority for billing Explanatory Codes Definitions Schedule of Benefits – Health Service Codes (HSC)
Physician's Bulletins	Provides current information for physicians on MSI related matters including new or modified fees, policies and procedures relating to claims for services provided
Interim Fee Guide	Provides all current interim fees. Interim fees are established in certain circumstances with approval from the DHW. When a health service code is assigned an interim fee, it is published in the MSI Physician's Bulletin and in the Interim Fee Reference Guide. If an interim fee is made permanent or terminated, it will be removed from the IF guide and update in the Physician's Bulletin and/or Physician's Manual as applicable.
Nova Scotia Formulary (Pharmacare)	The Nova Scotia Formulary is updated every month electronically. It can be searched by Drug Name (Brand or Generic) or DIN. The benefit status (plans for which the product is a benefit) is listed by each medication. There is a legend in the front of the Formulary (page iv). It can be found on the DHW website: https://novascotia.ca/dhw/pharmacare/formulary.asp

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Getting Started

All service items claimed to MSI are the sole responsibility of the physician rendering the service with respect to appropriate documentation and claim submission.



https://msi.medavie.bluecross.ca/physician-registration/

Important Terms

•**Provider Number**: a six-digit number used to identify a physician.

•**Business Arrangement (BA)**: An agreement between a service provider and MSI covering the payment arrangements for health services provided.

•**Medical Service Unit (MSU)**: The value used to obtain the actual monetary value of a service. 2025-26 value is $2.90. *E.g., 13 units x 2.90 MSU = $37.70*

•**Service Encounter:** Identifies each claim submission. A *Service Encounter Number* is assigned to each service encounter which distinguishes that encounter from others.

•**Facility**: A physical location, e.g., hospital, office etc. All facilities are formally recognized on the MSI register and are assigned a Facility Number used for claim submission.

•**eLink**: the web application used to download incentive/contract payment statements

•**Payment Responsibility:** a mandatory field on a claim that identifies which organization is responsible for payment of the service, i.e., MSI, WCB, etc.

•**Multiples**: used to indicate the number of services performed, the length of time etc.

•**Add-on**: a procedure that is always performed in association with another procedure and never by itself.

•**Premium**: Premium fees are additional amounts paid above normal/customary rates on eligible services.

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Business Arrangements (BAs)

Examples:

CMPA BA – For issuing CMPA rebates and/or incentives – no billing occurs on this BA.

FFS BA - For FFS physicians or FFS eligible claims (WCB etc.)

Locum BA – A temporary or long-term BA set up for physician locum payments.

- **LFM Attachment BA** – For the purpose of payment for the patient attachment component for the LFM model. Physicians should not bill any health service codes to this BA.
- **LFM Hourly BA** - For the purpose of payment of funds for LFM hourly contracted hours component of the contract. No shadow billings should be billed to this BA except for the new hourly health service fee codes.
- **LFM FFS 30% BA** - For the purpose of 30% remuneration of submitted health service code claims. Services provided under your LFM will be submitted to this BA.

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Timing of Claims Submissions



- 90 days from the date of service to submit claims
- 185 days to resubmit from the date of service
- Services to residents of other provinces must be submitted within 1 year of date of service
- Exceptions can be made to allow submission of claims outside of the 90-day timeframe in **extenuating** circumstances.
  - Acceptable examples include an office fire/flood, prolonged power outages, severe illness, death of a family member etc.
- Adjudication responses should be reviewed regularly to correct claims that have been rejected, reduced or paid at 0. Claims will have an explain code attached advising why the claim was not paid in full.

*Changes to submission timelines are expected per the 2023-27 Physician Agreement; any updates/changes will be published in a Physician's Bulletin.

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Importance of Billing Correctly

- Accountability for the services being billed
- Billing correctly affects income
- Accurate patient history
- Data collection on services rendered
  - Aids in future decision making

Basics of Billing

The format of a service encounter

03.03 A LO=OFFC SP=GENP

Health Service Code (HSC): A code identifying services or procedures performed by a service provider to a service recipient.

Qualifier: An alpha character appended to some HSCs to subdivide the code and distinguish differences specific to the service.

Modifier: MSI adjudication system uses modifiers to determine the payment amount of a service encounter. They can affect payment by:

- Adding or subtracting an amount from basic fee
- Replacing the basic fee with a different amount
- Indicating role, time, method, age

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Documentation

- Documentation of services that are being claimed to MSI must be completed **before** claims for those services are submitted to MSI

- For MSI purposes, it is required that physicians maintain records supporting services claimed to MSI for a period of **five years** in order to substantiate claims submitted.

- When implementing business practices at the time of entering into a group practice or locum tenens, or when winding down a practice, physicians should confirm that their records will be easily retrievable if they are required to substantiate claims to MSI

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Preamble 5.1.7, Preamble 5.2.201, https://cpsns.ns.ca/resource/management-of-medical-records/

Uninsured Services

- Services such as (but not limited to) removal of cerumen, missed appointments, sick notes or completion of forms are not insured and therefore not billable to MSI.

