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

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

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

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

In partnership with

NOVA SCOTIA

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MSI News

MSI Online Services Now Available to Nova Scotia Residents

Nova Scotia has launched **MSI Online**, a new web-based portal designed to make it easier for residents to manage their information with MSI.
Residents can now conveniently update their information, renew their health card, register for programs, and submit inquiries and forms electronically.

MSI Online is available to eligible residents aged 19 and older who hold a Nova Scotia health card. The service can be accessed through any internet-enabled device using a standard web browser (such as Safari, Chrome, or Microsoft Edge), or through the **YourHealthNS** mobile app.

Through MSI Online, users can:

- Register an email address to receive convenient electronic notifications, including health card renewal reminders
- Request a replacement Nova Scotia health card
- Update address and contact information
- Register for or renew coverage under the Nova Scotia Seniors' Pharmacare Program
- Update organ and tissue donation preferences
- Opt in to participate in medical research opportunities
- Submit inquiries and forms electronically for processing
- Contact MSI directly

Physician offices are encouraged to inform residents of this option, particularly when individuals present with an expired Health Card. Residents are encouraged to take advantage of this new service and may benefit from easier access to MSI services.

HPV VACCINE (13.59L RO=HPV9)

Effective June 15, 2026, eligibility has been expanded to include individuals less than 21 years of age who have missed or refused the HPV vaccine as part of the school-based program.
Nova Scotia Vaccine and Immunoglobulin Eligibility Policy

ADCP1 – Advance Care Planning Discussion Billing

As announced in the June 26, 2026 Physician's Bulletin, Interim Health Service Code (HSC) ADCP1 was inadvertently terminated effective May 31, 2026. This is now resolved and any rejected or held claims back to May 31 can now be submitted.

CFP1 – monthly meeting update

As outlined in the billing guidelines for the monthly CFP1 fee, the Health Service Code (HSC) is claimable only for months in which the family physician actively participates in at least one structured team meeting per month.

As a reminder, these meetings must be patient-centred and focused on collaborative care planning and the delivery of optimal patient care. Meetings held to discuss operational, facility, or staffing matters do not meet the requirements for CFP1 billing.

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.

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.

While revisions to the HSC billing process are planned for a future update, in the interim, please include a note in the CFP1 claim indicating that no monthly meeting occurred during that month and ensure that supporting documentation is maintained to support the unplanned absence from the meeting.

NEW INTERIM FEES

Effective July 17, 2026 the following health service code is available for billing:

Category	Code	Description	Base Units
CONS	03.08B	**Focused Assessment – Family Physician** RF=REFD **Description** A Focused Assessment is a face to face, in-person visit rendered to a patient by a family physician: a) who has submitted a signed ME=CARE declaration to Medavie, is approved, and is providing care to a patient who is not on their patient panel OR b) is providing women's sexual and reproductive health services, including peri-menopause care, who is qualified to furnish advice or a service because of additional training or expertise in an area of medicine recognized by their peers, but who does not hold a CAC and therefore may not claim a consultation (HSC 03.08).	17 MSU +MU

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Category	Code	Description	Base Units

Documentation of the physical examination must describe the pertinent positive and negative findings of the physical examination. It is not adequate to indicate 'physical exam is normal' without indicating what has been examined

The assessment of the patient must include: a history and physical examination appropriate for the presenting problem, and a review of relevant diagnostic imaging and/or laboratory results.

This service requires a written or documented verbal referral from a referring provider with an MSI number and a brief written report that includes the findings, opinion and recommendations to the referring provider for future ongoing care.

May be claimed up to four times per patient per physician per new medical condition per year. If the patient is seen again by the same physician for the same medical condition more than four times in one year, only a limited office visit may be claimed.

Billing Guidelines

- If only one MU (base rate) is claimed, start and stop times are not required.
- 80% of the total time must be spent in-person, face to face, with both the physician and patient present. There must be a minimum of 24 minutes of direct contact with the patient to claim the second multiple.
- When claiming an additional MU, start and stop times that captures the time spent with the patient must be recorded in the patient's health record and in text field of the claim.
- A Focused Assessment may be claimed to a maximum total of 60 minutes per patient per day.
- May be claimed up to four times per patient per physician per new medical condition per year.
- Physicians must have submitted a ME=CARE declaration letter before billing a Focused Assessment service
  OR
- Use the modifier RO=WSRH to indicate that this is for women's reproductive and sexual health services, including peri-menopause care
- Not available for Virtual Care.

Premium Eligible:
TI=GPEW

Specialty Restriction:
SP=GENP with ME=CARE
OR
SP=GENP with RO=WSRH

Location:
LO=OFFC

Multiples:

Multiple	MSU	Total Time (Min)	Minimum Direct Patient Contact (Min)
1	17	15	N/A
2	17 + 13	30	24
3	17 + 13 + 13	45	36
4	17 + 13 + 13 + 13	60	48

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FEE UPDATES

Effective July 17, 2026 the following health service code has been updated:

Category	Code	Description	
CONS	03.08	**Family Physician Consultation** **Description** A comprehensive consultation may only be claimed by family physicians (GENP) who hold and maintain a Certificate of Added Competence (CAC) awarded by the College of Family Physicians of Canada (CFPC) and only in the area of the CAC in which they hold. All Preamble rules pertaining to consultations and comprehensive visits must be followed. Prolonged consultations are paid in 15-minute time blocks or portion thereof, 80% of the total time must be in direct physician to patient contact. Prolonged consultations are not to be confused with active treatment associated with detention. **Billing Guidelines** • When claiming an additional MU, start and stop times that captures the time spent with the patient must be documented in the health record and on the text field of the claim. • 80% of the total time must be spent in-person, face to face, with both the physician and patient present. There must be a minimum of 24 minutes of direct contact with the patient to claim an additional multiple. • Each consultation can be billed up to a maximum of 60 minutes (60MSU) per day. This would include a base fee plus up to 2 additional multiples of 15 minutes each. • Multiples/prolonged not applicable for virtual care, except when the service is performed via the provincial telehealth network using ME=TELE (see July 2016 bulletin). • New providers must submit evidence of their CAC to DNS to be added to the list of providers who may claim 03.08. **Multiples** 15 MSU per 15 minutes to a maximum of 2 multiples (60 minutes) per day **Specialty Restriction:** SP=GENP with Certificate of Added Competence (CAC) (Addiction Medicine, Care of the Elderly, Emergency Medicine, Enhanced Surgical Skills, Family Practice Anesthesia, Obstetric Surgical Skills, Palliative Care, Sports and Exercise Medicine) **Location:** LO=OFFC **Multiples:**	30 MSU +MU

Multiple	MSU	Total Time (Min)	Minimum Direct Patient Contact (Min)
1 (no additional multiples)	30	< 30	N/A
2	30 + 15	45	36
3	30 +15 + 15	60	48

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It is important to be aware that if you work at a comprehensive family practice (ME=CARE eligible), a new fee code has been established to allow referred patients who are not a part of your practice panel to be billed at the enhanced rate for the first 15 minutes with an option for prolonged visits for more complex cases. Patients referred to ME=CARE physicians for focused assessments should use the Focused Assessment code. The ME=CARE prolonged 03.03 code should be used for services to those patients as indicated on the ME=CARE declaration.

Effective **July 17, 2026** the following health service code has been updated:

Category	Code	Description	
CONS	03.09K 03.09L	**Consultant Physician - providing synchronous advice** **Referring Provider - requesting advice**	25 MSU + MU 13 MSU + MU

Description

This health service code may be billed for synchronous verbal communication between the consultant physician and the referring provider regarding the assessment and management of the patient but without the consultant physician examining the patient.

It must be in real-time and includes face to face conversations, telephone calls, or secure video calls using a Nova Scotia Health approved platform.

The referring provider, after evaluation of the patient, shall formally request an opinion from a physician qualified to furnish advice.

The referring health care provider may be a family physician, specialist, nurse practitioner, midwife, optometrist, dentist, or other MSI referring provider seeking an expert opinion from the consulting physician due to the complexity and severity of the case.

The consultant physician may be a specialist registered with the College of Physicians and Surgeons in Nova Scotia, a family physician who has a certificate of added competence or a family physician authorized to use HSC 03.08 Consultation GENP.

The referring provider service includes the following elements:

- A formal request for an opinion is communicated to the consultant.
- A review of the patient's relevant history, relevant family history and relevant history of present complaint, any laboratory data, PACS images, medical records or other data and a review of the relevant physical findings are communicated to the consultant.

The consultant physician service includes the following elements:

- Providing an opinion and advice to the referring provider.
- A written report outlining the advice to the referring provider regarding medical management of the patient.

Documentation Requirements

Both the consultant physician and the referring health care provider shall document in their respective charts or EMRs:

1. The patient demographic information
2. The date of service and the start and stop times if multiples (MU) are billed

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3. The clinical concern outlined by the referring provider including the relevant history, physical findings, medications, laboratory and diagnostic imaging results
4. The advice provided by the consultant
5. The name and/or provider number of the colleague providing or receiving advice

Billing Guidelines
The service is not billable when the purpose of the communication is to co-ordinate clerical or administrative aspects of a patient's care including but not limited to: arranging transfer, a hospital bed, a consultation, laboratory or diagnostic tests, etc. or relaying the results of investigations.

This service is not billable for synchronous conversations of less than 5 minutes of two-way medical discussion.

The service is billable only when the communication is rendered personally by the physician providing the service and it is not billable if the service is delegated to another health professional such as:

- Nurse practitioner (may be in the role of referring health care provider only)
- Resident in training
- Clinical fellow
- Medical student

The referring health care provider's billing number must be noted on the MSI claim from the consultant. This is not required for the referring health care physician's claim unless multiples are being claimed.

The consultant physician:

- The consultant physician's code is not payable in addition to any other service for the same patient on the same day.
- It is not payable if the patient is seen for an in-person consultation for the same issue within the subsequent 7 days after the scheduled discussion date.

The referring provider:

- The referring health care provider may bill their code when the communication with the consultant occurs on the same day as a patient visit or other service.

Multiples
Multiples are available for prolonged synchronous advice with select consultants only:

- General Internal Medicine,
- Neurology,
- Physical Medicine
- Paediatrics
- Obstetrics and Gynecology
- Psychiatry
- Palliative Medicine
- Endocrinology
- Geriatric Medicine
- Infectious Disease
- Respirology

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Category	Code	Description

- Rheumatology
- Family Medicine with CAC or authorization to use HSC 03.08 Consultation GENP.

03.09K

Multiple	MSU	Total Time (Min)	Minimum Direct two way Medical Discussion (Min)
1	25	< 30	<24
2	25 + 17.5	45	36

03.09L

Multiple	MSU	Total Time (Min)	Minimum Direct two way Medical Discussion (Min)
1	13	< 30	24
2	13 + 13	45	36

All referring providers must include the consultant's billing number on their claim when claiming multiples.

If the discussion exceeds 30 minutes, an additional multiple may be claimed to a maximum total time of 45 minutes, 80% of the time must be spent in two-way medical discussion. Where MU are claimed, start/stop times must be recorded in the patient's health record and in the text of the claim.

03.09K 17.5 MSU per 15 mins
03.09L 13 MSU per 15 mins

Specialty Restriction:
No restriction without multiples

For Consultant multiples only:
SP=IMND, SP=NEUR, SP=PHMD, SP=PEDI, SP=OBGY, SP=PSYC, SP=ENME, SP=GEMD, SP=INDI, SP=RSMD, SP=RHEU, SP=GENP with CAC or authorization to use HSC 03.08 Consultation.

For referring providers:
Multiples are only paid when the referral is to one of the above consultants

C1001 – COMMUNITY ON CALL FOR CEC PHYSICIANS

Physicians are advised that **Eastern Memorial** has been added to the current facilities eligible for C1001 • Annapolis Community Health Centre • South Cumberland Community Centre • All Saint's Hospital • North Cumberland Memorial • Twin Oaks Memorial • Musquodoboit Valley Memorial • Baddeck: Victoria County Memorial • Cheticamp: Sacred Heart Community Health Centre • Guysborough: Guysborough Memorial • Neils Harbour: Buchanan Memorial • Tatamagouche: Lillian Fraser Memorial • Eastern Shore Memorial • Eastern Memorial.

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PREAMBLE UPDATES

Please see new preamble effective July 17, 2026

New Definition
Family Physician (GENP) Comprehensive Consultation (03.08): When a patient is referred to a family physician (GENP), a comprehensive consultation may only be claimed by family physicians (GENP) who hold and maintain a Certificate of Added Competence (CAC) awarded by the College of Family Physicians of Canada (CFPC) and only in the area of the CAC in which they hold. All Preamble rules pertaining to consultations and comprehensive visits must be followed. (5.1.225)

Effective July 17, 2026 preamble 5.1.266 has been updated:

Current Definition	New Definition
Urine Drug Screen Tray Fee (UDS1) (5.1.266) When the physician has incurred the cost of supplies when performing a UDS, a tray fee can be claimed. The tray fee may not be claimed if the UDS kits have been provided free of charge. (5.1.267) The HSC UDS1 is an add on for 03.03J, 03.03K, 03.03L, OAT1 and OAT2. (5.1.268) Maximum of 1 UDS tray fee per patient for health service codes 03.03J, 03.03K and 03.03L. (5.1.269) Maximum of 4 UDS tray fees per patient per 30 days for health service codes OAT1 and OAT2. Special permission is required if greater than 4 tests have been provided to a patient in 30 days. (5.1.270)	**Urine Drug Screen Tray Fee (UDS1) (5.1.266)** When the physician has incurred the cost of supplies when performing a UDS, a tray fee can be claimed. The tray fee may not be claimed if the UDS kits have been provided free of charge. (5.1.267) The HSC UDS1 is an add on for 03.03J, 03.03K, 03.03L, OAT1, OAT2 **and 03.08 (SP=GENP).** (5.1.268) Maximum of 1 UDS tray fee per patient for health service codes 03.03J, 03.03K and 03.03L. (5.1.269) Maximum of 4 UDS tray fees per patient per 30 days for health service codes OAT1 and OAT2. Special permission is required if greater than 4 tests have been provided to a patient in 30 days. (5.1.270)

Effective July 17, 2026, the eligible time for GP Enhanced Hours Modifier (5.1.188) has been updated:

Current Definition

5.1.230
TI=GPEW

Time Period	Time
Monday to Friday	6:00am-8:00am
Monday to Friday	5:00pm-10:00pm
Saturday and Sunday	9:00am-10:00pm
Recognized Holidays	9:00am-10:00pm

New Definition

5.1.230
TI=GPEW

Time Period	Time
Monday to Friday	6:00am-8:00am
Monday to Friday	5:00pm-10:00pm
Saturday and Sunday	**6:00am**-10:00pm
Recognized Holidays	**6:00am**-10:00pm

Effective July 17, 2026 the following Preamble has been updated:

Current Definition	New Definition
Comprehensive Evaluation of Suspected Autism Spectrum Disorder (HSC 03.04J) *(5.2.160)* This is a comprehensive health service code for the developmental paediatrician who is present for all components of the diagnostic evaluation and assessment of patients referred with suspected autism disorder performed by a multidisciplinary team at the IWK Health Centre. This service is expected to encompass at least three hours of time with the patient and care providers plus one hour for scoring of assessment tools. This HSC may be reported	Comprehensive Evaluation of Suspected Autism Spectrum Disorder (HSC 03.04J) *(5.2.160)* This is a comprehensive health service code for the developmental paediatrician who is present for all components of the diagnostic evaluation and assessment of patients referred with suspected autism disorder performed by a multidisciplinary team at the IWK Health Centre. This service is expected to encompass at least three hours of time with the patient and care providers plus one hour for scoring of assessment tools. This HSC may be reported only when

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Current Definition	New Definition
only when the physician's time has been dedicated to this service encounter and no other concurrent clinical work. Time to generate a report and recommendations is considered to be included in the service. Start and stop times must be recorded in the health record. Reportable no more than once per patient per 12-month period. Restricted to IWK and Developmental Paediatrics trained in the administration of the Autism Diagnostic Interview. *(5.2.161)*	the physician's time has been dedicated to this service encounter and no other concurrent clinical work**. If two visits are planned to complete the required elements, only the final visit may be reported as the health service code 03.04J. The first visit is included with the final 03.04J billing.** **If the service occurs over 2 visits, at least one of the visits must be in-person and the visit must occur within 2 weeks of the first. The medical record must clearly indicate when the visit is virtual. If exceptional circumstances that are beyond the physician's control occur, documentation must clearly indicate the reason for the second visit being delayed.** Time to generate a report and recommendations is included in the service**. Physicians must ensure all elements and dates of the 03.04J are documented in a single form, which should be within the patient's chart on the final service date of the 03.04J billing.** Start and stop times must be recorded in the health record. Reportable no more than once per patient per 12-month period. Restricted to IWK and Developmental Paediatrics trained in the administration of the Autism Diagnostic Interview. *(5.2.161)*

Billing Matters Billing Reminders, Updates, New Explanatory Codes

FAMILY PHYSICIAN ENHANCED OFFICE VISIT FEES (ME=CARE)

On April 7, 2026, the Department of Health and Wellness (DHW) initiated a review of eligibility for enhanced office visit fees applicable to family physicians responsible for delivering comprehensive and continuous patient care. These enhanced fees are intended to distinguish longitudinal, full-scope care from episodic care typically provided in walk-in settings.

Eligibility for enhanced fees is restricted to family physicians who formally declare to providing comprehensive and continuous care.

Eligibility Requirements and Declaration

To maintain or obtain eligibility, physicians were required to submit a signed declaration confirming that they meet all of the following criteria:

- The physician is licensed to practice as a Family Physician in the Province of Nova Scotia.
- The physician delivers comprehensive, full-scope family medicine services to a defined panel of attached patients, including:
  - Maintaining a patient panel whose members recognize the physician as their primary "family doctor" and routinely schedule appointments accordingly;
  - Establishing and sustaining an ongoing therapeutic relationship as the primary care provider;
  - Ensuring continuity of care for patients across time and clinical needs.
- The physician maintains a complete and current primary healthcare record (medical chart) for each attached patient within the clinic where the patient is rostered.

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- Where appropriate, the physician ensures access to qualified colleagues within their practice to support continuity of care during periods of absence.

All physicians intending to bill, or currently billing, enhanced office visit fees (ME=CARE) were required to submit an updated ME=CARE declaration to remain eligible.

Review Outcome and Billing Guidance
The eligibility review was completed, and physician records were updated effective July 20, 2026.
Physicians practicing across multiple clinics and/or payment models are reminded that ME=CARE fees may only be billed within clinical settings where the above eligibility criteria are fully satisfied.
Physicians who believe their eligibility for enhanced office visit fees (ME=CARE) has been incorrectly revoked may submit a new declaration using the form available at the following link:

Declaration Form:
https://www.novascotia.ca/family-physician-mecare-declaration

Exception: Longitudinal Family Medicine (LFM) Physicians
Physicians practicing under a Longitudinal Family Medicine (LFM) contract or LFM-aligned contract, including Dalhousie Family Medicine (DFM) physicians, are exempt from submitting a ME=CARE declaration. This exemption is based on the contractual requirement inherent to the LFM funding model, which already obligates the provision of comprehensive and continuous care to an attached patient panel.

FEE FOR SERVICE ROSTERING GRANT

Physicians are advised that the Fee for Service Rostering Grant has been issued. Please reach out to PhysicianAgreement@novascotia.ca if you have questions related to the grant.

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.

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NEW AND UPDATED EXPLANATORY CODES

Code	Description
AD107	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS IS AN ADD ON FEE THAT MAY ONLY BE CLAIMED WITH 03.08 SP=GENP, 03.08B OR HSCS ASSOCIATED WITH OAT PROVISION
GN151	SERVICE ENCOUNTER HAS BEEN REFUSED. THIS HSC MAY ONLY BE CLAIMED BY FAMILY PHYSICIANS (GENP) WHO HOLD AND MAINTAIN A CERTIFICATE OF ADDED COMPETENCE (CAC) AWARDED BY THE COLLEGE OF FAMILY PHYSICIANS OF CANADA (CFPC)
GN152	SERVICE ENCOUNTER HAS BEEN REFUSED. THIS HSC HAS ALREADY BEEN CLAIMED 4 TIMES IN THE PREVIOUS 12 MONTHS FOR THIS DIAGNOSIS. PLEASE DELETE AND SUBMIT A LIMITED OFFICE VISIT INSTEAD.
GN153	SERVICE ENCOUNTER HAS BEEN DISALLOWED. PLEASE RESUBMIT WITH TEXT INDICATING THE CONSULTANT PROVIDER NUMBER
GN154	SERVICE ENCOUNTER HAS BEEN REFUSED. 03.09K MAY NOT BE CLAIMED WITH ANY OTHER SERVICE ON THE SAME DAY
GN155	SERVICE ENCOUNTER HAS BEEN REFUSED. 03.09K HAS ALREADY CLAIMED ON THIS DATE FOR THIS PATIENT. NO OTHER SERVICE MAY BE CLAIMED ON THIS DATE FOR THIS PATIENT.
GN156	SERVICE ENCOUNTER HAS BEEN REFUSED. YOUR SPECIALTY IS NOT ELIGIBLE TO CLAIM THIS HSC WITH MULTIPLES
GN157	SERVICE ENCOUNTER HAS BEEN REFUSED BECAUSE 03.09K HAS BEEN CLAIMED FOR THIS PATIENT IN THE PREVIOUS 7 DAYS
GN158	SERVICE ENCOUNTER HAS BEEN REFUSED. SERVICE PROVIDER MUST HAVE SUBMITTED A SIGNED ME=CARE DECLARATION LETTER OR BE PROVIDING WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH SERVICES TO CLAIM THIS HSC
VT183	SERVICE ENCOUNTER HAS BEEN REFUSED. THIS CODE MAY ONLY BE CLAIMED BY PAEDIATRICIANS TRAINED IN THE ADMINISTRATION OF THE AUTISM DIAGNOSTIC INTERVIEW AND APPROVED BY PPAS.
VT184	SERVICE ENCOUNTER HAS BEEN REFUSED. A COMPREHENSIVE CONSULT (03.08) MUST HAVE PREVIOUSLY BEEN BILLED FOR THE SAME PATIENT WITHIN THE PREVIOUS 12 MONTHS TO CLAIM THIS CODE
VT185	SERVICE ENCOUNTER HAS BEEN REFUSED. 03.04L HAS ALREADY BEEN CLAIMED FOR THIS PATIENT

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

UPDATED FILES

Updated files reflecting changes are available for download on July 17, 2026. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), Modifiers (MODVALS.DAT) and Explanatory Codes (EXPLAIN.DAT)

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

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

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

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PHYSICIAN'S BULLETIN
May 22, 2026: Vol. LXXI, ISSUE 5

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Billing Matters Billing Reminders, Updates, New Explanatory Codes

CFP1 – Collaborative Family Practice Monthly Fee

LFM physicians are advised the CFP1 health service code can be submitted to their 100% FFS Business Arrangement for full payment.

Outdated Claims

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

Examples of extenuating circumstances may include physical damage to office such as fire or flood and/or a serious technical issue etc.
Circumstances relating to staffing issues/shortages and mislaid, misfiled, or lost claims cannot be accepted by MSI as valid explanations for a late submission.

Please note: Failure to use a preauthorization code given by MSI and annotate the text field with the previous service encounter number will result in an adjudication paid at "zero".

Claims submitted within 90 days from the date of service that were originally refused or incorrect must be resubmitted to MSI within 185 days of the date of service. Each resubmission must contain an annotation in the text field of the service encounter submission referencing the previous service encounter number, and a preauthorization number obtained from MSI.

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

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday May 22, 2026. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT) and (FACILITY.DAT)

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

Phone: 902-424-5818
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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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PHYSICIAN'S BULLETIN
April 27, 2026: Vol. LXXI, ISSUE 4

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NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

OPOR – INCOME STABILIZATION GRANT AND LOAN PROGRAMS

Central Zone Only

The Department of Health and Wellness (DHW) will be launching an income stabilization program for fee-for-service physicians affected by the One Patient One Record (OPOR) planned service slowdown.

The slowdown aims to create capacity for physicians and staff to care for patients at the same time as they adjust to the new system. DHW, the NSH and DNS recognize that this will result in income loss for some fee-for-service physicians and this program is designed to minimize those impacts.

The income stabilization program is voluntary and has two components: a grant program and a loan program.

GRANT PROGRAM https://forms.cloud.novascotia.ca/opor-income-stabilization-grant-program
The first component is a grant program, which will launch on April 27 and aims to help stabilize physician remuneration during the approved clinical slowdown. Physicians may voluntarily apply in advance of or during the slowdown.

- Physicians will be paid at a half-day or full-day (four or eight hours, respectfully) calculated as the average daily fee-for-service (FFS) billings for their specialty, based on 2024-25 earnings with MOU adjustments applied.
- Physicians can withdraw from the grant program at any time but will not be able to return to the grant program after withdrawing.
- All grants will cease on June 7, 2026, however, if service volumes have not returned to baseline for reasons directly attributable to OPOR, NSH can request a grant extension by service area.

The program includes both a proactive and a reactive element:

- **PROACTIVE:** This is available only for physicians in NSH-designated slowdown areas. You will be able to proactively apply for income stabilization for the number of days of service delivery affected, using a webform application process to be launched soon for physicians working in designated slowdown areas in CZ.
- **REACTIVE:** Physicians working outside NSH-designated slowdown areas who experience an unanticipated clinical slowdown as a result of OPOR implementation may also apply using the webform application. This will be available after OPOR rollout (not in advance). DHW will consult with NSH for an understanding of the OPOR impact and timelines for rectification.

LOAN PROGRAM https://forms.cloud.novascotia.ca/opor-income-stabilization-loan-program

The second component is a loan program, which will begin processing applications on May 11, 2026. Unlike the grant program which is designed to respond to volume reductions during the slowdown period, the loan program is focused on billing delays attributable to OPOR reporting. The loan program will provide a prepayment for clinical services delivered after the OPOR go-live but that could not be billed due to the OPOR implementation (e.g., unavailable reports, delayed documentation access).

- Physicians will identify the number of days affected and will be paid a daily stipend of $1,714.58.
- This rate may be more or less per day than the physician normally earns but will effectively provide a pay advance on future FFS earnings.
- The total amount requested ($1,714.58 x number of days per week x number of weeks) will be "smoothed" over the number of weeks requested, based on current pay periods.
- Once billings are submitted, FFS earnings will be reduced by 10% until the loan is paid in full within the fiscal year. (The percentage may be adjusted to ensure repayment within the current fiscal year.)

FAQ: https://doctorsns.com/sites/default/files/2026-04-24-OPOR-IS-FAQ.pdf

For questions, please reach out to psaccountability@novascotia.ca

PHYSICIAN'S BULLETIN
April 7, 2026: Vol. LXXI, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

ME=CARE RENEWAL

FAMILY PHYSICIAN ENHANCED OFFICE VISIT FEES: ME=CARE

On March 19th, 2018, DHW announced an enhanced fee for both office and geriatric visits for family physicians who are responsible for the comprehensive and continuous care of their patients. The enhanced fees are meant to differentiate this level of care from episodic care provided to walk-in patients. The enhanced fees are only available to family physicians who attest that they are providing comprehensive and continuous care.

We are undertaking a ME=CARE renewal and a new, signed declaration is required if you:

- Are a Family Physician licensed to practice in Nova Scotia;
- Provide full-scope family medicine to a panel of attached patients:
  - Have a panel of patients who would describe you as their "family doctor" and schedule appointments to see you.
  - Have an ongoing relationship as a primary care provider to your patients and ensure continuity in their medical care.
  - Maintain a primary health care record (chart) for each of your patients in the clinic to which the patient is attached.
- When appropriate, provide access to colleagues in your practice who may share the responsibility for providing care to your patients in your absence.

All family physicians who intend to use, or have been using, the enhanced fees are required to submit a new ME=CARE declaration in order to continue to be eligible to bill these enhanced fees.

Longitudinal Family Medicine (LFM) physicians:
If you are practising under a Longitudinal Family Medicine (LFM) contract, you do not need to complete a ME=CARE form as this funding model contractually obligates you to provide comprehensive and continuous care to a panel of patients.

Link to Declaration: https://www.novascotia.ca/family-physician-mecare-declaration

For questions regarding the declaration, please contact: physicianagreement@novascotia.ca

PHYSICIAN'S BULLETIN

March 30, 2026: Vol. LXXI, ISSUE 2

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT
Effective April 1, 2026, the Medical Service Unit (MSU) value will increase from $2.90 to $2.96

ANAESTHESIA UNIT
Effective April 1, 2026, the Anesthesia Unit (AU) will increase from $27.38 to $27.93

Sessional hourly rates, Longitudinal Family Medicine (LFM) hourly and panel rates, Intensive Care Unit (ICU) minimum income daily guarantees, General Internal Medicine (GIM) minimum income daily guarantees, Emergency Department (ED) hourly rates, Psychiatry hourly rates, Collaborative Emergency Centre (CEC) rates, Community Hospital Inpatient Program (CHIP) rates, Regional Hospitalist daily stipend rates, Primary Maternity Care Program hourly rates, Pathology List B payments, and Alternative Payment Plan (APP) annual rates will increase by 2% effective April 1, 2026.

NEW INTERIM FEE

Effective April 1, 2026, the CPIP has transitioned from the yearly incentive payment to a monthly health service code for work required to create and maintain a Collaborative Family Practice.

The previous CPIP annual incentive remunerated physicians for collaborative work. The payment was made in the fiscal year based on previous calendar year billing threshold eligibility. The new Collaborative Family Practice (CFP) fee code will remunerate eligible physicians for collaborative work on a monthly basis.

Eligible physicians will still need to complete a final annual application process in order to receive the incentive payment owed to them for the 2025/26 year. This final lump sum payment will be issued in Fall 2026. It is expected this application process will launch in mid-April. More information to follow, via notification from DNS and Physician's Bulletins.

Prior to submitting CFP claims, the family physicians in the collaborative practice must complete the verification declaration form. Please reach out to DNS if you require access to this declaration. Should the physician leave the CP, notice must be given to MSI.

The new Health Service Code is available effective April 1, 2026 for monthly billing:

Category	Code	Description	Base Units
PRVR	CFP1	**Collaborative Family Practice Work with Interdisciplinary Team of Health Care Professionals – Monthly Fee** **Description:** This HSC will be claimable for the month in which the family physician participates face-to-face (in-person) or virtually with other Regulated Health Care Provider (RHP) team members to provide services in support of the Collaborative Family Practice (CP) as outlined below: ○ Active participation in structured team meetings at least once per month, ○ Discussions with other regulated health care providers working in the collaborative practice regarding patient care that are not otherwise billable, ○ Family physicians must have an average monthly billing of ≥1000 MSU per month in the Collaborative Family Practice. Fee codes for team leadership and development may be subsequently developed and this does not preclude physicians claiming other leadership development fee codes that may be developed. The work must be verifiable, where possible, in the physician's practice schedule (EMR calendar). Meetings must be attended by more than one team member. Minutes of any team meeting must be kept on location in the physician's CP office and available upon request. Meeting minutes must include the date of the meeting, topics discussed, and a list of attendees. Team members may attend the meetings virtually or in person. Note: The work involved in running the business of the physician's medical corporation or independent practice is not considered to be included. Collaborative Practice is defined as: • A Collaborative family practice with at least three regulated health care providers (RHPs), 2 of which are in different professions, at least one being a family physician, working together collaboratively.	146.7

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Category	Code	Description	Base Units

- All RHPs provide team based comprehensive, continuous primary health care (ME=CARE) to a common group of patients and have access to their respective health records in an EMR.
- All health care providers are preferable co-located however, recognizing that some providers will work in several locations, providers must at least be in attendance, either in person or virtually, for deliverables.
- The non-physician RHP must be an integral part of the CP team. Non-physician RHP must collectively provide at least 20 hours per week to the CP.

Notes:

- This HSC for CP work is intended for family physician's.
- Clinics in which health care is provided on an episodic basis, such as walk in clinics, are not eligible for this model of care.
- CP incentive HSCs are intended for permanent members of the CP. Locum physician's in the CP are not eligible to claim for CP incentive HSCs unless they are covering for an approved leave of absence.
- CP incentive HSCs are intended to support multidisciplinary office-based primary care and are not intended for groups with hospital-based practices only, such as hospitalists.

Billing Guidelines:

- Physician's must sign a verification declaration form prior to having access to this HSC.
  ME=CARE eligible physician's only.
- The verification must be updated yearly.
- Should the physician leave the CP, notice must be given to MSI and the CFP1 fee code must not be billed.
- This HSC may be claimed once per physician per month per fiscal year (1 April – 31 March) even if the physician meets the eligibility requirements for more than one practice location.
- Physician's must have an average monthly billing of greater than or equal to 1000 MSU per month in the Collaborative Practice.
- Meetings must be documented and verifiable in the physician's practice schedule (EMR calendar)
- Meeting minutes with the date of the meeting, topics discussed, and a list of attendees must be kept in the physician's CP office and be available upon request.
- Meeting time spent discussing the business of the physician's medical corporation or independent practice may not be claimed.

The CFP code will be subject to audit in accordance with billing guidelines. DHW may facilitate a verification process to ensure eligibility criteria are met.

Claims must be submitted to HCN: 0016417388, DOB April 1, 1969
Dx code: V68.9 (unspecific administrative purpose)

Specialty Restriction:
SP=GENP Eligible for ME=CARE

Location:
LO=OFFC

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FEE UPDATES

AHCP1- ALLIED HEALTH CARE PROVIDER TO PHYSICIAN (PHYSICIAN ADVICE REQUESTED BY A REGULATED HEALTH PROFESSIONAL)

Effective March 27, 2026, to better support the use of this interim fee and upcoming changes, supporting text is required to indicate the method of interaction 'i.e., 'Synchronous' for each claim submitted.

FACILITY ON CALL

Effective April 1, 2026, two additional facilities (20 and 37) will be available for FCHP1

Health Service Code	Description	Weekday	Weekend/Holiday (DA=RGE1)	Approved Facilities
FCHP1	Community Hospital Inpatient Program	$350	$500	Strait-Richmond, Northside General, Fisherman's Memorial, Soldiers Memorial, Queens General, Roseway, New Waterford Consolidated, Inverness, **Digby General, Hants Community**

PRECEPTOR PREMIUMS

The following list of health service codes are excluded from the 5% billing premium eligibility, due to the nature of the HSC compensating for a flat rate or not compensating for the provision of a particular service. Please do not submit the CV10 on these HSC, If the compensation variable is attached to these HSC upon submission the 5% will not be payable.

Health Service Code	Description
All Facility On Call	Facility on-call categories, Community on-call
All LFM/FN Hourly	All HSC for LFM/First Nations hourly tracking
PREC1, PREC2, PREC3	DAILY PRECEPTOR STIPENDS
HOVM1	BLENDED MILEAGE AND TRAVEL DETENTION TIME FOR HOME VISITS .46 UNITS/KM
C9999	COMMUNITY SERVICES
TPR1	TELEPHONE PRESCRIPTION RENEWAL
UDS1	URINE DRUG SCREEN TRAY FEE
13.59M	PROVINCIAL IMMUNIZATION-TRAY FEE
03.26B	PAP SMEAR-TRAY FEE
NSHP1/NSHP2	ALLIED HEALTH CARE PRACTITIONER SERVICE
CFP1	COLLABORATIVE FAMILY PRACTICE WORK WITH INTERDISIPLINARY TEAM OF HEALTH CARE PROFESSIONALS MONHTLY FEE

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PREAMBLE UPDATE - CLARIFICATION

Please see below clarification on the paediatric overage preamble:

New Definition

5.2.114

A. PAEDIATRIC CARE OF PATIENTS 0-18 YEARS OF AGE INCLUSIVE. (UP TO 19TH BIRTHDAY)

- Paediatric fee codes apply to patients 0-18 years of age inclusive. This includes services provided in the hospital or office for consultations and visits, provided all other health service code requirements are met. *(5.2.115)*

B. PAEDIATRIC CARE OF OVERAGE PATIENTS 19 YEARS OF AGE AND OLDER *(5.2.116)*

- Overage is defined as the day of the 19th birthday and over.
- **All** services associated with the care of overage patients in hospital by a paediatrician are to be paid at paediatric rates.
- Paediatric consultations, whether comprehensive or limited, **outside hospital** for overage patients are to be paid at paediatric rates.
- Visits, excluding paediatric consultations, outside hospital for overage patients are **not** to be paid at paediatric rates except **with prior approval**, for:
    - Behavioral management.
    - Follow-up visits in a paediatrician's office for approved overage patients with complex multi-system medical problems.

Application must be made in writing to the MSI Medical Consultant and prior approval obtained for each patient. Application for approval must clearly state the diagnosis and provide sufficient clinical information to support complex multi-system medical problems. **Approvals will be granted for a maximum of 24 months**. *(5.2.117)*

Billing Matters Billing Reminders, Updates, New Explanatory Codes

DAILY PRECEPTOR STIPENDS

For clarity on the PREC1 – 'Physician Assistants' are Physician Assistant Students. Approval of other allied providers not explicitly listed will require an application process. Further communication will be provided on this process once finalized.

LFM SERVICE ENCOUNTER CHEAT SHEET

LFM physicians are reminded of the 'LFM Service Encounter Cheat Sheet' located on the MSI Website: https://msi.medavie.bluecross.ca/longitudinal-family-medicine/ where an updated version has been published.

CMPA REBATES

Physicians are reminded of the CMPA rebate process. Physician's do not need to sign up each year, rebates are automatically processed based on a list of eligible physician's provided by CMPA. You may wish to ensure that CMPA has Nova Scotia as your main province of residence https://www.cmpa-acpm.ca/en/connect/contact-us A physician is eligible to receive a reimbursement of 90% of their premium fees in excess of $1,750. Rebates are issued quarterly, however if the threshold is not met, no rebate will be issued.

Payment statements can be found on your eLink under 'Downloads'. For assistance with logging into eLink, please contact our provider coordinator dept msiproviders@medavie.ca 902-496-7011 (option 1, option 1). If you require assistance with navigating and viewing your statements, please contact the assessment dept at 902-496-7011 msi_assessment@medavie.bluecross.ca.

ELECTIVE OUT OF PROVINCE AND OUT OF COUNTRY SERVICES REMINDER

Written pre-approval from the MSI Medical Consultant is required, before referring a patient for medical services outside Nova Scotia, if the patient is to be considered for coverage under the Nova Scotia Health Insurance Program and financial assistance with travel and accommodation.

Referrals must be completed by an appropriate referring physician, defined as a Nova Scotia physician who is treating the patient and has a relevant specialty for the requested service.

Pre-approval applies only to specific service(s) and facility authorized. Approval must be obtained before arranging care and making any financial commitments. Service(s) must be received within the approved time period. If additional services or an extension is needed, the referring Nova Scotia physician must submit a new request.

Application instructions, required documentation and submission details are available on the Department of Health and Wellness website and will be maintained there going forward:
https://www.novascotia.ca/apply-pre-approval-medical-services-outside-nova-scotia-health-card

TELEPHONE PRESCRIPTION RENEWAL REMINDER

As a reminder, this code (TPR1) is billable when a patient requests either by telephone, fax, or email to the physician to communicate a prescription renewal to a pharmacy, with no requirement to see the patient for an in-person visit. Full details can be found in the Interim Fee Guide: MSI - Interim Fees –

*Note: 4x/year is based on rolling year. There are no multiples attached to this HSC, it is meant to remunerate for the service, not the number of prescriptions written.

Physicians should exercise caution for billing TPR1 when a renewal request is received directly from the pharmacy to ensure prescriptions are not being ordered twice. As a reminder, the request must be patient initiated. 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. If using the EMR as documentation, it must indicate all of the required elements listed.
If the physician does receive a renewal request initiated by their patient, with all the required elements documented, the physician would be eligible to bill for this service. The TPR1 prescription refill must be assessed, ordered and completed by the physician, not another allied health care provider such as a Nurse Practitioner or Pharmacist.

As with all interim fee codes, the TPR1 is in its evaluation period and as such an analysis was completed regarding prescription renewals. The findings determined cases where physicians and pharmacists are both potentially billing for the same renewal. In cases where a pharmacist completes the renewal without a requirement for physician intervention, only the pharmacist should bill for the renewal. Clarification is also being provided to pharmacists for awareness on eligible and appropriate billing practices.

PROVIDER PROFILES

Physicians are advised the 2024/2025 Provider Profiles are available to request. Provider profiles are sent out per request only. If you would like to receive your 2024/25 provider profile, please send your request to msi_assessment@medavie.bluecross.ca. In the email, please include your name and provider number, and the profile will be mailed to the address on file.

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 available on the MSI website, which provides a comprehensive list of all current interim fees.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
PV001	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOUR COLLABORATIVE PRACTICE DECLARATION FORM MUST BE SUBMITTED BEFORE CLAIMING CFP1
PV002	SERVICE ENCOUNTER HAS BEEN REFUSED AS ONLY ME=CARE ELIGIBLE PHYSICIANS MAY CLAIM CFP1
PC003	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED THIS HSC IN THE CURRENT MONTH
PV004	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED THIS HSC 12 TIMES DURING THE CURRENT FISCAL YEAR

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

UPDATED FILES

Updated files reflecting changes are available for download on March 27, 2026. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

Phone: 902-496-7011
Toll-Free: 1-866-553-0585
Fax: 902-490-2275
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NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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HELPFUL LINKS

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Physician Agreement - Program Payment Schedule (2026/27)

Program	Payment Date	Notes
CMPA Premium Reimbursement Covering January – March 2026	To be issued by May 31, 2026	.
CME (GP & Specialist) Payment for 2025/26 fiscal year (eligible billings based on 2024 calendar year)	To be issued by May 31,2026	
FFS Rostering Grant	Spring 2026	
Physician Retirement Fund	Spring 2026	
CMPA Premium Reimbursement Covering April - June 2026	To be issued by August 31,2026	
Electronic Medical Records (EMR – B&C) Payments for 2024/25 Fiscal Year	To be issued by August 31,2026	
Surgical Assist Payments Payment based on eligible billings from April 1, 2025 – March 31, 2026	To be issued by September 30, 2026	
Collaborative Practice Incentive Program **Final** payments for old version of program	To be issued by October 31, 2026	Transitioning to fee code as of April 1st, 2026 (CFP1)
CMPA Premium Reimbursement Covering July – September 2026	To be issued by November 30, 2026	
Rural Specialist Incentive Program Measurement period April 1, 2025 – March 31, 2026	To be issued by December 31, 2026	
Specialist Practice Support	To be issued by December 31, 2026	
CMPA Premium Reimbursement Covering October – December 2026	To be issued by February 28, 2027	
CMPA Premium Reimbursement Covering January – March 2027	To be issued by May 31, 2027	
EMR (Envelope "A" Payments) One time EMR Investment grant for eligible physicians.	Monthly	Continues to be issued monthly to eligible physicians.

**Please be advised payment dates noted are anticipated payments for these programs*

PHYSICIAN'S BULLETIN

January 16, 2026: Vol. LXXI, ISSUE 1

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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NEW FEES

Effective **January 1, 2026** the following health service codes are available for billing:

Category	Code	Description	Value*
DEFT	PREC1	Daily Preceptor Stipend for Pre-Clerkship (Med 1 and Med 2), Clerkship (Med 3 and Med 4), First Year Residents (PGY1), Physician Assistants, and any approved Allied Providers.	$210
DEFT	PREC2	Daily Preceptor Stipend for Second Year Residents (PGY2) and Integrated Family Medicine Emergency Medicine Residents (iFMEM).	$130
DEFT	PREC3	Daily Preceptor Stipend for Senior Residents (PGY3+)	$100
		Description Precepting Stipend health service codes for Dalhousie-appointed and approved preceptors. The Stipends are now available for teaching Physician Assistants while in a formal Dalhousie-accredited program. The Stipends for Medical Students and Residents are available for all learners who are located in Nova Scotia at the time of their instruction, not just Dalhousie learners. The Stipends are available for physicians paid via following modalities: FFS, LFM, APP, ED, Sessional, hospitalist/hourly, and FFS academic department or division at the FFS rate. Physicians who are part of C/AFP will be eligible to shadow bill the daily stipends. The stipends are not available to physicians who are paid outside of the Physician Agreement (e.g., medical officers of health and medical examiners).	**Rate for RP=INTL*

Category	Code	Description	Value*

Billing Guidelines

- Claims must be submitted using generic health card number 0000002352.
- Text is required on the claim indicating the name and student ID# for the learner(s) present on the day this code is being claimed. Claim will be refused without text.
- When teaching multiple learners at the same time on the same day, the claim for the highest rate learner should be submitted with RP=INTL and subsequent learners should be submitted with RP=SUBS with multiples.
- When teaching a learner (or learners) for a half day, the claim should be submitted with PO=HALF.
- Only one PREC with RP=INTL per day **or** two PREC RP=INTL with PO=HALF.
- Stipends are available for billing 7 days a week.

Modifiers

- RP=INTL – use on first PREC claim when teaching one student, or the highest paying PREC when teaching multiple students.
- RP=SUBS – use when teaching multiple students (append to appropriate PREC code after the PREC RP=INTL claim) If additional learners, claim multiples for each additional learner thereafter)

Following guidelines above, use PO=HALF when teaching half day.
(Half Day for these stipends is equal to 3.5 hours)

- RP=INTL, PO=HALF
- RP=SUBS, PO=HALF

These new Preceptor Stipend codes replace the **TESP1 and TESP2 that have now been terminated**. As announced in the December 22, 2025 bulletin, **claims for preceptor work completed back to January 1, 2026 may now be submitted using the above codes**.

For greater clarity, no TESP1 or TESP2 health service codes should be used for service dates January 1, 2026 onward.

C/AFP physicians are remunerated for medical education through their block funding. These incentives **will not** be paid in addition to the block funding; however, the precepting codes and premium amounts are eligible to be shadow billed to support accountability measures and future data analysis.

Please see joint communication from DHW and DNS: MEWG Message

*Please note the above daily stipends follow the eligibility guidelines as defined in Preamble 5.2.5 Clinical Supervision. (See February 14, 2025 Physician's Bulletin for Clinical Supervision Preamble Update)

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FEE UPDATES

Effective **January 16, 2026**, the following Health Service Codes for SP=INMD, SP=NEUR and SP=PHMD have adjusted fees:

Health Service Code	New Value	Specialties
03.03 RP=SUBS	**17** MSU	SP=NEUR, SP=INMD, SP=PHMD
03.03 RO=CNTC	**17** MSU	SP=NEUR, SP=INMD, SP=PHMD
03.03 RO=CNTC AG=OV65	**21** MSU	SP=NEUR, SP=INMD, SP=PHMD
03.03A	**21** MSU	SP=NEUR, SP=INMD, SP=PHMD
03.03 RO=DIRC	**17** MSU	SP=NEUR, SP=INMD, SP=PHMD
03.03 RO=DIRC AG=OV65	**21** MSU	SP=NEUR, SP=INMD, SP=PHMD

Effective **January 16, 2026**, the following Health Service Code: **03.03 RO=INTL, SP=PHMD** has been terminated.