- If a patient's sole purpose for the appointment is an uninsured service, you may not bill MSI for the visit or procedure.

- NOTE: Each doctor can set their own fees for uninsured services or may choose not to charge. A doctor must inform a patient of any costs **before** providing a service that is not covered by MSI.

- When physicians are providing non-insured services, they are required to advise the patient of any insured alternatives, if any exist.

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Services Provided by other Health Care Professionals

If a fee-for-service family physician directly employs a nurse or nurse practitioner, the physician may claim for pap smears and simple injections such as immunizations done by the nurse, provided the physician is on the premises.

This does not apply to other procedures, visits or counselling, nor for services done by nurses who are employed by third parties such as the Nova Scotia Health Authority.

To bill an office visit code for a visit the nurse participates in, you must personally participate in the visit, provide an insurable service and meet preamble requirements. **The chart note must reflect this**.

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Same Day, Same Patient, Same Physician

- A second visit can be claimed for a patient seen in the same day provided the visit is:
  - For a different condition/diagnosis, or
  - For worsening of the condition presented at the first visit

- Documentation Requirements:
  - Medical necessity of the second or subsequent services
  - Time of the second or subsequent service
    - Each occurrence must be at separate and distinct times.
  - Must be documented both in the text field on the claim and in the medical chart

- Submitted as 'Service Occurrence #2' to indicate the second encounter that same day, same patient, same physician.
  - This is a field on the claim submission that must be changed from the standard #1, to #2, etc.

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Questions



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Family Physician Specific Billing

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LFM Hourly Billing Codes

- HDAY1 - Longitudinal Family Medicine (LFM) model hourly fee code for clinical daytime hours worked (both direct and indirect).
- HEVW1 - Longitudinal Family Medicine (LFM) model hourly fee code for clinical evening/weekend/holiday hours worked.

• The HSC's must be billed under the LFM Hourly Health Card Number 0015800568, DOB April 1, 1969

(Dx Code V689)

Physicians must submit the number of hours in the claimed units of the claim (i.e., 8.5 daytime hours = 8.5 units).

• Only one HDAY1 per day per provider

• Only one HEVW1 per day per provider

• Maximum of 24 hours per day across both HSC

The HSC Pays $0 – Physicians are required to submit these claims under their LFM Hourly BA for tracking purposes.

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https://msi.medavie.bluecross.ca/longitudinal-family-medicine/

03.03 Limited Visit

- 03.03 - Diagnostic Interview and Evaluation, described as Limited - Limited assessment with history of the presenting problem

  - Most commonly billed code for Family Physicians
    - ❖ Office Visit: 03.03 RP=SUBS (patients under 65)
    - ❖ Geriatric Office Visit: 03.03A (patients 65+)

- A limited visit may be claimed when:
  - ❖ You see the patient and perform a limited assessment for a new condition
  - ❖ When monitoring or providing treatment of an established condition
  - ❖ It includes a history of the presenting problem and an evaluation of relevant body systems.

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ME=CARE Enhanced Office Visits

- Family physicians who deliver comprehensive and continuous care to patients with whom they have an ongoing relationship are eligible for an increase to several health service code fees (see full list in section 8 Family Practice section Physicians Manual).

- The enhanced fees are only available to family physicians who attest, via confirmation letter, that they are providing comprehensive and continuous care to patients. To claim the enhanced fee, physicians should use the ME=CARE modifier on applicable claims.

- It does not include episodic care provided to walk-in patients. If your practice offers evening hours or walk-in service, you should bill the enhanced fee whenever you are seeing one of your own patients, or a patient of your practice.

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Prolonged Office Visits

- When a standard office visit (03.03 and 03.03A) becomes prolonged for a ME=CARE patient, multiples may be billed to compensate the physician for the additional time spent.
    - Only physicians eligible to bill the ME=CARE modifier may bill for prolonged office visits. I.E., family physicians who are delivering face to face comprehensive and continuous care to patients with whom they have an ongoing relationship.