Please note the following prolonged nursing home description update:

Category	Code	Description	Base Units
VIST	03.03	**Prolonged Nursing Home Visit** **Description** This fee may be billed for any resident of the nursing home or **Residential Care Facility** receiving care, whether they be the first patient seen or an extra patient**.** Prolonged nursing home and **Residential Care Facility** visits are paid in 15-minute time blocks or portion thereof, 80% of the time must be direct physician to patient contact with the patient alone **or the patient and their legally identified substitute decision maker, and/or the regulated health care professional providing care to the patient at the nursing home, as appropriate to the patient's medical condition. The physician must spend at least a portion of the visit in direct face to face (in person) contact with the patient. The substitute decision maker may be accessed virtually if they are not immediately present with the patient.** Prolonged nursing home visits are not to be confused with active treatment associated with detention. **Billing Guidelines** • A prolonged nursing home **or RCF** visit can be billed up to a maximum of 60 minutes per patient per day. This would include a base visit plus up to 3 additional multiples of 15 minutes each. • Start and stop times are required for any visit billed with multiples greater than 1. The start and stop times must be documented in the health record and on the text field of the claim. • Multiples/prolonged not applicable for virtual care. **Multiples:** 17 MSU per 15 minutes to a maximum of 4 multiples (60 minutes) per day **Modifiers:** TI=EVNT = Time 1701-2000 – 28.3 MSU + MU (22.95 MSU per 15 minutes) TI=ETMD = Time 2001-2359 – 28.3 MSU + MU (22.95 MSU per 15 minutes)	21.3 MSU +MU

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Category	Code	Description	Base Units
		TI=MDNT = Time 0000-0800 – 38.3 MSU + MU (25.5 MSU per 15 minutes) DA=RGE1, TI=AMNN = Time 0801 – 1200, Sat., Sun., Holidays – 28.3 MSU + MU DA=RGE1, TI=NNEV= Time 1201 – 1700, Sat., Sun., Holidays – 28.3 MSU + MU **Specialty Restriction:** SP=GENP **Location:** LO=NRHM	

If a physician has an encounter dating back to July 1, 2025 that would satisfy a prolonged nursing home visit under these guidelines, but were unable to submit due to previous requirements, please reach out to msi_assessment@medavie.bluecross.ca

Please note that the Prolonged Nursing Home Visit is not to be billed for any virtual visit.

Physicians providing virtual care (telephone/video) to their patients in Nursing Homes **from an office location (LO=OFFC**) can bill an 03.03 or 03.03A, provided they satisfy all other billing requirements (no multiples).

Billing Matters Billing Reminders, Updates, New Explanatory Codes

RETIREMENT FUND WEBPAGE

Physicians are advised of a new page on the MSI website dedicated to the Physician Retirement Fund, where you will find the program overview and updates, resources, and key dates. MSI - Physician Retirement Fund –

Reminder Physicians are issued a 6-digit MSI provider number at the time of registration with MSI. This number is used for billing and identification purposes and is needed when applying for the Retirement Fund. Please ensure you retain this number in your records.

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.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
GN146	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED A PRECEPTOR STIPEND ON THIS DATE.
GN147	SERVICE ENCOUNTER HAS BEEN REFUSED. PLEASE RESUBMIT WITH TEXT INDICATING THE NAME AND STUDENT NUMBER OF THE LEARNER.
GN148	SERVICE ENCOUNTER HAS BEEN REFUSED AS A PRECEPTORSHIP STIPEND MAY NOT BE CLAIMED ON THE SAME DAY AS A TEACHING STIPEND.

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Code	Description
GN149	SERVICE ENCOUNTER HAS BEEN REFUSED AS PRECEPTORSHIP STIPEND HAS ALREADY BEEN CLAIMED AT EITHER HALF OR FULL VALUE FOR THE SAME SERVICE DATE.
GN150	SERVICE ENCOUNTER HAS BEEN REFUSED AS A PRECEPTORSHIP STIPEND HAS ALREADY BEEN CLAIMED AT FULL VALUE FOR THE SAME SERVICE DATE.

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UPDATED FILES

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PHYSICIAN'S BULLETIN
December 22, 2025: Vol. LXX, ISSUE 8

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians - TEACHING STIPEND CODES

TESP1 AND TESP2 – DAILY STIPENDS

As part of the 2023 Physician Agreement, the Medical Education Working Group (MEWG) was struck to provide recommendations on remuneration for physicians providing medical education in Nova Scotia. The MEWG was tasked with reviewing the weekly and daily preceptor stipends currently in effect.

Changes are coming into effect as of January 1, 2026, however, new fee codes will not be available to submit until the January 16, 2026 system update. As a result, claims for preceptor work completed between **January 1 - January 15, 2026 inclusive, should be held until January 16, 2026**.

A Physician's Bulletin will be published in January with further detail.

Please see joint communication from DHW and DNS: **MEWG Message**

PHYSICIAN'S BULLETIN

November 21, 2025: Vol. LXX, ISSUE 7

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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NEW FEES

Effective November 21, 2025 the following health service code is available for billing:

Category	Code	Description	Base Units
DEFT	NHTA1	Nursing Home Telephone Patient Assessment with Regulated Nursing Professional **Description** This service is billable when a physician has a telephone conversation with a Regulated Nursing Professional to provide advice on a patient, with whom thephysician (or physician group) has an established relationship, to determine a management decision. 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. 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. **Billing Guidelines** All interactions must be recorded in the patient's chart, including, but not limited to: • The time of the call if claiming TI=GPEW • The documentation should be clear that the conversation /assessment occurred with a Regulated Nursing Professional • The history of the presenting problem, review of relevant body systems or investigations, diagnosis and treatment plan • The name of the nursing professional is recommended 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 as per CMPA Guidelines.	16.5 MSU

Category	Code	Description	Base Units
		• This fee code may not be billed with, TPR1 Telephone Prescription Renewal, AHCP1 or LTC Medical Chart Review for the same patient, same day, same provider. • 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. • This code may not be billed if the physician is present in the LTC facility. • Only billable once per patient per day. • Not to be billed on the same day as a visit unless the status of the patient has changed in the intervening time. If there is a visit on the same day, text is required on the visit claim regarding the intervention. **Premium** TI=GPEW **Specialty** SP=GENP **Location** LO=OFFC	

FEE UPDATES

Effective November 21, 2025, the following health service code has been updated to **Location Office:**

Category	Code	Description	Base Units
VIST	03.03 RO=NHCR	Nursing Home Medical Chart Review with telephone call/email/fax advice communicated to a regulated health care professional for patients in licensed, provincially registered nursing homes and residential care facilities. Groups of up to three telephone calls, faxes or e-mails per day per patient. Note: each additional group of three telephone calls, faxes or e-mails per day per patient can be claimed at 11.5 units. **Description** Physicians may claim for medical chart review with telephone call/email/fax advice provided for patients in licensed, provincially registered nursing homes and residential care facilities. Only advice provided to regulated health care professionals within the patient's circle of care at the nursing home or residential care facility is eligible for this reimbursement. Telephone calls/faxes/e-mails between by the patient, their SDM, or their family members are not eligible. Physicians and nursing home staff involved are advised to keep a detailed record of telephone call/email/fax advice requested and provided. Medical chart review with telephone call/email/fax advice may be claimed in groups of three interactions per day for the same patient at a total of 11.5 MSU. Each additional group of three interactions either for the same patient or a different patient per day can be claimed at 11.5 MSU. **Billing Guidelines** • Communication must be with a regulated health care professional within the patients circle of care.	11.5 MSU

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Category	Code	Description	Base Units
		• Not for discussions with the patient, their SDM, or family members. • Detailed record of the chart review and advice provided to be available upon request. • Payable for groups of up to three services per claim. • Additional groups of three services may be claimed at the same value. **Specialty Restriction:** SP=GENP **Location:** **LO=OFFC**	

PREAMBLE UPDATE

Effective November 21, 2025, the following preamble has been updated.

Current Definition	New Definition
5.2.114 **PAEDIATRIC CARE OF OVERAGE PATIENTS AGE 16 UP TO AND INCLUDING 18 YEARS OF AGE** a) Services associated with the care of overage patients in hospital by a paediatrician are to be paid at paediatric rates. b) Paediatric consultations, whether comprehensive or limited, at any location for overage patients are to be paid at paediatric rates. c) Visits, excluding paediatric consultations, outside hospital for overage patients are not to be paid at paediatric rates except for: i) Behavioral management. ii) Follow-up visits in a paediatrician's office for approved overage patients with complex multi-system medical problems. Application must be made in writing to the MSI Medical Consultant and prior approval obtained for each patient. Application for approval must clearly state the diagnosis and provide sufficient clinical information to support complex multi-system medical problems.	5.2.114 **A. PAEDIATRIC CARE OF PATIENTS 0-18 YEARS OF AGE INCLUSIVE. (UP TO 19TH BIRTHDAY)** • Paediatric fee codes apply to patients 0-18 years of age inclusive. This includes services provided in the hospital or office for consultations and visits, provided all other health service code requirements are met. *(5.2.115)* **B. PAEDIATRIC CARE OF OVERAGE PATIENTS 19 YEARS OF AGE AND OLDER** *(5.2.116)* • Overage is defined as the day of the 19th birthday and over. • Services associated with the care of overage patients in hospital by a paediatrician are to be paid at paediatric rates. • Paediatric consultations, whether comprehensive or limited, at any location for overage patients are to be paid at paediatric rates. • Visits, excluding paediatric consultations, outside hospital for overage patients are not to be paid at paediatric rates except for: ○ Behavioral management. ○ Follow-up visits in a paediatrician's office for approved overage patients with complex multi-system medical problems. Application must be made in writing to the MSI Medical Consultant and prior approval obtained for each patient. Application for approval must clearly state the diagnosis and provide sufficient clinical information to support complex multi-system medical problems. *(5.2.117)*

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BILLING QUESTIONS – HEALTH CARD Q&A

Providers and their staff should ensure they are gathering patient information prior to the appointment/procedure (or after the procedure in an emergency) and make every attempt to contact the patient if the claim submitted to MSI has been rejected due to ineligibility.

Please take special care to review the patient's personal health card the first-time treatment is provided. Additional identification must be requested to ensure the patient's identity. *(Preamble 2.3.35)* The existence of a health card is not a guarantee of coverage. It is the service provider's responsibility to try and contact the patient *(Preamble 2.3.36)*

Prior to the appointment with the patient (or after, if emergency), the following information should be collected, and questions considered:

- Do they have a valid NS Health Card? What is the number and expiry date?
- Do they currently have, or have they ever had, coverage in another Canadian province? What is that Health Card Number and information? (Just because they have a NS card, does not mean their NS card is the active/appropriate card to use, and vise versa with an OOP health card.)
- Do they have private insurance?
- Have they moved in the previous 4 years?
- Is their contact information correct? i.e., phone number and address.

If a patient does not have MSI coverage (or coverage from another Canadian province) providers may charge patients fees for clinical services. It is important providers are aware of the patient's current coverage and have their contact information prior to them leaving the facility.

Q&A

Q. Sometimes a claim is rejected with an error code. What does that mean?

A. If the provider receives the error code **ED103** (service recipient birth date does not match date of birth on health card) this is typically a clerical error. They should confirm they entered the claim accurately and used the correct date of birth, and/or try to contact the patient to confirm the health card details. Often the month and day have been switched which will result in this error.

If the provider receives the error code **ED049** (invalid service recipient health card number for date of service or recipient is ineligible for the program), try to contact the patient to confirm the health card details and verify if the patient is eligible for health care with another Canadian province.

The following new explain codes have also been developed to help clarify health card rejections:

ED130: Patient health card number is missing and cannot be 000 000 000.

A: This code is a result of the health card number field being blank or zero filled. Please check your submission and submit a new claim with the proper health card number.

ED131: Patient health card number submitted was not recognized by MSI; please check number for errors.

A: This code is a result of the health card number attached to the claim does not exist. I.e., the number submitted is incorrect and is not a recognized health card number. This could be a result of a claim being submitted prior to the health card number registration or effective/eligibility date.

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ED132: Ineligible patient health card number. Patient did not have MSI coverage on the date of service, please contact patient.
A: This code is a result of the patient not having coverage on the date of service. This means that it is a valid health card number, however the patient does not have MSI coverage on the date of service. You will need to contact to patient to determine appropriate payment.

Q. What if it is known that the patient is unhoused and is unable to confirm details of their health card number?
A. Providers can call MSI at 902-496-7008 or 1800-563-8880 to receive assistance with patient's health card eligibility. MSI can search the system and troubleshoot issues over the phone. Please have the following information ready to provide to MSI:

- The provider name/number
- Patient details: name, date of birth, etc.

Q. The claim was rejected after the information was confirmed to be correct. What should we do now?
If clarification is required, the first point of contact should be the patient as this information should be collected at the time of the appointment. If you are not successful contacting the patient, please call MSI at 902-496-7008 or 1-800-563-8880 to confirm the patient's date of birth and/or eligibility for MSI coverage. Please have the following information ready to provide to MSI:

- The provider name/number
- Patient details: health card number, name, date of birth, address and phone number, if available

If the provider has attempted the steps above to contact the patient and MSI and has been unsuccessful in obtaining the required information due to extenuating circumstances, MSI can review a request to determine if payment of service can be made. This would be considered in limited circumstances such as:

- Residents unable to complete the application/renewal process for a health card due to circumstances outside of existing eligibility, e.g., homelessness, mental health capacity, etc.
- Patient passed away before they could update their health card.

Note: Providers should take special attention to identify noninsured situations prior to delivery of services. These scenarios could include:

- A non-Canadian who is vacationing in Nova Scotia,
- Refugee Claimants that are not eligible for MSI coverage but could have the Interim Federal Health Program (IFHP) coverage. Physicians must register as a health-care provider under this program to receive payment for these services Interim Federal Health Program (canada.ca),
- Canadian citizens who live out of country and are here visiting or passing through Nova Scotia on their way to reside in another Canadian province. They do not meet Nova Scotia's residency requirements,
- International students during the 12-month waiting period. They should have insurance through the university,
- Non-Canadians who specifically travel to Nova Scotia or another Canadian province for medical services.
- Quebec does not participate in reciprocal medical billing. When providing services to Quebec residents you can bill them directly and provide a detailed invoice/receipt which they can submit to the RAMQ for reimbursement of insured services.

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Billing Matters Billing Reminders, Updates, New Explanatory Codes

RETIREMENT FUND WEBPAGE

Physicians are advised of a new page on the MSI website dedicated to the Physician Retirement Fund, where you will find the program overview and updates, resources, and key dates. MSI - Physician Retirement Fund –

LFM SER UPDATE

Physicians are advised encounter claims of the Telephone Prescription Renewal (TPR1) fee code now qualify as one service encounter to LFM physicians.

MULTIPLES FOR SERVICES PROVIDED BY A MEDICAL LEARNER

Physicians are allowed to submit claims for prolonged visits and other health service codes with multiples when rendered by the learner, provided the claim reflects the length of time it would take for the physician to provide the service themselves. It is not appropriate to claim extra multiples to reflect the additional time taken by the learner. As always, documentation of the visit must reflect the complexity of the visit when billing a prolonged visit.

MEET AND GREET REMINDER (Preamble 2.2.54)

Physicians are reminded that all services billed to MSI must be medically necessary. There must be a specific health related concern/complaint that has led the patient to seek medical attention. It is not appropriate to bill MSI for a 'meet and greet' visit with a new patient unless a health-related concern/complaint has been addressed at the visit.
When **accepting a patient into your practice**, the NPIV1 new patient intake visit can be claimed for the purpose of gathering a detailed patient history **to establish an ongoing patient-physician relationship** and to construct the patient's medical record. (see full guidelines in the interim fee guide Interim-Fee-Reference-Guide-May-2025.pdf)
The NPIV1 is an initial visit with the patient and cannot be done virtually.

LOCATION OF PHYSICIAN DURING VIRTUAL ENCOUNTERS

Physicians should be aware of the location code they are using on claims when providing phone or virtual video encounters to patients. Physicians should not use the location of the patient. Physicians should use the location of 'office' (LO=OFFC). As currently defined in section 5.0.11 of the preamble, an office refers to the location where a physician is practicing their profession. An office may be located in the physician's home, in a hospital, in an institution, or in other facilities or buildings.

A location of 'home' (LO=HOME) should not be used for phone/virtual encounters if the physician was in their 'office' and the patient was in their home. Use of location of home, as outlined in preamble 5.1.48 indicates the service was rendered by a physician following travel to the patient's home. If the physician does not travel to the patients home, a location of home should not be used.

Additionally, locations of outpatient or emergency departments (LO=HOSP, FN=EMCC/FN=OTPT) are to be used when physicians provide medical treatment to a patient presenting to an OPD emergency department (5.1.28). To use a location other than office, the physician must be physically present at that location when they render services to the patient.

PHYSICIAN CONTACT

Physicians are reminded of the importance of keeping their contact information (email address, telephone, and mailing address) current with MSI. To update your contact information, you may reach out to MSIProviders@medavie.ca or 902- 496-7011 (toll-free 1-877-910-4674)

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.

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NEW AND UPDATED EXPLANATORY CODES

Code	Description
GN141	AHCP1 AND TPR1 MAY NOT BE CLAIMED WITH NHTA1
GN142	NHTA1 MAY NOT BE CLAIMED WITH AHCP1 OR TPR1
GN143	NHAT1 MAY NOT BE CLAIMED WITH NURSING HOME MEDICAL CHART REVIEW
GN144	NHAT1 MAY NOT BE CLAIMED DURING THE SAME SERVICE OCCURRENCE AS A VISIT OR CONSULT
GN145	THIS HEALTH SERVICE CODE MAY NOT BE CLAIMED DURING THE SAME SERVICE OCCURRENCE AS NHTA1
VT182	NURSING HOME MEDICAL CHART REVIEW MAY NOT BE CLAIMED WITH NHTA1

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2026 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE	CONTRACT PAY PERIOD
December 26, 2025**	January 1, 2026	January 7, 2026	December 19, 2025-January 1, 2026
January 12, 2026	January 15, 2026	January 21, 2026	January 2, 2026-January 15, 2026
January 26, 2026	January 29, 2026	February 4, 2026	January 16, 2026-January 29, 2026
February 9, 2026	February 12, 2026	February 18, 2026	January 30, 2026-February 12, 2026
February 23, 2026	February 26, 2026	March 4, 2026	February 13, 2026-February 26, 2026
March 9, 2026	March 12, 2026	March 18, 2026	February 27, 2026-March 12, 2026
March 23, 2026	March 26, 2026	April 1, 2026	March 13, 2026-March 26, 2026
April 2, 2026**	April 9, 2026	April 15, 2026	March 27, 2026-April 9, 2026
April 20, 2026	April 23, 2026	April 29, 2026	April 10, 2026-April 23, 2026
May 4, 2026	May 7, 2026	May 13, 2026	April 24, 2026-May 7, 2026
May 15, 2026**	May 21, 2026	May 27, 2026	May 8, 2026-May 21, 2026
June 1, 2026	June 4, 2026	June 10, 2026	May 22, 2026-June 4, 2026
June 15, 2026	June 18, 2026	June 24, 2026	June 5, 2026-June 18, 2026
June 26, 2026**	July 2, 2026	July 8, 2026	June 19, 2026-July 2, 2026
July 13, 2026	July 16, 2026	July 22, 2026	July 3, 2026-July 16, 2026
July 27, 2026	July 30, 2026	August 5, 2026	July 17, 2026-July 30, 2026
August 10, 2026	August 13, 2026	August 19, 2026	July 31, 2026-August 13, 2026
August 24, 2026	August 27, 2026	September 2, 2026	August 14, 2026-August 27, 2026
September 4, 2026**	September 10, 2026	September 16, 2026	August 28, 2026-September 10, 2026
September 21, 2026	September 24, 2026	**September 29, 2026****	September 11, 2026-September 24, 2026
October 5, 2026	October 8, 2026	October 14, 2026	September 25, 2026-October 8, 2026
October 19, 2026	October 22, 2026	October 28, 2026	October 9, 2026-October 22, 2026
November 2, 2026	November 5, 2026	**November 10, 2026****	October 23, 2026-November 5, 2026
November 16, 2026	November 19, 2026	November 25, 2026	November 6, 2026-November 19, 2026
November 30, 2026	December 3, 2026	December 9, 2026	November 20, 2026-December 3, 2026
December 14, 2026	December 17, 2026	December 23, 2026	December 4, 2026-Dec 17, 2026
December 22, 2026**	**December 30, 2026****	January 6, 2027	December 18, 2026-December 31, 2026
11:00 AM CUT OFF	**11:59 PM CUT OFF**		

NOTE:

Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Sessional Payments and Locum Claim Forms. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut off date to ensure processing for that payment period.

PLEASE NOTE, THE ** INDICATES A DATE VARIATION

2026 HOLIDAY DATES

Please make a note in your schedule of the following dates MSI will accept as "Holidays".	
NEW YEAR'S DAY	THURSDAY, JANUARY 1 2026
HERITAGE DAY	MONDAY, FEBRUARY 16, 2026
GOOD FRIDAY	FRIDAY, APRIL 3, 2026
EASTER MONDAY	MONDAY, APRIL 6, 2026
VICTORIA DAY	MONDAY, MAY 18, 2026
CANADA DAY	WEDNESDAY, JULY 1, 2026
CIVIC HOLIDAY	MONDAY, AUGUST 3, 2026
LABOUR DAY	MONDAY, SEPTEMBER 7, 2026
NATIONAL DAY FOR TRUTH AND RECONCILIATION	WEDNESDAY, SEPTEMBER 30, 2026
THANKSGIVING DAY	MONDAY, OCTOBER 12, 2026
REMEMBRANCE DAY	WEDNESDAY, NOVEMBER 11, 2026
CHRISTMAS DAY	FRIDAY, DECEMBER 25, 2026
BOXING DAY	MONDAY, DECEMBER 28, 2026
NEW YEAR'S DAY	FRIDAY, JANUARY 1, 2027

PHYSICIAN'S BULLETIN
October 3, 2025: Vol. LXX, ISSUE 7

NOVA SCOTIA MEDICAL SERVICES INSURANCE

FEE UPDATES

Effective September 25, 2025, Hospital Discharge Fees 03.02A and 03.04F have been updated:

Category	Code	Description	Base Units
ADON	03.02A	Hospital Discharge This fee may be claimed by the physician, either a general practitioner or a specialist when a patient is admitted for non-surgical hospitalization, who performs the activities involved in discharging a hospital inpatient. These activities include, as necessary, the completion of the patients chart, discharge summary, writing prescriptions for the patient, providing discharge instructions to the patient and arranging for follow-up care for the patient. This fee is not payable where major surgery, minor surgery, major fracture and/or minor fracture care is provided in a hospital setting unless a patient is transferred to a general practitioner **or internal medicine specialist*** for follow-up care after surgery/fracture care. In this case, the general practitioner **or internal medicine specialist*** may claim the discharge fee if the general practitioner **or internal medicine specialist*** performs the discharge duties. This fee cannot be claimed by the operation surgeon in association with any surgical code being billed. A hospital visit fee may be claimed in addition to the discharge fee where a hospital visit is provided on the same day. (5.1.216) **Specialty Restriction (for post-surgical transfers only):** SP=GENP, **SP=INMD, SP=NEUR, SP=PHMD** ***General internal medicine, neurology, physical medicine.** **Location:** LO=HOSP, FN=INPT	10 MSU

FEE UPDATES (CONTINUED)

Category	Code	Description	Base Units
VIST	03.04F	Complex Comprehensive Acute Care Hospital Discharge This fee may be claimed by the most responsible physician (MRP) only (the general practitioner **or internal medicine specialist*** in charge of the patients care for any given day and only once per hospital inpatient hospital admission. It is intended to be used when the services provided on the day of discharge require greater than 30 minutes of the physician's time. This HSC includes all services provided to the patient on the day of discharge from the acute care hospital. These services include the discharge day examination of the patient, the completion of the patients chart, discharge summary, writing any prescriptions required for the patient, providing discharge instructions to the patient (or caregivers) and arranging for follow-up care for the patient. Every effort is made by the discharge physician to communicate with the community physician who will be most responsible for the patients care after discharge. If the situation arises where the complex comprehensive discharge process occurs over 2 days, the code must be reported on the date of discharge, the cumulative time spent must be greater than 30 minutes, the code may only be claimed once by the MRP and may not be unbundled to accommodate splitting the workload. A hospital visit is considered an integral part of this service and is not reportable in addition. The physician claiming this health service code may not report any other visit service for the same patient, same day. In addition, 03.02A may not be claimed as this service is included in the 03.04F. Do not count time for services provided after the patient physically leaves the hospital. This fee is not payable where major surgery, minor surgery, major fracture and/or minor fracture care is provided in a hospital setting unless a patient is transferred to a general practitioner **or internal medicine specialist** for follow-up care after surgery/fracture care. In this case, the general practitioner **or internal medicine specialist** may claim the complex discharge fee if the general practitioner **or internal medicine specialist** performs the discharge duties. This fee cannot be claimed by the operation surgeon in association with any surgical code being billed. **Specialty Restriction:** SP=GENP, **SP=INMD, SP=NEUR, SP=PHMD** ***General internal medicine, neurology, physical medicine.** **Location:** LO=HOSP, FN=INPT	45 MSU

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PHYSICIAN'S BULLETIN

September 25, 2025: Vol. LXX, ISSUE 6

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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NEW FEES

Effective **October 15, 2025** the following health service code is available for billing:

Category	Code	Description	Base Units
ADON	13.59L	**Beyfortus – passive immunization for the prevention of respiratory syncytial virus (RSV)** RO=RSVM (PT=RISK)	6 MSU

Description
Monoclonal antibody indicated for the prevention of RSV lower respiratory tract disease in neonates and infants during their first RSV season and high-risk children up to 24 months who remain vulnerable to RSV disease through their second RSV season.

Billing Guidelines
Universal
Single 50mg or 100mg (weight-based) dose for infants aged less than 8 months at the time of immunization, and during the defined RSV season*
*RSV season may vary year to year. For 2025-26, the season is October 15, 2025 – April 30, 2026.

High Risk – must indicate high-risk.
Up to 300mg** over the child's first **two** RSV seasons for infants aged less than 24 months who meet the high-risk criteria outlined in the *Nova Scotia's Publicly Funded Vaccine/Immunoglobulin Eligibility Policy*.

- *50mg or 100mg (weight-based) given during the first RSV season.*
- *200mg given during the second RSV season (100mg dose may be used at clinical discretion for children weighing less than 10kg).*

Total of up to 300mg lifetime dose if high-risk, refer to the Canadian Immunization Guide for high-risk dosing considerations.

Follows provincial immunization guidelines outlined in 5.3.26 and 5.3.33.

Category	Code	Description	Base Units
		• Doses administered outside of the defined season will not be reimbursed. • Doses administered to individuals aged 8 months and older will not be reimbursed without text indicating high-risk. • Doses administered to individuals aged 24 months and older will not be reimbursed. Additional Resources: RSV Infant Immunization Information for Health Care Professionals Vaccine Eligibility for High Risk Conditions Nirsevimab Storage and Handling Requirements	

FEE UPDATES

Effective September 5, 2025 health service code has been updated:

Category	Code	Description	Base Units
ADON	13.59L	**Provincial Immunization – Respiratory Syncytial Virus Vaccine for older adults** RO=RSVV (PT=RISK) **Description** Respiratory Syncytial Virus (RSV) Vaccine for the following adults who did not previously receive one: • **Adults 75 years and older** • Adults 60 years and older residing in licensed long-term care facilities. • Hospital inpatients 60 years and older who are awaiting placement in long term care. **Billing Guidelines:** • Maximum 1 **lifetime** dose **regardless of indication** • **Universal: Adults aged 75 years and older** • **High Risk: (must include text to indicate high-risk)** Minimum 60 years of age residing in licensed long-term care facilities and those minimum 60 years of age hospital inpatients who are awaiting placement. Follows provincial immunization guidelines outlined in 5.3.26 and 5.3.33.	6 MSU

Tray Fees are permitted with both RO=RSVM and RO=RSVV as per the guidelines outlined in 5.3.33 of the Physicians Manual:

When a physician has incurred the cost of supplies when administering an immunization covered by the provincial program, a tray fee can be claimed for each injection. There is to be no charge to the patient or family for the supplies and/or disposables associated with any of these immunizations.

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EXPLANATORY CODES

Sometimes claims are rejected due to errors with the health card being submitted. This can be a result of entry errors, or an invalid health card number (HCN). When a claim is rejected, there will be an error code attached explaining why the claim was not paid. The full list of explanatory codes can be found in Appendix I in the Physicians Manual.

In an attempt to make the error clearer for physicians, the following new explain codes have been developed:

Code	Description	Error
ED130	Patient health card number is missing and cannot be 000 000 000.	This code is a result of the health card number field being blank or zero filled. Please check your submission and submit a new claim with the proper health card number.
ED131	Patient health card number submitted was not recognized by MSI; please check number for errors.	This code is a result of the health card number attached to the claim does not exist. I.e., the number submitted is incorrect and is not a recognized health card number.
ED132	Ineligible patient health card number. Patient did not have MSI coverage on the date of service, please contact patient.	This code is a result of the patient not having coverage on the date of service. This means that it is a valid health card number, however the patient does not have MSI coverage on the date of service. You will need to contact to patient to determine appropriate payment.

Billing Matters Billing Reminders, Updates, New Explanatory Codes

MEDICAL EDUCATION PRECEPTING 5% RETRO PAYMENT

Physicians are advised that the 5% retro payment covering the period of September 15, 2023 – February 14, 2025 will be issued on the October 1, 2025 payment for physicians that completed an application for the options: lump sum based on TESP dates, Flat rate based on 20 days/year, flat rate on longer core rotations, and PRAP physicians. The retro will be issued onto your CMPA Business Arrangement under the adjustment 'Medical Education.'

Physicians that chose the detailed report (actuals) option will receive their retro at a later date once DHW has completed the review and calculations.

If you have any questions on the 5% retro, please send an email to physicianagreement@novascotia.ca, incentives@doctorsns.ca and msi_assessment@medavie.bluecross.ca and the appropriate party to assist with your enquiry will reach out.

C1001 – COMMUNITY ON CALL FOR CEC PHYSICIANS

Physicians are advised the current facilities eligible for C1001 are: • Annapolis Community Health Centre • South Cumberland Community Centre • All Saint's Hospital • North Cumberland Memorial • Twin Oaks Memorial • Musquodoboit Valley Memorial • Baddeck: Victoria County Memorial • Cheticamp: Sacred Heart Community Health Centre • Guysborough: Guysborough Memorial • Neils Harbour: Buchanan Memorial • Tatamagouche: Lillian Fraser Memorial • Eastern Shore Memorial.

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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.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
AD102	SERVICE ENCOUNTER HAS BEEN REFUSED AS CLAIMS FOR THE RSVM IMMUNIZATION FOR PATIENTS GREATER THAN 8 MONTHS OF AGE REQUIRE PT=RISK. PLEASE RESUBMIT WITH THE APPROPRIATE MODIFIERS.
AD104	SERVICE ENCOUNTER HAS BEEN REFUSED A SECOND OR SUBSEQUENT INJECTION FOR RO=RSVM REQUIRES PT=RISK. PLEASE RESUBMIT WITH THE APPROPRIATE MODIFIERS.
AD105	SERVICE ENCOUNTER HAS BEEN REFUSED. NO MORE THAN 2 DOSES DURING A SINGLE SEASON MAY BE CLAIMED.
AD106	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF RSVM INJECTIONS HAS BEEN REACHED.

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

UPDATED FILES

Updated files reflecting changes are available for download on Thursday September 25, 2025. The files to download are: Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), Modifiers (MODVALS.DAT) and Explanatory Codes (EXPLAIN.DAT).

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PHYSICIAN'S BULLETIN

July 21, 2025: Vol. LXX, ISSUE 5

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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NEW FEES

Effective July 18, 2025 the following health service code is available for billing:

Category	Code	Description	Base Units
VIST	03.03 RO=NHCR	**Nursing Home Medical Chart Review with telephone call/email/fax advice communicated to a regulated health care professional for patients in licensed, provincially registered nursing homes and residential care facilities. Groups of up to three telephone calls, faxes or e-mails per day per patient.** **Note: each additional group of three telephone calls, faxes or e-mails per day per patient can be claimed at 11.5 units.** **Description** Physicians may claim for medical chart review with telephone call/email/fax advice provided for patients in licensed, provincially registered nursing homes and residential care facilities. Only advice provided to regulated health care professionals within the patient's circle of care at the nursing home or residential care facility is eligible for this reimbursement. Telephone calls/faxes/e-mails initiated by the patient, their SDM, or their family members are not eligible. Physicians and nursing home staff involved are advised to keep a detailed record of telephone call/email/fax advice requested and provided. Medical chart review with telephone call/email/fax advice may be claimed in groups of three interactions per day for the same patient at a total of 11.5 MSU. Each additional group of three interactions either for the same patient or a different patient per day can be claimed at 11.5 MSU. **Billing Guidelines** • Communication must be with a regulated health care professional within the patients circle of care. • Not for discussions with the patient, their SDM, or family members. • Detailed record of the chart review and advice provided to be available upon request. • Payable for groups of up to three services per claim. • Additional groups of three services may be claimed at the same value. **Specialty Restriction:** SP=GENP **Location:** LO=NRHM	11.5 MSU

FEE UPDATES

Please note, effective **May 23, 2025**, the following prolonged consults for SP=INMD, SP=NEUR, and SP=PHMD have adjusted fees:

A prolonged consultation may be claimed only by the following specialties:

a) Anaesthesia	15 units per 15 minutes
b) Internal medicine	**15.5 units per 15 minutes**
c) Neurology	**15.5 units per 15 minutes**
d) Physical medicine	**15.5 units per 15 minutes**
e) Paediatrics	16.3 units per 15 minutes
f) Obstetrics and gynaecology	13.5 units per 15 minutes
g) Palliative Care	15.5 units per 15 minutes *(5.1.105)*

Example: Internal Medicine Comprehensive Consultation

MU=1	1 hour	Total Time
MU=2	1 1/4 hour	Total Time
MU=3	1 1/2 hour	Total Time
MU=4	1 3/4 hour	Total Time
MU=5	2 hour	Total Time

Prolonged Consultation: A prolonged consultation may be applied to cases where the consultation extends beyond one hour for comprehensive consultations. A prolonged consultation cannot be claimed with a limited consultation. Prolonged consultations are paid in 15-minute time blocks or portion thereof, 80% of the total time must be in direct physician to patient contact. Prolonged consultations are not to be confused with active treatment associated with detention. These are entered on the service encounter as multiples. As with all services paid based on time, start and finish times must be recorded on the patient record. (*5.1.103*)

Repeat Consultation: A repeat consultation 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 consultation requires all the elements of a limited consultation and implies interval care by another physician. *(5.1.101)*

Effective **May 23, 2025**, the following Health Service Codes for SP=INMD, SP=NEUR, and SP=PHMD have adjusted fees:

VIST 03.03
LO=HOSP, FN=INPT, RO=DIRC, SP=NEUR. 18.39
LO=HOSP, FN=INPT, RO=DIRC, SP=INMD. 18.39
LO=HOSP, FN=INPT, RO=DIRC, SP=PHMD 18.39

VIST 03.03
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, SP=NEUR. 18.39
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, SP=INMD. 18.39
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, SP=PHMD. 18.39

VIST 03.03
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, SP=NEUR. 18.39
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, SP=INMD. 18.39
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, SP=PHMD. 18.39

VIST 03.04
LO=HOSP, FN=INPT, SP=NEUR. 30
LO=HOSP, FN=INPT, SP=INMD. 30
LO=HOSP, FN=INPT, SP=PHMD. 30

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Effective April 1, 2025 the following Facility On-Call health service code has been updated to include the following additional facilities:

Code	Description	Value
C1001	**Community on Call for CEC Physicians** **Sites:** • Annapolis Community Health Centre • South Cumberland Community Centre • All Saint's Hospital • North Cumberland Memorial • Twin Oaks Memorial • Musquodoboit Valley Memorial • **Baddeck: Victoria County Memorial** • **Cheticamp: Sacred Heart Community Health Centre** • **Guysborough: Guysborough Memorial** • **Neils Harbour: Buchanan Memorial** • **Tatamagouche: Lillian Fraser Memorial** **Billing Guidelines:** • Only one physician can bill the stipend per site, per night • Call coverage is remunerated at $150/night regardless of weeknight/weekend/holiday. **When submitting claims for Facility On-Call:** • Use the generic health card number 0015713084, date of birth April 1, 1969 and diagnostic code V689 for billing purposes. • Use the service date that aligns with the beginning time of the shift covered (for both normal coverage and call-backs). For a weekday coverage running from 1700 to 0800 hours the following day, the claim should include the service date that aligns with the 1700 start time.	$150/night Weeknight/Weekend/Holiday rate

Effective April 1, 2025, Pediatrics Facility On-Call at Yarmouth Regional has been updated to a level 1:

Health Service Code	Description	Weekday	Weekend/Holiday (DA=RGE1)	Approved Facilities
F1011	Facility on Call Category 1 – Pediatrics	$350	$500	Valley Regional, Colchester East Hants, St. Martha's, Cape Breton Regional, **Yarmouth Regional**

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PREAMBLE UPDATE

Effective July 18, 2025 preamble 5.1.66 has been updated:

CASE MANAGEMENT CONFERENCE FEE ***(5.1.65)***

Current Definition	New Definition
A case management conference is a formal, scheduled, multidisciplinary health team meeting. It is initiated by an employee of the Nova Scotia Health Authority/Izaak Walton Killam Hospital or a Director of Nursing or Director of Care of an eligible long term care facility to discuss the provision of health care to a specific patient. Neither the patient nor the family need to be present. *(5.1.66)*	A case management conference is a formal, scheduled, multidisciplinary health team meeting. It is initiated by an employee of the Nova Scotia Health Authority/Izaak Walton Killam Hospital or a **non-physician regulated health care professional within the patients circle of care at a provincially registered nursing home, residential care facility or hospital** ~~Director of Nursing or Director of Care of an eligible long term care facility~~ to discuss the provision of health care to a specific patient. Neither the patient nor the family need to be present. *(5.1.66)* (5.1.67 – 5.1.74 remain unchanged)

WORKERS' COMPENSATION BOARD FEE VALUE CHANGES

READ WCB'S STATEMENT TO PHYSICIANS: Physician compensation continues at WCB (July 16/25)

JULY 18, 2025 WCB PHYSICIAN'S BULLETIN: WCB-Physicians-Bulletin-July-18-2025.pdf

WORK SAFE. FOR LIFE.
WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

Billing Matters Billing Reminders, Updates, New Explanatory Codes

PHYSICIAN RETIREMENT FUND

Physicians are advised of a new email dedicated to retirement fund enquiries. Please direct any retirement fund enquires to retirement.fund@novascotia.ca

TIME-BASED RECORD KEEPING

Physicians are reminded that all time-based codes and codes that have minimum time interval requirements must have start and stop times documented in the patients health record.

For example, 03.03B Complex Care Visit, the physician must spend at least 15 minutes in direct patient intervention, therefore the start and stop times must be documented even though there are no multiples associated with this HSC. As well as HSC such as 08.19A, 08.43A that have a minimum of two time intervals (three multiples) be claimed (i.e. a minimum of 30 minutes) must have the start and stop times documented in the patients health record.

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GP ENHANCED HOURS MODIFIER TI=GPEW

Physicians are reminded the GP Enhanced Hours Modifier preamble was updated in the July 26, 2024 Physician's Bulletin. As indicated in 5.1.192, please ensure the time the patient was seen is recorded in the patient's record. The following excerpt of 5.1.192 shows the changes made in 2024:

NOTE… a record must be maintained and readily available to verify that the patient was ~~booked, registered, or intended to be~~ seen for an appointment during an premium-eligible time period. The appointment time should be recorded in the patient's record ~~or office appointment books retained.~~

Please see 5.1.188 in the Physician's Manual for the most up to date GPEW preamble.

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.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
VT181	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.03D MAY ONLY BE BILLED FROM A LOCATION OF HOSP OR NRHM.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday July 18, 2025. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), Modifiers (MODVALS.DAT) and Explanatory Codes (EXPLAIN.DAT).

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NEW FEE

Due to implementation of a new shingles immunization program for individuals 65+, the following service is effective May 28, 2025:

Category	Code	Description	Base Units
ADON	13.59L	Provincial Immunization RO=SHVV Shingles Vaccine program eligibility for individuals 65 years and older as a 2-dose vaccine series.	6 MSU

INTERIM FEE UPDATE

Effective May 23, 2025 the guidelines for TPR1 have been clarified:

Category	Code	Description	Base Units
DEFT	TPR1	**Telephone Prescription Renewal** **Description** This service is billable by a family physician when the physician is requested by a patient to communicate a prescription renewal by telephone, fax, or email with no requirement to see the patient for an in-person visit. **Billing Guidelines** • 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. • This HSC is not to be billed for writing new prescriptions. • This HSC may not be billed if the physician bills a visit with the patient (face to face or virtually) on the same day. • May not be billed more than 4 times per year per patient per provider. **Specialty Restriction:** SP=GENP	4 MSU

Billing Matters Billing Reminders, Updates, New Explanatory Codes

LONG TERM CARE CGA1 REMINDER

Physicians are reminded when billing for the LTC CGA, 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. Prior to claiming the CGA fee, the physician 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 (progress notes) corroborating that the CGA has been completed. (Preamble 5.1.168)

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
AD099	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF SHVV INJECTIONS HAS BEEN REACHED.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday May 23, 2025. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), Modifiers (MODVALS.DAT) and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

Phone: 902-496-7011
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Fax: 902-490-2275
Email:
MSI_Assessment@medavie.bluecross.ca

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

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

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

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PHYSICIAN'S BULLETIN

March 28, 2025: Vol. LXX, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT
Effective April 1, 2025, the Medical Service Unit (MSU) value will increase from $2.84 to $2.90

ANAESTHESIA UNIT
Effective April 1, 2025, the Anesthesia Unit (AU) will increase from $26.84 to $27.38

Sessional hourly rates, Intensive Care Unit (ICU) minimum income daily guarantees, General Internal Medicine (GIM) minimum income daily guarantees, Emergency Department (ED) hourly rates, Psychiatry hourly rates, Collaborative Emergency Centre (CEC) rates, Community Hospital Inpatient Program (CHIP) rates, Regional Hospitalist daily stipend rates, Primary Maternity Care Program hourly rates, Pathology List B payments, and Alternative Payment Plan (APP) annual rates will increase by 2% effective April 1, 2025.

INTERIM FEE UPDATES

Effective April 1, 2025, interim health service codes 03.03R and 03.03Q are terminated. Physicians are reminded telephone and virtual video encounters may be submitted by using the appropriate AP=PHON and AP=VIRC modifiers. Physicians are reminded to select the appropriate health service codes when claiming for phone and virtual services. As a reminder, phone and virtual visits are not eligible for prolonged/multiples.

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

LFM BILLING UPDATES

LFM MILEAGE

Physicians remunerated under the LFM funding model may submit the below mileage health service codes under their Fee for Service business arrangement for payment at full value when rendering a health service that allows for mileage. The health service itself must still be billed under the LFM business arrangement for payment at the LFM value.

This applies to:

- HOVM1 – Blended mileage and travel detention for home visits
- HHCMI – Blended mileage/detention time for home care

LFM TEACHING STIPEND

Physicians remunerated under the LFM funding model may submit teaching stipend health service codes under their Fee for Service business arrangement for payment at full value.

This applies to:

- TESP1 – Teaching Stipend for Medical Student
- TESP2 – Teaching Stipend for Resident Elective

Physicians are not required to go back and delete and resubmit any previously submitted mileage or teaching stipends, as MSI will issue a one-time retroactive top-up payment to LFM physicians for any mileage and/or TESP claims submitted under the LFM business arrangement from October 1, 2023 – March 27, 2025. This will be reconciled once 90 days has elapsed.

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LFM

Effective April 1, 2025, the following health service codes for the purpose of tracking non-primary care health service LFM hours included within an LFM contract will be available for billing: This change primarily applies to LFM Rural contracts who are able to bill ED/UTC/Inpatient hours when within their LFM Rural contract. LFM Core physicians who are doing inpatient services within their LFM contract can bill these inpatient hours to have inpatient services isolated from their LFM SER calculations.

Category	Code	Description	Base Units
		Longitudinal Family Medicine (LFM) model hourly fee codes for clinical daytime and/or evening work in specific settings.	
PRVR	HUTC1	Urgent Treatment Centre (UTC) All Times	0 MSU
PRVR	HEDD1	Emergency Department Level 4 (ED4) Daytime	0 MSU
PRVR	HEDE1	Emergency Department Level 4 (ED4) Evening/Weekend	0 MSU
PRVR	HIPD1	Inpatient Daytime	0 MSU
PRVR	HIPE1	Inpatient Evening/Weekend	0 MSU

Description
Billable clinical hours for patient specific clinical services both direct and indirect in each setting.

Daytime hours mean the hours between 0800-1700 Monday through Friday Evening, Weekend and Holiday hours follow the eligible time period for the GP Enhanced Hours Premium (1700 – 0800) as outlined in the Physician's Manual.

Please see 'Schedule C' of the 2023-27 Physician's Agreement for full details on the LFM Model.

Billing Guidelines

- 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 instance of each fee code (HUTC1, HEDD1, HEDE1, HIPD1, HIPE1) can be claimed per day per provider.
- Maximum of 24 hours per day across all hourly tracking HSC. (Includes these 5 new codes and the existing HDAY1 and HEVW1 hourly tracking codes).
- The HSC's must be billed under the LFM Hourly Health Card Number 0015800568, DOB April 1, 1969, Dx Code V689.

When it comes to Inpatient, if completing indirect services in the evening hours, these should be claimed as daytime hours if there are no direct services in addition. There must be direct services completed in evening hours to claim the evening health service code HIPE1.

Documentation Requirements
Physicians are responsible to ensure they are entering the correct number of claimed units to match the time worked.

Specialty Restriction:
SP=GENP

LFM SERVICE ENCOUNTER VALUE ADJUSTMENTS FOR HOSPITAL ADMISSIONS AND DISCHARGES

Effective immediately, the LFM Service Encounter values for some services utilized in the LFM payment model will change. The changes will apply effective April 1, 2025 onwards, and will be reflected in LFM physicians' historical SER on their quarterly reports. Changes include:

Admissions and Discharges:

Service	Code + Modifiers	Current Value	New Value
DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS COMPREHENSIVE	3.04 RP=INTL FN=INPT;LO=HOSP;SP=GENP	2	**3**
INITIAL GERIATRIC INPATIENT MEDICAL ASSESSMENT	03.04E FN=INPT;LO=HOSP;SP=GENP	2	**3**
HOSPITAL DISCHARGE FEE	03.02A FN=INPT;LO=HOSP;SP=GENP	0	**1**
COMPLEX COMPREHENSIVE ACUTE CARE HOSPITAL DISCHARGE	3.04F FN=INPT;LO=HOSP;SP=GENP	2	**4**

Minor Procedures:

Health Service	Code + Modifiers	Current Value	New Value
INCISION ABSCESS, SUBCUTANEOUS - BOIL, CARBUNCLE, INFECTED CYST, SUPERFICIAL LYMPHADENITIS, PARONYCHIA, FELON, ETC.	98.03A AN=GENL	1	**2**
CARCINOMA OF SKIN - LOCAL EXCISION, PRIMARY CLOSURE	98.12B	1	**3**
EXCISION OF PLANTAR WARTS OR JUNCTIONAL NEVI OR MOLLUSCUM CONTAGIOSUM	98.12N	1	**2**
REMOVAL OF FIBROMA	98.12A	1	**2**
EXCISION OF TOENAIL - SIMPLE, COMPLETE, PARTIAL OR WEDGE	98.96D	1	**2**
EXCISION OF FINGERNAIL - RADICAL, TO INCLUDE DESTRUCTION OF NAIL BED AND SHORTENING OF PHALANX, IF NECESSARY	98.96A	1	**3**
SIMPLE EXCISION OF WARTS, INCLUDING PAPILLOMATA, KERATOSES, NEVI, MOLES, PYOGENIC GRANULOMATA, ETC., FOR MALIGNANT OR PRE-MALIGNANT CONDITION - INCLUDES CLINICAL SUSPICION OF MALIGNANCY	98.12W	1	**2**
SUTURE MINOR LACERATION OR FOREIGN BODY WOUND	98.22D	1	**2**
SUTURE EXTENSIVE LACERATION OR FOREIGN BODY WOUND	98.22F	1	**3**
BIOPSY OF SKIN/MUCOSA-MALIGNANT OR RECOGNIZED PRE MALIGNANT CONDITION OR BIOPSY NECESSARY FOR HISTOLOGICAL DIAGNOSIS FOR PATIENT MANAGEMENT	98.81C	1	**2**
INCISION WITH REMOVAL OF FOREIGN BODY OF SKIN AND SUBCUTANEOUS TISSUE	98.04	1	**2**
INCISION OF PILONIDAL SINUS OR CYST	98.02	1	**2**
LOCAL EXCISION FOR MALIGNANCY	61.2C	1	**2**

*Please also see the LFM Cheat Sheet with minor updates: LFM Service Encounter Cheat Sheet

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PREAMBLE UPDATES

Please be advised of the following Preamble update:

New Definition

5.1.118
Supervision of a patient on long term ~~anticoagulant~~ **warfarin** therapy (13.99C) may be claimed once monthly if the patient's treatment is managed by telephone/fax or e-mail advice and the patient is not participating in the Community Pharmacy-led Anticoagulant Management Services. If the date of the service falls within a complete month of hospitalization, this service may not be claimed.