- The first 15 minutes is considered the base fee (1 multiple) (standard fees apply).
    - After that point, additional multiples are used to bill for each additional 15 minutes spent, up to a maximum of 4 multiples (60 mins total time)
    - 80% of the total time billed must be spent in direct physician to patient contact

- Start and stop times must be documented in both the health record and the text field of the claim (for services billed with multiples greater than 1)

- Prolonged visits are not eligible via virtual care

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https://msi.medavie.bluecross.ca/interim-fees/

NPIV1 New Patient Intake Visit

- Billable when you accept a new patient into your practice and arrange an appointment for the purpose of gathering a detailed medical and social history in order to establish an ongoing relationship and to build the patient's medical record
- Documentation should include:
  - Current health status & past medical history
  - Relevant social and family history
  - Current list of medications and allergies
  - Physical exam when clinically appropriate
- Any medically necessary services completed during this visit are considered included in the fee and can contribute to the multiples claimed

- Only billable for new patients, and only for physicians who have submitted a ME=CARE letter
- The standard rate accounts for up to 30 minutes in length (1 multiple) (including both the face to face and non-face to face time)
- NPI visits that exceed 30 minutes in length should be billed with multiples, up to a maximum of 5 (i.e., 90 minutes)
  - The total time must be documented in the health record as well as the text field of the claim
- Services must be in-person and cannot be claimed virtually
- All components of this service must be completed on the same day

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TI=GPEW Enhanced Hours

GP Enhanced Hours Modifier – 25% increase in claim value

- Intended to promote enhanced patient access to primary care outside of traditional office hours.
- Available to physicians who have an ongoing clinical relationship with the patient (ME=CARE) and select services for physicians providing care at walk-in clinics.
    - Weekdays M-F from 6 a.m. to 8 a.m. and 5p.m. to 10 p.m.
    - Weekends S-S/Holidays from 9 a.m. to 10 p.m.

For services where the Enhanced Hours Modifier has been claimed, a record must be maintained and readily available to verify that the patient was seen for an appointment during an eligible time period. The appointment time should be recorded in the patient's record.

See full list of GPEW eligible HSC in the Physician's Manual

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03.03B Complex Care Visit

- May be billed a maximum of 4x per patient per fiscal year by the regular FP and/or the practice i.e., not by walk-in clinics:

- Patient must be under active management for **3 or more** of the following chronic diseases:

Asthma	**Chronic Liver Disease**	**Hypertension**	**Chronic Renal Failure**
COPD **Chronic Obstructive Pulmonary Disease**	**Diabetes**	**Congestive Heart Failure**	**Ischemic Heart Disease**
	Dementia	**Chronic Neurological Disorders**	**Cancer**

- Start and finish times required to be recorded on the clinical record **and** in the text field of the MSI claim

- 15 minutes must be spent in direct patient intervention & visit must address at least 1 chronic disease directly or indirectly

03.04 Comprehensive Visit

A comprehensive visit or a subsequent comprehensive visit is an in-depth evaluation of a patient necessitated by the seriousness, complexity, or obscurity of the patient's complaints or medical condition.

Requirements:

- Complete physical exam including:
  - ❖ Complete physical exam, appropriate to the physician's specialty and relevant to the presenting complaint
  - ❖ Documentation describing the pertinent positive and negative findings of the physical exam.
    - ▪ It is not adequate to indicate "physical exam is normal" without indicating what was examined
- **Detailed** patient history including:
  - ❖ Relevant history of presenting complaint
  - ❖ Relevant past medical and surgical history
  - ❖ Medication List, Allergies
  - ❖ Family history, Social history
  - ❖ Documentation of the above

- Comprehensive visits when there are no signs, symptoms or family history of disease or disability that would make such an examination medically necessary are not insured.
- Comprehensive visits claimed within 30 days of a previous limited or comprehensive visit will require text indicating what the medical necessity of the comprehensive visit was
- All visit services billed must be medically necessary.

In situations in which these criteria are not met, it would be appropriate to instead claim a limited visit.

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Questions



03.08 Family Physician Consultation

- FPs may only claim a consult if the patient is referred to them and the GP has additional specialized expertise in one of the following areas: **Pain Management, Sports Medicine or Palliative Care.**

- Services considered within the scope of a FP would be considered a transfer of care and a consultation may not be claimed. If the patient is referred for a simple procedure, only the procedure may be claimed.

- Consultations require a formal request, documentation of a complete history and physical, and a report back to the referring practitioner.

Common errors:

- no or minimal physical exam
- billing consult for follow-up examination or transferal of care within the same specialty group

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13.59L Immunizations

- Physicians may claim for the administration of immunizations covered by the Provincial Immunization Program.
- E.g., 13.59L + (RO=INFL – Flu Shot) (RO=TEDV (PT=RISK) – Tetanus toxoid)

- Most provincial immunizations allow for a tray fee. Tray fees can only be billed when the cost of materials is incurred by the physician/practice.
    - A tray fee can be billed for a maximum of 4 immunizations. Enter the corresponding number of multiples on a separate claim for HSC 13.59M.

    - Claims for Rotavirus (HSC 13.34A) do not allow a tray fee to be billed

- Classified as VADT (Visit Allowed procedure) – if a visit is also completed during this visit, both the visit and immunization(s) can be billed
- If the sole purpose of the visit is the immunization only, bill only the immunization(s), no office visit can be billed.