OTHER MISCELLANEOUS ANTICOAGULANT SUPERVISION NEC

VADT	13.99C	Supervision of long-term ~~anticoagulant~~ **warfarin** therapy (per month telephone/fax/e-mail communications) 10

Note: Other anticoagulants do not have the same monitoring requirements as warfarin, code 13.99C is specific for warfarin management.

Please be advised of the following Preamble addition:

New Definition

Incentive for use of Official Interpreter services when caring for a patient of Limited English Proficiency (LEP) - OFI1

This incentive is available to health care professionals who utilize the services of an official interpreter, as designated by the NSHA or IWK, when providing care to a patient of Limited English Proficiency (LEP). LEP refers to individuals who do not speak English as their primary language and have a limited ability to read, speak, write, or understand English. This definition includes individuals 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.

Note: Health Service Code ADON: OFI1 was announced and effective Feburary 8, 2019. There are no changes to the code or guidelines, however the description is being added to the Physicians Manual Preamble.

WORKERS COMPENSATION BOARD UNIT VALUE CHANGES/INCREASES

WCB MEDICAL SERVICE UNIT

Effective April 1, 2025, the Workers Compensation Board Medical Service Unit (WCB MSU) value will increase to $3.23.

WORKERS COMPENSATION BOARD ANAESTHESIA UNIT

Effective April 1, 2025, the Workers Compensation Board Anesthesia Unit (WCB AU) value will increase to $30.43.

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Workers' Compensation Board Fee Code Updates

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been calculated for the listed WCB specific fees for fiscal year 2025-26.

The WCB specific services listed below will have their values increased effective April 1, 2025:

CODE	DESCRIPTION	APRIL 2025 VALUE
WCB12	EPS physician assessment Service. Combined office visit and completion of Form 8/10 For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15-minute increments to a maximum of 1 additional hour	**Initial visit:** $225.65 + $66.05 per 15 minutes to a maximum 4x (RO=EPS1 and RP=INTL) **Subsequent visit:** $225.65 (RO=EPS1 and RP=SUBS)
WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable	GPs ..... $55.27 per 15 min EPS (RO=EPS1)..$66.05 per 15 min Specialists ..... $74.32 per 15 min
WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable	GPs ..... $55.27 per 15 min EPS (RO=EPS1)..$66.05 per 15 min Specialists ..... $74.32 per 15 min
WCB17	Photocopies of Chart Notes	10 pgs or less (ME=UP10)..... $33.11 11-25 pgs (ME=UP25)…..... $66.05 26-50 pgs (ME=UP50)…..... $131.91 Over 50 pgs (ME=OV50)… $197.68
WCB20	Carpal Tunnel Syndrome (CTS) Assessment Report	$84.66
WCB21	Follow-up visit report	$49.58
WCB22	Completed Mandatory Generic Exemption Request Form	$16.63 per form
WCB23	Completed Non-Opioid Special Authorization Request Form	$16.63 per form
WCB24	Completed Opioid Special Authorization Request Form	$55.56 per form
WCB25	Completed WCB Substance Abuse Assessment Form	$37.08
WCB26	Return to Work Report – Physician's Report Form 8/10	$84.66
WCB27	Eye Report	$74.32
WCB28	Comprehensive Visit for Work Related Injury or Illness	$85.21
WCB29	Initial Request Form For Medical Cannabis	$91.93
WCB30	Extension Request Form For Medical Cannabis	$55.27
WCB31	WCB Interim Fee – Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed	$85.21
WCB32	WCB Safe Work Connectedness Report	Specialists…… $74.32

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FACILITY ON-CALL

Physicians are reminded that Facility On-Call payments transitioned to electronic billing effective July 1, 2021. Claims for Facility On-Call are to be submitted as Fee-For-Service (FFS) using the appropriate health service code. Please see section 5.2.191 in the Physician's Manual for more information on submitting for Facility On-Call and the associated health service codes.

90-DAY SUBMISSION TIMELINE POLICY REMINDER

Physicians are reminded all original claims must be submitted to MSI within 90 days from the date of service. Service encounters submitted over the 90-day limitation will be adjudicated to pay "zero" with the following exceptions:

- Reciprocal billing claims (out of province) must be submitted within 12 months of the date(s) of service.
- Resubmission of refused claims or incorrect billings. These claims must be resubmitted to MSI within 185 days of the date of service. Each resubmission must contain an annotation in the text field of the service encounter submission referencing the previous service encounter number.

Service encounters submitted beyond 90 days from date of service shall not be payable and will be adjudicated to pay zero unless MSI is of the opinion the delay is justified.

Exception to this policy for claims that are outside of the specified time limitations will be made only be through special consideration if extenuating circumstances can be demonstrated for a late submission and are within a reasonable time frame past the 90-day limit. Request for an extension must be made to MSI in writing and will be approved on a case-by-case basis.

The time frame for submitting the request to MSI for late submission should be within one month following the 90-day limit. Examples of extenuating circumstances may include physical damage to office such as fire or flood and/or a serious technical issue.
Circumstances relating to staffing issues/shortages and mislaid, misfiled, or lost claims cannot be accepted by MSI as valid explanations for a late submission. Explanations relating to late discharge summaries, or facilities not consolidating the required information for the physician, cannot be accepted as a valid explanation for a late submission.
Failure to use a preauthorization code given by MSI and annotate the text field with the previous service encounter number will result in an adjudication paid at "zero".

Notes:

- WCB and facility-based service encounters follow the same ruling.
- Claims for registered hospital in-patients must also be submitted within the 90-day time limitation regardless if the patient has been discharged or continues on an in-patient basis. It is incumbent on the physician to obtain the required billing information for these patients and submit claims within the prescribed time limitations.
- **All health service codes, including codes without a patient (Facility On-Call, LFM hours, etc.) and shadow billings are all subject to the same requirements.**

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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
LF004	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 24 HOURS MAY BE BILLED PER DAY FOR ALL LONGITUDINAL FAMILY MEDICINE (LFM) MODEL HOURLY FEE CODES COMBINED
LF006	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 24 HOURS MAY BE BILLED PER DAY FOR HSC HUTC1
LF007	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 24 HOURS MAY BE BILLED PER DAY FOR HSC HEDD1
LF008	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 24 HOURS MAY BE BILLED PER DAY FOR HSC HEDE1
LF009	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 24 HOURS MAY BE BILLED PER DAY FOR HSC HIPD1
LF010	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 24 HOURS MAY BE BILLED PER DAY FOR HSC HIPE1

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

UPDATED FILES

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Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

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PHYSICIAN'S BULLETIN
February 14, 2025: Vol. LXX, ISSUE 2

NOVA SCOTIA MEDICAL SERVICES INSURANCE

UPDATE

5% PRECEPTOR PREMIUM

As announced in the 2023-2027 Physician Agreement, effective September 15, 2023, a Supervising Physician who holds an academic appointment with Dalhousie Medical School and is an approved preceptor by Dalhousie Medical School to supervise a Medical Trainee will be paid a premium of 5 percent on all Nova Scotia Medical Services Insurance (MSI) claims for insured services provided by the Supervising Physician when a Medical Trainee is present in person and working with the Supervising Physician.

A Medical Trainee is defined as the following:

a) Undergraduate medical students registered with Dalhousie Medical School
b) Residents in an accredited postgraduate specialty or subspecialty training program registered with Dalhousie Medical School
c) Practice ready assessees participating in the remaining cohorts of the Practice Ready Assessment Program (PRAP)
d) Other practice ready assessees not part of the Physician Assessment Centre of Excellence (PACE)

A Medical Trainee does not include:

a) Clinical observers
b) Clinical fellows
c) PACE assessees
d) Physician extenders, such as physician assistants or associate physicians, and their learners
e) Other healthcare providers, and their learners

Physicians who are employees or paid through other arrangements not governed by the Physician Agreement, or who are compensated through a Clinical/Academic Funding Plan (C/AFP), are not eligible for the 5% Preceptor Premium.

Beginning **February 15, 2025**, Supervising Physicians must begin claiming the 5% Preceptor Premium on eligible claims to receive the premium payment. These claims must be identified by selecting the appropriate new compensation variable field in the vendor's software. Please contact your vendor for assistance with this new field. If eligible claims are submitted without the appropriate field selection on and after February 15, 2025, the claims will need to be deleted and resubmitted to be appropriately captured and paid. All standard billing rules apply, including the 90-day billing window.

Fee for Service (FFS) and Alternate Payment Plan (APP) Supervising Physicians will receive the 5% Preceptor Premium on all eligible claims in the usual billing cycle; as part of the normal bi-weekly payment deposit, the 5% Preceptor Premium will appear as a separate payment on the detailed statement for any eligible claims where the 5% Preceptor Premium field was selected.

When a Longitudinal Family Medicine (LFM) Supervising Physician submits an eligible claim under their LFM 30% business arrangement (BA) with the 5% Preceptor Premium, the bi-weekly payment deposit will contain payment for the 30% LFM BA as well as any eligible claims where the 5% Preceptor Premium field was selected. For clarity, LFM Supervising Physicians will receive a total payment of 35% of eligible claims, and the 5% preceptor premium will appear as a separate payment on the detailed statement.

Electronic statements are available for download via the vendor software that identifies all claims submitted during the payment period per BA and will identify the claims submitted with the 5% Preceptor Premium field adjustment.

Further information will be provided to physicians in District Psychiatry for updated claim form submission.

Note: There will be a separate process for claiming eligible encounters on or before February 14, 2025. Eligible encounters provided between September 15, 2023 and February 14, 2025 inclusive will be processed through a retroactive application process. Further detail will be provided in the upcoming weeks on this retroactive payment for eligible claims between September 15, 2023, and February 14, 2025.

For more information, please see the FAQ.

PHYSICIAN'S MANUAL PREAMBLE UPDATE

Clinical Supervision (5.2.5) in Section 5 of the Physician's Manual has been replaced with the following:

CLINICAL SUPERVISION (5.2.5)

1. **ELIGIBLE CLAIMS:**

   a. A physician who supervises a Medical Trainee who renders an insured service is eligible to submit a claim for the insured service as if the physician had performed the insured service personally, subject to any terms, conditions and limitations found in this Clinical Supervision section.

   b. The terms, conditions and limitations described in this Clinical Supervision section are for the sole purpose of defining when an insured service is payable by Nova Scotia Medical Services Insurance (MSI). These terms and conditions do not alter the College of Physicians and Surgeons of Nova Scotia professional standards and guidelines, or any requirements of Dalhousie Medical School providing the undergraduate or postgraduate medical education.

2. **DEFINITIONS:**

   a. **Supervision:** is performed by the Supervising Physician and includes the responsibility to guide, observe and assess the clinical activities of the Medical Trainee and assures the quality of an insured service while being rendered by the Medical Trainee.
      i. Supervision of the Medical Trainee may occur in person, by telephone or PHIA compliant virtual care video platform, provided that the Supervising Physician and the Medical Trainee are physically present in the same clinical facility at the time the insured service is rendered.
      ii. Supervision is provided in a setting approved by Dalhousie Medical School.
      iii. The Supervising Physician and the Medical Trainee must be physically present in Nova Scotia.

   b. **Supervising Physician:** is a physician who performs Supervision of a Medical Trainee who renders an insured service to an insured person. The Supervising Physician must hold an academic appointment with Dalhousie Medical School and be an approved preceptor with Dalhousie Medical School. The Supervising Physician shall be present at the performance of such insured services or shall be immediately available to render assistance when necessary. The Supervising Physician may or may not be the Most Responsible Physician (MRP) for the patient to whom the insured service is being provided.

   c. **Medical Trainee:**
      i. A Medical Trainee is defined as the following:
         1. Undergraduate medical students registered with Dalhousie Medical School;
         2. Residents in an accredited postgraduate specialty or subspecialty training program through Dalhousie Medical School;
         3. Practice ready assessees participating in the remaining cohorts of the Practice Ready Assessment Program (PRAP);

4. Other practice ready assessees not part of the Physician Assessment Centre of Excellence (PACE).

ii. A Medical Trainee does not include:
    1. Clinical observers
    2. Clinical fellows
    3. PACE assessees
    4. Physician extenders such as physician assistants or associate physicians, and their learners
    5. Other healthcare providers, and their learners

3. BILLING GUIDELINES:

a. An insured service rendered by a Medical Trainee is only eligible for payment to the Supervising Physician where Supervision is provided as defined in the other areas of this Clinical Supervision section.

b. Where a Medical Trainee with an MSI provider number is providing insured services independently and outside their training program, the insured service is not eligible for payment to a Supervising Physician as there is no supervision provided.

c. Provider to provider insured services are not eligible for payment to the Supervising Physician when rendered by a Medical Trainee (e.g., 03.09K, 03.09L, etc.).

4. INSURED SERVICES:

a. An insured service rendered by a Medical Trainee is only eligible for payment to the Supervising Physician when the Supervising Physician:
    i. Is aware the Medical Trainee will render the insured service; and
    ii. Is physically present in the same clinical facility as the Medical Trainee at the time the insured service is rendered; and
    iii. Is immediately available to personally respond to the patient when requested by the patient, the Medical Trainee or other healthcare professionals.

b. An insured service that includes the completion of a form is not eligible for payment to a Supervising Physician if rendered by a Medical Trainee unless the form has been reviewed and signed by the Supervising Physician.

c. When there is more than one Medical Trainee participating in the rendering of an insured service, only the insured service (and time units or multiples, if applicable) rendered by one Medical Trainee are eligible for payment to the Supervising Physician.

d. Any time taken in general medical education with the Medical Trainee about the case, but not specific to the insured service, *is not eligible* for payment in this Clinical Supervision section.

e. As a reminder, as per the Canadian Medical Protective Association (CMPA), patients must be informed about the involvement of Medical Trainees in their care.

5. DOCUMENTATION:

a. Supervision of the Medical Trainee by the Supervising Physician must be evident in the patient's medical record. This may include a physical visit to the patient and/or a chart review with detailed discussion between the Supervising Physician and the Medical Trainee and other member(s) of the healthcare team (where appropriate).

b. An insured service is only eligible for payment to the Supervising Physician when the medical record of the patient(s) identifies all the following information at the time of the provision of the insured service:
    i. The Supervising Physician

ii. The Medical Trainee and the level of training.
iii. The description of the insured service performed by the Medical Trainee.

c. The Supervising Physician must have signed off on the insured service rendered by the Medical Trainee in the patient's medical record.

d. The service date used for claims is the date the Medical Trainee rendered the insured service to the patient.

PHYSICIAN RETIREMENT FUND REMINDER

The newly established Physician Retirement Fund by the Department of Health and Wellness (DHW) was launched this past December. All eligible physicians should have received an email with their specific eligibility.

To provide flexibility and to maximize a physician's opportunity to participate, DHW has extended the contribution deadline for the 2024 Physician Retirement Fund to align with the opt-in deadline. If applicable, physicians must contribute to their chosen retirement vehicle by March 31, 2025, and must opt into the program by completing and submitting the following online attestation form by March 31, 2025:

CLICK HERE TO OPT IN

If the individual email was not received, or if there are any questions or concerns, please email psaccountability@novascotia.ca. For more information about this program, please visit the MSI website for a Frequently Asked Questions document in the December 13, 2024 Physician's Bulletin.

NEW EXPLANATORY CODES

Code	Description
ED126	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE COMPENSATION VARIABLE MUST BE A TWO DIGIT NUMERICAL VALUE.
ED127	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE COMPENSATION VARIABLE USED IS INVALID.
ED128	SERVICE ENCOUNTER HAS BEEN REFUSED AS COMPENSATION VARIABLE MAY NOT BE CLAIMED FOR PAYMENT RESPONSIBILITY USED.
ED129	SERVICE ENCOUNTER HAS BEEN REFUSED AS A COMPENSATION VARIABLE MAY NOT BE USED FOR PROVIDER TYPE USED.

NOTICE TO VENDORS

A new Vendor's Manual has been published on the MSI Website. table 5.2.3 Provider Total Records has been updated to support the new 5% premium.

PHYSICIAN'S BULLETIN

January 17, 2025: Vol. LXX, ISSUE 1

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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NEW INTERIM FEE

The following service is effective December 1, 2024; Physicians may now submit any claims they may have been holding for Advance Care Planning Discussion:

Category	Code	Description	Base Units
DEFT	ADCP1	**Advance Care Planning Discussion**	15 MSU

Description

Advance Care Planning Discussion may be claimed when the patient's family physician, or if the patient is admitted to an acute care facility, their most responsible physician, has a face to face (in person) conversation with the patient (or the patients substitute decision maker either face to face or virtually) to discuss their wishes for future health care based on their beliefs and values, determines the substitutes decision maker (SDM), documents the conversation in the patient's health record, and captures the outcome of that conversation by completing the initial Patient-Centered Priorities and Goals of Care (GOC) form. In extenuating circumstances, for established homebound patients only, as defined by the Preamble, this service may be rendered virtually by telephone or PHIA compliant video platform. The circumstances necessitating the virtual visit must be documented in the health record. Where possible, the GOC form should be submitted to the patient's hospital chart through the appropriate health records department. A copy of the document must be shared with the patient so that it may be added to their Green Sleeve folder, if applicable.

Category	Code	Description	Base Units
		Billing Guidelines: Documentation of the Advance Care Planning Discussion, the patient appointment substitute decision maker, and resultant completion of the Patient-Centered Priorities and Goals of Care (GOC) form must be in the patient's health record AND, where possible, the GOC form must be sent/faxed to the appropriate hospital records department for inclusion in the patient's hospital chart. May not be claimed where this service is part of the compensation for an existing health service: • 03.04D Geriatrician's Initial Comprehensive Consultation • 03.04E Family Physician's Initial Geriatric Inpatient Medical Assessment • CGA1 LTC Clinical Geriatric Assessment • 03.09C Palliative Care Consultation • 03.09H Antenatal Palliative Care Consultation • Critical Care HSC's Adult and Pediatric	

FACILITY ON-CALL UPDATES

Effective January 1, 2025, the Orthopedic rota F2010 has been terminated from a level 2 and replaced as a level 1 rota for Dartmouth General (Facility 65):

Health Service Code	Description	Weekday	Weekend/Holidays (DA=RGE1)	Approved Facilities
F1010	Facility On-Call Category 1 Orthopedics	$350	$500	Valley Regional, Aberdeen, Cape Breton Regional, Dartmouth General

Must meet the established Facility On-Call billing guidelines for a level 1 rota.

Billing Matters Billing Reminders, Updates, New Explanatory Codes

PROVIDER PROFILES

Physicians are reminded that provider profiles are sent out per request. If you would like to receive your 2023/2024 provider profile, please send your request to msi_assessment@medavie.bluecross.ca. In the email, please include your name and provider number, and the profile will be mailed to the address on file.

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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
DE049	SERVICE ENCOUNTER IS REFUSED AS IT IS INCLUDED IN A SERVICE ALREADY CLAIMED ON THIS DATE.
DE050	SERVICE ENCOUNTER HAS BEEN REFUSED. PLEASE RESUBMIT WITH TEXT INDICATING THE CIRCUMSTANCES OF THE VIRTUAL SERVICE.
GN138	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE MAY NOT BE CLAIMED WITH ADCP1.
OP057	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS AN OPTOMETRIC VISION ANALYSIS HAS BEEN APPROVED WITHIN THE PREVIOUS 2 YEARS. AT LEAST ONE DIAGNOSTIC CODE FOR THIS PT=CMPX CLAIM MUST BE FOR AN APPLICABLE NON ROUTINE DIAGNOSIS IN ORDER FOR CLAIM TO BE ELIGIBLE.
VE044	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS PRIOR APPROVAL IS REQUIRED FOR THIS SERVICE.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday January 17, 2025. 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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NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

Phone: 902-424-5818
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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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PHYSICIAN'S BULLETIN
December 30, 2024

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to CEC Physicians

COMMUNITY ON CALL STIPEND

Effective January 3, 2025, when physicians are providing community call the following health service code may be billed:

Code	Description	Value
C1001	**Community on Call for CEC Physicians** **Sites:** • Annapolis Community Health Centre • South Cumberland Community Centre • All Saint's Hospital • North Cumberland Memorial • Twin Oaks Memorial • Musquodoboit Valley Memorial **Billing Guidelines:** • Only one physician can bill the stipend per site, per night • Call coverage is remunerated at $150/night regardless of weeknight/weekend/holiday. **When submitting claims for Facility On-Call:** • Use the generic health card number 0015713084, date of birth April 1, 1969 and diagnostic code V689 for billing purposes. • Use the service date that aligns with the beginning time of the shift covered (for both normal coverage and call-backs). For a weekday coverage running from 1700 to 0800 hours the following day, the claim should include the service date that aligns with the 1700 start time.	$150/night Weeknight/Weekend/Holiday rate

Updated January 10, 2025

PHYSICIAN'S BULLETIN
December 13, 2024: Vol. LXIX, ISSUE 9

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Retirement Fund FAQ for Physicians

Last updated: February 13, 2025

The Government has introduced a retirement fund initiative for physicians practicing in Nova Scotia. This retirement fund will support physicians in their continued clinical practice in Nova Scotia and assist in their long-term financial planning.

Eligibility

Who is eligible?

A physician is eligible for the Retirement Fund for the 2024 tax year if, as of March 31, 2024, they:

- Had a valid license in the province of Nova Scotia
- Delivered and were paid for direct patient care or clinical services in Nova Scotia between April 1, 2023, and March 31, 2024 (fiscal year 2023/2024).

Physicians who started practicing in Nova Scotia on or after April 1, 2024, will not be eligible for the retirement fund until the 2025 tax year.

What physician licenses are eligible?

An active license in Nova Scotia is required to be eligible for the retirement fund.
A physician's time as a Resident will not be counted towards their years of practice.
A physician's time spent on a Practice Ready Assessment will not be counted towards their years of practice.
A physician's time as a Fellow will be counted towards their years of practice so long as they had an active license.

Will physicians who practiced between April 1, 2023, and March 31, 2024, but who no longer have a license, be eligible?

Physicians must have a valid license as of March 31 of the relevant tax year. If physicians retire earlier than this, they must keep their license until March 31 to be eligible for a retirement fund payment (which would be prorated based on income in the 2024 tax year). For eligibility for the 2024 tax year this means you must have had a valid license on March 31, 2024.

Will physicians who retired prior to March 31, 2024, be eligible?

Only physicians with a valid license on March 31, 2024, will be eligible. Physicians who retired and did not have a valid license as of March 31, 2024, will not be eligible for the fund.

What remuneration methods will be accepted?

The Retirement Fund is inclusive of all remuneration methods by which physicians are paid for patient care and clinical service delivery.

What physician services will be considered eligible?

All publicly funded **insured** patient care is eligible for the retirement fund. Additionally, essential clinical services that have direct patient-benefit have also been included, such as radiology and pathology services.

Will physicians who work part-time be eligible?

Physicians who work part-time will have their maximum reimbursement amount proportionally prorated relative to their FTE, which will be calculated using CIHI FTE and compensation benchmarks across various specialties.

Will physicians who left the province and then returned be eligible? Will previous years of practice count?
Contributions from the fund will be based on number of years of continuous practice in Nova Scotia and will be based on the start date of a physician's most recent licensure with the College.

Will physicians who live out of province but who have a valid Nova Scotia license and have billable hours in Nova Scotia, be eligible?
Physicians with a valid license who practice in Nova Scotia will be eligible for the fund regardless of where they live. They will receive a pro-rated retirement incentive based on NS billings compared to their applicable CIHI FTE compensation benchmark.

Will the retirement fund be available to those on Parental Leave?
Yes, physicians on parental leave will be eligible to receive the retirement fund amount as long as they meet the eligibility requirements (including maintaining a valid license). Eligibility will be based on the annualized extension of their FTE before they go on leave.

For example, if a full-time physician with two years of practice worked half the year (i.e., April 1, 2023 to Sept 30, 2023) before going on parental leave, they would still be eligible for the max reimbursement amount of $5000 as long as they opt-into the program and maintain their license through March 31, 2024.

If an eligible physician was on parental leave for the entire clinical period (April 1, 2023 to March 31, 2024), their FTE will be calculated on the previous fiscal year earnings and their years of experience to determine the maximum amount eligible.

Will physicians on Parental Leave who gave up their license be eligible?
An exception will be made to physicians on parental leave between April 1, 2023 and March 31, 2024, who gave up their license during that time. This exception will apply to the 2024 tax year only. For the 2025 tax year forward, physicians on parental leave will have to maintain their license to be eligible for the fund.

Calculation

How will the contribution amount be determined?
Retirement benefits will be based on continuous years of practice, full or part-time status, and the amount contributed by a physician to their preferred retirement savings option.

Years of practice	Maximum Reimbursement	Matching Required
0-5 years	$5,000 per year	No
5-15 years	$10,000 per year	Yes
15+ years	$15,000 per year	Yes

How will full-time and part-time status be calculated?
Physician full-time equivalent (FTE) status will be determined by total clinical compensation, independent of funding modality, against the CIHI benchmark for their predominant license type. This is a nationally accepted standard for determining FTE for physicians and ensures the most consistent and equitable administration of the retirement fund across all clinical services delivered by a provider.
FTE will be rounded to the nearest single decimal point to pro-rate the eligible reimbursement amount. Physicians who are part-time will have their FTE prorated. More information will be provided on the exact calculation in December 2024.

How was my FTE calculated?
Your FTE was calculated using CIHI's methodology, which uses clinical payments to estimate physician workload.

- Specialty Benchmark: The CIHI methodology looks at the total clinical earnings of individual physicians within each specialty. It looks at relative ranges in compensation and applies statistical methods to adjust for differences in

workloads and earnings to calculate a total compensation benchmark for a full-time-equivalent (FTE) within each specialty.

- Your FTE: Your own clinical earnings are compared to this benchmark to calculate your individual FTE for the purposes for pro rating your maximum retirement fund eligibility amount.

This method provides a standardized way to estimate physician FTEs activity across different specialties, payments methods, and contracts in Nova Scotia.

What is the CIHI methodology?

The CIHI methodology looks at the total clinical earnings of individual physicians within each specialty to estimate physician workload. Briefly, the methodology entails the following steps:

- All physicians within a specialty group with earnings from the 40th percentile to 60th percentile are considered a 1.0 FTE.
- Physicians between 0 and the 39th percentile are prorated against the 40th percentile physician. The 61st percentile physician to the 100th percentile use a log formula against the 60th percentile physician to develop their FTE which will be higher than 1.0 FTE (but not prorated).
- Then the sum of the total compensation is divided by the sum of total FTE to calculate average FTE for the specialty.
- For purposes of calculating FTE for the retirement fund, each physician's individual earnings were then compared to the average for the specialty. Physicians with earnings greater than the average are calculated as a 1.0 FTE, and physicians with earnings less than the average are prorated and rounded up to the nearest decimal. For example, a physician with earnings at 1.1 times the average is a 1.0 FTE; a physician with earnings at 0.76 times the average is a 0.8 FTE; a physician with earnings at 0.42 FTE is a 0.5 FTE.

For more information on CIHI's FTE methodology, please see the National Physician Database Data Release, Appendix B.

Are Nova Scotia physicians being compared against physicians in other provinces in calculating FTE?

No, the data used to calculate FTE was solely Nova Scotia physician earnings, grouped by specialty.

What about specialties that are not usually included in the CIHI Reports, such as Pathology and DI?

The same approach and methodology was used. Nova Scotia data on earnings for each physician with the specialty was gathered and the methodology above was applied to that data.

Why were earnings used to calculate FTE, instead of hours worked?

A consistent approach to calculating FTE, regardless of payment modality, was needed. Under the fee-for-service payment model and some others, there is no data or reporting on hours worked. This is why total clinical earnings compared with average earnings by specialty was used to calculate FTE for purposes of the retirement fund.

For physicians who practice multiple specialties (for instance family medicine and emergency medicine), which specialty are they being compared against for purposes of calculating FTE?

For the purposes of the retirement fund calculation, a physician's license type has been assigned based on their predominant payment model. For instance, if payments in Family Medicine are higher than payments in Emergency Medicine, the physician will be compared within the Family Medicine group for purposes of calculating FTE.

How will years of practice be calculated?

Years of practice will be assessed against the College of Physicians and Surgeons of Nova Scotia (CPSNS) most recent licensure date, with demonstrated clinical work in each fiscal year within the province of Nova Scotia. Years of practice will be calculated as of March 31 of the current tax year. A physician's residency will not be counted towards their years of practice. A physician's fellowship will be counted towards their years of practice so long as they meet the eligibility requirements.

Do all physicians start at zero (0) years of practice when the fund is implemented?

Each physician's years of practice under this program will be calculated starting with the date of their most recent licensure with the NS College. For example, if you have been practicing in NS for 16 years, you will be eligible for a matched reimbursement up to $15,000 for the 2024 tax year as you have greater than 15 continuous years of practice in NS.

How will I know if matching is required?
Physicians with less than 5 years of service in Nova Scotia will not be required to provide proof of retirement savings contributions to receive a reimbursement from the province, though this fund is intended to support long term retirement fund investment. However, they will still be required to opt-in and enroll in the program. Physicians with more than 5 years of experience will need to make contributions to a retirement savings vehicle of their choice (e.g., TFSA, RRSP, etc.) and retain proof of contribution before receiving a matched reimbursement up to the maximum eligible amount.

Will Workers Compensation Board (WCB) billing be included in the calculation of FTE?
No, only publicly insured clinical service billings will be included in the FTE calculation.

Will Tip Top reduced earnings impact a physicians FTE calculation?
A physician's FTE will be based on clinical earnings; if their workload and total compensation reduces as they transition to retirement, whether under the Tip Top program or not, their corresponding incentive eligibility will align with that calculated FTE.

Is the program retroactive?
The retirement fund eligibility is assessed annually and is not retroactive.

Will eligible reimbursement payments accumulate year-over-year if they aren't used?
Eligible payments will not accumulate year-over-year if physicians decide not to opt-in to the fund.

Process

When will physicians be informed of their eligibility and conditions for matching (if applicable)?
The Department of Health and Wellness is currently working to calculate each eligible physician retirement fund maximum reimbursement amount based on years of service, and full or part-time status.
Physicians will be informed of their individual retirement fund eligibility amount and the conditions for matching (if applicable) by December 2024.

What is the deadline for eligible physicians with more than five years of practice to contribute to a chosen retirement vehicle? UPDATED
To provide flexibility and to maximize a physician's opportunity to participate, the Department of Health and Wellness has **extended the contribution deadline for the 2024 Physician Retirement Fund to align with the opt-in deadline.** If applicable, physicians must contribute to their chosen retirement vehicle by **March 31, 2025**.

Note: Before the extension, contribution deadlines were aligned to the 2024 tax year contribution window (e.g., March 3, 2025, for RRSPs). For simplicity, and to maximize participation, we will now accept physician contributions made up to March 31, 2025.

Will eligible physicians with more than 5 years of experience be required to show proof of contribution?
Physicians with more than 5 years of practice will have until the end of the 2024 tax year contribution window to contribute to their chosen retirement vehicle. Physicians must provide an attestation of their contributions by March 31, 2025, in order to be eligible for the 2024 payment under this program. Late notification will NOT be considered. More details on the attestation process and how to enroll will be provided in December 2024.

Do I need to sign-up?
All physicians, including those with less than 5-years' experience and no matching requirement, will be required to opt-in to the retirement fund program. Details on how to enroll will be provided by December 2024.

What retirement vehicles are eligible?
The retirement vehicle is the choice of the physician but includes individual or spousal RRSP, TFSAs, Third-Party Pension Plans, Individual Pension Plan or a Multi-Employer Pension Plan (e.g., Medicus).

Does the retirement vehicle have to be registered?
The retirement vehicle chosen by the physician does not need to be registered.

Are there restrictions on what a physician can do with the reimbursement funds they receive under this program?
Having provided proof of contribution, the money a physician receives from the retirement fund is the reimbursement of this contribution and does not have restrictions.

Reimbursement

How will eligible physicians be reimbursed?
Medavie, on behalf of the Province, will issue individual lump sum physician reimbursement for their eligible amount in Spring 2025.

Where will the reimbursement be deposited?
The reimbursement will be deposited to each physician's bank account associated with their CMPA Business Arrangement (BA) already established with Medavie. If you wish to change the banking information associated with this BA, please complete the MSI Provider Arrangement (BA) form located on the MSI website at https://msi.medavie.bluecross.ca/new-registration/. If you no longer have a CMPA BA with MSI, you will instead be issued a cheque to the address on file.

Is the retirement fund a taxable benefit?
Yes, and reimbursement received from the retirement fund will be deposited into the account associated with the physicians CMPA Business Arrangement (BA) and will be counted as income. Like other income that is received, it is the physician's responsibility to determine how it is reported for tax purposes. Tax related questions should be directed to a tax professional suited to advise you related to your personal circumstances.

Could the reimbursement payment be audited?
Yes, a physicians reimbursement payment may be audited to ensure that the physician meets the requirements.

Contact Information

Who do I contact for more information?
Details of your individual eligibility will be provided to you through DNS in December. If you have questions about your eligibility once this is received, please email psaccountability@novascotia.ca for all retirement fund inquiries.

PHYSICIAN'S BULLETIN

November 22, 2024: Vol. LXIX, ISSUE 8

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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NEW INTERIM FEE

Effective September 18, 2024 the following interim health service code is available for billing:

Category	Code	Description	Base Units	Anae Units
MASG	92.84B	**Arthroscopic Repair (Hip) with Labral Tear**	473 MSU	4 + T

Description
This interim fee code is only for orthopedic surgeons who specialize in hip arthroscopy with labral tear. MSI must pre-approve use of this code by providers.

Billing Guidelines:

- Restricted to orthopedic surgeons with prior approval from MSI.
- Maximum one hip arthroscopy payable per patient per day.
- Hip arthroscopies are composite fees and include all necessary procedures. No other procedures involving the hip are payable during the same operation.

Specialty:
SP=ORTH with expertise in this procedure – prior approval required

Assistant:
RO=SRAS allowed

Regions:
RG=LEFT or RG=RIGT

Location:
LO=HOSP

NEW UPCOMING INTERIM FEE

The following service will be effective December 1, 2024; however, physicians are required to hold their claims until the system is updated. Notification and the health service code will be published in an upcoming Physician's Bulletin when claims can be submitted.

Category	Code	Description	Base Units
DEFT	TBD	**Advance Care Planning Discussion** **Description** Advance Care Planning Discussion may be claimed when the patient's family physician, or if the patient is admitted to an acute care facility, their most responsible physician, has a face to face (in person) conversation with the patient (or the patients substitute decision maker either face to face or virtually) to discuss their wishes for future health care based on their beliefs and values, determines the substitutes decision maker (SDM), documents the conversation in the patient's health record, and captures the outcome of that conversation by completing the initial Patient-Centered Priorities and Goals of Care (GOC) form. In extenuating circumstances, for established homebound patients only, as defined by the Preamble, this service may be rendered virtually by telephone or PHIA compliant video platform. The circumstances necessitating the virtual visit must be documented in the health record. Where possible, the GOC form should be submitted to the patient's hospital chart through the appropriate health records department. A copy of the document must be shared with the patient so that it may be added to their Green Sleeve folder, if applicable. **Billing Guidelines:** Documentation of the Advance Care Planning Discussion, the patient appointment substitute decision maker, and resultant completion of the Patient-Centered Priorities and Goals of Care (GOC) form must be in the patient's health record AND, where possible, the GOC form must be sent/faxed to the appropriate hospital records department for inclusion in the patient's hospital chart. May not be claimed where this service is part of the compensation for an existing health service: • 03.04D Geriatrician's Initial Comprehensive Consultation • 03.04E Family Physician's Initial Geriatric Inpatient Medical Assessment • CGA1 LTC Clinical Geriatric Assessment • 03.09C Palliative Care Consultation • 03.09H Antenatal Palliative Care Consultation • Critical Care HSC's Adult and Pediatric	15 MSU

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FACILITY ON CALL UPDATES

Effective October 21, 2024, the following Rota may be billed from an additional facility (18):

Health Service Code	Description	Weekday	Weekend/Holidays (DA=RGE1)	Approved Facilities
F1008	Facility on Call Category 1 Family Medicine O.R. Call Assists	$350	$500	Valley Regional, St. Martha's, Cape Breton Regional, Dartmouth General, Aberdeen, Cumberland Regional, Colchester East Hants Health Centre

Effective November 25, 2024, the following Rota may be billed from an additional facility (166528):

Health Service Code	Description	Weekday	Weekend/Holidays (DA=RGE1)	Approved Facilities
F1006	Facility on Call Category 1 Hospitalist	$350	$500	IWK/Grace, West Bedford Transitional Care Facility

Billing Matters Billing Reminders, Updates, New Explanatory Codes

Physician Retirement Fund

The Government has introduced a retirement fund initiative for physicians practicing in Nova Scotia. This retirement fund will support physicians in their continued clinical practice in Nova Scotia and assist in their long-term financial planning. Please see an updated FAQ: Retirement Fund FAQ

Audiologist Referrals to Specialists

As published in the July 26, 2024 physician's bulletin, the specialties otolaryngology, neurology, and internal medicine may claim a consultation when a patient is referred to them by an audiologist. The referring audiologist number is only required when claiming an 03.07 or 03.08 as this is a referral required service. The specialist may then claim any necessary insured procedures or services as they have received a valid referral for that patient. The referring audiologist number is not required on claims for any follow-up care/procedures after the consultation. Entering an audiologist referring provider number in procedures/services after the consultation may result in the claim being rejected, as a referring provider is not required on these claims.

As a reminder, MSI will pay for a visit or consultation to determine if a treatment method is insured, even though the proposed procedure is non-insured. If the proposed procedure or treatment is always uninsured, a visit or consultation may not be claimed. *(2.2.9)*

Physicians 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.

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NEW AND UPDATED EXPLANATORY CODES

Code	Description
GN131	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST SUBMIT YOUR COMPLETED GAC PHYSICIAN DECLARATION IN ORDER TO CLAIM 03.04K.
MJ095	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 92.84B HAS ALREADY BEEN CLAIMED FOR THIS PATIENT ON THIS DAY.
MJ096	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 92.84B IS A COMPOSITE FEE AND MAY NOT BE CLAIMED AT THE SAME SERVICE OCCURRENCE AS ANY OTHER PROCEDURES INVOLVING THE HIP.
MJ097	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 92.84B IS A COMPOSITE FEE. NO OTHER PROCEDURES INVOLVING THE HIP MAY BE CLAIMED AT THE SAME SERVICE OCCURRENCE.

NOTICE TO VENDORS – UPCOMING TECHNICAL CHANGES REQUIRED

Communication has been sent to vendors on October 16, and October 31, 2024 regarding upcoming technical changes related to the service encounter detail record data to support upcoming payment requirements. The specifications were included in the communication, and an updated Vendor Manual has been uploaded on the MSI website.

The modifications made to vendor software need to be communicated to, and validated by, Medavie Blue Cross.

To schedule a date to have your software tested, or if you have not received the communications and require more information, please contact us by email: BC_MSIBusinessAnalysts@medavie.ca

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday November 22, 2024. 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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HELPFUL LINKS

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

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2025 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE	CONTRACT PAY PERIOD
December 24, 2024**	January 2, 2025	January 8, 2025	December 20, 2024-January 2, 2025
January 13, 2025	January 16, 2025	January 22, 2025	January 3-16, 2025
January 27, 2025	January 30, 2025	February 5, 2025	January 17-30, 2025
February 7, 2025**	**February 12, 2025****	February 19, 2025	January 31-February 13, 2025
February 24, 2025	February 27, 2025	March 5, 2025	February 14-27, 2025
March 10, 2025	March 13, 2025	March 19, 2025	February 28-March 13, 2025
March 24, 2025	March 27, 2025	April 2, 2025	March 14-27, 2025
April 7, 2025	April 10, 2025	April 16, 2025	March 28-April 10, 2025
April 21, 2025	April 24, 2025	April 30, 2025	April 11-24, 2025
May 5, 2025	May 8, 2025	May 14, 2025	April 25-May 8, 2025
May 16, 2025**	May 22, 2025	May 28, 2025	May 9-22, 2025
June 2, 2025	June 5, 2025	June 11, 2025	May 23-June 5, 2025
June 16, 2025	June 19, 2025	June 25, 2025	June 6-19, 2025
June 27, 2025**	July 3, 2025	July 9, 2025	June 20-July 3, 2025
July 14, 2025	July 17, 2025	July 23, 2025	July 4-17, 2025
July 25, 2025**	**July 30, 2025****	August 6, 2025	July 18-31, 2025
August 11, 2025	August 14, 2025	August 20, 2025	August 1-14, 2025
August 22, 2025**	**August 27, 2025****	September 3, 2025	August 15-28, 2025
September 8, 2025	September 11, 2025	September 17, 2025	August 29-September 11, 2025
September 19, 2025**	**September 24, 2025****	October 1, 2025	September 12-25, 2025
October 3, 2025**	**October 8, 2025****	October 15, 2025	September 26-October 9, 2025
October 20, 2025	October 23, 2025	October 29, 2025	October 10-23, 2025
October 31, 2025**	**November 5, 2025****	November 12, 2025	October 24-November 6, 2025
November 17, 2025	November 20, 2025	November 26, 2025	November 7-20, 2025
December 1, 2025	December 4, 2025	December 10, 2025	November 21-December 4, 2025
December 15, 2025	December 18, 2025	December 24, 2025	December 5-18, 2025
December 24, 2025**	January 1, 2026	January 7, 2026	December 19, 2025-January 1, 2026
11:00 AM CUT OFF	**11:59 PM CUT OFF**		

NOTE:

Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Sessional Payments and Locum Claim Forms. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut off date to ensure processing for that payment period.

PLEASE NOTE, THE ** INDICATES A DATE VARIATION

Please make a note in your schedule of the following dates MSI will accept as "Holidays".	
NEW YEAR'S DAY	WEDNESDAY, JANUARY 1 2025
HERITAGE DAY	MONDAY, FEBRUARY 17, 2025
GOOD FRIDAY	FRIDAY, APRIL 18, 2025
EASTER MONDAY	MONDAY, APRIL 21, 2025
VICTORIA DAY	MONDAY, MAY 19, 2025
CANADA DAY	TUESDAY, JULY 1, 2025
CIVIC HOLIDAY	MONDAY, AUGUST 4, 2025
LABOUR DAY	MONDAY, SEPTEMBER 1, 2025
NATIONAL DAY FOR TRUTH AND RECONCILIATION	TUESDAY, SEPTEMBER 30, 2025
THANKSGIVING DAY	MONDAY, OCTOBER 13, 2025
REMEMBRANCE DAY	TUESDAY, NOVEMBER 11, 2025
CHRISTMAS DAY	THURSDAY, DECEMBER 25, 2025
BOXING DAY	FRIDAY, DECEMBER 26, 2025
NEW YEAR'S DAY	THURSDAY, JANUARY 1, 2026

PHYSICIAN'S BULLETIN
October 4, 2024: Vol. LXIX, ISSUE 5

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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NEW FEES

Effective November 1, 2024 the following health service code is available for billing:

Category	Code	Description	Base Units
ADON	13.59L	**Provincial Immunization – Respiratory Syncytial Virus Vaccine for older adults RO=RSVV** **Description** Respiratory Syncytial Virus (RSV) Vaccine for 60 years and older residing in licensed long-term care facilities and those hospital inpatients 60 years and older who are awaiting placement. **Billing Guidelines:** • Maximum 1 dose • Minimum 60 years of age residing in licensed long-term care facilities and those minimum 60 years of age hospital inpatients who are awaiting placement. **Location:** LO=NRHM, LO=HOSP	6 MSU

FACILITY ON CALL UPDATES

Effective August 1, 2024, the following Rota may only be claimed from the IWK facility.

Heath Service Code	Description	Approved Facility
F1006	Facility on Call Category 1 – Hospitalist	17

Physicians are advised of the correction to the following Facility On-Call Rotas effective September 27, 2024. The following must meet the established Facility On-Call billing guidelines for a **Level 3 Rota**.

Health Service Code	Description	Weekday	Weekend/Holidays (DA=RGE1)	Approved Facility
F3040	Inpatient Withdrawal Management	$200	$250	165388

May only be claimed one per day per physician.

Health Service Code	Description	Weekday	Weekend/Holidays (DA=RGE1)	Approved Facility
F3041	Recovery Support Center	$200	$250	165388

LFM SERVICE ENCOUNTER VALUE ADJUSTMENTS FOR SELECT SERVICES

Effective immediately, the LFM Service Encounter values for some services under the Longitudinal Family Medicine payment model will change. The changes will apply retroactively, effective April 1, 2024 onwards, and will be reflected in LFM physicians' historical SER on their quarterly reports. Changes include:

Service	Code + Modifiers	Current Value	New Value
Comprehensive Well Infant/Child Visit Using the Rourke Baby Record	03.03 CT=RKBR; ME=CARE, RO=WBCR	1	2
Routine Pre Natal Visit	03.03 LO=OFFC, RO=ANTL, RP=SUBS, ME=CARE	1	2
Well Baby Care	03.03 LO=OFFC, ME=CARE, RO=WBCR	1	2
Complete Pregnancy Exam	03.04 LO=OFFC, RO=ANTL, RP=INTL (RF=REFD)	1	2
Post Natal Care Visit	03.03 LO=OFFC, RO=PTNT	1	2
Medical Abortion	03.03V	1	3
IUD Insertion	81.8	2	3
Long Term Care Clinical Geriatric Assessment	CGA1	1	2

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NEW PREMABLE ADDITION

The following has been added to the Physician's Manual Preamble to clarify the use of the Comprehensive Geriatric Assessment (CGA) tool in the community setting. The CGA tool may form part of a prolonged geriatric office visit (03.03A). Existing preamble rules for visits must be satisfied.

Community-based Comprehensive Geriatric Assessment

A community-based Comprehensive Geriatric Assessment (CGA) equips primary health care providers with a well-established, evidence-informed process to detect the early onset of health problems in their geriatric patients and potentially enable timely intervention to improve health. The CGA is a process of care available to all physicians, in which older adults health and function are assessed and a corresponding treatment plan is developed. The CGA and documentation thereof in the patient's health record may form part of the prolonged geriatric visit. Age-related health problems once identified through the CGA could be modified through targeted interventions. Evidence supports the role of early intervention in slowing the progression of health conditions and improving long-term health outcomes.

It is recommended that the CGA process be initiated and documented as a baseline in all patients over the age of 65 or who exhibit signs of frailty. If frailty is identified, development and implementation of a wellness plan is recommended with the CGA process repeated and documented yearly. In the non-frail elderly population, it is recommended that the CGA process be repeated every five years. The CGA should be made available to frail patients for inclusion in their Green Sleeve, for presentation when seeking acute care, and be attached to all consultation requests.

The CGA tool is available to all primary care providers in paper-based or electronic format in their EMRs.

Billing Matters Billing Reminders, Updates, New Explanatory Codes

Physicians 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.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
GN137	INVALID REFERRAL PROVIDER TYPE FOR THIS SERVICE.
CN022	INVALID REFERRAL PROVIDER TYPE FOR SPECIALITY CODE PRESENT ON SERVICE ENCOUNTER.
AD098	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS RO=RSVV MAY NOT BE CLAIMED FROM THIS LOCATION

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday September 27, 2024. The files to download are:
Health Service (SERVICES.DAT), Modifiers (MODVALS.DAT), Health Service Description (SERV_DSC.DAT), and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

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

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

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PHYSICIAN'S BULLETIN
July 26, 2024: Vol. LXIX, ISSUE 4

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

LFM TRAY FEES - UPDATE

Effective immediately, physicians remunerated under the LFM funding model may submit Tray Fees under their Fee for Service business arrangement for payment at full value when rendering a health service that allows for Tray Fees. The health service itself must still be billed under the LFM business arrangement for payment at the LFM value. This applies to:

- 03.26B – Pap smear tray fee
- 13.59M – Provincial immunization tray fee
- UDS1 – Urine drug screen tray fee

Physicians are not required to go back and delete and resubmit any previously submitted tray fees, as MSI will issue a one-time retroactive top-up payment to LFM physicians for any Tray Fees submitted under the LFM business arrangement from October 1, 2023 - July 26, 2024. This will be reconciled once 90 days has elapsed.

PREAMBLE UPDATES

Please be advised of the following Preamble addition:

New Definition

Substitute Decision Maker

When a patient lacks the capacity to make decisions, physicians may interact with the patient's substitute decision maker (SDM), as described through the Nova Scotia Personal Directives Act, to provide services to their patients. The patient must be present during the service encounter. This provision is not intended for family meetings. The SDM and the circumstances requiring the physician to provide care through the SDM must be documented in the patient's health record. *(1.1.62)*

PREAMBLE UPDATES CONTINUED

Please be advised of the following Preamble update:

Updated Definition

GP Enhanced Hours Modifier (5.1.188)

This modifier is intended to promote enhanced patient access to primary care outside of traditional office hours. This modifier is available for select services provided by family physicians who have an ongoing relationship with their patients, and for select services provided by family physicians in walk-in clinics. *(5.1.189)*

Billing Guidelines:

- The eligible time periods are from 6a.m. to 8a.m. weekday mornings and 5p.m. to 10p.m. on weeknights, where weekdays are defined as Monday through Friday. On Saturday, Sunday and Holidays (as defined by the MSI Physicians Bulletin) the eligible time period is from 9a.m. to 10p.m.
- Physicians should offer and book appointments during these time periods.
- Select services provided in walk-in clinics are eligible for the GP Enhanced Hours Modifier during these eligible time periods. *(5.1.190)*

The following visit services are eligible for the GP Enhanced Hours Modifier:

- 03.03 Office visits – includes WBCR, ANTL, PTNT etc.
- 03.03A Geriatric office visits
- 03.03C Palliative care support
- 03.03E Adults with developmental disabilities
- 03.03J OAT initial visit
- 03.03K OAT transfer of care from program
- 03.03L OAT transfer of care
- 03.03V Medical abortion
- 03.04 Comprehensive visit
- 03.04I PSP Mental health visit
- 03.09C Palliative care consultation
- 08.41 Hypnotherapy
- 08.44 Group therapy
- 08.45 Family therapy
- 08.49A Counselling
- 08.49B Psychotherapy

The following visit services are eligible for the GP Enhanced Hours Modifier when billed by the patient's family physician only. Walk-in clinics may not bill the following services:

- 03.03B Complex care
- 08.49C Lifestyle counselling *(5.1.229)*

Claims for eligible services should be submitted with the modifier TI=GPEW. *(5.1.191)*

NOTE: For services where the GP 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. *(5.1.192)*

Contract physicians may shadow bill the GP Enhanced Hours Modifier as appropriate. *(5.1.193)*

AUDIOLOGISTS REFERRING TO SPECIALISTS

As part of the Premier's Healthcare Improvement Challenge, one of the top ten ideas proposed was expanding the accepted referring provider types to include audiologists to send direct referrals to ear, nose and throat (ENT) physicians.

Effective August 1, 2024, the following specialties may claim a consultation when a patient is referred to them by an audiologist:

- OTOL - Otolaryngology
- NEUR - Neurology
- INMD – Internal Medicine

Referrals from audiologists apply to HSC 03.07 and 03.08 only. All applicable preamble rules for consultations apply.

Specialists are not eligible to claim 03.09K when providing advice to audiologists. However, audiologists are considered eligible allied health care practitioners for family physicians claiming AHCP1.

Audiologists who intend to refer are required to complete an application and register to receive an MSI Provider Number for the purpose of referring patients to the identified specialties.

Physicians will need to use this provider number when submitting their claims. Audiologists should send an email to MSIProviders@medavie.ca to receive and return their application.

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.

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

UPDATED FILES

There are no updated files to download.

CONTACT INFORMATION

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PHYSICIAN'S BULLETIN
June 10 2024: Vol. LXIX, ISSUE 4

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Job Title: Medical Consultant (Medicare Programs-Monitoring)

Job Title:	Medical Consultant
Department:	Nova Scotia Medicare Programs
Competition:	87139
Internal/External:	Internal/ External
Employment	External Medical Consultant- Part Time
Location:	Dartmouth, Nova Scotia
Salary:	Competitive Compensation
Reports To:	Team Leader, NS Medicare Programs

Role Summary:
We are currently accepting applications for an external Medical Consultant to join the Medicare Programs Team on a part time basis. The successful candidate will work with the Medicare Programs Team and will be responsible for supporting the MSI post-payment monitoring function. The Medical Consultant will provide the medical link between paying agency and providers. In collaboration with the MSI Audit Team, they will advise key stakeholders of Medavie Blue Cross and the Department of Health and Wellness of Nova Scotia on MSI Monitoring related matters including the development of policies and procedures.

As a MSI Monitoring Medical Consultant, your key responsibilities will include:

- Support a team of Medicare Auditors whose primary focus is to conduct billing audits.
- Support the evaluation of select alternative funding contracts, includes interviews with providers and other parties.
- Assist in the development of the annual audit plan, procedures to enhance monitoring operations.
- Participate and provide feedback into the development of risk analysis strategies to utilize departmental resources efficiently.
- Communicate with providers, Nova Scotia residents, Department of Health and Wellness, Doctors Nova Scotia, law enforcement, other government agencies in relation to MSI audit.
- Provide feedback and billing guidance to the audit team and physicians as required, in relation to billing audit results. This feedback can include face to face meetings to discuss audit findings.
- Support the development of Physician Education on the NS fee code and guidelines. Provide education to physician as requested through presentations and feedback through post payment audit results.
- Participate in various meetings with the Department of Health and Wellness and other stakeholders as required.
- Resolve issues and maintain productive, professional relationships with medical provider community and Department of Health and Wellness; inform providers through MSI Physician Bulletin publications of changing audit policies, administrative procedures, and billing issues.
- Liaise with and provide support to staff from other MSI departments including the provision of claims assessment support as required.
- Provide support to the Nova Scotia Department of Health and Wellness regarding physician appeals of billing audits. This support includes attending Facilitated Resolutions and Arbitrations to discuss audit findings.
- Maintain confidentiality, respecting both patients and provider matters.

As the ideal candidate, you possess the following qualifications:

Education: University degree with a Doctor of Medicine with an active medical license in good standing in the current jurisdiction, an active member with the Canadian Medical Protective Association and eligibility for licensure with the College of Physicians and Surgeons of Nova Scotia.

Work Experience: 10 to 15 years' experience as a physician in a range of practice settings. Specialist training and administrative experience would be an asset.

Computer Skills: General computer knowledge, including functional knowledge of Microsoft Office products (Word, Excel, Power Point) and email.

Communication Skills: Excellent written and verbal communication skills are fundamental to the position. Strong interpersonal skills and the ability to build relationships, mentor and support providers and resolve conflicts.

Other Qualifications: Ability to travel throughout the province of Nova Scotia.

You also demonstrate the following core competencies:

Knowledge: Uses knowledge and industry best practices to provide guidance and/or advice to practitioners, leaders, and coworkers on key issues in own area of expertise. Demonstrates a specialized knowledge of all processes, policies, and precedents to do the job and solve day to day issues independently. This includes familiarity with safe prescribing guidelines, as well as relevant standards and expectations as outlined by each licensing authority.

Analytical Thinking: Uses knowledge and experience to solve a variety of routine and complex technical problems. Identifies the cause of problems and implements the most appropriate solution.

Communication: Able to communicate complex information effectively through both oral and written means. Demonstrates the full range of effective verbal communication skills in a variety of settings such as formal meetings, presentations and across disciplines.

Customer Orientation: Able to support, mentor and guide practitioners even when their viewpoint may be different than your own.

Execution and Organizational Skills: Exceptional organizational and time-management skills. Able to prioritize work within a changing work environment under the pressure of deadlines.

Teamwork: Provides professional advice and support to team members, proactively searches for ways to improve work effectiveness and performance.

If you are interested in working with a team of professionals in a challenging role and you possess the necessary qualifications, please follow the instructions for applying via the Medavie Blue Cross Corporate website by clicking the link below.

APPLY NOW

We would like to thank all candidates for expressing interest. Please note only those selected for interviews will be contacted.

Medavie Blue Cross is an equal opportunity employer.

PHYSICIAN'S BULLETIN
May 24, 2024: Vol. LXIX, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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Public Health – COVID-19 Vaccines

This fall, physicians will be able to offer COVID-19 vaccines to their patients. Vaccine products will include Moderna for individuals 6 months and older, Pfizer for individuals 12 years and older (no pediatric or infant formulation will be available), and Novavax for individuals 12 years and older. More details will be provided in early September when the provincial publicly funded influenza and COVID-19 immunization programs are finalized.

While pharmacists continue to utilize CANImmunize to assist with appointment booking and documentation, physicians are not required to use this system, and can enter the vaccination record directly into their EMR system. Physicians using CANImmunize can continue to do so or can switch to the EMR for documentation purposes.

As a reminder, the NSH Provincial EMRs & Integrated Solutions website contains helpful guides, tips and templates for EMR use.

Public Health – Measles Vaccination

The publicly funded immunization program eligibility for measles containing vaccines is now updated due to the risk of importation of a case of measles case into Nova Scotia associated with travel.

Please see full eligibility for measles containing vaccines on pages 9 and 10 of the Publicly Funded Vaccine/Immunoglobulin Eligibility Policy.

Physicians who were holding 13.59L RO=MMRT PT=RISK claims for patients born prior to 1970 may now be submitted.

In addition, effective April 3, 2024 the eligibility for 13.59L RO=MMAR also includes:

- Students born before 1970 in post-secondary education settings are eligible for 1 dose of measles-containing vaccine.
- Health care workers regardless of age/year of birth are eligible for 2 doses of measles-containing vaccine.

For MMR vaccine given for travel purposes:
(Infants 6 months to less than 12 months and adults born before 1970)
13.59L RO=MMRT, PT=RISK Measles, Mumps, Rubella vaccine for travel to areas at risk for measles: text required to indicate travel/risk

For MMRV vaccine given in the routine childhood schedule:
13.59L RO=MMRV Measles, Mumps, Rubella and Varicella vaccine

For routine MMR vaccine given in the routine adult schedule:
13.59L RO=MMAR Measles, Mumps, Rubella vaccine

FEE UPDATE

Category	Code	Description	Base Units
ADON	13.59L	Injection for pneumococcal pneumonia, bacteraemia and meningitis (Pneumovax or Prevnar 20) **RO=PNEU** **Billing Guidelines** Maximum doses per lifetime will be increased from 3 to 5. Patient must be minimum 6 weeks old. Text is required when claiming with high-risk modifier (PT=RISK)	6 MSU
ADON	13.59L	Pneumococcal conjugate vaccine (Prevnar 13 or Vaxneuvance) **RO=PNEC** **Billing Guidelines** Maximum 4 doses per lifetime, a 4th dose will no longer require the PT=RISK modifier. Patient must be minimum 6 weeks old. Text is required when claiming with high-risk modifier (PT=RISK)	6 MSU

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NEW FEES

Effective May 24, 2024 the following health service codes are available for billing:

The new HSC must meet the established Facility On-Call billing guidelines for a Level 1 Rota.

Health Service Code	Description	Weekday	Weekend/Holidays (DA=RGE1)
F1040	Inpatient Withdrawal Management	$350	$500

F1040 is not tied to a specific facility/site but must be submitted using facility # 165388
May only be claimed one per day per physician.

Health Service Code	Description	Weekday	Weekend/Holidays (DA=RGE1)	Approved Facility
F1041	Recovery Support Center	$350	$500	Dartmouth Recovery Support Center (165388FACILITY)

INTERIM FEE UPDATES

Category	Code	Description	Base Units
DEFT	NPIV1	**New Patient Intake Visit** **Description** A new patient intake visit may be billed when a family physician accepts a new patient into their office practice and arranges an appointment for the purpose of gathering a detailed medical and social history in order to establish an ongoing patient-physician relationship and to construct the patient's medical record. Includes review of clinical documents prior to the visit and establishment of medical record on the same day. (Includes face to face and non-face to face time) **Billing Guidelines** • Such an encounter shall include documentation of the new patient's current health status, past medical history, relevant social and family history, and a list of current medications and allergies, as well as any physical examination as clinically appropriate. All components of this service must be completed on the same day. • If a medically necessary service is indicated during the initial visit, the time taken to address this can contribute to the multiples claimed. This fee is considered to compensate for a medically necessary service, if required at the initial visit. • Physician must submit ME=CARE declaration letter before billing any NPIV services. • The fee can only be billed once per physician per patient when the physician is first accepting the patient into their attached roster, it cannot be billed for patients already on your roster. For physicians in a collaborative practice, you may bill the NPIV1 when you are accepting a patient from a retiring/relocating physician within your collaborative	34 MSU +MU

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Category	Code	Description	Base Units
		practice for whom you may have billed ME=CARE in the past, as long as the patient is new to your panel. • For New Patient Intake Visits that are less than 30 minutes (including both the face to face and non-face to face time), the physician should bill fee code NPIV1 with one multiple. For New Patient Intake Visits that are greater than 30 minutes the physician can bill a maximum of 5 multiples, i.e., 90 minutes. Prolonged office visits are paid in 15-minute time blocks or portion thereof. When billing multiples, start and stop times of the encounter time must be documented in the health record and on the text field of the claim. • The NPIV fee code can only be billed once per patient per physician. • May not be billed with any other visit code or procedure code at the same encounter. • Not applicable for virtual care. • **When billed in the Nursing Home location (LO=NRHM), the following rules apply:** ○ **Only the physician most responsible for the ongoing primary care of the patient may use this code** ○ **Physicians on the LFM payment model must have Nursing Home/ Long Term Care included in their LFM hours to use this code; LFM physicians who see patients in Nursing Home / Long Term Care outside of their LFM hours may not use this code.** **Multiples:** 17 MSU per 15 minutes to a maximum of 5 multiples (90 minutes) **Premium Eligible:** TI=GPEW **Specialty Restriction:** SP=GENP **Location:** LO=OFFC, LO=NRHM, **LO=HOME**	

Nursing Home Attachment Initiative

Until July 31, 2024, family physicians providing comprehensive and continuous primary care to their patients in long-term care may bill 1(one) NPIV1 encounter with 1(one) multiple for the purpose of formally rostering an existing patient. This type NPIV1 billing is available in the long-term care/nursing home setting only (LO=NRHM).

When billing NPIV1 for an existing patient, the requirements for an office visit must be met. The text field of the claim must include the text “Existing Patient Nursing Home Attachment.” After July 31, 2024, NPIV1 claims for existing patients will no longer be accepted and NPIV1 shall be used for new patients only.

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The following interim health service codes have been made **permanent:**

Category	Code	Description	Base Units	Anaes Units
VEDT	47.25C	**Transcutaneous Aortic Valve Implantation/Replacement (TAVI)** **First Physician (RO=FPHN)** **Second Physician (RO=SPHN)** **Description** This comprehensive health service code includes all physician work required to perform a transcutaneous aortic valve implantation. This work includes, when performed percutaneous and/or open arterial cardiac access, placement of any sheath required, balloon aortic valvuloplasty, delivery, deployment and placement of the valve, temporary pacemaker insertion and closure of access sites. All means used to guide the procedure such as contrast injections, angiography, fluoroscopy, right and left cardiac catheterization, supravalvular aortography, aortic and left ventricular outflow tract measurements are included such that any radiological supervision and interpretation should not be reported or claimed. **Billing Guidelines** Do not report with the following same patient same day: • 47.03 – Closed heart valvotomy, aortic valve • 47.25 – Other replacement of aortic valve • 47.52A – Closure of arterial septal defect • 49.73 – Implantation of endocardial electrodes • 50.82 – Aortography • 50.82C – Aortic arch study • 50.91 – Arterial catheterization • 50.99C – Femoral vein puncture • 51.61B – Off pump coronary artery bypass surgery Do not report with: R1071 – Aortic root (cardiac) ADON 99.09A Morbid Obesity Surgical Add on is not applicable as this is a transcutaneous procedure **Specialty Restriction:** SP=CASG, SP=CARD, SP=GNSG, SP=INMD **Location:** LO=HOSP (QEII only)	 611 MSU 611 MSU	20+T

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Category	Code	Description	Base Units	Anae Units
MASG	97.79B	**Masculinization of Chest Wall** **Prior Approval/Preauthorization required (PA)** **Description** Complete masculinization of the chest wall for surgical treatment of well documented persistent gender dysphoria to include bilateral subcutaneous mastectomy, nipple and or areolar reduction or transposition, nipple areolar flap or free graft, chest contouring, complex wound closure and initial scar camouflage as required. No additional uninsured services may be performed or charged to the patient during this encounter. Insertion of pectoral implants is not an insured service. **Billing Guidelines** • Must have prior approval from MSI for gender affirming surgery (GAS) based on a complete and approved GAS application which is available online: https://novascotia.ca/dhw/gender-affirming-surgery/ • May not be claimed with: ○ Mastectomy HSC's: 97.12, 97.13, 97.14, 97.15, 97.31A, 97.31C, 97.32, 97.32B ○ Reconstruction of nipple HSC: 97.77 ○ Tissue shift/graft HSC's to include, but not limited to: 98.51B, 98.51C, 98.51D, 98.51E • Once per patient per lifetime RO=SRAS applicable **Specialty Restriction:** SP=PLAS **Location:** LO=HOSP	425 MSU	4+T

Category	Code	Description	Base Units	Anae Units
MASG	97.44A	**Feminization of chest wall** **Prior Approval/Preauthorization required (PA)** **Description** Complete feminization of the chest wall for the surgical treatment of well documented persistent gender dysphoria to include bilateral augmentation mammoplasty with insertion of prosthesis or prostheses, nipple-areolar reconstruction, advancement flaps, tissue shifts, complex wound closure and initial scar camouflage as required. No additional uninsured services may be performed or charged to the patient during this surgical encounter. **Billing Guidelines** • Must have prior approval from MSI for gender affirming surgery (GAS) based on a complete and approved GAS application which is available online: https://novascotia.ca/dhw/gender-affirming-surgery/	350 MSU	4+T

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Category	Code	Description	Base Units	Anae Units
		• May not be claimed with: ○ Augmentation Mammoplasty HSC's: 97.43, 97.44 ○ Insertion of tissue expander HSC: 98.98 ○ Breast Reconstruction HSC's: 97.6B, 97.6C, 97.6D, 97.75A ○ Reconstruction of nipple HSC: 97.77 ○ Tissue shift/graft HSC's to include, but not limited to: 98.51B, 98.51C, 98.51D, 98.51E • Once per patient per lifetime RO=SRAS applicable **Specialty Restriction:** SP=PLAS **Location:** LO=HOSP		

Category	Code	Description	Base Units	Anae Units
MISG	97.99B	**Revision of gender affirming chest surgery** **Prior Approval/Preauthorization required (PA)** **Description** Revision of chest surgery performed within 18 months of MSI approved gender affirming chest surgery to address complications and functional impairment only. This comprehensive service includes any scar revision, re-contouring of the chest wall, revision of nipple, and areolar reconstruction as required. The physician will submit a written request documenting the reason for the proposed revision to MSI for PA. Photographs of the affected area may be requested to support the request. No additional uninsured services may be performed or charged to the patient during this surgical encounter. **Billing Guidelines** • Original chest surgery must have had prior approval from MSI for gender affirming surgery based on a complete and approved GAS application. • Only one per patient per lifetime • Requires a formal request for prior approval/ preauthorization from MSI by the physician proposing the procedure. • May not be claimed with: ○ Reconstruction of nipple HSC: 97.77 ○ Tissue shift/graft HSC's to include, but not limited to: • 98.51B, 98.51C, 98.51D, 98.51E RO=SRAS applicable **Regions (Required)** RG=LEFT, RG=RIGT, RG=BOTH **Specialty Restriction:** SP=PLAS **Location:** LO=HOSP	150 MSU	4+T

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Category	Code	Description	Base Units
CONS	03.09M	**Preoperative comprehensive assessment for gender affirming surgery** **Description** This health service code is for the comprehensive assessment of the patient with a confirmed diagnosis of persistent gender dysphoria by the plastic surgeon intending to perform the surgery. The patient's MSI approval for gender affirming surgery should be in place prior to the consultation. The assessment must be documented in the health record and include, but is not limited to: • History and physical examination • Discussion of surgical care • Documentation that the current WPATH (World Professional Association for Transgendered Health) standards for care for surgical readiness have been met • Review of psychological assessment to ensure patient is a candidate for reconstructive surgery and discussion with other health professionals concerning patient eligibility as required • Discussion with patient support person(s) as required **Billing Guidelines** Once per patient per lifetime **Specialty Restriction:** SP=PLAS **Location:** LO=OFFC	62 MSU

Category	Code	Description	Base Units
VIST	03.03Y	**Post operative care – gender affirming chest surgery** **Description** This health service code is for the post operative assessment of the patient who has undergone MSI approved gender affirming chest surgery in the previous 18 months. May be claimed once in the 18 months after gender affirming chest surgery by the surgeon who performed the surgery. **Billing Guidelines** May be claimed once per patient within 18 months post gender affirming surgery by the physician who claimed the original gender affirming surgery. **Specialty Restriction:** SP=PLAS **Location:** LO=OFFC	36 MSU

For a full listing of current Interim Health Service Codes please see the Interim Fee Reference Guide (PDF) available on the MSI website.

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PREAMBLE UPDATE

Effective July 24, 2023, TI=GPEW was made available to walk-in clinics. Please note, the preamble requirements must be met for any office claiming TI=GPEW, and greater clarity has been added for walk-in clinics:

New Definition

This premium is intended to promote enhanced patient access to primary care outside of traditional office hours. This premium is available for select services to physicians who have an ongoing relationship with their patients and select services for physicians providing care at walk-in clinics. *(5.1.189)*

Billing Guidelines:

- The eligible time periods are from 6a.m. to 8a.m. weekday mornings and 5p.m to 10p.m on weeknights where weekdays are defined as Monday through Friday. On Saturday, Sunday and Holidays (as defined by the MSI Physicians Bulletin) the eligible time period is from 9a.m to 10p.m
- Physicians should offer and book appointments during these time periods.
- Select services provided in walk-in clinics are eligible for the Enhanced Hours Premium during premium eligible time periods. *(5.1.190)*

The following visit services are eligible for the 25% Enhanced Hours Premium:

- 03.03 Office visits – includes WBCR, ANTL, PTNT etc.
- 03.03A Geriatric office visits
- 03.03C Palliative care support
- 03.03E Adults with developmental disabilities
- 03.03J OAT initial visit
- 03.03K OAT transfer of care from program
- 03.03L OAT transfer of care
- 03.03V Medical abortion
- 03.04 Comprehensive visit
- 03.04I PSP Mental health visit
- 03.09C Palliative care consultation
- 08.41 Hypnotherapy
- 08.44 Group therapy
- 08.45 Family therapy
- 08.49A Counselling
- 08.49B Psychotherapy

The following visit services are eligible for the 25% Enhanced Hours Premium when billed by the patient's family physician only. Walk-in clinics may not bill the following services:

- 03.03B Complex care
- 08.49C Lifestyle counselling *(5.1.229)*

Only one premium can be claimed per patient encounter regardless of the number of services provided during the encounter. Claims for eligible services should be submitted with the modifier TI=GPEW. *(5.1.191)*

NOTE: For services where the Enhanced Hours Premium has been claimed, a record must be maintained and readily available to verify that the patient was booked, **registered, or intended to be seen** for an appointment during a premium-eligible time period. The appointment time should be recorded in the patient's record or office appointment books retained. *(5.1.192)*

Contract physicians may shadow bill the GP Enhanced Hours Premium **as appropriate** *(5.1.193)*

The Enhanced Hours Premium should not be claimed in circumstances where the patient is booked, **registered or intended to be seen** for an appointment time that is not eligible for the premium and then the physician "runs late". *(5.1.194)*

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PROLONGED VISIT CLARIFICATION

Please be advised of the clarifying language with regards to the 03.03 and 03.03A Prolonged Office Visit & Prolonged Geriatric Office Visit for ME=CARE:

Category	Code	Description	Base Units
VIST	03.03	**Prolonged Office Visit for ME=CARE** ME=CARE, RP=SUBS	17 MSU +MU
VIST	03.03A	**Prolonged Geriatric Office Visit for ME=CARE** ME=CARE	20.99 MSU +MU

An 03.03/03.03A is defined as a limited visit. A limited visit or an initial limited visit may be claimed when the physician provides a limited assessment for diagnosis and treatment of a patient's condition. It includes a history of the presenting problem and an evaluation of relevant body systems.

Description
A prolonged visit service is paid to family physicians who are delivering face-to-face ('in person') comprehensive and continuous care to patients whom they have an ongoing relationship. Prolonged office visits are paid in 15-minute time blocks or portion thereof, 80% of the time must be spent in direct physician to patient contact. Prolonged office visits are not to be confused with active treatment associated with detention.

As with all medical chart documentation, the clinical encounter should be documented as outlined in the CPSNS Professional Standards and Guidelines Regarding Charting, and should capture enough detail to support the rationale for billing a prolonged visit. It should be evident from the patient record that it was a face-to-face ('in-person') encounter. The start and stop time of the face-to-face encounter must be recorded in the patient record and in the text of the MSI claim.

Billing Guidelines
- Only physicians eligible to bill the ME=CARE modifier may bill for prolonged office visits.
- Each office visit can be billed up to a maximum of 60 minutes (68MSU) per day. This would include a base fee plus up to 3 additional multiples of 15 minutes each.
- Start and stop times are required for any visit billed with multiples greater than 1.
- The start and stop times must be documented in the health record and on the text field of the claim.
- Multiples are not applicable for virtual care.

Documentation
Documentation of the following provides a clear indication that a prolonged visit has taken place:
- It is evident from the patient record that it was a face-to-face ('in person') encounter.
- Start and stop times of the encounter are recorded in the patient record and the text of the MSI claim.

Multiples:
03.03 – 17 MSU per 15 minutes to a maximum of 4 multiples (60 minutes) per day
03.03A – 20.99 MSU per 15 minutes to a maximum of 4 multiples (60 minutes) per day

Premium Eligible:
TI=GPEW

Specialty Restriction:
SP=GENP

Location:
LO=OFFC

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TELEPHONE PRESCRIPTION RENEWAL (TPR1) REMINDER

Physicians are reminded that the documentation required when billing for TPR1 must include the name of the pharmacy, drug, dose, and amount prescribed. If using the EMR as documentation, it must indicate all of the required elements listed. Full details can be found in the Interim Fee Reference Guide (PDF)

ALLIED HEALTH CARE PROVIDER TO PHYSICIAN (AHCP1) REMINDER

Physicians are reminded that with regards to pharmacists, this code is for discussion of patient care. It is not for prescription renewal, clarifying ineligible prescriptions or switching to a generic form of drug. With regards to documentation, all interactions must be recorded in the patient's chart, including the time of the call, the name and professional capacity of the allied healthcare worker involved, the medical issue addressed, and the advice given. Full details can be found in the Interim Fee Reference Guide (PDF)

NEW PATIENT INTAKE VISIT (NPIV1) REMINDER

When submitting multiples greater than 1, start and stop times are required to be documented in the patients health record and the text field of the MSI claim.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
AD096	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE DATE OF BIRTH OF THE PATIENT IS PRIOR TO JANUARY 1, 1970. PLEASE RESUBMIT WITH TEXT INDICATING IF THE PATIENT IS A HEALTHCARE WORKER OR POST SECONDARY STUDENT.
AD097	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF DOSES OF 13.59L RO=PNEU IMMUNIZATIONS HAVE PREVIOUSLY BEEN PAID.
GN135	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED A FACILITY ON-CALL INPATIENT WITHDRAWAL MANAGEMENT ROTA FOR THIS SERVICE DATE.
GN136	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED A FACILITY ON-CALL RECOVERY SUPPORT CENTER ROTA FOR THIS SERVICE DATE.

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

UPDATED FILES

Updated files reflecting changes are available for download on May 24, 2024. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

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

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

In partnership with

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Physician Agreement - Program Payment Schedule (2024/25)

Program	Payment*
EMR (Envelope "A" Payments) EMR Envelope "A" payments continue monthly to eligible physicians	Monthly
CME (GP & Specialist) Payment for 2023/24 Fiscal Year (eligible billings based on 2023 calendar year)	Issued by May 31, 2024
CMPA Premium Reimbursement Covering April - June 2024	Issued by August 31, 2024
Electronic Medical Records (EMR – B&C) Payments for 2023/24 Fiscal Year	Issued by August 31, 2024
Surgical Assist Payments Payment based on eligible billings from April 1, 2023 – March 31, 2024	Issued by September 30, 2024
Collaborative Practice Incentive Program Payment for 2023/24 Fiscal Year	Issued by October 31, 2024
CMPA Premium Reimbursement Covering July – September 2024	Issued by November 30, 2024
Rural Specialist Incentive Program Measurement period April 1, 2023 – March 31, 2024	Issued by December 31, 2024
CMPA Premium Reimbursement Covering October – December 2024	Issued by February 28, 2025
Rostering Grant (FFS ME=CARE Family Physicians) Payment for 2024/25 Fiscal Year	Issued by May 31, 2025
CME (GP & Specialist) Payment for 2024/25 Fiscal Year (eligible billings based on 2024 calendar year)	Issued by May 31, 2025
CMPA Premium Reimbursement Covering January – March 2025	Issued by May 31, 2025

***Please be advised payment dates noted are anticipated payments for these programs**

PHYSICIAN'S BULLETIN

March 15, 2024: Vol. LXIX, ISSUE 2

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

Public Health – Measles Vaccination

The publicly funded immunization program eligibility for measles containing vaccines is now updated due to the risk of importation of a case of measles case into Nova Scotia associated with travel.

Please see full eligibility for measles containing vaccines on pages 9 and 10 of the Publicly Funded Vaccine/Immunoglobulin Eligibility Policy.

The eligibility now includes the following:

- Infants 6 months to less than 12 months of age travelling to regions where measles is endemic or there is community-based transmission during an outbreak are eligible for 1 dose of measles, mumps, rubella (MMR) vaccine.
  - Infants 6 months to less than 12 months of age who received 1 dose of MMR vaccine for travel still require the routine childhood 2 dose schedule.
- Adults born before 1970 without measles immunity travelling to regions where measles is endemic or there is community-based transmission during an outbreak are eligible for 1 dose of measles-containing vaccine.
- Adults born in 1970 or later without measles immunity are eligible for 2 doses of measles-containing vaccine as part of the routine adult schedule.

For MMR vaccine given for travel purposes:
(Infants 6 months to less than 12 months and adults born before 1970)
13.59L RO=MMRT, PT=RISK Measles, Mumps, Rubella vaccine for travel to areas at risk for measles: text required to indicate travel/risk
Physicians will need to hold their MMRT claims for patients born prior to 1970 until the May 24, 2024 system update. A Bulletin will be published when physicians can submit these claims.

For MMRV vaccine given in the routine childhood schedule:
13.59L RO=MMRV Measles, Mumps, Rubella and Varicella vaccine

For routine MMR vaccine given in the routine adult schedule:
13.59L RO=MMAR Measles, Mumps, Rubella vaccine

MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT
Effective April 1, 2024, the Medical Service Unit (MSU) value increased from $2.76 to $2.84

ANAESTHESIA UNIT
Effective April 1, 2024, the Anaesthesia Unit (AU) increased from $26.06 to $26.84

PSYCHIATRY

Effective April 1, 2024, the hourly psychiatry rate for General Practitioners increased to $170.59 while the hourly rate for Specialists increased to $226.85 per the tariff agreement.

NEW FEES

Effective March 15, 2024 the following codes are available for billing:

Category	Code	Description	Base Units	Anae Units
MISG	97.6F	Minor Fat Grafting to breast post mastectomy or lumpectomy for malignant or premalignant conditions to breast – to include harvesting and grafting of autologous fat ≤100ml	100 MSU	4+T
MISG	97.6G	Major Fat Grafting to breast post mastectomy or lumpectomy for malignant or premalignant conditions to breast – to include harvesting and grafting of autologous fat >100ml	150 MSU	4+T
		Description: This is a comprehensive fee for lipoaspiration from the autologous donor site(s), preparation of the grafting material by the physician, and lipoinjection to clinically significant deformities of the breast post-surgery for malignant or premalignant conditions of the breast. Based on total volume of the injectate not on the number of injection sites in the recipient area. Not intended for liposuction which is an uninsured service. **Billing Guidelines:** Maximum of 3 procedures per patient per lifetime **Regions Required:** RG=RIGT, RG-LEFT, RG=BOTH **Specialty Restriction:** SP=PLAS **Location:** LO=HOSP		

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Effective March 15, 2024 the following code is available for billing:

Category	Code	Description	Base Units
ADON	02.25C	Unilateral Diagnostic Digital Breast Tomosynthesis - Not to be used for screening	5 MSU
ADON	02.25D	Bilateral Diagnostic Digital Breast Tomosynthesis - Not to be used for screening	10 MSU

Description:
When digital breast tomosynthesis is performed and interpreted by the radiologist in addition to diagnostic mammography, digital breast tomosynthesis may be claimed as an add on to R485 is unilateral. If the imaging is bilateral, bilateral DBT may be claimed as add on to R490.

Billing Guidelines:
May be claimed as an add on to diagnostic breast imaging studies only,
not for screening breast imaging
ADON to R485 Diagnostic Mammography Unilateral (5 MSU)
ADON to R490 Diagnostic Mammography Bilateral (10 MSU)

Regions Required:
RG=RIGT, RG-LEFT, RG=BOTH

Specialty Restriction:
SP=DIRD

Location:
LO=HOSP

Effective March 15, 2024 the following code is available for billing:

Category	Code	Description	Base Units	Anae Units
MASG	72.1E	Laser Anatomic Endoscopic Enucleation of prostate >60 grams with morcellation (HoLEP, ThuLEP not for photoselective vaporization or green light laser)	406 MSU	7+T

Description:
This comprehensive fee is for the complete anatomic enucleation of large prostates (>60 grams) using laser (Holmium, Thulium) with morcellation and removal of tissue. This fee includes all endoscopic and imaging procedures required to accomplish the prostatectomy including, but not limited to, cystoscopy, urethroscopy, and retrograde pyelography. This fee includes removal of tissue, control of hemorrhage, meatotomy, vasectomy, urethrotomy, urethral dilation/calibration, as required. May not be claimed with any other prostatectomy health service codes.

Billing Guidelines:
This comprehensive fee may not be claimed with:

- MAAS 72.1A Endoscopy – revision of transurethral resection of prostate
- MASG 72.1B Endoscopy – transurethral electro-resection
- MASG 72.1C Endoscopy – resection of bladder neck – transurethral prostatectomy
- MASG 72.1D Endoscopy – transurethral electro-resection of the prostate by laser

Specialty Restriction:
SP=UROL

Location:
LO=HOSP

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INTERIM FEE UPDATE

Effective March 15, 2024, Health Service Codes 03.09L 03.09K have been adjusted to allow for multiples if the discussion exceeds 24 minutes. Please see updates below:

Category	Code	Description	Base Units
CONS	03.09K	Specialist Telephone Advice – Consultant Physician – providing advice	25 MSU **+ MU**
CONS	03.09L	Specialist Telephone Advice – Referring Physician – requesting advice	13 MSU **+ MU**

Description

This health service code may be reported for two-way telephone (or other synchronous electronic verbal communication) or face to face conversations regarding the assessment and management of the patient but without the consulting physician seeing the patient.

This service includes a review of the patient's relevant history, relevant family history, relevant history of presenting complaint, and a review of any laboratory data, PACS images, medical records or other data as needed to provide advice. This health service includes a discussion of the relevant physical findings as reported by the referring health care provider.

This health service code may also be reported for asynchronous communication regarding the assessment and management of a patient, but only when utilizing a health authority-approved platform and consistent with all other billing requirements. **Multiples may not be claimed for asynchronous services.**

The referring physician may be a nurse practitioner, midwife, optometrist, family physician or other specialist seeking an opinion from the consulting physician due to the complexity and severity of the case.

The referring physician or provider must document:

1. The patient demographic information
2. The date and time of the communication with the consultant
3. The clinical concern
4. The advice received from the consultant – including the name of the consultant

The referring physician or provider must provide an electronic or written copy of this documentation within 7 days of the service to the consultant physician.

The consultant physician must review the documentation from the referring physician or provider within 14 days of the service. If clarification or corrections are indicated in the documentation, the consulting physician must provide a written addendum to provide this clarification and return it to the referring physician or provider within 21 days of the service. Both physicians/providers are responsible for retaining medical records pertaining to this service.

The services are not reportable when the purpose of the communication is to:

- Arrange transfer
- Arrange a hospital bed for the patient
- Arrange a telemedicine consultation
- Arrange an expedited face to face consultation
- Arrange a laboratory, other diagnostic test or procedure
- Inform the referring physician of the results of diagnostic investigations
- Decline the request for a consultation or transfer the request to another physician

The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another health professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student

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Category	Code	Description	Base Units

This service is not reportable for telephone calls or face to face conversations of less than 5 minutes of two-way medical discussion.
If the discussion exceeds 24 minutes, multiple units may be claimed in 15-minute increments up to a total of maximum time of 60 minutes for the entire encounter. Where MU are claimed, start and stop times must be recorded in the patient's health record and in the text of the claim. Multiples may not be claimed for asynchronous services.

Documentation Requirements

- The referring physician or provider must document that he/she/they have communicated the reason for the consultation and relevant patient information to the consultant physician
- Both the consultant physician and the referring health care provider must document the patient's name, identifying data, date and encounter time in their respective charts or EMRs.
- The names of the referring health care provider and the consultant physician must be documented by both the referring health care provider and the consultant physician.
- The diagnosis, reason for referral, elements of the history and physical as relayed by the referring health care provider, the opinion of the consultant physician and the plan for future management must be documented by the referring health care provider and the specialist consultant. The consulting physician may use a copy of the documentation from the referring health care provider to support this HSC claim, but it must be reviewed and 'signed off' by the consulting physician.
- A written report must be sent to the referring health care provider by the specialist consultant. The specialist consultant may satisfy this requirement by returning a copy of the documentation from the referring provider as long as it was reviewed and 'signed off' by the consultant physician.
- The referring health care provider's billing number must be noted on the claim from the consultant. This is not required for the referring health care provider's claim.

Billing Guidelines
The consultant physician service is not reportable in addition to any other service for the same patient by the same physician on the same day.

The referring health care provider service may be reported when the communication with the consultant occurs on the same day as the patient visit or other service.

Multiples:
03.09K 17.5 MSU per 15 minutes
03.09L 13 MSU per 15 minutes

Specialty Restriction:
SP=GENP, SP=PSYC, SP=INMD, SP=PEDI, SP=OBGY

Location:
LO=OFFC

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WORKERS COMPENSATION BOARD UNIT VALUE CHANGES/INCREASES

WCB MEDICAL SERVICE UNIT
Effective April 1, 2024, the Workers Compensation Board Medical Service Unit (WCB MSU) value will increase to $3.16.

WORKERS COMPENSATION BOARD ANAESTHESIA UNIT
Effective April 1, 2024, the Workers Compensation Board Anesthesia Unit (WCB AU) value will increase to $29.83.

Workers' Compensation Board Fee Code Update

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been calculated for the listed WCB specific fees for fiscal year 2024-25.
The WCB specific services listed below will have their values increased effective April 1, 2024:

CODE	DESCRIPTION	APRIL 2024 VALUE
WCB12	EPS physician assessment Service. Combined office visit and completion of Form 8/10 For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15-minute increments to a maximum of 1 additional hour	**Initial visit:** $220.54 + $64.53 per 15 minutes to a maximum 4x (RO=EPS1 and RP=INTL) **Subsequent visit:** $220.54 (RO=EPS1 and RP=SUBS)
WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable	GPs…….$54 per 15 min EPS (RO=EPS1)..$64.53 per 15 min Specialists ..... $72.62 per 15 min
WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable	GPs ..... $54.00 per 15 min EPS (RO=EPS1)..$64.53 per 15 min Specialists ..... $72.62 per 15 min
WCB17	Photocopies of Chart Notes	10 pgs or less (ME=UP10)..... $32.33 11-25 pgs (ME=UP25)..... $64.53 26-50 pgs (ME=UP50)..... $128.90 Over 50 pgs (ME=OV50)..... $193.20
WCB20	Carpal Tunnel Syndrome (CTS) Assessment Report	$82.73
WCB21	Follow-up visit report	$48.44
WCB22	Completed Mandatory Generic Exemption Request Form	$16.24 per form
WCB23	Completed Non-Opioid Special Authorization Request Form	$16.24 per form
WCB24	Completed Opioid Special Authorization Request Form	$54.29 per form
WCB25	Completed WCB Substance Abuse Assessment Form	$36.21
WCB26	Return to Work Report – Physician's Report Form 8/10	$82.73
WCB27	Eye Report	$72.62
WCB28	Comprehensive Visit for Work Related Injury or Illness	$83.27
WCB29	Initial Request Form For Medical Cannabis	$89.84
WCB30	Extension Request Form For Medical Cannabis	$54.00
WCB31	WCB Interim Fee – Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed	$83.27

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PROLONGED VISIT UPDATE

Please review the updated description and requirements below:

Category	Code	Description	Base Units
VIST	03.03	**Prolonged Office Visit for ME=CARE** ME=CARE, RP=SUBS	17 MSU +MU
VIST	03.03A	**Prolonged Geriatric Office Visit for ME=CARE** ME=CARE	20.99 MSU +MU

An 03.03/03.03A is defined as a limited visit. A limited visit or an initial limited visit may be claimed when the physician provides a limited assessment for diagnosis and treatment of a patient's condition. It includes a history of the presenting problem and an evaluation of relevant body systems.

Description
A prolonged visit service is paid to family physicians who are delivering face-to-face ('in person') comprehensive and continuous care to patients whom they have an ongoing relationship. Prolonged office visits are paid in 15-minute time blocks or portion thereof, 80% of the time must be spent in direct physician to patient contact. Prolonged office visits are not to be confused with active treatment associated with detention.

A statement of the rationale for the length of the appointment, noting it was a face-to-face ('in person') encounter, documentation of the clinical encounter as outlined in the CPSNS Professional Standards and Guidelines Regarding Charting, and the start and stop time of the face-to-face encounter are documentation elements that support the claim for this fee code.

Billing Guidelines
- Only physicians eligible to bill the ME=CARE modifier may bill for prolonged office visits.
- Each office visit can be billed up to a maximum of 60 minutes (68MSU) per day. This would include a base fee plus up to 3 additional multiples of 15 minutes each.
- Start and stop times are required for any visit billed with multiples greater than 1.
- The start and stop times must be documented in the health record and on the text field of the claim.
- Multiples are not applicable for virtual care.

Documentation
Documentation of the following provides a clear indication that a prolonged visit has taken place:
- The visit occurred face-to-face ('in person')
- Rationale for the length of the appointment time. *For example: 'due to xx health concern, xx required in depth evaluation involving xx which resulted in prolonged appointment time'.*
- Patients' current health status and concerns
- Relevant history of the presenting complaint(s)
- Assessment relevant to the presenting complaint(s)
- Physical assessment relevant to the presenting complaint (if required)
- Diagnostic Impression
- Advice given to the patient (or documented substitute decision maker)
- Management and follow-up plan
- Start and Stop times of the time spent with the patient.

Multiples:
03.03 – 17 MSU per 15 minutes to a maximum of 4 multiples (60 minutes) per day
03.03A – 20.99 MSU per 15 minutes to a maximum of 4 multiples (60 minutes) per day

Premium Eligible:
TI=GPEW

Specialty Restriction:
SP=GENP

Location:
LO=OFFC

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PROLONGED VISIT REMINDERS

- Multiples are not eligible for virtual care for prolonged visits. I.E., the prolonged visit must occur in person and may not be claimed when provided over the phone or via virtual care platform.
- Time spent on provision of uninsured services, such as, but not limited to: sick slips, completion of third party forms, removal of ear wax, cannot be counted as time for multiples for a prolonged visit.
- If the purpose of the visit is to provide a procedure or injection, only the procedure or injection may be claimed. The procedural/injection fee encompasses all aspects of the procedure including advice to the patient concerning the procedure.
- A visit or prolonged visit may only be claimed in conjunction with a pap smear when the visit is for a non-gynecologic diagnosis. Time spent on the pap smear cannot be counted towards multiples for the prolonged visit.

ME=CARE FOR LOCUM PHYSICIANS

Physicians are advised that if they are hosting a long-term locum that will be billing the ME=CARE modifier for the comprehensive and continuous care of their patients during the locum, please advise the Physician Services team so that your patients can be manually adjusted for the attachment algorithm: LFMfunding@novascotia.ca

PHYSICIAN CONTACT

Physicians are reminded of the importance of keeping their contact information (email address, telephone, and mailing address) current with MSI. To update your contact information, you may reach out to MSIProviders@medavie.ca or 902-496-7011 (toll-free 1-877-910-4674).