13.59 Injections

Classified as ‘VEDT’ (visit excluded procedure)

- **No visit can be claimed in conjunction.**

Used for simple injections

- **Such as B12, Depo-Provera**

No tray fee billable in addition

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TPR1 Telephone Prescription Renewal

- Billable by Family Physicians when you are requested by a patient to communicate a prescription renewal by phone, fax, or email with no requirement to see the patient for an in-person visit.
- Cannot be used when writing new prescriptions or when billing a visit with the patient on the same day
- Documentation on the patient's chart must indicate that this service was initiated at the patients request. The drug, dose, and amount prescribed must be documented. These can be done in the form of a visit note and must be retrievable upon request

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https://msi.medavie.bluecross.ca/interim-fees/

AHCP1 Allied Health Care Provider to Physician

- To provide advice via phone, fax, email or face to face when you have a conversation with an allied health care practitioner regarding a patient with whom you have an established relationship to determine a management decision.
- Intended to compensate for unexpected interruptions to your normal practice routine and includes the time needed to make chart updates after the discussion
- Can only be used for interactions with providers outside of your practice and must be recorded in the patient's chart
- Full billing guidelines are available in the Interim Fee Reference Guide

https://msi.medavie.bluecross.ca/interim-fees/

08.49A Counselling

- Prolonged discussions directed at addressing problems associated with acute adjustment disorder or bereavement.

- May be claimed by family physicians for patients who meet the current DSM dx criteria for a mental health disorder.

- May be claimed in 15 min intervals
  - ❖ At least 80% of the time claimed must be spent in direct patient intervention.

Documentation requirements:

- Presenting problem should be outlined as well as advice given
- Ongoing management/treatment plan
- The recording of symptoms followed by "long discussion" "counselled" etc., is not considered sufficient documentation
  - ❖ Documentation MUST be as specific as possible
- Start and stop times

Note: *Not to be used for prolonged visits for medical problems. Document well what you discussed and therapeutic interventions as well as the start and stop times of the visit*

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08.49C Lifestyle Counselling

- Prolonged discussion where the physician attempts to direct the patient in the proper management of a health-related concern. E.G., lipid or dietary counselling, AIDS advice, smoking cessation.
- This is only billable by the GP providing ongoing primary care to the patient
- May be claimed in 15 min intervals
- At least 80% of the time claimed must be spent in direct patient intervention.
- Document the start and stop times of the visit in the chart as well as the specifics of the discussion.

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08.49B Psychotherapy

Treatment for mental illness, behavioral maladaptation and/or other problems that are assumed to be of an emotional nature in which a physician deliberately establishes a professional relationship with a patient for the purposes of removing, modifying or reducing existing symptoms, of attenuating or reversing disturbed patterns of behaviour and of promoting positive personality growth and development.

- This service, when performed by a GP, is limited to 20 hours per patient or family or group per physician per year.

- Claimed in 15-minute intervals with a minimum of two intervals
  - At least 80% of the time claimed must be spent in direct patient intervention.

- Documentation must include specifics of the discussion as well as the method(s) of psychotherapy used to treat the patient

- Treatment for medical complaints, acute adjustment reactions or bereavement reactions do not qualify as psychotherapy

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Compare and Contrast Counselling

Service	Details	Value	What's different?	What's the same?
Counselling (08.49A)	Claimed when patient has an underlying mental health disorder, acute adjustment disorder or bereavement.	**30MSU per 30 min** **15MSU per 15-minute interval**	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 and advice given to the patient, not just state "long discussion," "counselled" etc. Start and stop times must be noted in the patient's medical record **and** the text of the MSI claim.
Lifestyle counselling (08.49C)	Claimed when providing advice on lifestyle items such as lipid or dietary counselling, smoking cessation, etc. to patients of your practice.	**15MSU per 15-minute interval**	Can't claim for: •More than 2 hours/patient, per physician/year •More than 30 minutes/patient, per day	
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 per 30 min** Claimed in 15 min intervals, a minimum of two intervals must be claimed per visit.	Can't claim for: •More than 20 hours/patient/family/group per physician/year •More than 90 continuous mins/patient/day	

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Home Visits

Rendered to a homebound patient following travel to the patient's home.

• Payment differs depending on the time of the appointment.
Standard home visit (0800-1700) 36 units.

• ADON: HOVM1 – blended mileage and travel detention – added onto a home visit claim when the physician must travel to the patient's home to provide services to a homebound patient.

- If the patient is not considered homebound:
  Visit is to be claimed with modifier ME=CONV (visit rendered at home for convenience) will be paid at the regular office rate, and travel cannot be claimed.

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Questions



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Maternity & Well Baby Care

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03.04 RO=ANTL Complete Pregnancy Exam

- Only one prenatal comprehensive visit may be claimed per pregnancy
  - ❖ This restriction is per patient, not provider

- Complete history & physical and gyn exam

- Includes a Pap smear when necessary.
- Includes venipuncture.