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
MJ092	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 92.89N CANNOT BE CLAIMED WITH HSC 91.35A OR 31.35C AT THE SAME ENCOUNTER
MF009	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS HEALTH SERVICE CODE CANNOT BE CLAIMED WITH HSC 92.89N AT THE SAME ENCOUNTER
MJ093	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED HSC 72.1A, 72.1B, 72.1C OR 72.1D AT THE SAME ENCOUNTER
MJ094	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED HSC 72.1E AT THE SAME ENCOUNTER
MI008	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM OF 3 PROCEDURES PER PATIENT PER LIFETIME HAS BEEN REACHED
DE048	SERVICE HAS BEEN DISALLOWED AS YOU HAVE CLAIMED A VISIT ON THE SAME DAY/ PLEASE RESUBMIT WITH EXPLANATORY TEXT
AD095	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST CLAIM THE DIAGNOSTIC MAMMOGRAPHY FEE PRIOR TO CLAIMING DIGITAL BREAST TOMOSYNTHESIS. THIS SERVICE MAY NOT BE CLAIMED INDEPENDENTLY

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

UPDATED FILES

Updated files reflecting changes are available for download on March 15, 2024. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

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

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS
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NEW FEES

Effective January 19, 2024 the following health service code is available for billing:

Category	Code	Description	Base Units	Anae Units
MASG	26.29G	**Glaucoma surgery (such as stent insertion) ab interno approach, for the relief of intraocular pressure through drainage of aqueous humor to the subconjunctival space** **Description** This fee is for the surgical treatment of glaucoma via the ab interno approach for procedures such as stent insertion resulting in the drainage of aqueous humor to the subconjunctival space. **Billing Guidelines:** May be claimed once per eye per surgical encounter Not billable with the following MASG codes: • 26.25 Trabeculectomy ab externo • 26.25C Trabeculectomy on an eye with a previous major ocular procedure with or without post op laser suture lysis • 26.25D Trabeculectomy with the use of anti-metabolites with or without post of laser suture lysis • 26.29D Trabeculoplasty • 26.29E Placement of glaucoma tube shunt • 26.34 Trabeculotomy ab externo **Regions:** RG=LEFT, RG=RIGHT, RG=BOTH **Premium Eligible:** PR=PREM, PR=PR50 **Specialty Restriction:** SP=OPTH **Assistant:** RO=SRAS **Location:** LO=HOSP	175 MSU	6+T

INTERIM FEE UPDATES

The following interim fees have been termed effective January 19, 2024:

09.13C – Ophthalmic ultrasound of the anterior segment by high resolution biomicroscopy or immersion B-scan (water bath) for the assessment of the anterior chamber, unilateral or bilateral.

26.29F – Glaucoma surgery (such as stent insertion) ab interno approach, for the relief of intraocular pressure.
*(*Note: 26.29F has been replaced with the new HSC 26.29G)*

The following interim fee has been made permanent:

Category	Code	Description	Base Units
VADT	02.02C	**Ophthalmic Biometry by partial coherence interferometry with IOL (intraocular lens) power calculation, unilateral or bilateral.** **Description** Ophthalmic biometry measurements by partial interferometry with IOL power calculation in one or both eyes. If ophthalmic biometry by ophthalmic US (A-scan) is also used for the same patient, claim for only one or the other but not both. The test, the results, and the physician's interpretation of the results must be documented in the patient's health record. **Billing Guidelines** Not billable with: • 03.12 Tonometry • 09.13A real time (eye) ultrasound • 09.13B Axial length measurement by ultrasound **Specialty Restriction:** SP=OPHT **Location:** LO=OFFC	25.44 MSU

Billing Matters Billing Reminders, Updates, New Explanatory Codes

Pap Smear (03.26A) and Visits

Physicians are reminded of Preamble 5.3.35: A Pap smear may not be claimed in addition to a visit, consultation or procedure for a gynecologic or obstetrical diagnosis, nor is it payable in addition to a complete physical examination. A Pap smear and an unrelated medical condition can include a claim for the office visit, pap smear, and pap smear tray fee. The same applies for prolonged visits.

Physicians should exercise caution when billing a pap smear and prolonged visit. Time spent on the pap smear can not be counted towards multiples for the prolonged visit, as this would be considered double billing. The physician must spend 80% of the total time of the unrelated visit in direct physician to patient interaction for the unrelated diagnosis in order to claim a prolonged visit in addition to a Pap.

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Arthroscopic Codes (92.89M, 92.89N)

Physicians are reminded that an arthroscopic debridement is tricompartmental and thus should only be claimed for services on the knee. 92.89M and 92.89N are to be claimed for arthroscopic procedures only. It is not appropriate to claim arthroscopic health service codes for open surgical procedures.

Billing for Virtual Appointments

To ensure appropriate tracking of virtual services, physicians are reminded of the modifiers and the importance of their use on claims, **AP=PHON** and **AP=VIRC** to denote when the service was conducted via telephone or PHIA compliant virtual care video platform. Text denoting the method is not required when using these modifiers.

Provider Profiles

Physicians are reminded that provider profiles are sent out per request. If you would like to receive your 2022/2023 provider profile, please send your request to msi_assessment@medavie.bluecross.ca. In the email, please include your name and provider number, and the profile will be mailed to the address on file.

Physicians 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.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
MJ089	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 26.29G MAY ONLY BE CLAIMED ONCE PER EYE PER SURGICAL ENCOUNTER.
MJ090	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 26.25, 26.25C, 26.25D, 26.29D, 26.29E OR 26.34 HAS ALREADY BEEN CLAIMED AT THE SAME ENCOUNTER.
MJ091	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 26.29G HAS ALREADY BEEN CLAIMED AT THE SAME ENCOUNTER.

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UPDATED FILES

Updated files reflecting changes are available for download on Friday January 19, 2024. The files to download are:
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Physicians are advised that the US=UNOF modifier is not eligible when submitting AP=PHON/VIRC encounters. Nursing home visits have been updated to utilize the AP=PHON/VIRC modifiers without the US=UNOF modifier.

As a reminder, virtual visits are not eligible for prolonged/multiples.

INTERIM FEE EXTENSIONS

The following interim fees have been extended:

15.93D - Removal or Revision of Intracranial Neurostimulator Electrodes (SEEG)
47.25C - Transcutaneous Aortic Valve Implantation (TAVI)
66.98E - Percutaneous Insertion of Tunneled Intraperitoneal Catheter for use in dialysis
66.98F - Removal of Tunneled Intraperitoneal Catheter (for use in dialysis)
66.98G - Repositioning of Tunneled Intraperitoneal Catheter for use in dialysis
03.03Y - Post operative care – gender affirming chest surgery
03.09M - Preoperative comprehensive assessment for gender affirming surgery
97.44A - Feminization of chest wall | Prior Approval/Preauthorization required (PA)
97.79B - Masculinization of the chest wall | Prior Approval/Preauthorization required (PA)
97.99B - Revision of gender affirming chest surgery | Prior Approval/Preauthorization required (PA)

For full guidelines, please see the Interim Fee Reference Guide (PDF)

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday November 24, 2023. The files to download are:
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2024 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE	CONTRACT PAY PERIOD
December 29, 2023**	January 4, 2024	January 10, 2024	December 22, 2023-January 4, 2024
January 15, 2024	January 18, 2024	January 24, 2024	January 5-18, 2024
January 29, 2024	February 1, 2024	February 7, 2024	January 19-February 1, 2024
February 9, 2024**	**February 14, 2024****	February 21, 2024	February 2-15, 2024
February 26, 2024	February 29, 2024	March 6, 2024	February 16-29, 2024
March 11, 2024	March 14, 2024	March 20, 2024	March 1-14, 2024
March 22, 2024**	**March 27, 2024****	April 3, 2024	March 15-28, 2024
April 8, 2024	April 11, 2024	April 17, 2024	March 29-April 11, 2024
April 22, 2024	April 25, 2024	May 1, 2024	April 12-25, 2024
May 6, 2024	May 9, 2024	May 15, 2024	April 26-May 9, 2024
May 17, 2024**	May 23, 2024	May 29, 2024	May 10-23, 2024
June 3, 2024	June 6, 2024	June 12, 2024	May 24-June 6, 2024
June 17, 2024	June 20, 2024	June 26, 2024	June 7-20, 2024
June 28, 2024**	July 4, 2024	July 10, 2024	June 21-July 4, 2024
July 15, 2024	July 18, 2024	July 24, 2024	July 5-18, 2024
July 26, 2024**	**July 31, 2024****	August 7, 2024	July 19-August 1, 2024
August 12, 2024	August 15, 2024	August 21, 2024	August 2-15, 2024
August 23, 2024**	**August 28, 2024****	September 4, 2024	August 16-29, 2024
September 9, 2024	September 12, 2024	September 18, 2024	August 30-September 12, 2024
September 20, 2024**	**September 25, 2024****	October 2, 2024	September 13-26, 2024
October 4, 2024**	**October 9, 2024****	October 16, 2024	September 27-October 10, 2024
October 21, 2024	October 24, 2024	October 30, 2024	October 11-24, 2024
November 1,2024**	**November 6, 2024****	November 13, 2024	October 25-November 7, 2024
November 18, 2024	November 21, 2024	November 27, 2024	November 8-21, 2024
December 2, 2024	December 5, 2024	December 11, 2024	November 22-December 5, 2024
December 12, 2024**	**December 18, 2024****	**December 24, 2024****	December 6-19, 2024
December 24, 2024**	January 2, 2025	January 8, 2025	December 20-January 2, 2025
11:00 AM CUT OFF	**11:59 PM CUT OFF**		

NOTE:

Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Sessional Payments and Locum Claim Forms. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut off date to ensure processing for that payment period.

PLEASE NOTE, THE ** INDICATES A DATE VARIATION

2024 HOLIDAY DATES

Please make a note in your schedule of the following dates MSI will accept as "Holidays".	
NEW YEAR'S DAY	MONDAY, JANUARY 1 2024
HERITAGE DAY	MONDAY, FEBRUARY 19, 2024
GOOD FRIDAY	FRIDAY, MARCH 29, 2024
EASTER MONDAY	MONDAY, APRIL 1, 2024
VICTORIA DAY	MONDAY, MAY 20, 2024
CANADA DAY	MONDAY, JULY 1, 2024
CIVIC HOLIDAY	MONDAY, AUGUST 5, 2024
LABOUR DAY	MONDAY, SEPTEMBER 2, 2024
NATIONAL DAY FOR TRUTH AND RECONCILIATION	MONDAY, SEPTEMBER 30, 2024
THANKSGIVING DAY	MONDAY, OCTOBER 14, 2024
REMEMBRANCE DAY	MONDAY, NOVEMBER 11, 2024
CHRISTMAS DAY	WEDNESDAY, DECEMBER 25, 2024
BOXING DAY	THURSDAY, DECEMBER 26, 2023
NEW YEAR'S DAY	WEDNESDAY, JANUARY 1, 2025

PHYSICIAN'S BULLETIN

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NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

Physicians are advised of the October Migration taking place on **October 29, 2023**. The information included in this bulletin will be in effect for billing purposes as of **October 29, 2023**.

Virtual ME=CARE Office Visits

Offices are advised that ME=CARE virtual office visits have been updated to the correct MSU effective October 29, 2023. Services submitted with the AP=PHON/AP=VIRC modifier from service dates July 24 - October 28, 2023 will be identified and a retro payment will apply once the 90-day billing window has elapsed.

03.03 AP=PHON/VIRC ME=CARE RP=SUBS 17 MSU
03.03 AP=PHON/VIRC ME=CARE RP=SUBS TI=GPEW 21.25 MSU

Prolonged Nursing Home Visits

Effective September 15, 2023 prolonged nursing home visits were updated to pay multiples for Daytime, TI=EVNT, TI=ETMD, TI=MDNT.

The weekend visits will be updated to start paying multiples for prolonged visits for service dates effective October 29, 2023 and therefore a retro payment will apply for prolonged visits when multiples are submitted and start and stop times are indicated in the text of the claim for service dates between July 24 - October 28, 2023.

03.03 DA=RGE1 TI=AMNN US=UNOF
03.03 DA=RGE1 TI=NNEV US=UNOF

Virtual Nursing Home Visits

Physicians are advised that the US=UNOF modifier is not eligible when submitting AP=PHON/VIRC encounters. This will be adjusted in an upcoming migration, and physicians should use text indicating virtual encounters until the US=UNOF modifier is removed from these applicable virtual visits.

*Reminder, virtual visits are not eligible for prolonged/multiples.

NEW FEES

Effective October 1, 2023 the following health service codes for the purpose of tracking the LFM hours based on those outlined in Schedule A of their LFM contract will be available for billing:

Physicians are required to submit these claims under their LFM Hourly Business Arrangement Number in order to meet the conditions of their LFM contract. The hours are paid bi-weekly and the hours submitted biweekly are for tracking purposes per Section 4.2.3. These billings will also be used to track any reconciliation payments physicians are entitled to when they work, and bill, more or less than their contracted hours. Reconciliation payments will be made annually after the billing period has expired.

Category	Code	Description	Base Units
PRVR	HDAY1	Longitudinal Family Medicine (LFM) model hourly fee code for clinical daytime hours worked (both direct and indirect). $92.70 per hour (weekdays)	0 MSU
PRVR	HEVW1	Longitudinal Family Medicine (LFM) model hourly fee code for clinical evening/weekend/holiday hours worked. $139.05 per hour (evenings/weekends/holidays) To claim a premium hour HEVW1, direct patient services must be provided during that hour. If no direct patient care is provided in an hour on evening, weekend or holidays, the evening/weekend/holiday hour(s) is to be billed at HDAY1. **Description** Billable clinical hours for patient specific clinical services both direct and indirect. HDAY1 for daytime HEVW1 for evenings/weekends/holidays Daytime hours mean the hours between 0800 – 1700 Monday through Friday. Evening, Weekend and Holiday hours follow the eligible time-period for the GP Enhanced Hours Premium as outlined in the Physician's Manual. Please see 'Schedule C' of the 2023-27 Physician Agreement full details on the LFM Model **Billing Guidelines / Exclusions** • 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'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).** **Documentation Requirements** Physicians are responsible to ensure they are entering the correct number of claimed units to match the time worked. **Specialty Restriction:** SP=GENP	0 MSU

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FEE UPDATES

New Patient Intake Visit (NPIV1)
Effective July 24, 2023 the NPIV1 is now billable from LO=NRHM for physicians who have Nursing Home incorporated in their LFM hours. For full guidelines, please see the Interim Fee Reference Guide (PDF)

NOTE: The rule preventing HSC NPIV1 from being claimed when the physician has claimed ME=CARE for that patient in the past has been removed. Physicians should no longer use HSC EC for their NPIV1 claims. The fee can only be billed once per physician per patient when the physician is first accepting the patient into their attached roster. NPIV1 cannot be billed for patients already on your roster.

Billing Matters Billing Reminders, Updates, New Explanatory Codes

New Patient Intake Visit (NPIV1) time
As noted in the billing guidelines: The first multiple for the NPIV1 health service code is for the first 30 minutes of service. For New Patient Intake Visits that are **less than 30 minutes** (including both the face-to-face and non-face-to-face time), the physician should bill fee code **NPIV1 with one (1) multiple only**. For New Patient Intake Visits that are **greater than 30 minutes** (including both face to face and non face to face time) the physician can bill four (4) additional multiples up to a **maximum of five (5) multiples and 90 minutes total duration.** When billing multiples, start and stop times of the total time spent in both face-to-face and non-face-to-face activities must be documented in the health record and on the text field of the claim.

Multiples	Total time spent (including direct and indirect time)
NPIV1	1-30 minutes
2	31-45 minutes
3	46-60 minutes
4	61-75 minutes
5	76-90 minutes

While most ADON codes are not able to be billed in addition to the NPIV1, 03.03P (First Visit after In-Patient Discharge – Maternal Care) and 03.03S (First Visit after In-Patient Discharge – Complex Care) are able to be billed in addition to the NPIV1, when appropriate.

GENP 03.03 Prolonged visits
Physicians are advised that, in most cases, it is not appropriate to claim ADON codes in addition to a prolonged visit. As a prolonged visit is intended to compensate for the complexities of the service being provided, it is not appropriate to claim any additional add on codes. Exception: physicians are eligible to claim provincial immunizations (13.34A) (13.59L) and applicable tray fees (13.59M) in addition to a prolonged visit.

Reminder for claiming multiples for the prolonged 03.03 visits:

To claim multiples for prolonged 03.03 visits, 80% of the total time must be spent in direct physician to patient contact. Start and stop times of the direct physician to patient contact must be documented in the health record and the text field of the MSI claim.

Multiples	Total Time	Direct physician to patient contact
MU 2	30 minutes	24 minutes
MU 3	45 minutes	36 minutes
MU 4	60 minutes	48 minutes

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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
LF001	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 24 HOURS MAY BE BILLED PER DAY FOR HSC HDAY1.
LF002	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 24 HOURS MAY BE BILLED PER DAY FOR HSC HEVW1.
LF003	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU CANNOT CLAIM 0 HOURS FOR THIS HSC.
LF005	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS HSC HAS ALREADY BEEN CLAIMED FOR THIS DATE.

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

UPDATED FILES

Updated files reflecting changes are available for download on October 29, 2023. The files to download are:
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PHYSICIAN'S BULLETIN
September 29, 2023: Vol. LXVIII, ISSUE 12

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

REVISED LOCUM PROGRAM EFFECTIVE JULY 24, 2023

The Provincial Locum Program is intended to facilitate the medical care to patients of eligible physicians, through the provision of funded coverage when the physician is away from their respective practice, due to vacation, continuing medical education, parental and/or unplanned leave due to illness. It is generally accepted that a physician, while being replaced by a locum, is not providing billable services elsewhere.

As per the 2023-27 Physician Agreement changes to the Nova Scotia Locum program effective July 24, 2023. The following revised guidelines, payment rates and claim forms are in effect as of July 24, 2023. All forms can be found online on the MSI website (https://msi.medavie.bluecross.ca/locum-registration/). Please note: all claims must be calculated prior to submission. The available forms are functional and will calculate the values for you when completed electronically. Please be sure to include your signature on each submission.

New Application and Claim Forms

Physicians should use the new application form effective immediately.
New Locum claim forms and Physician Locum Application Form can be found on the MSI website
https://msi.medavie.bluecross.ca/locum-registration/

Physician Billing Expectations

Physicians should continue to submit existing claim forms up to and including the October 6 paper cut-off, after this date, physicians must use the new updated locum claim form. Existing claim forms will not be accepted after October 6, these will be returned with instruction to use the new claim form.

Reconciliation

As the locum guidelines were updated effective July 24, 2023, physicians previously working under the Provincial Locum Program only who have not received reimbursement for components under the new guidelines such as accommodations, licensing fees and/or travel time may submit a claim form for these components only for review and consideration.

A reconciliation will be completed at a later date to update payment rates effective July 24, 2023 for locum claims previously paid at the existing rate.

Locum Physician Eligibility

Locum physicians are required to be licensed by the College of Physicians and Surgeons of Nova Scotia and privileged by a health authority.

Revised Locum Guidelines

- For family physicians and specialists, the locum program will fund coverage for: Scheduled leave of physician for vacation, CME, parental, or unplanned leave due to illness.
- Specialist services covered: general internal medicine, general surgery, orthopedic surgery, anaesthesia, obstetrics/gynecology, psychiatry, pediatrics, radiology, pathology and urology.
- For daily/hourly paid physicians such as (Hospitalists, Emergency Departments, Psychiatry, CHIP, PMC, etc.). These physicians may be able to claim the travel elements of the locum program and not the daily income guarantees.
- A full locum day is defined as providing a minimum of 7.5 hours of clinical coverage, a half locum day is defined as minimum of 3.75 hours of clinical coverage.

The Locum Program is available:

- To provide coverage for vacancies but only if they are actively being recruited for by a health authority.
- For a maximum coverage period of 30 days per fiscal year, per physician.

The Locum Program is not available:

- For providing service coverage at your regular work sites.
- For providing service coverage in a regional hospital where physician groups have an approved facility on-call call rotation of 5 or more physicians.
- To C/AFP Departments, although individual AFP Physicians may be eligible for work outside of the C/AFP Department with their Department Head approval.

Services to be provided

Family Physicians

- Family practice coverage (may include inpatient and nursing home if part of FP normal practice).

Royal College Specialists

- Specialist hospital coverage including on-call.
- Office coverage where indicated, as requested on application form.

Payment Rates

Daily Rates

- The minimum daily income guarantee for a locum Physician is:
  - $1,200 for FP's providing full day coverage; $600 for half day coverage.
  - $1,600 for Specialists providing full day coverage; $800 for half day coverage.

Shadow Billing Above Daily Rates

- If shadow billings for Insured Medical Services are higher than the applicable minimum daily rate on a given day, including for Insured Medical Services delivered after hours, the locum physician will receive the amount of shadow billings greater than the applicable minimum daily rate.

Travel

If required by the health authority to travel for the locum assignment, travel will be reimbursed as follows:

- Kilometrage from the Physician's residence or regular work site (whichever is closer to the required non-regular work site) to the required locum work site, and return, at the then-prevailing Nova Scotia Government kilometrage rate (unless NSH has provided a rental car for physician's use).
- Per diem of $100 per day for full day coverage; $50 for half day coverage.
- Accommodations at 100% to a maximum of $300 per night, receipts of which must be provided to be eligible for reimbursement.
- Airfare to and from Nova Scotia, where required, 100% covered at regular economy fare up to a maximum of $1,500, receipts must be provided for reimbursement.
- Travel time at $100 per hour up to a maximum of 10 hours return (5 hours each way) per week.
- No travel time or expenses are payable for travel that is less than one hour total travel time roundtrip.

Licensing Fees

- For Atlantic Registry physicians the CPSNS Atlantic Registry license fee is reimbursed.
- For locum physicians outside the Atlantic Registry, the CPSNS locum license fee is reimbursed.

Facility On Call

- Facility On Call Rotas may be claimed through the applicable Facility On Call fee code. Locum physicians are not entitled to receive payment for any services while on call unless the total daily shadow billings exceed the minimum daily income guarantee.

Additional Payment

- The host physician is eligible for $250 per day for the duration of the locum if covering for leaves.

DHW – MEDICAL CONSULTANTS POSTING

DEPARTMENT OF HEALTH AND WELLNESS – MEDICAL CONSULTANT

The Department of Health and Wellness (DHW) is seeking the services of two physician Medical Consultants to provide expert advice on the development of a range of policies and initiatives that impact physicians, and to serve as a departmental expert on provincial health policy, clinical, benefit eligibility and physician issues, including compensation and audits.

The Department of Health and Wellness administers a number of insured health programs, including physician services, pharmacare, children's oral health program, and other extended health benefits programs. The Physician Consultants will also provide support and advice across the Department and directly to the Deputy Minister and Minister, as required.

The Physician Consultants will fulfill several key roles including:

- Providing broad clinical expertise to support policy development within DHW, across all program areas as needed.
- Review of requests for new/revised physician billing fees.
- Advising on out-of-province or out-of-country referrals to determine medical necessity and eligibility.
- Provide medical knowledge and expertise in billing practices, tariff, and clinical procedures.
- Representing DHW on various committees and providing advice to negotiating teams.
- Support the implementation of the Physician Services Agreement through various joint committees with Doctors Nova Scotia.

Primary Accountabilities

The Medical Consultants provide expert advice to DHW in a variety of settings all under the direction of the Department, including the Minister, Deputy Minister, and Senior Executive Director(s) Physician Services, Benefits Eligibility and Clinical. The Medical Consultant's services will include, at the Department's direction, the following:

- Advising on the development of policies and guidelines and recommending the insurance of new services that are medically necessary.
- Advising on the application of policies and guidelines and, where required, on requests made for non-standard approvals in exceptional circumstances.
- Advising, representing, and acting for the Department in physician payment audits, reviews, and appeals, including dispute resolution processes, as agent for and under the direction of the Department.
- Providing direction to the Physician Consultant(s) at the MSI administrator (currently Medavie Blue Cross) to review cases where the application of policy does not provide a clear answer with regard to the insurability of new types of cases or procedures.
- Advising on requests for new fees and reviewing the fees paid for similar services across Canada. Advice is provided regarding the necessity for new or amended fee codes, including recommendations for implementation of interim fees and final fees (tariff) for the Fee Schedule.
- Representing DHW on various committees and task forces dealing with insured medical services, MSI policy and technology assessment.

- Providing advice to DHW in preparation for the renewal of the Physician Agreement, the Academic Funding Plan Contract, and other contracts for the provision of insured medical services.
- Advising as needed on provincial standards and provincial initiatives that directly impact upon physicians to ensure that they reflect physician input. For this purpose, the Medical Consultants will develop and maintain positive relationships with physician groups including, but not limited to, the Health Authorities, Medavie, College of Physicians & Surgeons, Doctors Nova Scotia, Dalhousie Faculty of Medicine, and Maritime Resident Doctors.

Qualifications and Experience

The successful Physician Consultant will have:

- Membership/Fellowship in the Royal College of Physicians and Surgeons in a medical or surgical specialty or College of Family Physicians.
- Minimum fifteen years of experience as a physician in a clinical setting.
- Demonstrable knowledge of Canadian and Nova Scotia health systems, clinical activity reporting, physician billing practices, tariffs, and clinical procedures.
- Knowledge and understanding of physician billing practices, tariff, and clinical procedures, especially as they relate to the Nova Scotia Medical Services Insurance system.
- Understanding of the Nova Scotia health care delivery system.
- Knowledge of the NS physician manual, fee structure, legislation, and regulation.
- Experience and training in health administration, policy development and analysis.
- Experience in clinical audit and/or economic analysis.

DHW Contract Position

The Medical Consultants will work up to 30 hours per week over 46 weeks. The Medical Consultants will be remunerated through a personal services contract for one year which may be extended by agreement of the parties and will be paid an hourly rate based on the specialist or family physician sessional rate.

Interested candidates are asked to send their cover letter and CV to:

Angela Purcell (angela.purcell@novascotia.ca)

Senior Executive Director,

Physician Services

Nova Scotia Department of Health and Wellness

Closing date: October 11, 2023

PHYSICIAN'S BULLETIN

September 20, 2023: Vol. LXVIII, ISSUE: 11

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

PHYSICIAN AGREEMENT 2023-2027

Any additional MSI items including new or modified fees, policies, and procedures with regard to the new Physician Agreement will be published as information becomes available.

MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT
Effective April 1, 2023, the Medical Service Unit (MSU) value increased from $2.68 to $2.76.

ANAESTHESIA UNIT
Effective April 1, 2023, the Anesthesia Unit (AU) increased from $25.30 to $26.06.

Note: These increases are automatically applied on any claims submitted with a date of service on or after September 15, 2023. Claims submitted with service dates from April 1 – September 14, 2023, will be identified and a retroactive payment will be sent to physicians once the 90-day submission window has elapsed.

WORKERS COMPENSATION BOARD UNIT VALUE CHANGES

WCB MEDICAL SERVICE UNIT
Effective April 1, 2023, the Workers Compensation Board Medical Service Unit (WCB MSU) value will increase from $2.98 to $3.07.

WORKERS COMPENSATION BOARD ANAESTHESIA UNIT
Effective April 1, 2023, the Workers Compensation Board Anesthesia Unit (WCB AU) value will increase from $28.11 to $28.96.

Note: These increases are automatically applied on any claims submitted with a date of service on or after September 15, 2023. Claims submitted with service dates from April 1 – September 14, 2023, will be identified and a retroactive payment will be sent to physicians once the 90-day submission window has elapsed.

LONGITUDINAL FAMILY MEDICINE (LFM)

The Longitudinal Family Medicine payment model (LFM) is focused on improving access, patient attachment, and positioning Nova Scotia to both retain and recruit to office-based, longitudinal family medicine. The LFM will be available to all family physicians providing office-based, longitudinal family medicine in Nova Scotia. Physicians can work full-time or part-time within the LFM.

Blended payment
Physicians in the LFM model will be paid a blended payment that is calculated based on hours worked, services delivered and panel attachment. The LFM model includes a community complexity modifier to account for age, sex and socio-economic status factors in different communities.

Details related to this payment model are included in Schedule C of the 2023 Physician Agreement.

Additional information will be published in a future bulletin.

★ Fees New Fees and Fee Revisions

NEW INTERIM FEES

Per the 2023-2027 Physician Agreement, the following new interim health service codes are now available for billing with service dates effective July 24, 2023.

Category	Code	Description	Base Units
DEFT	NPIV1	**New Patient Intake Visit** **Description** A new patient intake visit may be billed when a family physician accepts a new patient into their office practice and arranges an appointment for the purpose of gathering a detailed medical and social history in order to establish an ongoing patient-physician relationship and to construct the patient's medical record. It includes review of clinical documents prior to the visit and establishment of a medical record on the same day. (Includes face to face and non-face to face time). **Billing Guidelines** • Such an encounter shall include documentation of the new patient's current health status, past medical history, relevant social and family history, and a list of current medications and allergies, as well as any physical examination as clinically appropriate. All components of this service must be completed on the same day. • If a medically necessary service is indicated during the initial visit, the time taken to address this can contribute to the multiples claimed. This fee is considered to compensate for a medically necessary service, if required at the initial visit. • Physician must submit ME=CARE declaration letter before billing any NPIV services. • The fee can only be billed once per physician per patient when the physician is first accepting the patient into their attached roster, it cannot be billed for patients already on your roster. For physicians in a collaborative practice, you may bill the NPIV1 when you are accepting a patient from a retiring/relocating physician within your collaborative practice for whom you may have billed ME=CARE in the past, as long as the patient is new to your panel. • For New Patient Intake Visits that are less than 30 minutes (including both the face to face and non-face to face time), the physician should bill fee code	34 MSU +MU

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NPIV1 with one multiple. For New Patient Intake Visits that are greater than 30 minutes the physician can bill a maximum of 5 multiples, i.e., 90 minutes. Prolonged office visits are paid in 15-minute time blocks or portion thereof. When billing multiples, start and stop times of the encounter must be documented in the health record and on the text field of the claim.

- The NPIV fee code can only be billed once per patient per physician.
- It may not be billed with any other visit code or procedure code at the same encounter.
- It is not applicable for virtual care.

Multiples:
17 MSU per 15 minutes to a maximum of 5 multiples (90 minutes)

Premium Eligible:
TI=GPEW

Specialty Restriction:
SP=GENP

Location:
LO=OFFC

NOTE: ADON health service codes 03.03S and 03.03P can be billed when services are provided in conjunction with NPIV1 as an added incentive to bring a patient onto your physician panel.

Amendment to NPIV1: This HSC may be billed if a physician accepts a patient from a physician in the same collaborative practice due to physician retirement, relocation etc. If you have billed ME=CARE for this patient in the past, please submit your NPIV1 claim as health service code 'EC' with text indicating 'NPIV1 for collaborative practice' until the system is updated in October.

Category	Code	Description	Base Units
DEFT	TPR1	**Telephone Prescription Renewal**	4 MSU

Description
This service is billable by a family physician when the physician is requested by a patient to communicate a prescription renewal by telephone, fax, or email without seeing the patient.

Billing Guidelines

- Documentation on the patient's chart must include the name of the pharmacy, as well as the drug, dose, and amount prescribed.
- This HSC is not to be billed for writing new prescriptions.
- This HSC may not be billed if the physician sees the patient (face to face or virtually) on the same day.
- It may not be billed more than 4 times per year per patient per provider.

Specialty Restriction:
SP=GENP

NOTE: In order to bill for the TPR1 Telephone Prescription Renewal, the prescription refill must be assessed, ordered and completed by the physician, not another allied health care provider such as a Nurse Practitioner or Pharmacist. The EMR 'Meds List' is adequate documentation.

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NEW INTERIM FEES CONTINUED

Category	Code	Description	Base Units
DEFT	AHCP1	**Allied Health Care Provider to Physician**	7.5 MSU

Description
This service is billable when a physician has a conversation with an allied health care practitioner, either face to face, by phone, email or fax to provide advice on a patient with whom the physician has an established relationship to determine a management decision.

This service is intended to compensate the physician for unexpected interruptions to the physician's normal practice routine. This would also include the physician's time to update the patient's chart.

Billing Guidelines

- The allied health care providers must work outside of the physician's practice.
- Telephone calls initiated by the patient, or patient's family member may not be billed under this code.
- All interactions must be recorded in the patient's chart, including the time of the call, the name and professional capacity of the allied healthcare worker involved, the medical issue addressed, and the advice given.
- Physicians may use a copy of the documentation from the allied health care worker to support this HSC claim, but it must be reviewed and 'signed off' by the physician. The physician should add any needed clarifications or corrections to this documentation as an addendum.
- Claims, outside the pharmacy pilot, can only be made for physician interaction and not for staff (clerks, nurses etc.) of the physician.
- With regards to pharmacists, this code is for discussion of patient care and is not for prescription renewal, clarifying illegible prescriptions or switching to a generic form of drug.
- This fee code may not be billed with the Telephone Prescription Renewal
- It is only billable once per patient per day per physician.
- It may not be billed more than 15 times per physician per week.
- It cannot to be billed on the same day as a visit unless the status of the patient has changed in the intervening time. If there has been a visit on the same day, text is required regarding the intervention.

Specialty Restriction:
SP=GENP

Location:
LO=OFFC

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Per the 2023-2027 Physician Agreement, the following health service codes have been updated to include multiples for prolonged services. Physicians may now claim multiples for prolonged visits with service dates effective date July 24, 2023 onward. Claims submitted with a date of service between July 24 – September 14 will not automatically pay at the new rate, a retroactive payment will be issued once the 90-day submission window has elapsed.

Category	Code	Description	Base Units
VIST	03.03	**Prolonged Office Visit for ME=CARE** ME=CARE, RP=SUBS **Description** This service is paid to family physicians who are delivering face to face comprehensive and continuous care to patients with whom they have an ongoing relationship. Prolonged office visits are paid in 15-minute time blocks or portion thereof, and 80% of the time must be spent in direct physician to patient contact. Prolonged office visits are not to be confused with active treatment associated with detention. **Billing Guidelines** • Only physicians eligible to bill the ME=CARE modifier may bill for prolonged office visits. • Each office visit can be billed up to a maximum of 60 minutes (68 MSU) per day. This would include a base fee plus up to 3 additional multiples of 15 minutes each. • Start and stop times are required for any visit billed with multiples greater than 1. The start and stop times must be documented in the health record and in the text field of the claim. • Multiples are not applicable for virtual care. **Multiples:** 17 MSU per 15 minutes to a maximum of 4 multiples (60 minutes) per day **Premium Eligible:** TI=GPEW **Specialty Restriction:** SP=GENP **Location:** LO=OFFC	17 MSU +MU
VIST	03.03A	**Prolonged Geriatric Office Visit for ME=CARE** ME=CARE **Description** This service is paid to family physicians who are delivering face to face comprehensive and continuous care to patients aged 65 or older with whom they have an ongoing relationship. Prolonged geriatric office visits are paid in 15-minute time blocks or portion thereof, and 80% of the time must be spent in direct physician to patient contact. Prolonged geriatric office visits are not to be confused with active treatment associated with detention.	20.99 MSU +MU

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Billing Guidelines

- Only physicians eligible to bill the ME=CARE modifier may bill for prolonged geriatric office visits.
- Each office visit can be billed up to a maximum of 60 minutes (83.96 MSU) per day. This would include a base fee plus up to 3 additional multiples of 15 minutes each.
- Start and stop times are required for any visit billed with multiples greater than 1. The start and stop times must be documented in the health record and on the text field of the claim.
- Multiples are not applicable for virtual care.

Multiples:
20.99 MSU per 15 minutes to a maximum of 4 multiples (60 minutes) per day

Premium Eligible:
TI=GPEW

Specialty Restriction:
SP=GENP

Location:
LO=OFFC

NOTE: The regular 03.03 and 03.03A visits may be billed as virtual, however prolonged visits with multiples cannot be billed as virtual.

Per the 2023-2027 Physician Agreement, nursing home visit codes have been updated to include multiples for prolonged services, as outlined below. Effective July 24, 2023, the nursing home visits requirement to use PT=FTPT and PT=EXPT have been removed and the unit value has been updated to reflect this.
Claims submitted without multiples for service dates between July 24 - September 14 will be identified and a retroactive payment will be issued once the 90-day submission window has elapsed.

Physicians holding their prolonged nursing home visit claims may now submit them to be paid for the multiples.

Category	Code	Description	Base Units
VIST	03.03	**Prolonged Nursing Home Visit** **Description** This service is paid to physicians who are delivering patient care to residents in nursing homes. This fee is to be billed for all residents of the nursing home, whether it is the first patient or extra patient. Prolonged nursing home visits are paid in 15-minute time blocks or portion thereof, and 80% of the time must be direct physician to patient contact. Prolonged nursing home visits are not to be confused with active treatment associated with detention. **Billing Guidelines** • Each nursing home visit can be billed up to a maximum of 60 minutes per patient per day. This would include a base visit plus up to 3 additional multiples of 15 minutes each. • Start and stop times are required for any visit billed with multiples greater than 1. The start and stop times must be documented in the health record and in the text field of the claim.	21.3 MSU +MU

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- Multiples are not applicable for virtual care.

Multiples:
17 MSU per 15 minutes to a maximum of 4 multiples (60 minutes) per day

Modifiers:
TI=EVNT = Time 1701-2000 – 28.3 MSU + MU (22.95 MSU per 15 minutes)
TI=ETMD = Time 2001-2359 – 28.3 MSU + MU (22.95 MSU per 15 minutes)
TI=MDNT = Time 0000-0800 – 38.3 MSU + MU (25.5 MSU per 15 minutes)

Specialty Restriction:
SP=GENP

Location:
LO=NRHM

NOTE: The regular 03.03 nursing home visit may be billed as virtual, however prolonged visits with multiples cannot be billed as virtual.

NEW FEE

The following health service code is now available for billing for service dates effective July 28, 2023
Please note the amendment to the physician requirements:

Category	Code	Description	Base Units
VIST	03.04K	**Gender Transition Readiness Assessment, follow up of patients undergoing medical transition, and follow up of patients undergoing surgical transition where the primary care provider is required to provide postoperative care** **Description** Gender transition readiness assessment, gender transition follow-up of patients who are undergoing medical transition, and postoperative care of patients who have had gender affirming surgery provided to them in or out of province. Physicians providing Gender Affirming Care (GAC) and billing for GAC fee codes must be informed, knowledgeable and experienced in providing culturally competent and safe trans care and are required to complete and return the GAC Competency Declaration. Any necessary counselling or physical examinations are included in this HSC and should not be claimed separately. **Billing Guidelines:** • This code is to be used only for services provided that are directly related to Gender Affirming Care; it does not replace all visit codes for that patient. • It has a base 30 minutes of time spent by the physician in direct patient care with multiples of 15 minutes when the service encounter exceeds 30 minutes to a maximum of 75 minutes. 80% of the time claimed must be in direct patient care.	40 MSU +MU

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- When claiming for multiples on a time-based service, the start and stop times must be documented in the health record and submitted in text with the claim.

Multiples:
20 MSU per 15 minutes to a maximum of 4 multiples (75 minutes)

Premium Eligible:
TI=GPEW

Specialty Restriction:
SP=GENP

Location:
LO=OFFC

FACILITY ON CALL UPDATES

Per the 2023-2027 Physician Agreement, the Facility On-Call program rates will continue in their current form and the following new rates will be effective October 1, 2023:

Category	Current Rate	Current Rate	New Rate (October 1, 2023)	New Rate (October 1, 2023)
	Weekday	Weekend/ Holidays (DA=RGE1)	Weekday (M-Thurs)	Weekend (Fri, Sat, Sun) / Holidays (DA=RGE1)
Category 1	$300	$400	$350	$500
Category 2	$250	$300	$300	$350
Category 3	$150	$200	$200	$250
Community Hospital Inpatient Program (CHIP)	$300	$400	$350	$500

Category	Current Rate	New Rate (October 1, 2023)
	Callback (US=CALL)	Callback (US=CALL)
Category 3	$100	$150
Category 4	$300	$350

Effective September 15, 2023, Obstetrics/Gynecology is eligible for level 1 rota at Cumberland Regional Health Care Centre

Health Service Code	Description	Approved Regional and Tertiary Hospitals
F1004	Facility on Call Category 1 – Obstetrics/Gynecology RO=OBS1 (Yarmouth and IWK only) RO=OBS2 (IWK only) RO=GYN1 (Dartmouth and IWK only)	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Aberdeen, St. Martha's, Cape Breton Regional, Dartmouth General, IWK, Cumberland Regional

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WORKERS COMPENSATION BOARD FEE CODE INCREASES

Workers' Compensation Board Fee Code Update

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been calculated for the listed WCB specific fees for fiscal year 2023-24.
The WCB specific services listed below will have their values increased effective April 1, 2023:

CODE	DESCRIPTION	APRIL 1, 2023 VALUE
WCB12	EPS physician assessment Service. Combined office visit and completion of Form 8/10 For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15-minute increments to a maximum of 1 additional hour	**Initial visit:** $211.98 + $62.01 per 15 minutes to a maximum 4x (RO=EPS1 and RP=INTL) **Subsequent visit:** $211.98 (RO=EPS1 and RP=SUBS)
WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable	GPs..... $51.88 per 15 min EPS (RO=EPS1)..$62.01 per 15 min Specialists.....$69.78 per 15 min
WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable	GPs..... $51.88 per 15 min EPS (RO=EPS1)..$62.01 per 15 min Specialists.....$69.78 per 15 min
WCB17	Photocopies of Chart Notes	10 pgs or less (ME=UP10) ..... $31.07 11-25 pgs (ME=UP25)…..... $62.01 26-50 pgs (ME=UP50)…..... $123.87 Over 50 pgs (ME=OV50)… $185.70
WCB20	Carpal Tunnel Syndrome (CTS) Assessment Report	$79.51
WCB21	Follow-up visit report	$46.54
WCB22	Completed Mandatory Generic Exemption Request Form	$15.60 per form
WCB23	Completed Non-Opioid Special Authorization Request Form	$15.60 per form
WCB24	Completed Opioid Special Authorization Request Form	$52.16 per form
WCB25	Completed WCB Substance Abuse Assessment Form	$34.78
WCB26	Return to Work Report – Physician's Report Form 8/10	$79.51
WCB27	Eye Report	$69.78
WCB28	Comprehensive Visit for Work Related Injury or Illness	$80.03
WCB29	Initial Request Form For Medical Cannabis	$86.33
WCB30	Extension Request Form For Medical Cannabis	$51.88
WCB31	WCB Interim Fee – Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed	$80.03

Note: These increases are automatically applied on any claims submitted with a date of service on or after September 15, 2023. Claims submitted with service dates from April 1 – September 14, 2023 will be identified and a retroactive payment will be sent to physicians once the 90-day submission window has elapsed.

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Reminder: Time-based codes

Time-based codes with a requirement of 80% direct patient intervention, such as the new prolonged 03.03 visit codes, means that a physician must spend 80% of the total time in direct patient care. I.e., to claim for a 30-minute visit, 24 minutes must be spent in direct patient care. If 24 minutes was not reached with the patient, the physician would not be eligible to claim for the additional multiple. For the prolonged 03.03 visits:

Multiples	*Total Time*	*Direct physician to patient contact*
MU 2	*30 minutes*	*24 minutes*
MU 3	*45 minutes*	*36 minutes*
MU 4	*60 minutes*	*48 minutes*

Reminder: Guidelines for a limited visit

Physicians are reminded that in order to claim for a visit code (e.g., prolonged 03.03) the guidelines must be met and satisfied per the preamble requirements. A limited visit may be claimed when the physician provides a limited assessment for diagnosis and treatment of a patient's condition. It includes a history of the presenting problem and an evaluation of relevant body systems.

Reminder: TI=GPEW

Per the August 4, 2023, Physician's Bulletin, the GP Evening and Weekend Premium (TI=GPEW) no longer requires the ME=CARE modifier on applicable codes. Effective July 24, 2023, TI=GPEW is available for patients seen in walk-in clinics. If physicians were holding TI=GPEW claims for non-ME=CARE patients, these may now be submitted.

03.09K 03.09L

Per the updated guidelines, effective July 24, 2023, the rule requiring start and stop times on these health service codes has been removed.

Amendment: The referring physician or provider must document:

1. *The patient demographic information*
2. *The date and time of the communication with the consultant*
3. *The clinical concern*
4. *The advice received from the consultant – including the name of the consultant*

The referring physician or provider must provide an electronic or written copy of this documentation within 7 days of the service ***to the consultant physician****.*

Please see full details in the Interim Fee Reference Guide.

Expanded eligibility for high-dose influenza vaccine during 2023/24 flu season

For the 2023-24 flu season, the high dose influenza vaccine (HSC 13.59L RO=HDIN) may be claimed for any eligible patient ≥65 years of age, regardless of location.

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NEW AND UPDATED EXPLANATORY CODES

Code	Description
DE037	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF 4 TELPHONE PRESCRIPTION RENEWALS PER PATIENT PER YEAR HAS BEEN REACHED.
DE038	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY BILLED A VISIT OR PROCEDURE SERVICE FOR THIS PATIENT ON THE SAME DAY.
DE039	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE MAY ONLY BE CLAIMED ONCE PER PATIENT PER DAY.
DE040	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS TEXT INDICATING NECESSITY/INTERVENTION IS REQUIRED WHEN THERE HAS ALREADY BEEN A VISIT CLAIMED FOR THIS PATIENT ON THE SAME DAY. PLEASE RESUBMIT WITH APPROPRIATE TEXT.
DE041	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST SUBMIT YOUR SIGNED CONFIRMATION LETTER IN ORDER TO CLAIM NPIV1.
DE042	SERVICE ENCOUNTER HAS BEEN REFUSED AS COMPREHENSIVE CARE SERVICES HAVE PREVIOUSLY BEEN CLAIMED FOR THIS PATIENT.
DE043	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE MAY ONLY BE CLAIMED ONCE PER PATIENT.
DE045	SERVICE ENCOUNTER HAS BEEN REFUSED AS A VISIT OR PROCEDURE HAS PREVIOUSLY BEEN BILLED FOR THIS PATIENT ON THE SAME DAY.
GN131	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST SUBMIT YOUR PROOF OF CBRC ONLINE TRAINING CERTIFICATION BEFORE CLAIMING THIS CODE.
GN132	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY BILLED A TELEPHONE PRESCRIPTION RENEWAL FOR THIS PATIENT ON THE SAME DAY.
GN133	SERVICE ENCOUNTER HAS BEEN REFUSED AS NPIV1 HAS PREVIOUSLY BEEN BILLED FOR THIS PATIENT ON THE SAME DAY.
GN134	SERVICE ENCOUNTER HAS BEEN REFUSED. HEALTH CARD NUMBER IS NOT VALID FOR THE HSC BEING CLAIMED.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday September 15, 2023. The files to download are: Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT) and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

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

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

In partnership with

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August 24, 2023: Vol. LXVIII, ISSUE 10

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

NEED A FAMILY PRACTICE (NaFP) INCENTIVE PROGRAM

The Need a Family Practice Incentive Program is open to all office-based family physicians. It will be available between July 1 and October 31, 2023. Patients must be onboarded, meaning their first appointment must occur before December 31, 2023. Physicians will be provided a block of 50 patients from the registry, and if they see all patients by December 31, 2023, will be compensated $10,000 for the first block of patients and $200 for every additional patient.

For information, please contact NSH:

ZONE	CONTACT	PHONE	EMAIL
Western	Allison Stewart	902-670-7656	Allison.Stewart@nshealth.ca
Northern	Cheryl Watson-Doucette	902-893-5554 x 42671	Cheryl.Watson-Doucette@nshealth.ca
Eastern	Stephanie Goodwin	902-867-4500	Stephanie.Goodwin@nshealth.ca
Central	Courtney MacKay Bridgette Belzevick	902-487-2018 902-843-6583	Courtney.MacKay@nshealth.ca Bridgette.Belzevick@nshealth.ca

An update will be made available as to the timing of these incentive payments.

PHYSICIAN'S BULLETIN
August 4 2023: Vol. LXVIII, ISSUE: 9

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

PHYSICIAN AGREEMENT 2023-2027

This bulletin is being issued to introduce new interim health service codes and rate changes as ratified in the 2023-27 Physician Agreement effective July 24, 2023.

The MSI system is anticipated to be updated September 15, 2023 with the information contained in this bulletin. For services that are required to be held, an additional bulletin will be published when these claims can be billed.

Any additional MSI items including new or modified fees, policies, and procedures with regards to the new Physician Agreement that are not outlined in this bulletin, will be published as information becomes available.

MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT
Effective April 1, 2023, the Medical Service Unit (MSU) value increased from $2.68 to $2.76.

ANAESTHESIA UNIT
Effective April 1, 2023, the Anaesthesia Unit (AU) increased from $25.30 to $26.06.

Note: These increases will be automatically applied on any claims submitted with a date of service on or after September 15, 2023. Claims submitted with service dates from April 1 – September 14, 2023 will be identified and a retroactive payment will be sent to physicians once the 90-day submission window has elapsed.

MSI RATE CHANGES

Please note rate changes not addressed in this bulletin will be published in a future bulletin as information becomes available.

PSYCHIATRY FEES

Effective April 1, 2023, the hourly psychiatry rate for General Practitioners increased to $165.62 while the hourly rate for Specialists increased to $220.24 per the tariff agreement.

Note: These rates will automatically take effect on any claims submitted as of September 15, 2023. Claims submitted and paid with service dates from April 1– September 14, 2023 will be identified and a retroactive payment will be sent to physicians once the 90-day submission window has elapsed.

SESSIONAL FEES

Effective April 1, 2023, the hourly sessional payment rate for General Practitioners increased to $165.62 while the hourly rate for Specialists increased to $193.23 per the tariff agreement.

Note: These rates will automatically take effect on any claims submitted and paid as of August 18, 2023. Claims submitted and paid from April 1 – August 17, 2023 will be identified and a retroactive payment will be sent to physicians once the 90-day submission window has elapsed.

LEVEL 3/4 ED REMUNERATION

Rate increases per the 2023-2027 Physician Agreement will automatically take effect on any claims submitted and paid as of August 18, 2023. Claims submitted and paid from April 1 – August 17, 2023 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window has elapsed.

CHIP & PMC

Rate increases per the 2023-2027 Physician Agreement will automatically take effect on any claims submitted and paid as of August 1, 2023. Claims submitted and paid from April 1 – July 31, 2023 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window has elapsed.

Payment Claim Forms:

New claim forms will be distributed along with timelines of implementing new rates for payment to those physicians and groups affected by the rate increases.

Please note rate changes not addressed in this bulletin will be published in a future bulletin as information becomes available.

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NEW INTERIM FEES

Per the 2023-2027 Physician Agreement, the following new interim health service codes will be available for billing with service dates effective July 24, 2023. Physicians are asked to hold their claims until the system is updated. Notification will be published when claims for these services can be submitted.

Category	Code	Description	Base Units
DEFT	TPR1	**Telephone Prescription Renewal** **Description** This service is billable by a family physician when the physician is requested by a patient to communicate a prescription renewal by telephone, fax, or email without seeing the patient. **Billing Guidelines** • Documentation on the patient's chart must include the name of the pharmacy, as well as the drug, dose, and amount prescribed. • This HSC is not to be billed for writing new prescriptions. • This HSC may not be billed if the physician sees the patient (face to face or virtually) on the same day. • May not be billed more than 4 times per year per patient per provider. **Specialty Restriction:** SP=GENP	4 MSU

Category	Code	Description	Base Units
DEFT	AHCP1	**Allied Health Care Provider to Physician** **Description** This service is billable when a physician has a conversation with an allied health care practitioner, either face to face, by phone, email or fax to provide advice on a patient with whom the physician has an established relationship to determine management decision. This service is intended to compensate the physician for unexpected interruptions to the physician's normal practice routine. This would also include the physician's time to update the patient's chart. **Billing Guidelines** • The allied health care providers must work outside of the physician's practice • Telephone calls initiated by the patient, or patient's family member may not be billed under this code	7.5 MSU

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- All interactions must be recorded in the patient's chart, including the time of the call, the name and professional capacity of the allied healthcare worker involved, the medical issue addressed, and the advice given
- Physicians may use a copy of the documentation from the allied health care worker to support this HSC claim, but it must be reviewed and 'signed off' by the physician. The physician should add any needed clarifications or corrections to this documentation as an addendum
- Claims, outside the pharmacy pilot, can only be made for physician interaction and not for staff (clerks, nurses etc.) of the physician
- With regards to pharmacists, this code is for discussion of patient care and is not for prescription renewal, clarifying illegible prescriptions or switching to a generic form of drug
- This fee code may not be billed with the Telephone Prescription Renewal
- Only billable once per patient per day per physician
- May not be billed more than 15 times per physician per week
- Not to be billed on the same day as a visit unless the status of the patient has changed in the intervening time. If there has been a visit on the same day, text is required regarding the intervention

Specialty Restriction:
SP=GENP

Location:
LO=OFFC

Category	Code	Description	Base Units
DEFT	NPIV1	**New Patient Intake Visit** **Description** A new patient intake visit may be billed when a family physician accepts a new patient into their office practice and arranges an appointment for the purpose of gathering a detailed medical and social history in order to establish an ongoing patient-physician relationship and to construct the patient's medical record. Includes review of clinical documents prior to the visit and establishment of medical record on the same day. (Includes face to face and non-face to face time) **Billing Guidelines** • Such an encounter shall include documentation of the new patient's current health status, past medical history, relevant social and family history, and a list of current medications and allergies, as well as any physical examination as clinically appropriate. All components of this service must be completed on the same day. • If a medically necessary service is indicated during the initial visit, the time taken to address this can contribute to the multiples claimed. This fee is considered to compensate for a medically necessary service, if required at the initial visit. • Physician must submit ME=CARE declaration letter before billing any NPIV services. • The fee cannot be billed for existing patients where ME=CARE has been billed by that family physician or collaborative practice.	34 MSU +MU

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- For New Patient Intake Visits that are less than 30 minutes (including both the face to face and non-face to face time), the physician should bill fee code NPIV1 with one multiple. For New Patient Intake Visits that are greater than 30 minutes the physician can bill a maximum of 5 multiples, i.e., 90 minutes. Prolonged office visits are paid in 15-minute time blocks or portion thereof. When billing multiples, total encounter time must be documented in the health record and on the text field of the claim.
- The NPIV fee code can only be billed once per patient per physician.
- May not be billed with any other visit code or procedure code at the same encounter.
- Not applicable for virtual care.

Multiples:
17 MSU per 15 minutes to a maximum of 5 multiples (90 minutes)

Premium Eligible:
TI=GPEW

Specialty Restriction:
SP=GENP

Location:
LO=OFFC

INTERIM FEE UPDATES

Per the 2023-2027 Physician Agreement, the following health service codes have been updated to include multiples for prolonged services. Prolonged visits have an effective date of July 24, 2023, however physicians are asked to hold their claims until the system is updated to allow for multiples. Notification will be published when claims for these services can be submitted.

Category	Code	Description	Base Units
VIST	03.03	**Prolonged Office Visit for ME=CARE** ME=CARE, RP=SUBS **Description** This service is paid to family physicians who are delivering face to face comprehensive and continuous care to patients whom they have an ongoing relationship. Prolonged office visits are paid in 15-minute time blocks or portion thereof, 80% of the time must be spent in direct physician to patient contact. Prolonged office visits are not to be confused with active treatment associated with detention. **Billing Guidelines** • Only physicians eligible to bill the ME=CARE modifier may bill for prolonged office visits. • Each office visit can be billed up to a maximum of 60 minutes (68MSU) per day. This would include a base fee plus up to 3 additional multiples of 15 minutes each.	17 MSU +MU

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- Start and stop times are required for any visit billed with multiples greater than 1. The start and stop times must be documented in the health record and on the text field of the claim.
- Multiples are not applicable for virtual care.

Multiples:
17 MSU per 15 minutes to a maximum of 4 multiples (60 minutes) per day

Premium Eligible:
TI=GPEW

Specialty Restriction:
SP=GENP

Location:
LO=OFFC

VIST	03.03A	**Prolonged Geriatric Office Visit for ME=CARE** ME=CARE	20.99 MSU +MU

Description
This service is paid to family physicians who are delivering face to face comprehensive and continuous care to patients aged 65 or older with whom they have an ongoing relationship.
Prolonged geriatric office visits are paid in 15-minute time blocks or portion thereof, 80% of the time must be spent in direct physician to patient contact. Prolonged geriatric office visits are not to be confused with active treatment associated with detention.

Billing Guidelines
- Only physicians eligible to bill the ME=CARE modifier may bill for prolonged geriatric office visits.
- Each office visit can be billed up to a maximum of 60 minutes (83.96MSU) per day. This would include a base fee plus up to 3 additional multiples of 15 minutes each.
- Start and stop times are required for any visit billed with multiples greater than 1. The start and stop times must be documented in the health record and on the text field of the claim.
- Multiples are not applicable for virtual care.

Multiples:
20.99 MSU per 15 minutes to a maximum of 4 multiples (60 minutes) per day

Premium Eligible:
TI=GPEW

Specialty Restriction:
SP=GENP

Location:
LO=OFFC

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Per the 2023-2027 Physician Agreement, nursing home visit codes have been updated to include multiples for prolonged services, as outlined below. In addition to allowing for multiples, the 2023-2027 Physician Agreement has also removed any differential rate for second or subsequent patients visited while in a nursing home facility. Effective July 24, 2023 nursing home visits requirements to use PT=FTPT and PT=EXPT have been removed and the unit value updated to reflect this.

Claims without multiples that are submitted with dates of service between July 24, 2023 and September 14, 2023 will be identified and a retroactive payment will be sent to physicians once the 90 day billing window has elapsed. Physicians are asked to hold their prolonged claims until the system is updated to allow for multiples.

Category	Code	Description	Base Units
VIST	03.03	**Prolonged Nursing Home Visit** **Description** This service is paid to physicians who are delivering patient care to residents in nursing homes. This fee is to be billed for all residents of the nursing home, whether the first patient or extra patient. Prolonged nursing home visits are paid in 15-minute time blocks or portion thereof, 80% of the time must be direct physician to patient contact. Prolonged nursing home visits are not to be confused with active treatment associated with detention. **Billing Guidelines** • Each nursing home visit can be billed up to a maximum of 60 minutes per patient per day. This would include a base visit plus up to 3 additional multiples of 15 minutes each. • Start and stop times are required for any visit billed with multiples greater than 1. The start and stop times must be documented in the health record and on the text field of the claim. • Multiples are not applicable for virtual care. **Multiples:** 17 MSU per 15 minutes to a maximum of 4 multiples (60 minutes) per day **Modifiers:** TI=EVNT = Time 1701-2000 – 28.3 MSU + MU (22.95 MSU per 15 minutes) TI=ETMD = Time 2001-2359 – 28.3 MSU + MU (22.95 MSU per 15 minutes) TI=MDNT = Time 0000-0800 – 38.3 MSU + MU (25.5 MSU per 15 minutes) **Specialty Restriction:** SP=GENP **Location:** LO=NRHM	21.3 MSU +MU

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The MSU for HSC 03.09L Specialist Advice – Referring Physician has increased, and the guidelines for the following health service codes have been updated and are effective July 24, 2023. HSC 03.09L claims that are submitted with dates of service between July 24, 2023 and September 14, 2023 will be identified and a retroactive payment will be sent to physicians once the 90 day billing window has elapsed.

Category	Code	Description	Base Units
CONS	03.09K	**Specialist Advice – Consultant Physician – providing advice**	25 MSU
	03.09L	**Specialist Advice – Referring Physician – requesting advice**	13 MSU

Description

This health service code may be reported for two-way telephone (or other synchronous electronic verbal communication) or face to face conversations regarding the assessment and management of the patient but without the consulting physician seeing the patient.

This health service code may also be reported for asynchronous communication regarding the assessment and management of a patient, but only when utilizing a health authority-approved platform and consistent with all other billing requirements.

The referring physician may be a nurse practitioner, midwife, optometrist, family physician or other specialist seeking an opinion from the consulting physician due to the complexity and severity of the case.

The referring physician or provider must document:

1. The patient demographic information
2. The date and time of the communication with the consultant
3. The clinical concern
4. The advice received from the consultant – including the name of the consultant

The referring physician or provider must provide an electronic or written copy of this documentation within 7 days of the service.

The consultant physician must review the documentation from the referring physician or provider within 14 days of the service. If clarification or corrections are indicated in the documentation, the consulting physician must provide a written addendum to provide this clarification and return it to the referring physician or provider within 21 days of the service. Both physicians/providers are responsible for retaining medical records pertaining to this service.

Billing Guidelines

This service includes a review of the patient's relevant history, relevant family history and relevant history of present complaint, and a review of any laboratory data, PACS images, medical records or other data as needed to provide advice. The health service includes a discussion of the relevant physical findings as reported by the referring physician or provider.

The consultant physician service is not reportable in addition to any other service for the same patient by the same physician on the same day.

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The referring physician or provider service may be reported when the communication with the consultant occurs on the same day as a patient visit or other service.

The services are not reportable when the purpose of the communication is to:

- Arrange transfer
- Arrange a hospital bed for the patient
- Arrange a telemedicine consultation
- Arrange an expedited face to face consultation
- Arrange a laboratory, other diagnostic test or procedure
- Inform the referring physician of the results of diagnostic investigations
- Decline the request for a consultation or transfer the request to another physician

The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another health professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student

This service is not reportable for telephone calls or face to face conversations of less than 5 minutes of two-way medical discussion.

This is billable once per patient issue regardless of the number of asynchronous interactions.

Documentation Requirements

- The referring physician or provider must document that the referring physician or provider has communicated the reason for the consultation and relevant patient information to the specialist
- Both the specialist consultant and the referring physician or provider must document the patient's name, identifying data, date and encounter time in their respective charts or EMRs.
- The names of the referring physician or provider and the consultant physician must be documented by both the referring physician or provider and the consultant physician.
- The diagnosis, reason for referral, elements of the history and physical as relayed by the referring physician or provider, the opinion of the consultant physician and the plan for future management must be documented by the referring physician or provider and the specialist consultant. The consulting physician may use a copy of the documentation from the referring provider to support this HSC claim, but it must be reviewed and 'signed off' by the consulting physician.
- A written report must be sent to the referring physician or provider by the specialist consultant. The specialist consultant may satisfy this requirement by returning a copy of the documentation from the referring provider as long as it was reviewed and 'signed off' by the consulting physician.
- The referring physician's or provider's billing number must be noted on the claim from the consultant. This is not required for the referring physician's or provider's claim.

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PREAMBLE UPDATE

Effective July 24, 2023, the GP Evening and Weekend Premium (TI=GPEW) will be available for patients seen in walk-in clinics. For GPEW services that are not for ME=CARE (comprehensive and continuous care patients), physicians are asked to hold their claims until the system is updated to remove the ME=CARE requirement. Notification will be published when claims for these services can be submitted.

New Definition

GP ENHANCED HOURS PREMIUM *(5.1.188)*

This premium is intended to promote enhanced patient access to primary care outside of traditional office hours. This premium is available for select services to physicians who have an ongoing relationship with their patients **and select services for physicians providing care at walk-in clinics**.

Billing Guidelines:

- The eligible time periods are from 6a.m. to 8a.m. weekday mornings and 5p.m. to 10p.m. on weeknights where weekdays are defined as Monday through Friday. On Saturday, Sunday and Holidays (as defined by the MSI Physician's Bulletin) the eligible time period is from 9a.m. to 10p.m.
- **Select services provided in walk-in clinics are eligible for the Enhanced Hours Premium during premium eligible time periods**. *(5.1.190)*

The following visit services are eligible for the 25% Enhanced Hours Premium:

- 03.03 Office visits – includes WBCR, ANTL, PTNT etc.
- 03.03A Geriatric office visits
- 03.03C Palliative care support
- 03.03E Adults with developmental disabilities
- 03.03J OAT initial visit
- 03.03K OAT transfer of care from program
- 03.03L OAT transfer of care
- 03.03V Medical abortion
- 03.04 Comprehensive visit
- 03.04I PSP Mental health visit
- 03.09C Palliative care consultation
- 08.41 Hypnotherapy
- 08.44 Group therapy
- 08.45 Family therapy
- 08.49A Counselling
- 08.49B Psychotherapy

The following visit services are eligible for the 25% Enhanced Hours Premium when billed by the patient's family physician only. Walk in clinics may not bill the following services:

- 03.03B Complex care
- 08.49C Lifestyle counselling

Only one premium can be claimed per patient encounter regardless of the number of services provided during the encounter. Claims for eligible services should be submitted with the modifier TI=GPEW.

NOTE: For services where the Enhanced Hours Premium has been claimed, a record must be maintained and readily available to verify that the patient was booked for an appointment during a premium-eligible time period. The appointment time should be record in the patient's record or office appointment books retained.

APP contract physicians may shadow bill the GP Enhanced Hours Premium.

The Enhanced Hours Premium should not be claimed in circumstances where the patient is booked for an appointment time that is not eligible for the premium and then the physician "runs late"

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July 28, 2023: Vol. LXVIII, ISSUE 8

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

NEW FEE FOR GENDER AFFIRMING CARE

The following health service code will be effective with service dates starting July 28, 2023; however, physicians are asked to hold their claims until the system is updated. Notification will be published in a Physician's Bulletin when claims can be submitted.
News Release: Province Implements Gender-Affirming Care Policy - Government of Nova Scotia, Canada

Category	Code	Description	Base Units
VIST	03.04K	**Gender Transition Readiness Assessment, follow up of patients undergoing medical transition, and follow up of patients undergoing surgical transition where the primary care provider is required to provide postoperative care** **Description** Gender transition readiness assessment, gender transition follow up, and postoperative care of patients who have had gender affirming surgery provided to them out of province. Physicians providing Gender Affirming Care (GAC) and billing for GAC fee codes, are required to take the Community Based Research Centre (CBRC) free online training program, which includes Mainpro certification for physicians and residents prior to having access to the code. Certification is required to be submitted and kept on file at MSI. Required CBRC modules for physicians include: 1. Gender Affirming Hormone Prescription training. 2. Introduction to Affirming Spaces training (not a Mainpro course) 3. Gender Affirming Care: Surgical Readiness and Aftercare training These courses can be accessed at CBRC Online Programming (teachable.com) Any necessary counselling or physical examinations are included in this HSC and should not be claimed separately. **Billing Guidelines:** • This code is to be used only for services provided that are directly related to Gender Affirming Care; it does not replace all visit codes for that patient.	40 MSU +MU

- Base 30 minutes of time spent by the physician in direct patient care with multiples of 15 minutes when the service encounter exceeds 30 minutes to a maximum of 75 minutes. 80% of the time claimed must be in direct patient care.
- When claiming for multiples on a time-based service the start and stop times must be documented in the health record and submitted in text with the claim

Multiples:
20 MSU per 15 minutes to a maximum of 4 multiples (75 minutes)

Premium Eligible:
TI=GPEW

Specialty Restriction:
SP=GENP

Location:
LO=OFFC

UPDATE

GAS Health Service Codes 97.79B, 97.44A, 97.99B, 03.09M and 03.03Y are now available to FFS physicians. For full details on these codes, please see the Interim Fee Reference Guide.

BREAST REDUCTION GUIDELINE UPDATE

Effective July 28, 2023, the Breast Reduction Guidelines have been updated.
The crtieria of removing a minimum of 400 grams of breast tissue per side is no longer required.
As well, if a functional issue is clearly described in the request letter and accompanying a consultation letter, such as pain in the shoulders, neck and back and interferring with activities of daily living, the shoulder grooving criteria will be considered part of this.

PHYSICIAN'S BULLETIN
July 27, 2023: Vol. LXVIII, ISSUE 7

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

Surgical Access Premium Payments

Effective August 1, 2023, the interim Surgical Access Premium Payment initiative (SAI) will facilitate more evening and weekend surgeries at NSH/IWK facilities to address surgical waitlist/backlog for Nova Scotians. Net new surgeries by NSH/IWK as part of the Surgical Waitlist Reduction Initiative will be eligible for premium payments for all cases scheduled and started in defined premium times.

Approved surgeries will be identified by Nova Scotia Health, where the following criteria must be met:

- Cases and/or lists ("cases") scheduled in off-hours or weekends cannot be cases purposely bumped from "regular hours" for a specific site and/or operating room.
- Surgeons and Anesthesiologists scheduled for off-hours or weekend cases cannot be on-call and will not be eligible for Surgical Access Premium Payment, outside of emergency cases.
- Scheduled cases must result in demonstrable *additional* surgical activity within a given timeframe to be eligible for Surgical Access Premium Payment.
- Where surgical services are regularly scheduled outside the 0800-1700 window (e.g., 0730 start time), only those cases which meet the criteria of "in addition to normal surgical activity" will be eligible for Surgical Access Premium Payment.

- The existing premium fees' structure will apply to scheduled surgical cases meeting the above criteria.
  - 35% for all cases started between 1700-2359 on weekdays; or from 0800-1659 on Saturdays.
  - 50% for all cases started between 0000-0759 on weekdays or from 1700-0759 on Saturdays, or for any cases started anytime on Sundays or holidays.

- Surgical Access Premium Payment will not be eligible for:
  - Additional cases that start in non-premium time; or
  - Regularly scheduled cases that go into premium time.

The NSH/IWK will be developing, on a monthly basis, the list of approved surgeries, to which eligible premiums will be applied. Premium payments for this program will only be issued if claims are submitted within the standard 90-day billing window.

Physicians are to submit these surgical claims **without** adding any premium modifiers. After a post-payment review, the appropriate premium of 35% or 50%, will be calculated on the value of the paid health service code(s) submitted and premium payments will be issued as a lump sum amount through a bottom-line adjustment after the reconciliation period.

- Alternate Payment Plan and Alternate Funding Plan physicians will be eligible for additional payment, above and beyond their regular APP/AFP payment for all surgeries performed that meet the above criteria.

    - AFP physicians must shadow bill the claims associated with the SAI to the new defined group business arrangement (BA) and will receive full payment for surgeries performed based on the health service code(s) adjudicated and paid (FFS rates plus premiums) to the defined group BA after a period of reconciliation.

    - APP physicians will submit the health service codes associated with the SAI on their FFS BA and receive the applicable payment once the claim is adjudicated, and subsequently will receive the premium amount to their CMPA BA after a reconciliation period.

    - Fee for Service physicians will submit the health service codes associated with the SAI as per normal process and receive the applicable payment once the claim is adjudicated, and subsequently will receive the premium amount to their CMPA BA after a reconciliation period.

For eligibility questions, please contact Nova Scotia Health or IWK.

- NSH: Medical Affairs – PhysicianContracts@nshealth.ca
- IWK: LeeAnn Larocque, Executive Lead, Clinical Transformation – Leeann.Larocque@iwk.nshealth.ca

*Please note that Premium Guidelines as outlined in the Physician's Manual must still be followed for all premium billing outside of this initiative.

PHYSICIAN'S BULLETIN
JULY 21, 2023: Vol. LXVIII, ISSUE 6

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FEE UPDATES

Effective May 26, 2023 the following health service codes have been updated for specialites SP=INMD and SP=RSMD to include home location LO=HOME. The locations OFFC, OTHR and HOME are restricted to the mobile INSPIRED program and physicians are required to enter 'INSPIRED' into the text field of the MSI claim when submitting for these services.

Category	Code	Description	Base Units
VEDT	03.38C	**Interpretation of Spirometry Pre and Post Bronchodilator** **Location:** LO=HOSP, LO=OFFC, LO=OTHR, LO=HOME	10 MSU
BULK	I1110	**Simple Spirometry** **Location:** LO=HOSP, LO=OFFC, LO=OTHR, LO=HOME	5 MSU
BULK	I1140	**Flow/Volume Loops** **Location:** LO=HOSP, LO=OFFC, LO=OTHR, LO=HOME	5 MSU

FEE UPDATES (CONTINUED)

Effective July 21, 2023 the following interim health service code has been updated to include region modifiers:

Category	Code	Description	Base Units	Anae Units
MISG	97.99B	**Revision of gender affirming chest surgery** **Prior Approval/Preauthorization required (PA)** **Description** Revision of chest surgery performed within 18 months of MSI approved gender affirming chest surgery to address complications and functional impairment only. This comprehensive service includes any scar revision, re-contouring of the chest wall, revision of nipple, and areolar reconstruction as required. The physician will submit a written request documenting the reason for the proposed revision to MSI for PA. Photographs of the affected area may be requested to support the request. No additional uninsured services may be performed or charged to the patient during this surgical encounter. **Billing Guidelines** • Original chest surgery must have had prior approval from MSI for gender affirming surgery based on a complete and approved GAS application. • Only one per patient per lifetime • Requires a formal request for prior approval/ preauthorization from MSI by the physician proposing the procedure. • May not be claimed with: ○ Reconstruction of nipple HSC: 97.77 ○ Tissue shift/graft HSC's to include, but not limited to: 98.51B, 98.51C, 98.51D, 98.51E RO=SRAS applicable **Regions (Required)** RG=LEFT, RG=RIGT, RG=BOTH **Specialty Restriction:** SP=PLAS (non fee for service) **Location:** LO=HOSP	150 MSU	4+T

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MSI DOCUMENTATION REMINDER

For MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the 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), the working diagnosis and the treatment prescribed, and start and stop times for time-based codes. Documentation should be descriptive with regards to the service performed, discussion and advice given.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptation's, or emotional problems, 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." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional wellbeing of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy," etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule. Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim. Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service on that date, then the service is not paid for or a lesser benefit is given. When the clinical record does not support the service claimed, there may be a recovery to MSI at the time of audit. Documentation of services which are being claimed to MSI must be signed off by the physician rendering the service and completed before claims for those services are submitted to MSI.

SERVICE ENCOUNTERS WITH UNINSURED SERVICES REMINDER

When providing non-insured services, physicians should be familiar with Preamble Section 1.1.22: Billing for insured and non-insured services at the same visit:

- A physician must exercise caution whenever billing MSI and the patient or a third party during the same visit. In principle, under no circumstances should any service, or any component of a service, be claimed for twice.
- Whenever possible, the attending physician must acquaint the patient, or person responsible for the patient, with the financial obligation involved in the patient's care.
- If the insured service is the primary reason for the visit, any additional charges for non-insured services must be explained to, and accepted by, the patient before provision of these services. Charges for noninsured services will reflect only those services over and above those provided on an insured basis. It is not appropriate to bill both MSI and Workers' Compensation Board (WCB) for the same service.
- At no time should provision of insured services be contingent upon the patient agreeing to accept additional non-insured services.
- When physicians are providing non-insured services, they are required to advise the patient of insured alternatives, if any exist.

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Incidental findings:

1. If an inconsequential health matter or finding is discovered or discussed during the provision of a non-insured service, it is not appropriate to claim for an insured service.
2. If a significant health matter or finding becomes evident, necessitating additional insured examinations or treatments, then these subsequent medically necessary services may be claimed to MSI.

- When a non-insured service is the primary reason for the visit, any service encounter for insured services provided as a medical necessity will reflect only services over and above those provided on a non-insured basis.

Preamble 5.1.9 stipulates that if the sole purpose of a visit is to provide a procedure then only the listed procedure fee will apply. However, removal of cerumen has been an uninsured service in Nova Scotia for many years except in the case of a febrile child. Physicians may not bill either a visit or a procedural code when the sole purpose of the encounter is cerumen removal in other clinical situations.

Physicians are reminded that release of newborn tongue tie has been an uninsured service since 1997. Therefore, physicians may not claim visit or procedural HSCs related to this.

If the primary purpose of the patient's visit to you was to receive an uninsured service such as an alternative therapy or cosmetic procedure, you may claim for other services in limited circumstances:

- The medical issue must be completely unrelated to the reason for the visit to your clinic.
- The medical issue is of a serious nature.

ELECTIVE OUT OF PROVINCE AND OUT OF COUNTRY SERVICES REMINDER

ELECTIVE OUT OF PROVINCE SERVICES (WITHIN CANADA)

Prior approval is required from the Nova Scotia Department of Health and Wellness before referring a patient out of province for insured health services unavailable in Nova Scotia if the patient wishes to be considered for travel and accommodation assistance. Approval must be sought through the Medical Consultant, MSI.
The referral must be from a specialist registered in Nova Scotia, who is actively involved in the eligible resident's care. The referral must include the following:

- A description of the eligible resident's relevant medical history.
- A description of the health services requested as well as an estimation of the expected benefit to the patient.
- Confirmation that the health service(s) are provided in a publicly funded facility and are covered by the medical insurer in the proposed province
- Written confirmation of the medical evidence supporting the requested health service.
- When the proposed health service is a new or emerging health service, documentation must be included of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.
- Information on the available health services in Nova Scotia and an explanation of why these are not sufficient for the resident's needs.
- The contact information of the physician who will be treating the patient so a copy of the approval documentation can be forwarded to their office.
- A description of any follow-up requirements.
- A written recommendation in support of the out-of-province health services, confirming that this is the specialist's recommendation and that the referral is not being provided solely at the request of the patient.
- Written confirmation of the patient's medical requirement for travel with an escort, if required.
- The costs for an escort will not be covered by DHW if there is no medical evidence to support the need for an escort. Evidence of medical need for an escort is not required if the resident is under 19 years of age.

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MSI will review the application and provide a response to the appropriate specialist within 30 days of receiving a complete application.
Upon approval of the application, the Department of Health and Wellness will contact the eligible resident and provide the appropriate application forms for travel and accommodation assistance.

ELECTIVE OUT OF COUNTRY SERVICES

Individuals requiring elective, insured health services that are not available within Canada must be authorized by the DHW prior to making any medical and/or travel arrangement to ensure the service will be insured and in order for the DHW/MSI to negotiate a reasonable and fair compensation with out of country providers prior to the provision of services.
In order for a patient to be referred outside Canada for treatment, prior written approval is required from the Medical Consultant, MSI.
The referral must be from a specialist registered in Nova Scotia, who is actively involved in the eligible resident's care. The referral must include the following:

- A description of the eligible resident's relevant medical history.
- A description of the health services requested as well as an estimation of the expected benefit to the patient.
- The contact information of the physician who will be treating the patient so a copy of the approval documentation can be forwarded to their office.
- Written confirmation of the medical evidence supporting the requested health service.
- When the proposed health service is a new or emerging health service, documentation must be included of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.
- Information on the available health services in Canada and an explanation of why these are not sufficient for the resident's needs.
- A description of any follow-up requirements.
- A written recommendation in support of the out-of-country health services, confirming that this is the specialist's recommendation and that the referral is not being provided solely at the request of the patient.
- Written confirmation of the patient's medical requirement for travel with an escort, if required.
- The costs for an escort will not be covered by DHW if there is no medical evidence to support the need for an escort. Evidence of medical need for an escort is not required if the resident is under 19 years of age.

MSI will review the application and provide a response to the appropriate specialist within 30 days of receiving a complete application.
Upon approval of the application, the Department of Health and Wellness will contact the eligible resident and provide the appropriate application forms for travel and accommodation assistance.

PHYSICIAN AGREEMENT UPDATES

Please be advised that any items on MSI related matters including new or modified fees, policies and procedures with regards to the new Physician Agreement will be published in Physician's Bulletins as information becomes available.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday July 21, 2023. The files to download are:
Health Service (SERVICES.DAT),

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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NEW FEES

Effective May 1, 2023 the following health service code is available for billing:

Code	Modifier	Description	Base Units
13.59L	RO=MPOX	**Imvamune – Vaccine for active immunization against mpox, smallpox, or other replicating orthopoxviruses.** **Description** Third generation smallpox vaccine, produced from the Modified Vaccinia Ankara-Bavarian Nordic strain of orthopoxvirus. Approved for active immunization against smallpox, monkeypox, and related orthopox infections. **Billing Guidelines:** • 2-dose series with 28 days between first and second dose • Patient must be 18 years of age and older • May be used off-label in those <18 years • 2 doses per lifetime Can be administered as pre-exposure prophylaxis to those who meet the high-risk eligibility criteria, or, if directed by public health, as post-exposure prophylaxis to those who meet the high-risk exposure criteria as outlined here (under interim guidance for pre-exposure prophylaxis or interim guidance for post-exposure prophylaxis, respectively). Cannot be administered in those with suspected or confirmed mpox. Eligible for tray fee (13.59M) when applicable.	6 MSU

NEW FEES CONTINUED

Effective May 26, 2023 the following health service codes are available for billing:

Category	Code	Description	Base Units
VEDT	99.82A	**Supervision of Photodynamic Therapy by Dermatologist - per patient per week in the office setting wherein the dermatologist is responsible for payment of the technician's salary in addition to the purchase and maintenance of phototherapy equipment.** **Description** This comprehensive weekly fee is for the management and supervision of patients receiving phototherapy by the attending dermatologist. The physician should be available for consultation for these treatments and adjust the time and dosage of treatment as necessary. The patients must be directly assessed in a face-to-face visit by the physician at a minimum of every four weeks and the results of this assessment be documented in the health record. No additional visit fees may be claimed for the same diagnosis, same patient, same physician throughout the period during which this comprehensive fee is claimed. This fee applies to the private office setting in which the physician is responsible for payment of the technician's salary in addition to the purchase and maintenance of the phototherapy equipment. **Billing Guidelines:** May not be claimed with any other visit fee for the same diagnosis, same physician, same patient, same time period. **Specialty Restriction:** SP=DERM **Location:** LO=OFFC	25 MSU
VEDT	99.82B	**Supervision of Photodynamic Therapy by Dermatologist - per patient per week in the hospital outpatient setting wherein the dermatologist is not responsible for payment of the technician's salary or the purchase and maintenance of phototherapy equipment.** **Description** This comprehensive weekly fee is for the management and supervision of patients receiving phototherapy by the attending dermatologist. The physician should be available for consultation for these treatments and adjust the time and dosage of treatment as necessary. The patients must be directly assessed in a face-to-face visit by the physician at a minimum of every four weeks and the results of this assessment be documented in the health record. No additional visit fees may be claimed for the same diagnosis, same patient, same physician throughout the period during which this comprehensive fee is claimed. This fee applies to the hospital outpatient setting in which the physician is not responsible for payment of the technician's salary or the purchase and maintenance of the phototherapy equipment **Billing Guidelines:** May not be claimed with any other visit fee for the same diagnosis, same physician, same patient, same time period. **Specialty Restriction:** SP=DERM **Location:** LO=HOSP (outpatient)	10 MSU

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NEW FEES CONTINUED

Effective May 26, 2023 the following health service code is available for billing from DGH (Facility 65)

Health Service Code	Description	Weekday	Weekend/Holidays (DA=RGE1)	Approved Regional and Tertiary Hospitals
F1017	Facility on Call Category 1 - Otolaryngology	$300	$400	Dartmouth General Hospital

FEE UPDATES

Effective February 1, 2023 HSC FCHP1 is now available to bill from Inverness Consolidated (Facility 34)

Health Service Code	Description	Weekday	Weekend/Holidays (DA=RGE1)	Approved Regional and Tertiary Hospitals
FCHP1	Facility on Call – Community Hospital Inpatient Program	$300	$400	Strait-Richmond Hospital, Northside General Hospital, Fishermans Memorial Hospital, Soldiers Memorial Hospital, Queens General Hospital, Roseway Hospital, New Waterford Consolidated Hospital, Inverness Consolidated Hospital

Effective May 26, 2023 the following health service codes have been expanded for specialties SP=INMD and SP=RSMD to be claimable from locations 'office' and 'other'

Category	Code	Description	Base Units
VEDT	03.38C	**Interpretation of Spirometry Pre and Post Bronchodilator** **Location:** LO=HOSP, LO=OFFC, LO=OTHR	10 MSU
BULK	I1110	**Simple Spirometry** **Location:** LO=HOSP, LO=OFFC, LO=OTHR	5 MSU
BULK	I1140	**Flow/Volume Loops** **Location:** LO=HOSP, LO=OFFC, LO=OTHR	5 MSU

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INTERIM FEE UPDATES

The following interim health service codes have been extended to September 30, 2023:

03.09K – Specialist Telephone Advice – Consultant Physician – providing advice
03.09L – Specialist Telephone Advice – Referring Physician – requesting advice
03.03R – Family Physician Telephone Management/Follow-up with Patient
03.03Q – Specialist Telephone Management/Follow-up with Patient

The following interim health service code has been extended to December 31, 2023:

47.25C – Transcutaneous Aortic Valve Implantation (TAVI)

Please see the Interim Fee Reference Guide for full billing guidelines

Billing Matters Billing Reminders, Updates, New Explanatory Codes

Master Agreement – Program Payment Schedule 2023-24

Please see attached the Master Agreement Program Payment Schedule for the 2023-24 fiscal year for anticipated payment dates. These payments are deposited through an electronic funds transfer. If you do not already have a CMPA Business Arrangement set up to receive these deposits, you may fill out the MSI Provider Business Arrangement Form with a void cheque and email to msiproviders@medavie.ca or fax to 902-469-4674.

The Department of Health and Wellness (through MSI) will continue to provide reimbursement of all eligible Canadian Medical Protective Association (CMPA) fees directly to physicians. Payments will be issued on a quarterly payment schedule, however due to the low cost of protection for the 2023 calendar year, physicians may not meet the criteria for the rebate, or may only qualify during one measurement period.

Should you have any questions regarding your CMPA rebate, please contact: CMPA@medavie.ca

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.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
AD092	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF MPOX INJECTIONS HAS BEEN REACHED
AD093	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR 13.59L RO=MPOX HAS BEEN APPROVED IN THE PREVIOUS 28 DAYS
BK064	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE NOT INCLUDED TEXT REFERRING TO THE INSPIRED PROGRAM. PLEASE RESUBMIT WITH APPROPRIATE TEXT.

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Code	Description
VE041	SERVICE ENCOUNTER HAS BEEN REFUSED. YOU MAY NOT CLAIM A VISIT AND 99.82A OR 99.82B WITH THE SAME DIAGNOSIS WITHIN THE SAME WEEK
VE042	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HEALTH SERVICE CODE 99.82A OR 99.82B FOR THIS PATIENT IN THE PREVIOUS WEEK
VE043	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE NOT INCLUDED TEXT REFERRING TO THE INSPIRED PROGRAM. PLEASE RESUBMIT WITH APPROPRIATE TEXT.
VT179	SERVICE ENCOUNTER HAS BEEN REFUSED. YOU MAY NOT CLAIM A VISIT AND 99.82A OR 99.82B WITH THE SAME DIAGNOSIS WITHIN THE SAME WEEK

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday May 26, 2023. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), Modifiers (MODVALS.DAT) Explanatory Codes (EXPLAIN.DAT) and (UNQNUSER.DAT).

CONTACT INFORMATION

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Master Agreement - Program Payment Schedule (2023/24)

Program	Payment*
EMR (Envelope A Payments) EMR Envelope "A" payments continue monthly to eligible physicians	Monthly
CME (GP & Specialist) Payment for 2022/23 fiscal year (eligible billings based on 2022 calendar year)	Issued by May 31, 2023
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from April 1, 2023 – June 30, 2023	Issued by July 31, 2023
CMPA Premium Reimbursement Covering April - June 2023	Issued by August 31, 2023
Electronic Medical Records (EMR - B&C) Payments for 2022/23 fiscal year	Issued by August 31, 2023
Family Physician Alternative Payment Plan 5.6% Incentive	Issued by September 30, 2023
Surgical Assist Payments Payment based on eligible billings from April 1, 2022 – March 31, 2023	Issued by September 30, 2023
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from July 1, 2023 – September 30, 2023	Issued by October 31, 2023
Collaborative Practice Incentive Program Payments for 2022/23 Fiscal Year	Issued by October 31, 2023
CMPA Premium Reimbursement Covering July - September 2023	Issued by December 31, 2023
Rural Specialist Incentive Program Measurement period April 1, 2022 – March 31, 2023	Issued by December 31, 2023
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from October 1, 2023 – December 31, 2023	Issued by January 31, 2024
CMPA Premium Reimbursement Covering October – December 2023	Issued by March 31, 2024
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from January 1, 2024 – March 31, 2024	Issued by April 30, 2024
CMPA Premium Reimbursement Covering January – March 2024	Issued by May 31, 2024

*Please be advised payment dates noted are **anticipated** payments for these programs

PHYSICIAN'S BULLETIN
May 2, 2023: Vol. LXVIII, ISSUE 4

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

APP Physicians

The current Master Agreement is in the process of negotiation. Therefore, there have been no changes to the APP rates for the 2023-2024 fiscal year.

You may have noticed that your biweekly payment for your Alternative Payment Plan agreement has changed slightly effective April 1, 2023. This is a result of 2023-24 being a leap year. Your annual payment is now being smoothed over 366 days instead of 365.

Your total annual payment amount is calculated into daily rates. This year, there are 366 days. Your annual remuneration remains the same (e.g., $278,099 for 1.0 FTE FP Collaborative, $356,278 for 1.0 FTE Anaesthesia). Physicians are contracted for minimum service levels per fiscal year. APP physicians are contracted to work a minimum number of hours and days per week for a minimum of 46 weeks per year. Essentially, this works out to 6 weeks of allowable leave per annum.

Note: Some physicians have alternative schedules to meet community needs (e.g., physicians who are regularly participating in a Hospitalist rota outside their APP may have an alternate number of weeks per year).

Physicians will not be expected to provide an extra day of service in this coming fiscal year. Your required hours, days and weeks will remain unchanged.

If you have any questions, please do not hesitate to reach out to MSI by email: contracts@medavie.bluecross.ca or by phone: 902-496-7011, toll-free: 1-866-553-0585

Payment Claim Forms: Sessional, ED Remuneration (Level 3 & 4) and District Psychiatry

As there are no current changes to the 2023-24 fiscal year rates, we ask that you continue to use the 2022-23 rate form going forward. Once new rates have been negotiated, new payment forms will be provided.

PHYSICIAN'S BULLETIN
April 13, 2023: Vol. LXVIII, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

WCB CLAIM SUBMISSION REMINDER

The following outlines submission requirements for submitting WCB Nova Scotia services electronically via MSI.

To avoid processing delays, please include one or both of the following when submitting claims with a payment responsibility of WCB:

- Patient's correct WCB Nova Scotia **claim number**
- Patient's injury date (accurate **month and year** required)

If both are provided, each much be correct for immediate processing

In some cases, you may provide a service before a WCB claim exists, in these cases, the date (**month and year only**) of the injury should be submitted.

This information is used to verify that the patient was eligible for WCB coverage on the date that the service was provided. Medavie continues to receive WCB eligibility updates daily, however, you may have noticed a decrease in the length of time it takes to process WCB claims. WCB Nova Scotia has reduced the time needed to complete the verification process to determine eligibility prior to claims being processed for payment.

If you are able to confirm your patient's eligibility for WCB benefits at the time the claim is submitted for payment, this can help prevent billing errors and reduce the need for payment reversals.

If you have any questions about WCB fees, billing or error codes, please contact MSI assessment staff:
Phone: 902-496-7011, toll-free 1-866-553-0585
Email: msi_assessment@medavie.bluecross.ca

For additional information on WCB, please see the physician site at:
https://www.wcb.ns.ca/Health-Services/Physicians.aspx

PHYSICIAN'S BULLETIN

March 17, 2023: Vol. LXVIII, ISSUE 2

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

INTERIM FEE REFERENCE GUIDE

Physicians are advised that a new document is available on the MSI website. The Interim Fee Reference Guide (PDF) provides all current interim fees. Interim fees are established in certain circumstances with approval from the Department of Health and Wellness. When a health service code is assigned to an interim fee, it is published in the MSI Physician's Bulletin. If an interim fee is terminated or made permanent, it will be removed from the guide and updated in the MSI Physician's Bulletin and/or Physician's Manual as applicable.

PHYSICIAN'S MANUAL

Applicable updates in the Physician's Bulletin's will now 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.

Billing Reminders and Updates

Update

NON-FACE-TO-FACE SERVICES DURING PANDEMIC

As noted in the March 4, 2022 Physician's Bulletin, eligible dates of service for non-face-to-face services provided by telephone, via telehealth network or via PHIA compliant virtual care platforms were extended to March 31, 2023. The use of the temporary codes for virtual care are being extended for six additional months to **September 30, 2023**. Physicians will be provided with adequate notice of future changes.

Physicians are reminded of the Policy for Provision of Publicly Funded Virtual Health Services:
https://novascotia.ca/dhw/publications/Provision-of-Publicly-Funded-Virtual-Health-Services.pdf

To ensure appropriate tracking of virtual services, physicians are reminded of the modifiers and the importance of their use on claims, AP=PHON and AP=VIRC to denote when the service was conducted via telephone or PHIA compliant virtual care video platform.

Reminder

ROLE MODIFIER

Physicians are reminded that when applicable, the ROLE modifier must be used to denote your role/function performed at the service encounter, e.g., RO=ANAE anaesthetist or RO=SRAS surgical assistant.

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

UPDATED FILES

There are no updated files for download on Friday March 17, 2023.

CONTACT INFORMATION

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PHYSICIAN'S BULLETIN

January 20, 2023: Vol. LXVIII, ISSUE 1

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FEE UPDATES

Facility On-Call

Effective October 1, 2022, HSC F1007 is available to bill from Cumberland Regional Hospital (Facility 30)

Health Service Code	Description	Approved Regional and Tertiary Hospitals
F1007	Facility on Call Category 1 – Diagnostic Imaging	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Aberdeen, St. Martha's, Cape Breton Regional, Dartmouth General, QEII, Cumberland Regional

Effective January 20, 2023, HSC F1008 is available to bill from Cumberland Regional Hospital (Facility 30)

Health Service Code	Description	Approved Regional and Tertiary Hospitals
F1008	Facility on Call Category 1 – Family Medicine O.R. Call Assists	Valley Regional, St. Martha's, Cape Breton Regional, Dartmouth General, Aberdeen, Cumberland Regional

Effective January 20, 2023, Cape Breton Regional Hospital is eligible an extra hospitalist ROTA per day.

Health Service Code	Description	Approved Regional and Tertiary Hospitals
F1006	Facility on Call Category 1 – Hospitalist	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Cumberland Regional, Aberdeen, St. Martha's, Cape Breton Regional, Glace Bay, QEII, Dartmouth General, IWK/Grace

*Must meet the established Nova Scotia Facility On-Call Program Guidelines.

Billing Matters Billing Reminders, Updates, New Explanatory Codes

Chronic Disease Management Incentive

Physicians are reminded that the CDM incentive can be billed once per patient per fiscal year, providing all eligibility requirements are met. CDM1 claims must be submitted to MSI on or before March 31 in order to receive payment for that fiscal year.