- Includes pregnancy related counselling or advice to the patient

- Documenting full details of the history and physical on the standardized Nova Scotia prenatal record form

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03.03 RO=ANTL Routine Pre-Natal Visit

- No more than 12 limited (routine) prenatal visits may be claimed for one patient's pregnancy regardless of the number of physicians involved.
- All prenatal visits include pregnancy related counselling or advice to the patient or patient's representatives.
  - ❖ Includes a Pap smear when 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 pregnancy such as preeclampsia and other hypertensive disorders, diabetes, etc. include the diagnostic code for the complication on the service encounter.
  - ❖ *Reserve prenatal care billings for uncomplicated/routine visits in pregnancy and use a different office visit code for conditions unrelated to pregnancy

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81.8 Intrauterine Contraceptive Device Insertion

Complete Care Code:

Minor surgical procedures that include the visit the same day, and related visits by the same physician for the following 14 days.

- The standard removal of an IUD in office may only be claimed as a visit.
  - ❖ Only surgical IUD removals that require anesthesia can be claimed under the HSC 11.71.

Not to be used for Intradermal Progestin Contraceptive Device:
Insertion: 13.53A
Removal: 13.53C

03.03 RO=WBCR Well Baby Visit

- RO=WBCR - Well infant/childcare visits are payable as one per month during the first six months; one visit during each three-month period up to one year of age; and one visit at 18 months of age.

- It is recommended that the Rourke Baby Record be used to guide each visit and be documented in the health record. In order to provide optimal protection, age recommendations from the Nova Scotia Provincial Immunization Schedule must be followed.

- RO=WBCR CT=RKBR - The comprehensive well infant/child visit, the Rourke Baby Record (RBR) must be used to guide the visit, completed in full, reviewed and signed by the physician and documented in the health record. Age-appropriate preventative care and education to the parent(s)/caregiver according to the RBR must be delivered and documented in the RBR and recorded in the health record.
- 2 visits between 0 and <6 months, 1 between 6 months and <12 months, 1 visit between 12 months and <18 months, and 1 visit between 18 months and <24 months

- All other well infant/child visits to be claimed at the regular, applicable well baby care rate. Maximum of 9 WBCR total, 5 of which can be RKBR

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Nursing Home & Hospital Care

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Long Term Care Facilities

- LTC visits must be specifically requested by patient, family or nursing home staff
- Must be documented with a progress note
- Visits made at the convenience of the physician must be claimed using the 0800-1700 M-F rate
- If claiming other than the 0800-1700 M-F fee, document when you were called and why
- If the visit is requested in one time period and conducted in another, the lesser fee must be claimed
- Documentation for patients at LTC facilities is still the responsibility of the physician

03.03	Nursing Home Visit (0800 - 1700)	
	LO=NRHM (RF=REFD)	21.3+MU
	LO=NRHM, RO=DETE (RF=REFD)	21.3+MU
03.03	Nursing Home Visit (1701 - 2000)	
	LO=NRHM, TI=EVNT (RF=REFD)	28.3+MU
	LO=NRHM, TI=EVNT, US=UNOF, RO=DETE (RF=REFD)	28.3+MU
03.03	Nursing Home Visit (2001 - 2359)	
	LO=NRHM, TI=ETMD (RF=REFD)	28.3+MU
	LO=NRHM, TI=ETMD, US=UNOF, RO=DETE (RF=REFD)	28.3+MU
03.03	Nursing Home Visit (0000 - 0800)	
	LO=NRHM, TI=MDNT (RF=REFD)	38.3+MU
	LO=NRHM, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)	38.3+MU
03.03	Nursing Home Visit (0801 - 1200) Sat., Sun., Holidays	
	LO=NRHM, DA=RGE1, TI=AMNN, US=UNOF (RF=REFD)	28.3+MU
	LO=NRHM, DA=RGE1, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)	28.3+MU
03.03	Nursing Home Visit (1201 - 1700) Sat., Sun., Holidays	
	LO=NRHM, DA=RGE1, TI=NNEV, US=UNOF (RF=REFD)	28.3+MU
	LO=NRHM, DA=RGE1, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)	28.3+MU
03.03	Nursing Home - Emergency Visit	
	LO=NRHM, US=UIOH (RF=REFD)	35.2
	LO=NRHM, US=UIOH, RO=DETE (RF=REFD)	35.2+MU

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03.03 Prolonged Nursing Home Visit

- Billable when a nursing home visit becomes prolonged
- Eligible to be billed for all residents of a nursing home or RCF for whom the physician is delivering patient care
- The first 15 minutes is considered the base fee (1 multiple) (standard fees apply).
    - After that point, additional multiples are used to bill for each additional 15 minutes spent, up to a maximum of 4 multiples (60 mins total time)
    - 80% of the total time billed must be spent in direct physician to patient contact
- Start and stop times must be documented in both the health record and the text field of the claim (for services billed with multiples greater than 1)
- Prolonged visits are not eligible via virtual care

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https://msi.medavie.bluecross.ca/interim-fees/

ENH1 Medication Review

- Medication Review **(ENH1)**

  - ❖ For reviewing, completing, dating and signing pharmacy-generated Medication Administration Recording System (MARS) drug review sheet for the patient

  - ❖ May be claimed a maximum of 2 times per fiscal year per resident.