Provider Profiles

Physicians are reminded that provider profiles are sent out per request. If you would like to receive your 2021/2022 provider profile, please send your request to msi_assessment@medavie.bluecross.ca. In the email, please include your name and provider number, and the profile will be mailed to the address on file.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday January 20, 2023. The files to download are:
Health Service (SERVICES.DAT)

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November 25, 2022: Vol. LXVII, ISSUE 14

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NEW INTERIM FEE

Effective November 25, 2022 the following interim health service code is available for billing:

Category	Code	Description	Base Units	Anae Units
MASG	26.29F	**Glaucoma surgery (such as stent insertion) ab interno approach, for the relief of intraocular pressure** **Description** This fee is for the surgical treatment of glaucoma via the ab interno approach for procedures such as stent insertion **Billing Guidelines:** May be claimed once per eye per surgical encounter Not billable with the following MASG codes: • 26.25 – Trabeculectomy on an eye with a previous major ocular procedure with or without post op laser suture lysis • 26.25D – Trabeculectomy with the use of anti-metabolites with or without post op laser suture lysis • 26.29D – Trabeculoplasty • 26.29E – Placement of glaucoma tube shunt • 26.34 – Trabeculectomy ab externo **Modifiers (regions required):** RG=RIGT, RG-LEFT, RG=BOTH **Premium Eligible:** Yes **Specialty Restriction:** SP=OPHT **Location:** LO=HOSP	175 MSU	6+T

FEE UPDATES

Effective November 25, 2022 the following health service code value has increased from $25.00 to $40.00:

Category	Code	Description	Payment Rate
DEFT	C9999	A medical assessment form completed for a patient on behalf of community services (COM) is to be forwarded to community services. The service encounter is submitted electronically to MSI. The same HSC is used when the 'Request for Essential Medical Treatments' form is completed for a patient on behalf of community services. Once completed, the form will be delivered to the assigned caseworker by the patient. The appropriate health service code is C9999, with the payment responsibility COM and diagnostic code Z99, i.e., community services. The health service code is claimed at 40 units, however in this case the payment rate is remunerated at one dollar ($1.00) per unit for a total of $40.00 Any patient over the age of 65 years of age does not qualify for this service.	40

Billing Matters Billing Reminders, Updates, New Explanatory Codes

Facility on Call

Yarmouth Ophthalmology rota is no longer billable as a Category 1 (HSC F1014).
Yarmouth Ophthalmology is available as Category 2 (HSC F2014) *Must meet the established Nova Scotia Facility On-Call Program Guidelines for a level 2 rota.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
MJ086	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 26.29F MAY ONLY BE CLAIMED ONCE PER EYE PER SURGICAL ENCOUNTER
MJ087	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 26.25, 26.25D, 26.29D, 26.29E OR 26.34 HAS ALREADY BEEN CLAIMED AT THE SAME ENCOUNTER
MJ088	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 26.29F HAS ALREADY BEEN CLAIMED AT THE SAME ENCOUNTER

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday November 25, 2022. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

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

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

In partnership with



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2023 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE	SALARY CONTRACT PAY PERIOD
December 30, 2022**	January 5, 2023	January 11, 2023	December 23, 2022-January 5, 2023
January 16, 2023	January 19, 2023	January 25, 2023	January 6-19, 2023
January 30, 2023	February 2, 2023	February 8, 2023	January 20-February 2, 2023
February 10, 2023**	**February 15, 2023****	February 22, 2023	February 3-16, 2023
February 27, 2023	March 2, 2023	March 8, 2023	February 17-March 2, 2023
March 13, 2023	March 16, 2023	March 22, 2023	March 3-16, 2023
March 27, 2023	March 30, 2023	April 5, 2023	March 17-30, 2023
April 10, 2023	April 13, 2023	April 19, 2023	March 31-April 13, 2023
April 24, 2023	April 27, 2023	May 3, 2023	April 14-27, 2023
May 8, 2023	May 11, 2023	May 17, 2023	April 28-May 11, 2023
May 19, 2023**	May 25, 2023	May 31, 2023	May 12-25, 2023
June 5, 2023	June 8, 2023	June 14, 2023	May 26-June 8, 2023
June 19, 2023	June 22, 2023	June 28, 2023	June 9-22, 2023
June 30, 2023**	July 6, 2023	July 12, 2023	June 23-July 6, 2023
July 17, 2023	July 20, 2023	July 26, 2023	July 7-20, 2023
July 28, 2023**	**August 2, 2023****	August 9, 2023	July 21-August 3, 2023
August 14, 2023	August 17, 2023	August 23, 2023	August 4-17, 2023
August 25, 2023**	**August 30, 2023****	September 6, 2023	August 18-31, 2023
September 11, 2023	September 14, 2023	September 20, 2023	September 1-14, 2023
September 22, 2023	**September 27, 2023****	October 4, 2023	September 15-28, 2023
October 6, 2023**	October 12, 2023	October 18, 2023	September 29-October 12, 2023
October 23, 2023	October 26, 2023	November 1, 2023	October 13-26, 2023
November 3,2023**	**November 8, 2023****	November 15, 2023	October 27-November 9, 2023
November 20, 2023	November 23, 2023	November 29, 2023	November 10-23, 2023
December 4, 2023	December 7, 2023	December 13, 2023	November 24-December 7, 2023
December 14, 2023**	**December 19, 2023****	December 27, 2023	December 8-21, 2023
December 29, 2023**	**January 4, 2024****	January 10, 2024	December 22, 2023-January 4, 2024
11:00 AM CUT OFF	**11:59 PM CUT OFF**		

NOTE:

Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Sessional Payments and Locum Claim Forms. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut off date to ensure processing for that payment period.

PLEASE NOTE, THE ** INDICATES A DATE VARIATION

2023 HOLIDAY DATES

Please make a note in your schedule of the following dates MSI will accept as "Holidays".	
NEW YEAR'S DAY	MONDAY, JANUARY 2 2023
HERITAGE DAY	MONDAY, FEBRUARY 20, 2023
GOOD FRIDAY	FRIDAY, APRIL 7, 2023
EASTER MONDAY	MONDAY, APRIL 10, 2023
VICTORIA DAY	MONDAY, MAY 22, 2023
CANADA DAY	MONDAY, JULY 3, 2023
CIVIC HOLIDAY	MONDAY, AUGUST 7, 2023
LABOUR DAY	MONDAY, SEPTEMBER 4, 2023
NATIONAL DAY FOR TRUTH AND RECONCILIATION	MONDAY, OCTOBER 2, 2023
THANKSGIVING DAY	MONDAY, OCTOBER 9, 2023
REMEMBRANCE DAY	MONDAY, NOVEMBER 13, 2023
CHRISTMAS DAY	MONDAY, DECEMBER 25, 2023
BOXING DAY	TUESDAY, DECEMBER 26, 2023
NEW YEAR'S DAY	MONDAY, JANUARY 1, 2024

PHYSICIAN'S BULLETIN

September 19, 2022 Vol. LXVII, ISSUE 13

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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Outdated Policy Reminder

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

The time frame for submitting the request to MSI for late submission should be within one month following the 90-day limit.

Examples of extenuating circumstances may include physical damage to office such as fire or flood and or a serious technical issue.

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

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

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

Circumstances relating to staffing issues/shortages and mislaid, misfiled, or lost claims cannot be accepted by MSI as valid explanations for a late submission.

Claims for registered hospital in-patients must also be submitted within the 90-day time limitation regardless if the patient has been discharged or continues on an in-patient basis. It is incumbent on the physician to obtain the required billing information for these patients and submit claims within the prescribed time limitations. Explanations relating to late discharge summaries, or facilities not consolidating the required information for the physician, cannot be accepted as a valid explanation for a late submission.

Please note: Failure to use a preauthorization code given by MSI and annotate the text field with the previous service encounter number will result in an adjudication paid at "zero".

FEE UPDATES

Physicians are advised that Health Service Codes 51.95A, 51.95B, 51.95C and 51.95D are now permanent.

Category	Code	Description	Base Units
VEDT	51.95A	**Chronic Dialysis – treatment and supervision of care for the patient with end stage kidney disease, in hospital (hemodialysis or peritoneal dialysis) or in central outpatient hemodialysis units (for example, Halifax Victoria General Hospital, Yarmouth Regional Hospital, Cape Breton Regional Hospital) for a 24 hour period.** **Description** This comprehensive, daily fee (24-hour period beginning at 12:00am until 11:59pm of the same calendar day) is for the treatment and supervision of care for a patient with end stage kidney disease who is registered in the Renal Program (NSHA, STARS or PHS, as a series visit for dialysis) and requires chronic dialysis (hospital or central outpatient hemodialysis unit). The physician is expected to supervise all aspects of the patient's dialysis care and to provide direct, face-to-face clinical assessment of the patient, including a physical examination appropriate to the patient's medical condition, at least once in every 14-day period with additional clinical assessments as required based on concerns related to changes in the patient's medical condition. Each assessment will be documented in the patient's health record. Elements of care include: A. All management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital in-patients and in-person emergency department visits related to the management of chronic dialysis. It does not include acute dialysis. Acute dialysis is defined as dialysis rendered to a hospital inpatient in an intensive care setting, or to a patient beginning dialysis for the first time in their lifetime through to their 6th treatment at which point the dialysis is defined as chronic. A visit service, consultation or directive care as appropriate, may be claimed for hospital inpatients if the nephrologist is asked by the patient's most responsible physician to render an opinion and furnish advice regarding the patient's ongoing nephrological care during their hospital stay. The most responsible physician requesting the advice may not be another nephrologist. B. All outpatient consultations and visits within the scope of practice of nephrology for the assessment and treatment of complications of chronic dialysis and management of end stage kidney disease. Including: a. Review of laboratory and diagnostic test results b. Management of volume status, ideal body weight and blood pressure c. Assessment of dialysis access, such as central venous catheter, arteriovenous fistula and peritoneal catheter, and management of any complications as required. d. Complete and document the Ambulatory Medication Reconciliation every six months C. All related counselling, interviews and family meetings D. Perform all assessments and consultation requests to refer the chronic dialysis patient to the Multiorgan Transplant Program for determination of kidney transplant eligibility. E. All related case conferences, such as, but not limited to: a. Weekly Morning Program Rounds b. Review of laboratory and diagnostic test results with multidisciplinary team	12.11 MSU

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For all patients in all hemodialysis units, the Nephrologist assigned to each unit will provide daily coverage of all dialysis patients to address any dialysis issues by being available to speak with the unit charge nurse or team lead every shift to discuss any problems or concerns with individual patients at any time.

The Nephrologist assigned to each unit will provide additional care and address concerns or problems that arise during the course of a hemodialysis treatment or within the 24-hour period of supervision, such as, but not limited to, changes to dialysis prescription or medications based on laboratory results like serum potassium or INR for patients on oral anticoagulants, when results are received after the treatment.
A standardized review of the patient's overall status on dialysis will be completed and updated every 6 weeks and documented in the patient's health record.

The document will include:

a. Review and interpretation of laboratory and diagnostic test results
b. Volume status, ideal body weight, blood pressure and physical examination appropriate to the patient's medical needs.
c. Assessment of dialysis access, such as central venous pressure, arteriovenous fistula, peritoneal catheter, and management of any complications as required.

Billing Guidelines

- Claimable by the Most Responsible Nephrologist once per patient per 24-hour period beginning at 12:00am (midnight) and ending at 11:59pm.
- May not claim any other chronic dialysis HSCs for the same patient, same 24-hour period.
- May not claim any other outpatient visit HSCs same physician, same patient, same 24-hour period.
- A Nephrologist providing coverage for care of the chronic dialysis patient on behalf of the most responsible nephrologist may not claim any outpatient visit HSC or chronic dialysis HSCs.
- Emergency hospital visits to attend the patient for a condition unrelated to the management of dialysis, its complications and end stage kidney disease may be claimed but must be submitted for manual assessment with supporting information in the text (clinical documentation may be required). Should the patient be admitted to hospital under the care of the nephrologist, who is acting as the most responsible physician, inpatient visits may be claimed.
- First claim may be made on the date of the patient's first chronic dialysis treatment.
- May not be claimed after the treatment terminates by, for example, successful transplantation, loss of resident status, or death.
- When a face-to-face clinical assessment is not documented in the patient's health record in the 14-day period, payment will be recovered from the Most Responsible Physician who claimed for the service the majority of the days in the preceding seven-day period at the end of which the examination was to have occurred.

Specialty Restriction:
SP=NEPH, SP=INMD acting in the role of the NEPH at the Yarmouth Regional Hospital as designated by NSHA Renal Program Senior Medical Director.

Location:
LO=HOSP

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Category	Code	Description	Base Units
VEDT	51.95B	**Chronic Hemodialysis – treatment and supervision of care for the patient with end stage kidney disease, in an urban satellite hemodialysis unit as designated by the Health Authority (for example, Halifax Infirmary, Dartmouth General, and North Sydney hemodialysis units) for a 24-hour period.** **Description** This comprehensive, daily fee (24-hour period beginning at 12:00 am until 11:59 pm of the same calendar day) is for the treatment and supervision of care for a patient with end stage kidney disease who is registered in the Renal Program (NSHA, STARS or PHS, as a series visit for dialysis) and requires chronic dialysis in an urban satellite hemodialysis unit as designated by the Health Authority. The physician is expected to supervise all aspects of the patient's dialysis care and to provide direct, face-to-face clinical assessment of the patient, including a physical examination appropriate to the patient's medical condition, at least once in every 42-day period, and via PHIA compliant, synchronous virtual care platform once in every 14-day period, with additional clinical assessments as required based on concerns related to changes in the patient's medical condition. Each assessment will be documented in the patient's health record. Elements of care include: A. All management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital in-patients and in-person emergency department visits related to the management of chronic dialysis. It does not include acute dialysis. Acute dialysis is defined as dialysis rendered to a hospital inpatient in an intensive care setting, or to a patient beginning dialysis for the first time in their lifetime through to their 6th treatment at which point the dialysis is defined as chronic. A visit service, consultation or directive care as appropriate, may be claimed for hospital inpatients if the nephrologist is asked by the patient's most responsible physician to render an opinion and furnish advice regarding the patient's ongoing nephrological care during their hospital stay. The most responsible physician requesting the advice may not be another nephrologist. B. All outpatient consultations and visits within the scope of practice of nephrology for the assessment and treatment of complications of chronic dialysis and management of end-stage kidney disease. Including: a. Review of laboratory and diagnostic test results b. Management of volume status, ideal body weight and blood pressure c. Assessment of dialysis access, such as central venous catheter, arteriovenous fistula and peritoneal catheter, and management of any complications as required. d. Complete and document the Ambulatory Medication Reconciliation every six months C. All related counselling, interviews and family meetings D. Perform all assessments and consultation requests to refer the chronic dialysis patient to the Multiorgan Transplant Program for determination of kidney transplant eligibility. E. All related case conferences, such as, but not limited to: a. Weekly Morning Program Rounds b. Review of laboratory and diagnostic test results with multidisciplinary team	12.11 MSU

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For all patients in all hemodialysis units, the Nephrologist assigned to each unit will provide daily coverage of all dialysis patients to address any dialysis issues by being available to speak with the unit charge nurse or team lead every shift to discuss any problems or concerns with individual patients at any time.

The Nephrologist assigned to each unit will provide additional care and address concerns or problems that arise during the course of a hemodialysis treatment or within the 24-hour period of supervision, such as, but not limited to, changes to dialysis prescription or medications based on laboratory results like serum potassium or INR for patients on oral anticoagulants, when results are received after the treatment time.

A standardized review of the patient's overall status on dialysis will be completed and updated every 6 weeks and documented in the patient's health record.

The document will include:

a. Review and interpretation of laboratory and diagnostic test results
b. Volume status, ideal body weight, blood pressure and physical examination appropriate to the patient's medical needs.
c. Assessment of dialysis access, such as central venous pressure catheter, arteriovenous fistula, peritoneal catheter, and management of any complications as required.

Billing Guidelines

- Claimable by the Most Responsible Nephrologist once per patient per 24-hour period beginning at 12:00 am (midnight) and ending at 11:59 pm.
- May not claim any other chronic dialysis HSCs for the same patient, same 24-hour period.
- May not claim any other outpatient visit HSCs same physician, same patient, same 24-hour period.
- A Nephrologist providing coverage for care of the chronic dialysis patient on behalf of the most responsible nephrologist may not claim any outpatient visit HSCs or chronic dialysis HSCs.
- Emergency hospital visits to attend the patient for a condition unrelated to the management of dialysis, its complications and end stage kidney disease may be claimed but must be submitted for manual assessment with supporting information in the text (clinical documentation may be required). Should the patient be admitted to hospital under the care of the nephrologist, who is acting as the most responsible physician, inpatient visits may be claimed.
- First claim may be made on the date of the patient's first chronic dialysis treatment.
- May not be claimed after the treatment terminates by, for example, successful transplantation, loss of resident status, or death.
- When a face-to-face clinical assessment is not documented in the patient's health record in the 42-day period, payment will be recovered from the Most Responsible Physician who claimed for the service for the majority of days in the preceding seven-day period at the end of which the examination was to have occurred.

Specialty Restriction:
SP=NEPH

Location:
LO=HOSP

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Category	Code	Description	Base Units
VEDT	51.95C	**Chronic Hemodialysis – treatment and supervision of care, in a rural satellite hemodialysis unit as designated by the Health Authority (for example, Inverness, Strait Richmond, Antigonish, Pictou, Springhill, Liverpool, Berwick) for a 24-hour period.** **Description** This comprehensive, daily fee (24-hour period beginning at 12:00 am until 11:59 pm of the same calendar day) is for the treatment and supervision of care for a patient with end stage kidney disease who is registered in the Renal Program (NSHA, STARS or PHS, as a series visit for dialysis) and requires hemodialysis in a rural satellite hemodialysis unit as designated by the Health Authority. The physician is expected to supervise all aspects of the patient's dialysis care and to provide direct, face-to-face clinical assessment of the patient, including a physical examination appropriate to the patient's medical condition, at least once in every 90-day period, and via PHIA compliant, synchronous virtual care platform once in every 14-day period, with additional clinical assessments as required based on concerns related to changes in the patient's medical condition. Each assessment will be documented in the patient's health record. Elements of care include: A. All management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital in-patients and in-person emergency department visits related to the management of chronic dialysis. It does not include acute dialysis. Acute dialysis is defined as dialysis rendered to a hospital inpatient in an intensive care setting, or to a patient beginning dialysis for the first time in their lifetime through to their 6th treatment at which point the dialysis is defined as chronic. A visit service, consultation or directive care as appropriate, may be claimed for hospital inpatients if the nephrologist is asked by the patient's most responsible physician to render an opinion and furnish advice regarding the patient's ongoing nephrological care during their hospital stay. The most responsible physician requesting the advice may not be another nephrologist. B. All outpatient consultations and visits within the scope of practice of nephrology for the assessment and treatment of complications of chronic dialysis and management of end-stage kidney disease. Including: a. Review of laboratory and diagnostic test results b. Management of volume status, ideal body weight and blood pressure c. Assessment of dialysis access, such as central venous catheter, arteriovenous fistula and peritoneal catheter, and management of any complications as required. d. Complete and document the Ambulatory Medication Reconciliation every six months C. All related counselling, interviews and family meetings D. Perform all assessments and consultation requests to refer the chronic dialysis patient to the Multiorgan Transplant Program for determination of kidney transplant eligibility. E. All related case conferences, such as, but not limited to: a. Weekly Morning Program Rounds b. Review of laboratory and diagnostic test results with multidisciplinary team	12.11 MSU

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For all patients in all hemodialysis units, the Nephrologist assigned to each unit will provide daily coverage of all dialysis patients to address any dialysis issues by being available to speak with the unit charge nurse or team lead every shift to discuss any problems or concerns with individual patients at any time.

The Nephrologist assigned to each unit will provide additional care and address concerns or problems that arise during the course of a hemodialysis treatment or within the 24-hour period of supervision, such as, but not limited to, changes to dialysis prescription or medications based on laboratory results like serum potassium or INR for patients on oral anticoagulants, when results are received after the treatment time.

A standardized review of the patient's overall status on dialysis will be completed and updated every 6 weeks and documented in the patient's health record.

The document will include:

a. Review and interpretation of laboratory and diagnostic test results
b. Volume status, ideal body weight, blood pressure and physical examination appropriate to the patient's medical needs.
c. Assessment of dialysis access, such as central venous pressure catheter, arteriovenous fistula, peritoneal catheter, and management of any complications as required.

Billing Guidelines

- Claimable by the Most Responsible Nephrologist once per patient per 24-hour period beginning at 12:00 am (midnight) and ending at 11:59 pm.
- May not claim any other chronic dialysis HSCs for the same patient, same 24-hour period.
- May not claim any other outpatient visit HSCs same physician, same patient, same 24-hour period.

- A Nephrologist providing coverage for care of the chronic dialysis patient on behalf of the most responsible nephrologist may not claim any outpatient visit HSCs or chronic dialysis HSCs.
- Emergency hospital visits to attend the patient for a condition unrelated to the management of dialysis, its complications and end stage kidney disease may be claimed but must be submitted for manual assessment with supporting information in the text (clinical documentation may be required). Should the patient be admitted to hospital under the care of the nephrologist, who is acting as the most responsible physician, inpatient visits may be claimed.
- First claim may be made on the date of the patient's first chronic dialysis treatment.
- May not be claimed after the treatment terminates by, for example, successful transplantation, loss of resident status, or death.
- When a face-to-face clinical assessment is not documented in the patient's health record in the 90-day period, payment will be recovered from the Most Responsible Physician who claimed for the service for the majority of days in the preceding seven day period at the end of which the examination was to have occurred.

Specialty Restriction:
SP=NEPH, SP=INMD acting in the role of the NEPH at the Yarmouth Regional Hospital as designated by NSHA Renal Program Senior Medical Director.

Location:
LO=HOSP

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Category	Code	Description	Base Units
VEDT	51.95D	**Chronic Dialysis – treatment and supervision of care for the patient on home peritoneal dialysis or home hemodialysis for a 24-hour period.** **Description** This comprehensive, daily fee (24-hour period beginning at 12:00 am until 11:59 pm of the same calendar day) is for the treatment and supervision of care for a patient with end stage kidney disease who is registered in the Renal Program (NSHA, STARS or PHS) and requires home peritoneal dialysis or home hemodialysis. The physician is expected to supervise all aspects of the patient's dialysis care and to provide direct, face-to-face clinical assessment of the patient, including a physical examination appropriate to the patient's medical condition, at least once in every 90-day period with additional clinical assessments as required based on concerns related to changes in the patient's medical condition. Each assessment will be documented in the patient's health record. Elements of care include: A. All management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital in-patients and in-person emergency department visits related to the management of chronic dialysis. It does not include acute dialysis. Acute dialysis is defined as dialysis rendered to a hospital inpatient in an intensive care setting, or to a patient beginning dialysis for the first time in their lifetime through to their 6th treatment at which point the dialysis is defined as chronic. A visit service, consultation or directive care as appropriate, may be claimed for hospital inpatients if the nephrologist is asked by the patient's most responsible physician to render an opinion and furnish advice regarding the patient's ongoing nephrological care during their hospital stay. The most responsible physician requesting the advice may not be another nephrologist. B. All outpatient consultations and visits within the scope of practice of nephrology for the assessment and treatment of complications of chronic dialysis and management of end-stage kidney disease. Including: a. Review of laboratory and diagnostic test results b. Management of volume status, ideal body weight and blood pressure c. Assessment of dialysis access, such as; central venous catheter, arteriovenous fistula and peritoneal catheter, and management of any complications as required. d. Complete and document the Ambulatory Medication Reconciliation every six months C. All related counselling, interviews and family meetings D. Perform all assessments and consultation requests to refer the chronic dialysis patient to the Multiorgan Transplant Program for determination of kidney transplant eligibility. E. All related case conferences, such as, but not limited to: a. Weekly Morning Program Rounds b. Review of laboratory and diagnostic test results with multidisciplinary team	12.11 MSU

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In addition, the nephrologist will be available on a daily basis to address the following:

a. All dialysis related concerns of outpatients that are managed by the home dialysis unit
b. Unexpected or planned drop-in visits by home dialysis patients with concerns related to their dialysis care
c. Concerns of patients who are training for home hemodialysis or peritoneal dialysis

A standardized review of the patient's overall status on dialysis will be completed and updated every 90 days in the patient's health record.

The document will include:

a. Review and interpretation of laboratory and diagnostic test results
b. Volume status, ideal body weight, blood pressure and physical examination appropriate to the patient's medical needs.
c. Assessment of dialysis access, such as; central venous pressure catheter, arteriovenous fistula, peritoneal catheter, and management of any complications as required.

Billing Guidelines

- Claimable by the Most Responsible Nephrologist once per patient per 24-hour period beginning at 12:00 am (midnight) and ending at 11:59 pm.
- May not claim any other chronic dialysis HSCs for the same patient, same 24-hour period.
- May not claim any other outpatient visit HSCs same physician, same patient, same 24-hour period.
- A Nephrologist providing coverage for care of the chronic dialysis patient on behalf of the most responsible nephrologist may not claim any outpatient visit HSCs or chronic dialysis HSCs.
- Emergency hospital visits to attend the patient for a condition unrelated to the management of dialysis, its complications and end stage kidney disease may be claimed but must be submitted for manual assessment with supporting information in the text (clinical documentation may be required). Should the patient be admitted to hospital under the care of the nephrologist, who is acting as the most responsible physician, inpatient visits may be claimed.
- First claim may be made on the date of the patient's first chronic dialysis treatment.
- May not be claimed after the treatment terminates by, for example, successful transplantation, loss of resident status, or death.
- When a face-to-face clinical assessment is not documented in the patient's health record in the 90-day period, payment will be recovered from the Most Responsible Physician who claimed for the service for the majority of days in the preceding seven day period at the end of which the examination was to have occurred.

Specialty Restriction:
SP=NEPH

Location:
LO=HOME, LO=OFFC

Modifiers:
ME=PERI (peritoneal dialysis), ME=HEMO (hemodialysis)

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FEE UPDATES (CONTINUED)

Effective October 1, 2022, DGH and QEII are eligible an extra hospitalist ROTA per day.

Health Service Code	Description
F1006	Facility on Call Category 1 – Hospitalist

*Must meet the established Nova Scotia Facility On-Call Program Guidelines.

HIGHLIGHTED FEES

Physicians are reminded of interim health service codes 03.09K and 03.09L:

Category	Code	Description	Base Units
CONS	03.09K	**Specialist Telephone Advice – Consultant Physician – Providing Advice**	25 MSU
	03.09L	**Specialist Telephone Advice – Referring Physician – Requesting Advice**	11.5 MSU

Description
This health service code may be reported for a two-way (or other synchronous electronic verbal communication) regarding the assessment and management of the patient. The referring physician may be a family physician or other specialist seeking an expert opinion from the consulting physician 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 consultant physician may also receive requests from a nurse practitioner.
The referring physician (or NP) must communicate to the specialist 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 this information was supplied to the specialist followed by a management decision and a written report from the specialist to the referring physician.
The formal consultation report must be available in the patient's medical record, both the referring physician (or NP) and the specialist must maintain copies of this document, both medical records must include the date and time of the service and any contemporaneous notes, in addition to the written documents.
The service is reportable for a new patient or an established patient with a new condition or exacerbation of an existing condition.

Billing Guidelines:
The HSC includes a review of the patient's relevant history, relevant family history and relevant history of present complaint, and a review of any laboratory data, PACS images, medical records or other data as needed to provide advice. The health service includes a discussion of the relevant findings as reported by the referring physician.
If subsequent phone calls are necessary within 14 days to complete the consultation, they are considered included in the HSC for the telephone consultation. The consultant physician HSC 03.09K is not reportable in addition to any other service for the same patient by the same physician on the same day.
The referring physician HSC 03.09L may be reported when the telephone call for an urgent consultation occurs on the same day as the patient visit that generated the consultation.

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The HSC is not reportable when the purpose of the communication is to:
- Arrange a transfer
- Arrange a hospital bed for the patient
- Arrange a telemedicine consultation
- Arrange an expedited face-to-face consultation
- Arrange a laboratory, other diagnostic test or procedure
- Inform the referring physician of the results of diagnostic investigations
- Decline the request for a consultation or transfer the request to another physician

The service is not reportable for other forms of communication such as:
- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another health professional such as:
- Nurse Practitioner
- Resident in training
- Clinical fellow
- Medical student

The service is not reportable by the consulting physician if the patient has had a face-to-face visit with the consultant or any member of their call group within the previous 14 days or the next available appointment of the consultant.
The service is not reportable for telephone calls of less than 5 minutes of two-way medical discussion. The service is not reportable for calls between a referring physician and specialist in the same institution or practice location.

Documentation Requirements:
- The referring physician must document that they have communicated the reason for the consultation and relevant patient information to the specialist
- Both the specialist consultant and referring physician must document the patient name, identifying data, date and start and stop time of the call in their respective EMRs.
- The names of the referring physician (or NP) and the consultant physician must be documented by both physicians.
- The diagnosis, reason for referral, elements of the history and physical as relayed by the referring physician, the opinion of the consultant physician and the plan for future management must be documented.
- A written report must be sent to the referring physician by the specialist consultant.
- The referring physicians billing number must be noted on the electronic claim.
- Both physicians must submit the start and stop time of the call in the text field of the MSI claim.

Location:
LO=OFFC

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Major Surgery (MASG) Location

Physicians are reminded to ensure selecting the appropriate facility when billing MASG services.

Virtual Encounters

When the AP=PHON and AP=VIRC modifiers were announced in the May 27, 2022 Physician's Bulletin it had indicated that the service is not reportable if delegated to another professional such as Nurse Practitioner, Resident in training, Clinical fellow or Medical student. However, the modifiers may be claimed when the service is performed by a resident including a licensed post graduate medical trainee (e.g., PGY-6 or PGY-7) under the direct supervision of a physician. The clinical record must indicate that they were supervised as well as the name of the supervising physician. The supervising physician must be onsite at the time the resident renders the service and additionally must be immediately available to render assistance.

AP=PHON and AP=VIRC apply to visit, consultation, counselling and psychiatric care non-procedural services and physicians are reminded to select the appropriate health service codes when claiming for virtual services.

Health Service Code Description Updates

The following health service codes have had their descriptions updated:
R1220 – Pelvis
69.29D – Cystoscopy with resection of bladder neck
72.1C – Endoscopy – resection of bladder neck – transurethral prostatectomy
75.61 – Vasectomy procedure, unqualified
05.29A – Fertility investigation – sperm count and morphology
03.26C – Comprehensive pelvic examination with speculum
71.4C – Synthetic mid urethral sling for urinary incontinence, any approach
71.4D – Pubo-vaginal sling with autologous fascia for urinary incontinence, includes cystoscopy as required
97.79B – Masculinization of the chest wall
97.44A – Feminization of the chest wall

NEW AND UPDATED EXPLANATORY CODES

Code	Description
GN122	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THIS SERVICE IS NOT REPORTABLE IF THE CONSULTATION RESULTS IN A FACE TO FACE SERVICE WITHIN THE NEXT 14 DAYS OR THE NEXT AVAILABLE APPOINTMENT.
GN123	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM OF 2 HOSPITALIST ROTAS HAVE ALREADY BEEN CLAIMED FROM THIS FACILITY ON THIS DATE.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday September 16, 2022. 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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HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)
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NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS
www.novascotia.ca/dhw/

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PHYSICIAN'S BULLETIN
September 15, 2022: Vol. LXVII, ISSUE 12

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

2022 HOLIDAY DATE

Physicians are advised that Monday, September 19, 2022 will be considered a recognized holiday by MSI with respect to billing. On this one occasion only, all services rendered are eligible for the holiday rate of 50% premium.

Physicians may use the US=PR50 modifier on this date of service. Services that do not have the US=PR50 modifier will be identified once the 90-day window has elapsed and a retroactive payment will be issued to physicians for this service date.

This is a one-time exception, therefore any service rendered outside of September 19, 2022 will follow the usual Preamble rules for premium fees (Preamble 5.1.81)

PHYSICIAN'S BULLETIN
August 2, 2022: Vol. LXVII, ISSUE 11

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

CHANGE TO GENDER AFFIRMING SURGERY APPLICATION REQUIREMENTS

Effective July 20, 2022, gender affirming applications no longer require a letter of support from a Nova Scotia specialist. A post-operative care letter from a physician or nurse practitioner is still required if the surgery is happening outside of Nova Scotia, but a letter from a specialist confirming post-operative care is no longer required if the surgery is happening in Nova Scotia.

A psychosocial assessment letter is still required. Physicians, nurse practitioners and specialists who have specific skills in gender-affirming care can now complete the assessment, provide the letter and sign the application.

Free courses in gender-affirming care are available online for healthcare professionals via prideHealth at: *https://www.nshealth.ca/content/pridehealth*

More information, including the list of publicly funder gender-affirming surgeries in Nova Scotia, is available at: *https://novascotia.ca/dhw/gender-affirming-surgery/*

PHYSICIAN'S BULLETIN

July 22, 2022: Vol. LXVII, ISSUE 10

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NEW FEES

As announced in the June 30, 2022 Physician's Bulletin, HSC 13.59R *Evusheld injection for the prevention of COVID-19 in immune compromised adults and children* is now available for billing retroactive to July 1, 2022.

For the intramuscular injection of tixagevimab and cilgavimab (Evusheld) for use as pre-exposure prophylaxis in individuals with severe immunocompromise, with no known history of cardiovascular disease. Prescribed by primary care providers or specialists and submitted to the COVID-19 Non-Severe Therapy Pharmacist Consult Service for criteria confirmation and facilitation of supply distribution for administration by the prescriber or their delegate.

Category	Code	Description	Base Units
ADON	13.59R	**Evusheld injection for the prevention of COVID-19 in immune compromised adults and children** **Description** Evusheld Intramuscular Injection for the prevention of COVID-19 in severely immune compromised adults and children. **Billing Guidelines:** Payable at 6 MSU for the first injection and 3 MSU for subsequent injections May be claimed in addition to a visit Eligible for 13.59M tray fee where appropriate **Multiples:** 2 IM injections	6 MSU +MU

NEW INTERIM FEES

As announced in the May 27, 2022 Physician's Bulletin, the following GAS health service codes are now available for billing retroactive to May 11, 2022:

Category	Code	Description	Base Units	Anae Units
MASG	97.79B	**Masculinization of the chest wall** **Prior Approval/Preauthorization required (PA)** **Description** Complete masculinization of the chest wall for surgical treatment of well documented persistent gender dysphoria to include bilateral subcutaneous mastectomy, nipple and or areolar reduction or transposition, nipple areolar flap or free graft, chest contouring, complex wound closure and initial scar camouflage as required. No additional uninsured services may be performed or charged to the patient during this encounter. Insertion of pectoral implants is not an insured service. **Billing Guidelines** • Must have prior approval from MSI for gender affirming surgery (GAS) based on a complete and approved GAS application which is available online: https://novascotia.ca/dhw/gender-affirming-surgery/ • May not be claimed with: ○ Mastectomy HSC's: 97.12, 97.13, 97.14, 97.15, 97.31A, 97.31C, 97.32, 97.32B ○ Reconstruction of nipple HSC: 97.77 ○ Tissue shift/graft HSC's to include, but not limited to: 98.51B, 98.51C, 98.51D, 98.51E • Once per patient per lifetime RO=SRAS applicable **Specialty Restriction:** SP=PLAS (non fee for service) **Location:** LO=HOSP	425 MSU	4+T

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Category	Code	Description	Base Units	Anae Units
MASG	97.44A	**Feminization of chest wall** **Prior Approval/Preauthorization required (PA)** **Description** Complete feminization of the chest wall for the surgical treatment of well documented persistent gender dysphoria to include bilateral augmentation mammoplasty with insertion of prosthesis or prostheses, nipple-areolar reconstruction, advancement flaps, tissue shifts, complex wound closure and initial scar camouflage as required. No additional uninsured services may be performed or charged to the patient during this surgical encounter. **Billing Guidelines** • Must have prior approval from MSI for gender affirming surgery (GAS) based on a complete and approved GAS application which is available online: https://novascotia.ca/dhw/gender-affirming-surgery/ • May not be claimed with: ○ Augmentation Mammoplasty HSC's: 97.43, 97.44 ○ Insertion of tissue expander HSC: 98.98 ○ Breast Reconstruction HSC's: 97.6B, 97.6C, 97.6D, 97.75A ○ Reconstruction of nipple HSC: 97.77 ○ Tissue shift/graft HSC's to include, but not limited to: 98.51B, 98.51C, 98.51D, 98.51E • Once per patient per lifetime RO=SRAS applicable **Specialty Restriction:** SP=PLAS (non fee for service) **Location:** LO=HOSP	350 MSU	4+T

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Category	Code	Description	Base Units	Anae Units
MISG	97.99B	**Revision of gender affirming chest surgery** **Prior Approval/Preauthorization required (PA)** **Description** Revision of chest surgery performed within 18 months of MSI approved gender affirming chest surgery to address complications and functional impairment only. This comprehensive service includes any unilateral or bilateral scar revision, re-contouring of the chest wall, revision of nipple, and areolar reconstruction as required. The physician will submit a written request documenting the reason for the proposed revision to MSI for PA. Photographs of the affected area may be requested to support the request. No additional uninsured services may be performed or charged to the patient during this surgical encounter. **Billing Guidelines** • Original chest surgery must have had prior approval from MSI for gender affirming surgery based on a complete and approved GAS application. • Only one per patient per lifetime • Requires a formal request for prior approval/ preauthorization from MSI by the physician proposing the procedure. • May not be claimed with: ○ Reconstruction of nipple HSC: 97.77 ○ Tissue shift/graft HSC's to include, but not limited to: 98.51B, 98.51C, 98.51D, 98.51E RO=SRAS applicable **Specialty Restriction:** SP=PLAS (non fee for service) **Location:** LO=HOSP	150 MSU	4+T

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NEW INTERIM FEES (CONTINUED)

Category	Code	Description	Base Units
CONS	03.09M	**Preoperative comprehensive assessment for gender affirming surgery** **Description** This health service code is for the comprehensive assessment of the patient with a confirmed diagnosis of persistent gender dysphoria by the plastic surgeon intending to perform the surgery. The patient's MSI approval for gender affirming surgery should be in place prior to the consultation. The assessment must be documented in the health record and include, but is not limited to: • History and physical examination • Discussion of surgical care • Documentation that the current WPATH (World Professional Association for Transgendered Health) standards for care for surgical readiness have been met • Review of psychological assessment to ensure patient is a candidate for reconstructive surgery and discussion with other health professionals concerning patient eligibility as required • Discussion with patient support person(s) as required **Billing Guidelines** Once per patient per lifetime **Specialty Restriction:** SP=PLAS (non fee for service) **Location:** LO=OFFC	62 MSU

Category	Code	Description	Base Units
VIST	03.03Y	**Post operative care – gender affirming chest surgery** **Description** This health service code is for the post operative assessment of the patient who has undergone MSI approved gender affirming chest surgery in the previous 18 months. May be claimed once in the 18 months after gender affirming chest surgery by the surgeon who performed the surgery. **Billing Guidelines** May be claimed once per patient within 18 months post gender affirming surgery by the physician who claimed the original gender affirming surgery. **Specialty Restriction:** SP=PLAS (non fee for service) **Location:** LO=OFFC	36 MSU

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NEW INTERIM FEES (CONTINUED)

As announced in the May 27, 2022 Physician's Bulletin, the following health service codes are now available for billing retroactive to May 1, 2022:

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

Category	Code	Description	Base Units
VADT	02.02C	**Ophthalmic Biometry by partial coherence interferometry with IOL (intraocular lens) power calculation, unilateral or bilateral.** **Description** Ophthalmic biometry measurements by partial interferometry with IOL power calculation in one or both eyes. If ophthalmic biometry by ophthalmic US (A-scan) is also used for the same patient, claim for only one or the other but not both. The test, the results, and the physician's interpretation of the results must be documented in the patient's health record. **Billing Guidelines** Not billable with: • 03.12 Tonometry • 09.13A real time (eye) ultrasound • 09.13B Axial length measurement by ultrasound **Specialty Restriction:** SP=OPHT **Location:** LO=OFFC	25.44 MSU

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FEE UPDATES

Facility On-Call

Effective March 1, 2022, HSC F1014 is available to bill from Yarmouth Regional Hospital (Facility 56)

Health Service Code	Description	Approved Regional and Tertiary Hospitals
F1014	Facility on Call Category 1 – Ophthalmology	St. Martha's, Cape Breton Regional, QEII, Yarmouth Regional.

Effective August 1, 2022, HSC F1008 will be available for billing from Aberdeen Hospital (Facility 11)

Health Service Code	Description	Approved Regional and Tertiary Hospitals
F1008	Facility on Call Category 1 – Family Medicine O.R. Call Assists	Valley Regional, St. Martha's, Cape Breton Regional, Dartmouth General, Aberdeen.

Effective August 1, 2022 the following Rota will be available for billing:

Health Service Code	Description	Approved Regional and Tertiary Hospitals
F3016	Facility on Call Category 3 – Nephrology	Yarmouth Regional.

*Must meet the established Nova Scotia Facility On-Call Program Guidelines.

Virtual Care Modifiers

As announced in the May 27, 2022 Physician's Bulletin, modifiers for Virtual Care and Telephone encounters were introduced and are effective April 1, 2022. The modifiers, AP=PHON and AP=VIRC apply to visit, consultation, counselling and psychiatric care non-procedural services and may now be used from all locations, retroactive to April 1, 2022, however, hospital claims are limited to LO=OTPT.

Interim Fee Extended

Interim health service code 02.75C *Coronary Computed Tomographic (CT) Angiography for the preoperative evaluation of paediatric patients with congenital heart disease* has been extended to January 31, 2024.

Billing Matters Billing Reminders, Updates, New Explanatory Codes

NEW AND UPDATED EXPLANATORY CODES

Code	Description
MJ081	SERVICE ENCOUNTER HAS BEEN REFUSED AS THERE IS ALREADY A PAID CLAIM ON HISTORY FOR HSC 97.12, 97.13, 97.14, 97.15, 97.31A, 97.31C, 97.32, 97.32B, 97.77, 98.51B, 98.51C, 98.51D OR 98.51E AT THE SAME ENCOUNTER
MJ082	SERVICE ENCOUNTER HAS BEEN REFUSED AS THERE IS ALREADY A PAID CLAIM ON HISTORY FOR HSC 97.79B AT THE SAME ENCOUNTER
MJ083	SERVICE ENCOUNTER HAS BEEN REFUSED AS THERE IS ALREADY A PAID CLAIM ON HISTORY FOR HSC 97.43, 97.44, 98.98, 97.6B, 97.6C, 97.6D, 97.75A, 97.77, 98.51B, 98.51C, 98.51D OR 98.51E AT THE SAME ENCOUNTER
MJ084	SERVICE ENCOUNTER HAS BEEN REFUSED AS THERE IS ALREADY A PAID CLAIM ON HISTORY FOR HSC 97.44A AT THE SAME ENCOUNTER

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Code	Description
MJ085	SERVICE ENCOUNTER HAS BEEN REFUSED AS THERE IS ALREADY A PAID CLAIM ON HISTORY FOR HSC 97.99B AT THE SAME ENCOUNTER
MN019	SERVICE ENCOUNTER HAS BEEN REFUSED AS THERE IS ALREADY A PAID CLAIM ON HISTORY FOR HSC 97.77, 98.51B, 98.51C, 98.51D OR 98.51E AT THE SAME ENCOUNTER
VA109	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 09.13A AT THE SAME ENCOUNTER
VA110	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED 09.13C AT THE SAME ENCOUNTER
VA111	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 03.12, 09.13A OR 09.13B AT THE SAME ENCOUNTER
VA112	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY BILLED HSC 02.02C AT THE SAME ENCOUNTER
VT177	SERVICE ENCOUNTER HAS BEEN REFUSED AS IT CAN ONLY BE CLAIMED BY THE PHYSICIAN WHO CLAIMED THE ORIGINAL GAS SURGERY
VT178	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE IS ONLY PAYABLE ONCE PER PATIENT WITHIN 18 MONTHS POST SURGERY
VT124	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS AN URGENT VISIT (ALL LOCATIONS) APPLIES ONLY WHEN A PHYSICIAN TRAVELS FROM ONE LOCATION TO ANOTHER. PREAMBLE 5.1.52. RESUBMIT WITH TEXT STATING DETAILS OF THE PHYSICIANS TRAVEL

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday July 22, 2022. The files to download are:
Health Service (SERVICES.DAT), and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

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HELPFUL LINKS

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NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS
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PHYSICIAN'S BULLETIN
June 30, 2022: Vol. LXVII, ISSUE 9

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

NEW FEE

The province of Nova Scotia has received a prophylactic COVID-19 therapy for high-risk patients.

A new health service code is being developed for the intramuscular injection of tixagevimab and cilgavimab (Evusheld) for use as pre-exposure prophylaxis in individuals with severe immunocompromise, with no known history of cardiovascular disease. Prescribed by primary care providers or specialists and submitted to the COVID-19 Non-Severe Therapy Pharmacist Consult Service for criteria confirmation and facilitation of supply distribution for administration by the prescriber or their delegate.

This will be effective July 1, 2022; however, physicians are asked to hold their claims until the system is updated on July 22, 2022. Notification will be published in the July bulletin when claims can be submitted.

Category	Code	Description	Base Units
ADON	13.59R	**Evusheld injection for the prevention of COVID-19 in immune compromised adults and children** **Description** Evusheld Intramuscular Injection for the prevention of COVID-19 in severely immune compromised adults and children. **Billing Guidelines:** Payable at 6 MSU for the first injection and 3 MSU for subsequent injections May be claimed in addition to a visit Eligible for 13.59M tray fee where appropriate **Multiples:** 2 IM injections	6 MSU +MU

Community-based family physicians are reminded that in order to claim for simple injections or immunizations provided by a nurse, the physician must directly employ the nurse and be physically on the premises. If the nurse is not employed by the physician, such as instances in which the nurse is an employee of the NSHA or IWK, no services rendered by the nurse may be claimed by the physician.

Physicians are also reminded they may not claim for injections, immunizations or other services provided by pharmacists.

PHYSICIAN'S BULLETIN
June 15, 2022: Vol. LXVII, ISSUE 8

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

MSI BILLING AUDITS - UPDATE

MSI would like to thank physicians who have been awaiting billing audit results for their patience.

A new Physician Master Agreement came into effect on December 9, 2019. Physicians whose audit was initiated on or after December 9, 2019 fall under the audit provision outlined in that agreement which allow for some first time audits to be educational. The Department of Health and Wellness and Doctors Nova Scotia continue to work through the new audit provisions. Further information will be communicated at a later date.

Audits initiated prior to December 9, 2019 do not fall under this agreement. MSI will be sending audit results to these physicians shortly.

As the provincial state of emergency has now been lifted, MSI will be commencing new physician audits in the coming weeks.

PHYSICIAN'S BULLETIN

May 27, 2022: Vol. LXVII, ISSUE 7

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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NEW INTERIM FEES

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

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

NEW INTERIM FEES (CONTINUED)

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

Billing Clarifications:

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

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

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

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NEW FEES

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

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

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NEW FEES (CONTINUED)

Category	Code	Description	Base Units	Anae Units
MASG	TBA	**Feminization of male chest** **Prior Approval/Preauthorization required (PA)** **Description** Complete feminization of the chest wall for the surgical treatment of well documented persistent gender dysphoria to include bilateral augmentation mammoplasty with insertion of prosthesis or prostheses, nipple-areolar reconstruction, advancement flaps, tissue shifts, complex wound closure and initial scar camouflage as required. No additional uninsured services may be performed or charged to the patient during this surgical encounter. **Billing Guidelines** • Must have prior approval from MSI for gender affirming surgery (GAS) based on a complete and approved GAS application which is available online: https://novascotia.ca/dhw/gender-affirming-surgery/ • May not be claimed with: ○ Augmentation Mammoplasty HSC's: 97.43, 97.44 ○ Insertion of tissue expander HSC: 98.98 ○ Breast Reconstruction HSC's: 97.6B, 97.6C, 97.6D, 97.75A ○ Reconstruction of nipple HSC: 97.77 ○ Tissue shift/graft HSC's to include, but not limited to: 98.51B, 98.51C, 98.51D, 98.51E • Once per patient per lifetime RO=SRAS applicable **Specialty Restriction:** SP=PLAS (non fee for service) **Location:** LO=HOSP	350 MSU	4+T

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NEW FEES (CONTINUED)

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

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NEW FEES (CONTINUED)

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

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

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NEW MODIFIERS

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

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

Applies to office based non-procedural services.