  - ❖ The completed MARS form must be readily available within the patient record (in the nursing home)

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03.03 RO=NHCR Nursing Home Chart Review

- Physicians may claim for a medical chart review with telephone call/email/fax advice provided for patients in licensed, provincially registered nursing homes and residential care facilities (RCF).
- Only advice provided to regulated health care professionals within the patient's circle of care at the nursing home or RCF is eligible.
- Not for discussions initiated by the patient, their SDM or family members, nor for discussions with the patient, their SDM or family members.
- May be claimed in groups of up to three interactions per day for the same patient at a total of 11.5 MSU. Additional groups of three services may be claimed at the same value.
- Physicians and nursing home staff involved are advised to keep a detailed record of telephone calls/email/fax advice requested and provided. Detailed record of the chart review and advice provided to be available upon request.

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NHTA1 Nursing home telephone patient assessment with regulated nursing professional

- This service is billable when a physician has a telephone conversation with a Regulated Nursing Professional to provide advice on a patient, with whom the physician (or physician group) has an established relationship, to determine a management decision.
- This is a virtual assessment using a Regulated Nursing Professional to assess the patient and who is authorized to speak on the patient's behalf.
- The limited assessment is conducted by a Regulated Nursing Professional who is in the same Nursing Home (LTC/RCF) location as the patient. No direct communication between physician and patient is required.

- Physicians may use a copy of the documentation from the Nurse to support this HSC claim, but it must be reviewed and 'signed off' by the physician prior to submitting the claim to MSI. The physician may add any needed clarifications or corrections to this documentation as an addendum.

- This code may not be billed if the call is to arrange an in-person Nursing Home visit or appointment, a prescription renewal, or for calls with other allied health care professionals
- Only billable once per patient per day.

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03.03D Case Management Conference Fee

- A time-based code that may be claimed for formal, scheduled, multi-disciplinary health team meetings
  - ❖ Meeting must be called by an employee of the NSH/IWK or a non-physician regulated health care professional within the patient's circle of care at a provincially registered nursing home, residential care facility or hospital to discuss the provision of health care to a specific patient
  - ❖ For ad hoc situations, e.g.: team conference regarding a patient in a nursing home with disruptive behaviour
  - ❖ Clinical record must include start and finish times and a list of all physician participants
  - ❖ Cannot be used for regularly scheduled rounds e.g., grand rounds, tumour rounds, teaching rounds, recurring regularly scheduled meetings, etc., or for family meetings

- Claims submission requires the start and stop time in the text as well as the clinical record. The appropriate number of multiples is required as well.
  - ❖ Minimum 15 minutes
  - ❖ 80% of a 15-minute time interval must be spent at the conference to bill that time interval

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03.03 Hospital Inpatient Visits

- 03.03 RP=SUBS DA=DA23 – A subsequent limited visit provided to patients admitted to hospital where the family doctor is the most responsible physician

- 03.03 RP=SUBS DA=DA47 – A subsequent limited visit provided to patients admitted to hospital where the family doctor is the most responsible physician

- After 7 days of admission (or if the physician is not the MRP) a regular limited visit may be claimed when the physician provides daily care to the patient. Includes reviewing lab work and discussions with the patient and/or family.
    - 03.03 RP=SUBS DA=DALY - Daily hospital visits up to 56 days
    - 03.03 RP=SUBS DA=WKLY - After 56 days admission, up to a maximum of 5 visits/week

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03.02A Discharge Fee

- Can be claimed when a patient is admitted for non-surgical hospitalization and is billable by the physician who performs the activities involved in discharging a hospital inpatient.
  - Activities include:
    - Completing the patient's chart and writing the discharge summary
    - Providing necessary prescriptions
    - Providing discharge instructions and arranging for follow-up care
  - Can be billed in addition to a hospital visit if one was provided on the same day

  In cases where surgery has occurred, the discharge fee is billable by a general practitioner (GENP), INMD, NEUR or PHMD only when the patient's care has been transferred to such specialty for follow-up care after surgery/fracture, and the physician performs the activities involved in discharging a hospital inpatient.

  - Solely signing the death certificate does not warrant billing the discharge fee or a visit.

US=UNOF, US=UIOH Urgent Fees

- An urgent visit is such that a physician must respond **immediately** with regard to the patient's condition.
  - ❖ Attendance due to personal choice or availability does not warrant billing an urgent visit

- The physician **must travel** from one location to another
  - ❖ This travel must be documented in the clinical record and in the text field of the claim
    - ❖ e.g.: Traveled from office to hospital, 5km

- Modifiers:
- **US=UNOF unscheduled** = urgent visit not interrupting normal office hours
- **US=UIOH unscheduled** = urgent visit interrupting normal office hours

RO=DETE Detention Time

- Medical detention occurs when a practitioner's time is given exclusively to one patient for active treatment and/or monitoring of that patient at the sacrifice of all other work.
- Detention time may only be claimed for emergency care and/or treatment provided outside of the office. **Detention time is not payable when provided in the office.**

- **Visits**: When detention is claimed with limited or comprehensive visit services, detention commences 30 minutes after the practitioner is first in attendance and may be claimed in 15-minute increments thereafter. The first 30 minutes is the appropriate visit fee.
- **Obstetrical Delivery**: When detention is claimed with an obstetric delivery provided by a general practitioner, detention time commences after 3 hours.
  - ❖ ADON 87.98A

- <u>Detention time does not apply to:</u>
  - ❖ Waiting time
  - ❖ Counselling or psychotherapy
  - ❖ Advice given to the patient or their representatives
  - ❖ Return trip if the physician is not in attendance
  - ❖ Completing/reviewing charts
  - ❖ More than one patient at a time
  - ❖ Office visits

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Questions



NOVA SCOTIA MEDICAL SERVICES INSURANCE

Physician Agreement Incentive Programs

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CDM1 Chronic Disease Management

- The Chronic Disease Management Incentive is intended to recognize the additional work of General Practitioners, beyond office visits, of providing guidelines-based care to patients with chronic diseases.

- The base incentive fee may be claimed once per fiscal year (April 1 to March 31) for each patient managed for one *qualifying* chronic disease condition.

The qualifying chronic diseases eligible for the CDM incentive payment are:

- Type 1 and Type 2 Diabetes
- Ischaemic Heart Disease (IHD)
- Chronic Obstructive Pulmonary Disease (COPD)

- An additional incentive amount per patient may be claimed once per fiscal year as part of the fee if the patient has additional qualifying chronic disease(s) for each qualifying disease. (use modifiers to identify 2nd and 3rd qualifying disease)
  - CDM1 RP=CON2 CDM1 RP=CON3

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CDM1 Chronic Disease Management (continued)

In order to claim the CDM1:

- the patient must be seen by the family physician in relation to their chronic disease(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 chronic disease(s) in the previous 12 months; and,

- the CDM indicators required for the CDM incentive payment have been addressed at the required frequency and documented in the clinical record or optional CDM flow sheet at or before the time of billing.

- indicators/risk factors are required to be addressed as part of the annual cycle of care for diabetes and/or IHD. The required indicators include all relevant common indicators plus the specific indicators for each disease.

  Indicators can be found in Physicians Manual 5.1.199

*The CDM1 **must** be submitted on or before March 31st of that fiscal year.

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CGA1 Clinical Geriatric Assessment

- LTC Clinical Geriatric Assessment **(CGA1)** is a form that should be kept near the front of every nursing home chart and will serve as the lead clinical document that will travel with the patient when a transfer occurs. The CGA is normally completed through a collaborative team process involving the family physician and other licensed long-term care healthcare providers.

- The physician is directly responsible for completing the diagnostic section, medication section, and provides the final overall opinion of the frailty level of the resident.

- The CGA requires one direct service encounter with the resident by the physician on the date of the final completion and signing of the CGA form. **This service encounter is included in the CGA fee.** The CGA evaluation process may involve additional service encounters (visits) which would be paid separately from the CGA per the Preamble requirements. The dates of all physician service encounters associated with the completion of the CGA must be tracked on the CGA form.

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Preamble 5.1.168

Common Billing Errors

- No/lack of documentation (other than recording diagnosis)
  - ❖ Documentation does not provide specifics of the visit/discussion/management plan etc.
  - ❖ Documentation missing sign-off or sign-off completed by a person other than the physician
- Lack of start and finish times for timed-based services
- Billing for prescriptions without an assessment of the patient (excl. TPR1)
- Billing for the work of other practitioners
- Billing a visit when only a procedure or injection was carried out
- Billing for uninsured services:
  - ❖ Third party requests, uninsured warts, services of other providers, alternative therapies.

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Take Home Messages

- Know the Preamble
- Read the Bulletins
- Ask questions if in doubt or unsure of appropriate billing
- Know what your billing clerk is submitting for each service
- Review your adjudication responses regularly
- Documentation, documentation, documentation
- Physicians are responsible for their billing

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Physician Agreement Incentive Programs

- CME (continuing medical education)
- EMR A
- EMR B & EMR C (rolled into LFM)
- GP Surgical Assist Incentive
- Collaborative Practice Incentive Program (CPIP) (rolled into LFM)
- CMPA Rebate
- Annual Preceptor Stipend
- Physician Retirement Fund

Physician Agreement | Doctors Nova Scotia (doctorsns.com)

Email: physicianagreement@novascotia.ca
retirement.fund@novascotia.ca CMPA@medavie.ca

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Contacts

- Medical Services Insurance (MSI)

Should you have any questions or uncertainty regarding billings, please contact MSI and seek clarification.

  - 902-496-7011
  - Toll-free: 1-866-553-0585
  - Fax: 902-490-2275
  - msi_assessment@medavie.bluecross.ca

- Department of Health and Wellness (DHW)
  - 902-424-5818
  - physicianagreement@novascotia.ca

- College of Physicians and Surgeons NS (CPSNS)
  - 902-422-5823
  - Info@cpsns.ns.ca

- Doctors Nova Scotia (DNS)
  - General Inquiries

    Tel: 902-468-1866
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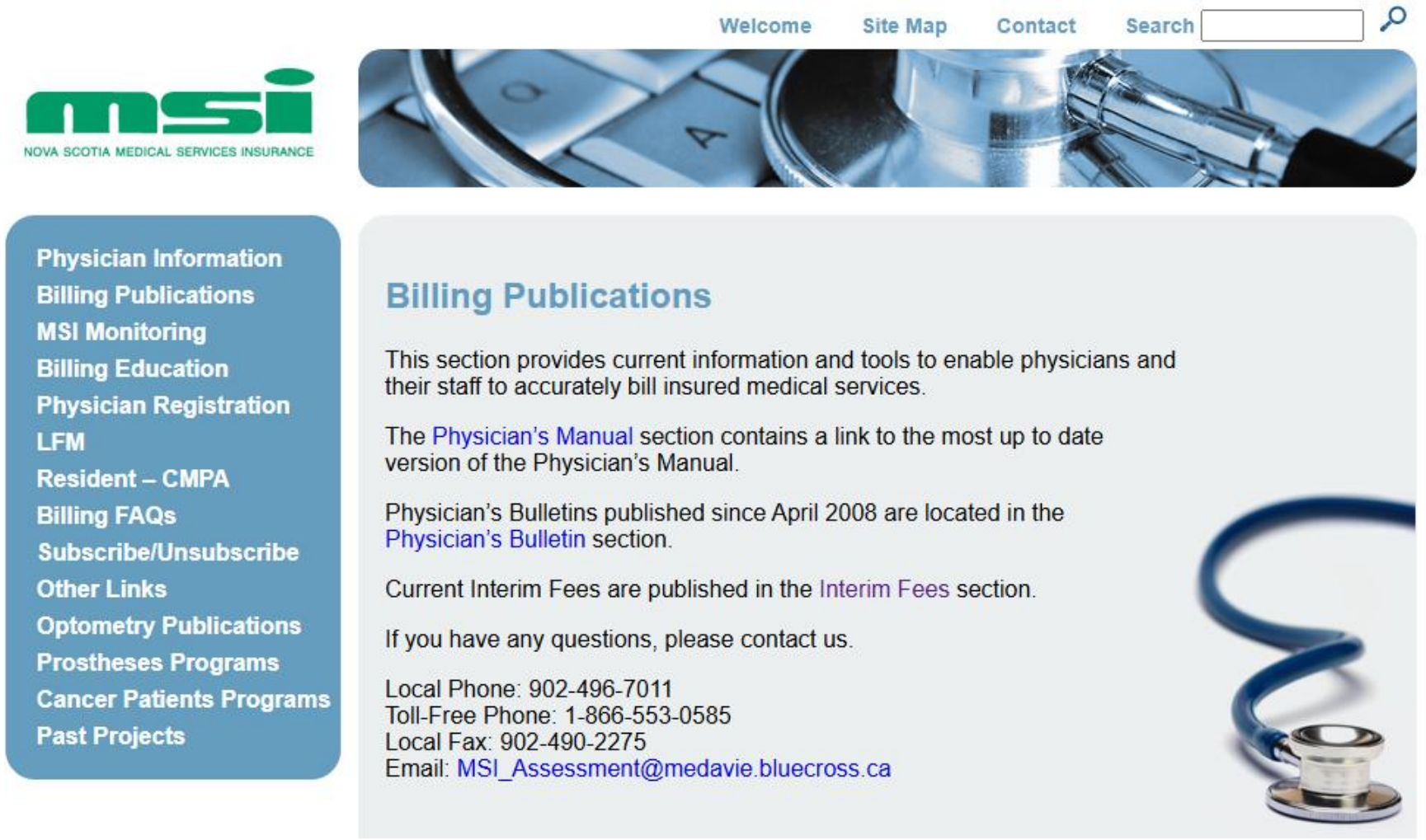
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Questions



MSI Website

https://msi.medavie.bluecross.ca/



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