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

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

Not reportable for other forms of communication such as:

- Written email or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another professional such as:

- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student

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

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

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FEE UPDATES

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

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

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

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

Billing Matters Billing Reminders, Updates, New Explanatory Codes

REMINDERS

Unbundling of Claims

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

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

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Facility On-Call

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

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

NEW AND UPDATED EXPLANATORY CODES

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

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

UPDATED FILES

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

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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Email:
MSI_Assessment@medavie.bluecross.ca

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

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

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

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PHYSICIAN'S BULLETIN
April 22, 2022: Vol. LXVII, ISSUE 6

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Job Title: Medical Consultant (Medicare Programs-Audit)

Job Title:	Medical Consultant
Department:	Nova Scotia Medicare Programs
Competition:	74950
Internal/External:	Internal/ External
Employment	External Consultant – Part Time (21.75 hours per week)
Location:	Dartmouth, Nova Scotia
Salary:	Competitive Compensation
Reports To:	Team Leader, NS Medicare Programs

Role Summary:

We are currently accepting applications for an external Medical Consultant to join the Medicare Programs Team. The successful candidate will work with the Medicare Programs Team and will be responsible for supporting the MSI post-payment monitoring function. The Medical Consultant will provide the medical link between paying agency and providers. In collaboration with the MSI Audit Team, they also will advise the key stakeholders of Medavie Blue Cross and the Department of Health and Wellness of Nova Scotia on MSI Monitoring related matters including the development of policies and procedures.

As a MSI Monitoring Medical Consultant, your key responsibilities will include:

- Conduct fee for service and shadow billing audits in collaboration with the Medicare Auditors.
- Support the evaluation of select alternative funding contracts, includes interviews with providers and other parties.
- Assist in the development of the annual audit plan, procedures to enhance monitoring operations.
- Participate and provide feedback into the development of risk analysis strategies to utilize departmental resources efficiently.
- Communicate with providers, Nova Scotia residents, Department of Health and Wellness, Doctors Nova Scotia, law enforcement, other government agencies in relation to MSI audit.
- Provide feedback and billing guidance to physicians in relation to billing audit results.
- Participate in various meetings with the Department of Health and Wellness and other stakeholders as required.
- Resolve issues and maintain productive, professional relationships with medical provider community and Department of Health and Wellness; inform providers through MSI Physician Bulletin publications of changing audit policies, administrative procedures, and billing issues.
- Liaise with and provide support to staff from other MSI departments including the provision of claims assessment support as required.
- Provide support to the Nova Scotia Department of Health and Wellness regarding physician appeals of billing audits.
- Maintain confidentiality, respecting both patients and provider matters.

As the ideal candidate, you possess the following qualifications:

Education: University degree with a Doctor of Medicine with an active medical license in good standing in the current jurisdiction, an active member with the Canadian Medical Protective Association and eligibility for licensure with the College of Physicians and Surgeons of Nova Scotia.

Work Experience: Minimum of 15 years experience as a physician in a range of practice settings. Specialist training and administrative experience would be an asset.

Computer Skills: General computer knowledge, including functional knowledge of Microsoft Office products (Word, Excel, Power Point) and email.

Communication Skills: Excellent written and verbal communication skills are fundamental to the position. Strong interpersonal skills and the ability to build relationships, mentor and support providers and resolve conflicts.

Other Qualifications: Ability to travel throughout the province of Nova Scotia.

You also demonstrate the following core competencies:

Knowledge: Uses knowledge and industry best practices to provide guidance and/or advice to practitioners, leaders, and coworkers on key issues in own area of expertise. Demonstrates a specialized knowledge of all processes, policies, and precedents to do the job and solve day to day issues independently. This includes familiarity with safe prescribing guidelines, as well as relevant standards and expectations as outlined by each licensing authority.

Analytical Thinking: Uses knowledge and experience to solve a variety of routine and complex technical problems. Identifies the cause of problems and implements the most appropriate solution.

Communication: Able to communicate complex information effectively through both oral and written means. Demonstrates the full range of effective verbal communication skills in a variety of settings such as formal meetings, presentations and across disciplines.

Customer Orientation: Able to support, mentor and guide practitioners even when their viewpoint may be different than your own.

Execution and Organizational Skills: Exceptional organizational and time-management skills. Able to prioritize work within a changing work environment under the pressure of deadlines.

Teamwork: Provides professional advice and support to team members, proactively searches for ways to improve work effectiveness and performance.

If you are interested in working with a team of professionals in a challenging role and you possess the necessary qualifications, please follow the instructions for applying via the Medavie Blue Cross Corporate website by clicking the link below.

Apply Now

We would like to thank all candidates for expressing interest. Please note only those selected for interviews will be contacted.

Medavie Blue Cross is an equal opportunity employer.

PHYSICIAN'S BULLETIN

March 18 2022: Vol. LXVII, ISSUE: 5

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT

Effective April 1, 2022, the Medical Service Unit (MSU) value will increase from $2.63 to $2.68.

ANAESTHESIA UNIT

Effective April 1, 2022, the Anaesthesia Unit (AU) value will increase from $23.88 to $25.30.

PSYCHIATRY FEES

Effective April 1, 2022, the hourly psychiatry rate for General Practitioners will increase to $157.70 while the hourly rate for Specialists increases to $213.83 as per the tariff agreement.

SESSIONAL FEES

Effective April 1, 2022, the hourly sessional payment rate for General Practitioners will increase to $160.80 and the hourly rate for Specialists will increase to $187.60 as per the tariff agreement.

WORKERS COMPENSATION BOARD UNIT VALUE CHANGES

WCB MEDICAL SERVICE UNIT

Effective April 1, 2022, the Workers Compensation Board Medical Service Unit (WCB MSU) value will increase from $2.92 to $2.98.

WORKERS COMPENSATION BOARD ANAESTHESIA UNIT

Effective April 1, 2022, the Workers Compensation Board Anaesthesia Unit (WCB AU) value will increase from $26.53 to $28.11.

FEE CODE INCREASES

INCREASES IN PSYCHIATRY FEE CODES

As per the master agreement, the following fees shall have their values increased for psychiatrists. (New Value is the value effective April 1, 2022) *Note: these increases are for psychiatrists only.*

	Old Value	New Value
Description	**MSU**	**MSU**
Routine Psychiatric Visit (08.5B)	43.41	43.56
Psychotherapy (08.49B)	44.46	44.76
Comprehensive Consultation (03.08)	103.24	105.75
Child Psychiatric Assessment (08.19A)	50.23	50.57
Group Therapy (08.44)	11.99	12.07
Therapeutic/Diagnostic Interview Relating to a child (08.19B)	44.44	44.73

NEW FEES

As announced in the February 14, 2022 Physician's Bulletin, the following health service code is available for billing effective March 18, 2022:

Category	Code	Description	Base Units
VADT	13.99H	Consult with pharmacy for patient participating in CPAMS (Community Pharmacy-led Anticoagulation Management Services) **Description:** This code is to be used when a patient is participating in the Community Pharmacy-led Anticoagulation Management Services program (CPAMS) and consultation with the pharmacy is required regarding the patient's case. If a physician's patient is participating in CPAMS, the physician may only bill the management fee when they are specifically asked to consult with the pharmacy on the patient's case and the request must be documented in the patient's health record. **Billing Guidelines:** • Only one primary care professional per patient can be reimbursed for ongoing monthly warfarin management. • May not be claimed more than once per month per patient. • May not be claimed in conjunction with any other monthly management fees (13.99C, CPO1).	10 MSU

For patients on warfarin who are not part of CPAMS, physicians may continue to use health service code 13.99C.

*Physicians with patients on warfarin who they believe would benefit from CPAMS are encouraged to refer patients to a participating pharmacy. Patients may also choose to identify themselves to their physician and/or pharmacist to express interest in the program. If a pharmacist confirms a patient is appropriate for the service, they will liase with the patient's physician about the patient enrolling in CPAMS. Pharmacists will notify a patient's physician of dosage changes resulting from INR testing through the program.

More information about the service, a list of pharmacies, and a referral form can be found on the Pharmacy Association of Nova Scotia (PANS) website: https://pans.ns.ca/cpams

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FEE UPDATE

Urine Drug Screen Tray Fee (UDS1)

As introduced in the November 26, 2021 Physician's Bulletin, Urine Drug Screen Tray Fee (UDS1) is available to claim for services from April 1, 2021.

MSI will provide billing instructions to those physicians currently holding claims for service dates between April 1, 2021 – November 25, 2021. Please email MSI at msi_assessment@medavie.bluecross.ca

WORKERS COMPENSATION BOARD FEE CODE INCREASES

Workers' Compensation Board Fee Code Update

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been calculated for the listed WCB specific fees for fiscal year 2022-23.

Due to the increase in CPI for 2021, all of the WCB specific services listed below will have their values increased by 4.06% effective April 1st, 2022:

CODE	DESCRIPTION	APRIL 2022 VALUE
WCB12	EPS physician assessment Service. Combined office visit and completion of Form 8/10 For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15-minute increments to a maximum of 1 additional hour	**Initial visit:** $197.13 + $57.66 per 15 minutes to a maximum 4x (RO=EPS1 and RP=INTL) **Subsequent visit:** $197.13 (RO=EPS1 and RP=SUBS)
WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable	GPs ..... $48.22 per 15 min EPS (RO=EPS1)..$57.66 per 15 min Specialists ..... $64.87 per 15 min
WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable	GPs .....$48.22 per 15 min EPS (RO=EPS1)..$57.66 per 15 min Specialists .....$64.87 per 15 min
WCB17	Photocopies of Chart Notes	10 pgs or less (ME=UP10)..... $28.88 11-25 pgs (ME=UP25)…..... $57.66 26-50 pgs (ME=UP50)…..... $115.18 Over 50 pgs (ME=OV50)… $172.69
WCB20	Carpal Tunnel Syndrome (CTS) Assessment Report	$73.93
WCB21	Follow-up visit report	$43.27
WCB22	Completed Mandatory Generic Exemption Request Form	$14.48 per form

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CODE	DESCRIPTION	APRIL 2022 VALUE
WCB23	Completed Non-Opioid Special Authorization Request Form	$14.48 per form
WCB24	Completed Opioid Special Authorization Request Form	$48.48 per form
WCB25	Completed WCB Substance Abuse Assessment Form	$32.33
WCB26	Return to Work Report – Physician's Report Form 8/10	$73.93
WCB27	Eye Report	$64.87
WCB28	Comprehensive Visit for Work Related Injury or Illness	$74.41
WCB29	Initial Request Form For Medical Cannabis	$80.28
WCB30	Extension Request Form For Medical Cannabis	$48.22
WCB31	WCB Interim Fee – Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed	$74.41

Billing Matters Billing Reminders, Updates, New Explanatory Codes

NEW AND UPDATED EXPLANATORY CODES

Code	Description
VA106	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR COMMUNITY PHARMACY-LED ANTICOAGULATION MANAGEMENT SERVICE (CPAMS) HAS PREVIOUSLY BEEN BILLED FOR THIS PATIENT IN THE SAME MONTH.
VA107	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM 13.99H (CPAMS) HAS PREVIOUSLY BEEN BILLED FOR THIS PATIENT IN THE SAME MONTH. 13.99C CANNOT BE CLAIMED WITH THIS FEE.
VA108	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR 13.99C HAS PREVIOUSLY BEEN BILLED FOR THIS PATIENT IN THE SAME MONTH. 13.99H (CPAMS) CANNOT BE CLAIMED WITH THIS FEE.
DE036	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM 13.99H (CPAMS) HAS PREVIOUSLY BEEN BILLED FOR THIS PATIENT IN THE SAME MONTH. CPO1 CANNOT BE CLAIMED WITH THIS FEE.

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UPDATED FILES

Updated files reflecting changes are available for download on Friday March 18th, 2022. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), Modifiers (MODVALS.DAT) and, Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

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Email:
MSI_Assessment@medavie.bluecross.ca

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

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

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

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Master Agreement - Program Payment Schedule (2022/23)

Program	Payment
EMR (Envelope "A" Payments) EMR Envelope "A" payments continue monthly to eligible physicians	Monthly
CME (GP & Specialist) Payment for 2021/22 fiscal year (eligible billings based on 2021 calendar year)	Issued by May 31, 2022
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from April 1, 2022 – June 30, 2022	Issued by July 31, 2022
CMPA Premium Reimbursement Covering April - June 2022	Issued by August 31, 2022
Electronic Medical Records (EMR – B&C) Payments for 2021/22 Fiscal Year	Issued by August 31, 2022
Family Physician Alternative Payment Plan 5.6% Incentive	Issued by September 30, 2022
Surgical Assist Payments Payment based on eligible billings from April 1, 2021 – March 31, 2022	Issued by September 30, 2022
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from July 1, 2022 – September 30, 2022	Issued by October 31, 2022
Collaborative Practice Incentive Program Payments for 2021/22 Fiscal Year	Issued by October 31, 2022
CMPA Premium Reimbursement Covering July -September 2022	Issued by December 31, 2022
Rural Specialist Incentive Program Measurement period April 1st, 2021 – March 31st, 2022 / Payment for 2021/22 fiscal year	Issued by December 31, 2022
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from October 2022 – December 2022	Issued by January 31, 2023
CMPA Premium Reimbursement Covering October -December 2022	Issued by March 31, 2023
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from January 2023 – March 2023	Issued by April 30, 2023
CMPA Premium Reimbursement Covering January - March 2023	Issued by May 31, 2023

Please be advised payment dates noted are the **anticipated payments for these programs.*

PHYSICIAN'S BULLETIN
March 4, 2022: Vol. LXVII, ISSUE 4

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

NON-FACE-TO-FACE SERVICES DURING PANDEMIC

Physicians are advised that eligible dates of service for non-face-to-face services provided by telephone, via telehealth network or via PHIA compliant virtual care platforms as outlined in the March 27, 2020 bulletin have been extended to **March 31, 2023**. As a reminder, all services are only eligible to be claimed when rendered by a physician currently physically located in Nova Scotia. Effective March 4, 2022, physicians providing care in a walk-in setting will also be able to claim for virtual care.

The Policy on the Provision of Publicly Funded Virtual Health Services is being reviewed and updated. The updated policy will be shared in an upcoming bulletin.

Work is underway to make changes to the existing fee codes that will enable more accurate reporting on virtual services to distinguish how the service was delivered i.e., provided by telephone, via telehealth network or via PHIA compliant virtual care platform. Further details will be provided when available.

PHYSICIAN'S BULLETIN
March 1, 2022: Vol. LXVII, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Medical Consultant Job Posting

Job Title:	Medical Consultant
Department:	Nova Scotia Medicare Programs
Competition:	84148
Internal/External:	Internal/ External
Employment	External Consultant – Part Time (21.75 hours per week)
Location:	Dartmouth, Nova Scotia
Salary:	Competitive Compensation
Reports To:	Team Leader, NS Medicare Programs
Closing Date:	March 20, 2022

Role Summary:

We are currently accepting applications for a part time external Medical Consultant to join the Medicare Programs team. The successful candidate will work with the Medicare Programs team and will be responsible for providing professional medical guidance in support of the MSI assessment and audit functions. The Medical Consultant will provide the medical link between paying agency and providers. In collaboration with the Medicare Programs team, they also will advise the key stakeholders of Medavie Blue Cross and the Department of Health and Wellness of Nova Scotia on pre-payment of claims, including the development of policies and procedures.

As an External Medical Consultant, your key responsibilities will include:

- Providing direction and guidance to the Claims Assessment team regarding claims adjudication and payment.
- Reviewing requests for pre-authorization of in-province physician services; out-of-province/country physician services or hospitalization and retroactive payment of out-of-province/country physician services or hospitalization claims.
- Ensuring all administrative processes are followed for out-of-province/country referrals for addiction and mental health services.
- Providing or assisting in the first level of appeals for citizen/provider complaints regarding issues of medical insurability, medical necessity and treatment not normally insured as well as provider appeals regarding claims payment.
- Support the development of the annual audit plan, procedures to enhance pre and post payment monitoring operations, and the development of risk analysis strategies to utilize departmental resources efficiently.
- Providing assistance to the Department of Health and Wellness Medical Consultant to support medical policy, medical tariff development and activities related to claims assessment.
- Participate in various Department of Health and Wellness meetings as required.
- Resolve issues and maintain productive, professional relationships with medical provider community and Department of Health and Wellness; inform providers through MSI Physician Bulletin publications of changing audit policies, administrative procedures and billing issues.
- Responding to enquiries from patients, physicians, Doctors NS, Nova Scotia College of Physicians and Surgeons, Medical Directors and the Department of Health and Wellness with respect to individual patient claims and the insurability of specific services for an individual according to Department of Health and Wellness policy.
- Conduct fee for service and shadow billing audits in collaboration with the Medicare Auditors.
- Support the evaluation of select alternative funding contracts; includes interviews with providers and other parties.
- Maintain confidentiality, respecting both patients and provider matters.

As the ideal candidate, you possess the following qualifications:

Education: University degree with a Doctor of Medicine with an active medical license in good standing in the current jurisdiction, an active member with the Canadian Medical Protective Association and eligibility for licensure with the College of Physicians and Surgeons of Nova Scotia.

Work Experience: 10 to 15 years' experience as a physician in a range of practice settings. Specialist training and administrative experience would be an asset. Computer Skills: General computer knowledge,

Computer Skills: General computer knowledge, including functional knowledge of Microsoft Office products (Word, Excel, Power Point) and email.

Communication Skills: Excellent written and verbal communication skills are fundamental to the position. Strong interpersonal skills and the ability to build relationships, mentor and support providers and resolve conflicts.

You also demonstrate the following core competencies:

Knowledge: Uses knowledge and industry best practices to provide guidance and/or advice to leaders and coworkers on key issues in own area of expertise. Demonstrates a specialized knowledge of all processes, policies and precedents to do the job and solve day to day issues independently.

Analytical Thinking: Uses knowledge and experience to solve a variety of routine and complex technical problems. Identifies the cause of problems and implements the most appropriate solution.

Communication: Able to communicate complex information effectively through both oral and written means. Demonstrates the full range of effective verbal communication skills in a variety of settings such as formal meetings, presentations, and any one on one situation.

Customer Orientation: Independently processes many unusual and demanding customer requests. Maintains library/database/network of all customer information and materials to meet both routine and complex customer needs.

Execution and Organization Skills: Exceptional organizational and time-management skills. Able to prioritize work within in a changing work environment under the pressure of deadlines.

Team Work: Provides professional advice and direction to team members and leads work processes and proactively searches for ways to improve team effectiveness and performance.

If you are interested in working with a team of professionals in a challenging role and you possess the necessary qualifications, please follow the instructions for applying online via the Medavie Blue Cross Corporate website by clicking on the link below.

Apply Now

We would like to thank all candidates for expressing interest. Please note only those selected for interviews will be contacted.

Medavie Blue Cross is an equal opportunity employer.

PHYSICIAN'S BULLETIN
February 14, 2022: Vol. LXVII, ISSUE 2

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

COMMUNITY PHARMACY-LED ANTICOAGULANT MANAGEMENT SERVICES

The **Community Pharmacy-led Anticoagulant Management Services (CPAMS)** has been expanded to allow all residents of Nova Scotia to access the service at select pharmacies across the province. This service enables patients on warfarin to see a pharmacist for point-of-care INR testing and dosage adjustments. Physicians with patients on warfarin who may benefit from CPAMS are encouraged to refer patients to a participating pharmacy. Currently, 41 pharmacies in the province are offering the service with an additional 40 pharmacies expected in the spring of 2022. Pharmacies must complete a 12-week educational course and are responsible for any patient monitoring, technology, or testing materials that are required. **More information about the service, a list of pharmacies, and a referral form can be found on the Pharmacy Association of Nova Scotia (PANS) website:** https://pans.ns.ca/cpams

As part of the expansion of coverage to allow more patients access to this service at a pharmacy, there is additional clarity for the monthly supervision of long-term anticoagulant therapy fee currently billed by physicians. Only one primary care professional per patient can be reimbursed for ongoing monthly warfarin management. Going forward, if a physician's patient is participating in CPAMS, the physician may only bill the management fee when they are specifically asked to consult with the pharmacy on the patient's case. This also applies to established patients who were part of the pilot project.

To assist with identifying patients who are participating in this program, a new heath service code will be created for use when a patient is part of CPAMS and the physician has been contacted by the pharmacy for a consultation. Additional information related to this new health service code will be communicated in the March bulletin, in the interim 13.99C can be used for these services. Please ensure it is documented in the patient health record that a consult was requested by the pharmacy as well as the date the consult took place.

PHYSICIAN'S BULLETIN

January 21, 2022: Vol. LXVII, ISSUE 1

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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NEW FEES

Effective January 21, 2022 the following health service code is available for billing:

Category	Code	Description	Base Units
VEDT	05.9A	**Complex, small surgical specimens, gross and microscopic** **Description** This service includes the gross assessment and description of the complex, small surgical specimen as described below, preparation of tissue cassettes and slides, followed by microscopic review, interpretation, ordering and reviewing additional studies, and the preparation of a final report. **Small, Complex Specimens Include Only:** 1. Core biopsy specimens of solid organs (limited to breast, prostate, lung, kidney, liver, lymph node, pancreas, and thyroid). 2. Endobronchial biopsy of lung. 3. Directed/targeted core biopsy of bone and soft tissue lesions. 4. LEEP or cone biopsies of uterine cervix for dysplasia or in situ/ invasive malignancy. 5. Trans-anal endoscopic microsurgical resections. **The following specimen types are excluded and are to be reported under P2345 or P2346 as appropriate:** 1. Endoscopic upper/lower gastrointestinal tract biopsies. 2. Skin biopsies/excisions. 3. Surgical resections (partial or complete) of vas deferens, fallopian tube, ovary, appendix, and gall bladder specimens with benign diagnosis. 4. Specimens that meet the definition for fee code P2346. **Premium Eligible:** US=PREM, US=PR50 **Specialty Restriction:** SP=PATH and associated subspecialties ANPA, HAPA, NEPA **Location:** LO=HOSP	60 MSU

NEW FEES (CONTINUED)

Effective January 21, 2022 the following health service codes are available for billing:

Category	Code	Description	Base Units
VEDT	03.8A	**Complete Autopsy, non-complex, gross and microscopic – all ages** **Description** This autopsy service includes the gross assessment and description of the corpse, the removal of tissue specimens as required with preparation of tissue cassettes and slides, followed by microscopic review, interpretation, ordering and reviewing additional studies, and the preparation of a final report. **Billing Guidelines** • May only be claimed once per unique health card number. • Service date is the date of the autopsy not the date of the final report. **Premium Eligible:** US=PREM, US=PR50 **Specialty Restriction:** SP=PATH and associated subspecialties ANPA, HAPA, NEPA **Location:** LO=HOSP	500 MSU

Category	Code	Description	Base Units
VEDT	03.8B	**Limited Autopsy, non-complex, gross and microscopic – all ages** **Description** This autopsy service includes the gross assessment and description of more than one organ system of the corpse, the removal of tissue specimens as required with preparation of tissue cassettes and slides, followed by microscopic review, interpretation, ordering and reviewing additional studies, and the preparation of a final report. For example, thorax and abdomen only, or brain and heart only. **Billing Guidelines** • May only be claimed once per unique health card number. • Service date is the date of the autopsy not the date of the final report. • Regions required: RG=CVOS – CARDIOVASCULAR ORGAN SYSTEM RG=RSOS – RESPIRATORY ORGAN SYSTEM RG=GIOS – GASTROINTESTINAL ORGAN SYSTEM RG=REOS – RENAL ORGAN SYSTEM RG=MROS – MALE REPRODUCTIVE SYSTEM RG=FROS – FEMALE REPRODUCTIVE SYSTEM RG=NROS – NEUROLOGICAL ORGAN SYSTEM RG=INOS – INTEGUMENTARY ORGAN SYSTEM	332.5 MSU

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RG=MSOS – MUSCOSKELETAL ORGAN SYSTEM
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RG=ENOS – ENDOCRINE ORGAN SYSTEM
RG=HLOS – HEMATOPOIETIC AND LYMPHOID ORGAN SYSTEM
RG=CRBC – CRANIAL BODY CAVITY
RG=SPBC – SPINAL BODY CAVITY
RG=THBC – THORIACIC BODY CAVITY
RG=APBC – ABDOMINOPELVIC BODY CAVITY

*More than one organ system is required in order to bill this code. Please bill the first organ system with the corresponding region modifier and indicate subsequent organ systems in text.

Premium Eligible:
US=PREM, US=PR50

Specialty Restriction:
SP=PATH and associated subspecialties ANPA, HAPA, NEPA

Location:
LO=HOSP

Category	Code	Description	Base Units
VEDT	03.8C	**Complex Autopsy, gross and microscopic – all ages**	665 MSU

Description
A complete, complex autopsy is indicated and may be claimed for the following indications only:

1. Multiple clinical questions or cause of death clinically uncertain, quality of care issues, post-surgical or post-obstetrical death.
2. Metastatic malignancy of unknown origin.
3. Prolonged acute hospital stay >1 month.
4. Congenital heart disease or metabolic autopsy in the paediatric setting.

This autopsy service includes the gross assessment and description of the corpse, the removal of tissue specimens as required with preparation of tissue cassettes and slides, followed by microscopic review, interpretation, ordering and reviewing additional studies, and the preparation of a final report.

Billing Guidelines

- May not be claimed with any other autopsy health service code.
- May only be claimed once per unique health card number.
- Service date is the date of the autopsy not the date of the final report.

Premium Eligible:
US=PREM, US=PR50

Specialty Restriction:
SP=PATH and associated subspecialties ANPA, HAPA, NEPA

Location:
LO=HOSP

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Category	Code	Description	Base Units
VEDT	03.8D	**Autopsy, brain and/or spinal cord only with detailed neuropathologic examination as part of a full autopsy, gross and microscopic – all ages** **Description** Examination, gross and microscopic, of the brain and/or spinal cord with a detailed neuropathologic assessment and report. **Billing Guidelines** • May only be claimed once per unique health card number. • Service date is the date of the autopsy not the date of the final report. **Premium Eligible:** US=PREM, US=PR50 **Specialty Restriction:** SP=PATH and associated subspecialties ANPA, HAPA, NEPA **Location:** LO=HOSP	200 MSU

Category	Code	Description	Base Units
VEDT	03.8E	**Autopsy, removal of brain and/or spinal cord only for detailed neuropathologic examination** **Description** The removal of the brain and/or spinal cord for detailed neuropathologic examination. **Billing Guidelines** • May not be claimed if performed as part of a complete autopsy. • May only be claimed once per unique health card number. • Service date is the date of the autopsy not the date of the final report. **Premium Eligible:** US=PREM, US=PR50 **Specialty Restriction:** SP=PATH and associated subspecialties ANPA, HAPA, NEPA **Location:** LO=HOSP	75 MSU

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FEE UPDATES

The following BULK pathology codes will be termed effective January 21, 2022.

P2320 – Autopsy, gross
P2321 – Autopsy, gross, negative cranium
P2322 – Autopsy, gross, limited
P2323 – Autopsy, tissues (maximum 25 per autopsy)

PREAMBLE UPDATE

Effective January 21, 2022 the GP Enhanced Hours Premium has been updated:

Current Definition	New Definition
GP ENHANCED HOURS PREMIUM ***(5.1.188)***	**GP ENHANCED HOURS PREMIUM** ***(5.1.188)***
This premium is intended to promote enhanced patient access to comprehensive primary care outside of traditional office hours. This premium will be available only to physicians who have an ongoing clinical relationship with the patient and are practicing comprehensive and continuous primary care. Physicians working in a group or collaborative care setting may report this premium when providing care during the premium hours for patients of the practice if they have access to the patient's medical record. This premium is not available for unattached patients. This premium is not available for patients being seen in a walk-in clinic where the care provided is episodic in nature. Billing Guidelines: • The eligible time periods are from 6a.m. to 8a.m. weekday mornings and 5p.m. to 10p.m. on weeknights where weekdays are defined as Monday through Friday. On Saturday, Sunday and Holidays (as defined by the MSI Physicians Bulletin) the eligible time period is from 9a.m. to 10p.m. • Physicians providing comprehensive and continuous primary care to patients (eligible for modifier ME=CARE only – see Physicians Bulletin May 17, 2018) should offer and book appointments during these time periods. • Services eligible for the Enhanced Hours Premium are office visit services provided by a practitioner providing comprehensive and continuous primary care and who maintains a comprehensive patient chart to record all patient encounters, provides all necessary follow-up care for each encounter and takes responsibility for the initiation of, and the follow-up on, all related referrals. • Eligible physicians may claim the premium for office services provided for their own patients as well as for patients from the registered patient panel of other eligible physicians within the same group practice, provided that the patient's health record can be accessed, and the encounter is recorded. • Services provided in walk-in clinics are not eligible for the Enhanced Hours Premium. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no requirement for an appointment, and episodic care with little or no follow-up. Walk in clinics have no standard patient panel and the patient list is constantly changing.	This premium is intended to promote enhanced patient access to comprehensive primary care outside of traditional office hours. This premium will be available only to physicians who have an ongoing clinical relationship with the patient and are practicing comprehensive and continuous primary care. Physicians working in a group or collaborative care setting may report this premium when providing care during the premium hours for patients of the practice if they have access to the patient's medical record. This premium is not available for unattached patients. This premium is not available for patients being seen in a walk-in clinic where the care provided is episodic in nature. Billing Guidelines: • The eligible time periods are from 6a.m. to 8a.m. weekday mornings and 5p.m. to 10p.m. on weeknights where weekdays are defined as Monday through Friday. On Saturday, Sunday and Holidays (as defined by the MSI Physicians Bulletin) the eligible time period is from 9a.m. to 10p.m. • Physicians providing comprehensive and continuous primary care to patients (eligible for modifier ME=CARE only – see Physicians Bulletin May 17, 2018) should offer and book appointments during these time periods. • Services eligible for the Enhanced Hours Premium are office visit services provided by a practitioner providing comprehensive and continuous primary care and who maintains a comprehensive patient chart to record all patient encounters, provides all necessary follow-up care for each encounter and takes responsibility for the initiation of, and the follow-up on, all related referrals. • Eligible physicians may claim the premium for office services provided for their own patients as well as for patients from the registered patient panel of other eligible physicians within the same group practice, provided that the patient's health record can be accessed, and the encounter is recorded. • Services provided in walk-in clinics are not eligible for the Enhanced Hours Premium. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no requirement for an appointment, and episodic care with little or no follow-up. Walk in clinics have no standard patient panel and the patient list is constantly changing.

Current Definition	New Definition
Refer to the MSI Physician's Bulletins for services eligible for the 25% Enhanced Hours Premium. Only one incentive can be claimed per patient encounter regardless of the number of services provided during the encounter. Claims for eligible services should be submitted with the modifier TI=GPEW NOTE: For services where the Enhanced Hours Premium has been claimed, a record must be maintained and readily available to verify that the patient was booked for an appointment during a premium - eligible time period. The appointment time should be recorded in the patient's record or office appointment books retained. APP contract physicians may shadow bill the GP Enhanced Hours Premium. The Enhanced Hours Premium should not be claimed in circumstances where the patient is booked for an appointment time that is not eligible for the premium and then the physician "runs late".	~~Refer to the MSI Physician's Bulletins for services eligible for the 25% Enhanced Hours Premium.~~ **The following visit services are eligible for the 25% Enhanced Hours Premium:** **03.03 Office visits – includes WBCR, ANTL, PTNT etc.** **03.03A Geriatric office visits** **03.03B Complex Care** ***03.03C Palliative Care Support**** ***03.03E Adults with developmental disabilities**** **03.03J OAT initial visit** **03.03K OAT transfer of care from program** **03.03L OAT transfer of care** **03.03V Medical Abortion** **03.04 Comprehensive visit** ***03.04C Adults with developmental disabilities, complete exam**** **03.04I PSP Mental Health visit** ***03.09C Palliative care consultation**** **08.41 Hypnotherapy** **08.44 Group therapy** **08.45 Family therapy** **08.49A Counselling** **08.49B Psychotherapy** **08.49C Lifestyle counselling** Only one incentive can be claimed per patient encounter regardless of the number of services provided during the encounter. Claims for eligible services should be submitted with the modifier TI=GPEW. NOTE: For services where the Enhanced Hours Premium has been claimed, a record must be maintained and readily available to verify that the patient was booked for an appointment during a premium - eligible time period. The appointment time should be recorded in the patient's record or office appointment books retained. APP contract physicians may shadow bill the GP Enhanced Hours Premium. The Enhanced Hours Premium should not be claimed in circumstances where the patient is booked for an appointment time that is not eligible for the premium and then the physician "runs late".

Time Period	Time	Payment Rate
Monday to Friday	6:00a.m – 8:00 a.m	TI=GPEW (25% premium)
Monday to Friday	5:00p.m – 10:00 p.m	TI=GPEW (25% premium)
Saturday and Sunday	9:00a.m – 10:00 p.m	TI=GPEW (25% premium)
Recognized Holidays	9:00a.m – 10:00 p.m	TI=GPEW (25% premium)

*Note: Additions to the GPEW eligible services are 03.03C, 03.03E, 03.04C and 03.09C.

Restricted to SP=GENP, ME=CARE, LO=OFFC

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Prior Approval Surgeries

Physicians are advised they will not have to write to MSI to request an extension for prior approvals received for surgeries being performed in Nova Scotia from March 2020 to present. These approvals will be extended for two additional years due to delays associated with the Pandemic. Surgeries being performed outside of Nova Scotia will still require a written request in order for an extension to be considered.

Chronic Disease Management Incentive

Physicians are reminded that the CDM incentive can be billed once per patient per fiscal year, providing all eligibility requirements are met. CDM1 claims must be submitted to MSI on or before March 31 in order to receive payment for that fiscal year. It is always advisable not to leave submissions to the last day.

Provider Profiles

Physicians are reminded that provider profiles are sent out per request. If you would like to receive your 2020/2021 provider profile, please send your request by email to msi_assessment@medavie.bluecross.ca. In the email, please include your name and provider number, and the profile will be mailed to the address on file.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
VE037	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE MAY ONLY BE BILLED ONCE PER PATIENT.
VE038	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE MAY NOT BE CLAIMED WITH ANY OTHER AUTOPSY HSC.
VE039	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.8C HAS ALREADY BEEN CLAIMED AT THE SAME ENCOUNTER.
VE040	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THIS SERVICE MAY NOT BE BILLED IF PERFORMED AS PART OF A COMPLETE AUTOPSY.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday January 21st, 2022. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), Modifiers (MODVALS.DAT) and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

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

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

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PHYSICIAN'S BULLETIN

November 26, 2021: Vol. LXVI, ISSUE 17

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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PREAMBLE CHANGE

Current Definition	New Definition
Continuing Care: is defined as a limited visit following a consultation that can be claimed for services provided in the office, home or to registered inpatients by specialist consultants. It is intended that the consultants assume responsibility for the care of the patient's medical condition. When the patient remains in the hospital and the consultant is providing continuing care, the general practitioner or paediatrician may claim supportive care. Only one consultant per specialty may claim continuing care for a patient at a time. When a specialist is providing continuing care in the home or office, the general practitioner may claim the appropriate visit code. (5.1.25)	Continuing Care: is defined as a limited visit following a consultation that can be claimed for services provided in the office, home or to registered inpatients by specialist consultants. It is intended that the consultants assume responsibility for the care of the patient's medical condition. When the patient remains in the hospital and the consultant is providing continuing care, the general practitioner or paediatrician may claim supportive care. **Only one consultant may claim continuing care for a hospital inpatient at a time.** When a specialist is providing continuing care in the home or office, the general practitioner may claim the appropriate visit code. (5.1.25)

FEE INCREASE

Effective April 1, 2021 the fee for Hospital Inpatient Continuing Care for SP=INMD and its associated specialties has been increased to 18.39 MSU.

Category	Code	Description	Base Units
VIST	03.03	**Continuing Care** RO=CNTC, LO=HOSP, FN=INPT, RF=REFD	18.39 MSU

**Increase will be automatically applied to any claims with a date of service on or after November 26, 2021. Claims made with service dates from April 1, 2021 – November 25, 2021 will be identified, and a retroactive payment will be sent to physicians once the 90-day window has elapsed.*

NEW FEE

Effective April 1, 2021 the following health service code is available for billing:

Category	Code	Description	Base Units
VIST	03.03	**Continuing Care – Attending Physician** **(Most Responsible Physician - MRP)** RO=CNTC, RF=REFD DA=DA23 – Days 2, 3 and first day out of ICU DA=DA47 – Days 4-7 **Description** This enhanced continuing care visit fee may be claimed by the attending physician (MRP) on days two through seven, and the first day out of ICU, when they are the specialist physician who is primarily responsible for the daily care of the hospital inpatient. There can only be one attending physician (MRP) on any given day. Attending physician (MRP) status must be recorded in the patient's health record. **Billing Guidelines** • May only be claimed once per patient per day by the attending physician most responsible for the daily care of the hospital inpatient. • First day out of ICU should be considered equivalent to Day 2 and subsequent inpatient days as 3,4,5,6,7 for the purpose of reporting these enhanced continuing care codes. • No other physician may claim an enhanced visit fee on the same patient, same day. • Other specialist physicians may claim directive care as appropriate. • Family physicians providing care may claim subsequent visits at the basic rate as appropriate. • If there is a transfer of care, the count of days in hospital remains the same and does not restart. • Rates to change in conjunction with the negotiated subsequent daily visit rates for GENP for the remainder of the current 2019 Master Agreement. **Specialty Restriction:** SP=INMD and all associated medicine specialties (CARD, CLIA, DERM, ENME, GAST, GEMD, HAGY, INDI, MDON, MEMI, NEPE, NEPH, NEUR, PHMD, RHEU, RSMD) **Location:** LO=HOSP FN=INPT	 26.43 MSU 21.84 MSU

**Physicians who have already submitted their claims at the lower rate may delete and resubmit to be paid at the higher fee. For claims that are now over 90 days, physicians are required to submit with a preauthorization number in the appropriate field.*

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NEW FEE

The following health service code is now available for billing back to September 17, 2021.

Category	Code	Description	Base Units
VIST	03.03	**Comprehensive well infant/child visit using the Rourke Baby Record CT=RKBR, RO=WBCR** **Description** This comprehensive visit code may be claimed when the Rourke Baby Record is used to guide the visit, is completed in full, reviewed and signed by the physician, and documented in the health record. A comprehensive physical and developmental assessment must be performed. Age-appropriate preventative care and education to the parent(s)/caregiver according to the RBR must be delivered and documented in the RBR and the health record. **Billing Guidelines** Claimable for 2 visits between 0 and <6 months 1 visit between 6 months and <12 months 1 visit between 12 months and <18 months 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. Immunizations may be claimed in addition to the visit and must be delivered in accordance with NS Public Health recommendations. **Specialty Restriction:** SP=GENP ME=CARE, SP=PEDI May be claimed by physicians in episodic care clinics (walk-in) if the patient is unattached (must be noted on the health record and text on the claim) **Premium:** TI=GPEW eligible **Location:** LO=OFFC	24 MSU

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PREAMBLE CHANGE

Current Definition	New Definition
Well Baby Care (5.2.105) Well baby care 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. The visit fee at 12 months of age has a four week buffer on either side of the first birthday for billing. The visit fee at 18 months of age has a two week buffer on either side of the date of 18 months of age for billing. (5.2.106)	**Well Baby Care (5.2.105)** Well **infant/child** 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.** **A comprehensive well infant/child visit may be claimed for 2 visits between 0 and <6 months, 1 visit between 6 months and <12 months, 1 visit between 12 months and <18 months, and 1 visit between 18 months and <24 months. In order to claim the comprehensive well infant/child visit, a complete physical and developmental assessment must be performed, 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.** **All other well infant/child visits to be claimed at the regular, applicable well baby care rate**. (5.2.106)

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NEW FEE

The following health service code is available for billing effective November 26, 2021.
This health service code will be backdated to April 1, 2021 but will not be available to bill for service dates prior to November 26, 2021 until the next system update. Notification will be provided in a future bulletin when physicians may start claiming their Urine Drug Screen Tray Fees back to April 1, 2021.

Category	Code	Description	Base Units
ADON	UDS1	**Urine Drug Screen Tray Fee** **Description** When the physician has incurred the cost of supplies when performing a UDS, a tray fee can be claimed. May not be claimed if the UDS kits have been provided free of charge. **Billing Guidelines** Add on to: DEFT OAT1 DEFT OAT2 VIST 03.03J VIST 03.03K VIST 03.03L **Multiples:** OAT1 – max 4 per patient per 30 days OAT2 – max 4 per patient per 30 days Special permission is required if greater than 4 tests have been provided to a patient in 30 days. 03.03J – max 1 per patient 03.03K – max 1 per patient 03.03L – max 1 per patient **Location:** LO=OFFC	2.3 MSU

Billing Matters Billing Reminders, Updates, New Explanatory Codes

13.59O Injection of ONA for Treatment of Chronic Migraine

Physicians are reminded of the approval period for 13.59O: Prior approval will be valid for treatment provided for a period of 24 months. If treatment continues to be recommended after this time period, prior approval must be requested again. Full details of the 13.59O health service code can be found in the May 14, 2020 Physicians Bulletin.

03.04I Practice Support Program Mental Health Comprehensive Visit

As announced in the October 27, 2021 Physician's Bulletin, health service code 03.04I has been made permanent. Physicians holding their claims may now bill this health service code back to November 1, 2021. Full details of 03.04I health service code can be found in the October 27, 2021 Physicians Bulletin.

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BILLING MATTERS (CONTINUED)

Teaching Stipend (TESP1 and TESP2)

MSI is working in collaboration with Dalhousie and the Department of Health and Wellness on the approval process for the teaching stipend (HSC TESP1 and TESP2) billing requests. Communication will be provided in the coming months.

Blood Alcohol Sampling

Physicians are advised as outlined in Preamble 2.2.45, claims for blood alcohol sampling on impaired drivers will be processed by Medavie Blue Cross. Please forward service encounters for blood alcohol sampling on the physician's letterhead to:
MSI Accounting Department
PO Box 500
Halifax, NS B3J 2S1

NEW AND UPDATED EXPLANATORY CODES

Code	Description
AD089	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS IS AN ADD ON FEE TO HSC ASSOCIATED WITH OAT PROVISION ONLY
AD090	SERVICE ENCOUNTER HAS BEEN REFUSED AS ONLY 1 URINE DRUG SCREEN TRAY FEE CAN BE BILLED IN ASSOCIATION WITH 03.03J, 03.03K OR 03.03L
AD091	SERVICE ENCOUNTER HAS BEEN DISSALLOWED AS THE MAXIMUM OF 4 URINE DRUG SCREEN TRAY FEES PER PATIENT IN THE PREVIOUS 30 DAYS HAS BEEN REACHED. PLEASE INCLUDE TEXT INDICATING IF SPECIAL PERMISSION HAS BEEN GRANTED TO EXCEED THIS MAXIMUM
BK063	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THIS SERVICE HAS ALREADY BEEN CLAIMED ON THE SAME DAY AS 50.0B. PLEASE RESUBMIT WITH TEXT INDICATING THE MEDICAL NECESSITY FOR AN ADDITIONAL CLAIM
GN121	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A CLAIM FOR HSC 50.0B HAS ALREADY BEEN CLAIMED AT THE SAME ENCOUNTER. HSC 50.0B IS A COMPREHENSIVE FEE THAT INCLUDES ALL ACCESS AND VISUALIZATION TO PERFORM THE PROCEDURE
VE036	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A CLAIM FOR ACCESS OR VISUALIZATION HAS ALREADY BEEN CLAIMED AT THE SAME ENCOUNTER. HSC 50.0B IS A COMPREHENSIVE FEE THAT INCLUDES ALL ACCESS AND VISUALIZATION TO PERFORM THE PROCEDURE
VT174	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM OF 9 WELL INFANT/CHILD VISITS HAS BEEN REACHED
VT175	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM OF 5 COMPREHENSIVE WELL INFANT/CHILD VISITS USING THE ROURKE BABY RECORD HAS BEEN REACHED
VT176	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A WELL INFANT/CHILD VISIT CLAIMED BY A PROVIDER OTHER THAN THE FAMILY PHYSICIAN REQUIRES TEXT INDICATING THAT THE PATIENT IS UNATTACHED.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday November 26th, 2021. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), Modifiers (MODVALS.DAT) and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

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

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

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2022 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE	SALARY CONTRACT PAY PERIOD
December 31, 2021**	January 6, 2022	January 12, 2022	December 24, 2021-January 6, 2022
January 17, 2022	January 20, 2022	January 26, 2022	January 7-20, 2022
January 31, 2022	February 3, 2022	February 9, 2022	January 21-February 3, 2022
February 11, 2022**	**February 16, 2022****	February 23, 2022	February 4-17, 2022
February 28, 2022	March 3, 2022	March 9, 2022	February 18-March 3, 2022
March 14, 2022	March 17, 2022	March 23, 2022	March 4-17, 2022
March 28, 2022	March 31, 2022	April 6, 2022	March 18-31, 2022
April 8, 2022**	**April 13, 2022****	April 20, 2022	April 1-14, 2022
April 25, 2022	April 28, 2022	May 4, 2022	April 15-28, 2022
May 9, 2022	May 12, 2022	May 18, 2022	April 29-May 12, 2022
May 20, 2022**	May 26, 2022	June 1, 2022	May 13-26, 2022
June 6, 2022	June 9, 2022	June 15, 2022	May 27-June 9, 2022
June 20, 2022	June 23, 2022	June 29, 2022	June 10-23, 2022
July 4, 2022	July 7, 2022	July 13, 2022	June 24-July 7, 2022
July 18, 2022	July 21, 2022	July 27, 2022	July 8-21, 2022
July 29, 2022**	August 4, 2022	August 10, 2022	July 22-August 4, 2022
August 15, 2022	August 18, 2022	August 24, 2022	August 5-18, 2022
August 26, 2022**	**August 31, 2022****	September 7, 2022	August 19-September 1, 2022
September 12, 2022	September 15, 2022	September 21, 2022	September 2-15, 2022
September 23, 2022**	**September 28, 2022****	October 5, 2022	September 16-29, 2022
October 7, 2022**	October 13, 2022	October 19, 2022	September 30-October 13, 2022
October 24, 2022	October 27, 2022	November 2 2022	October 14-27, 2022
November 4, 2022**	**November 9, 2022****	November 16, 2022	October 28-November 10, 2022
November 21, 2022	November 24, 2022	November 30, 2022	November 11-24, 2022
December 5, 2022	December 8, 2022	December 14, 2022	November 25-December 8, 2022
December 15, 2022**	**December 20, 2022****	December 28, 2022	December 9-22, 2022
December 30, 2022**	January 5, 2023	January 11, 2023	December 23, 2022-January 5, 2023
11:00 AM CUT OFF	**11:59 PM CUT OFF**		

NOTE:
Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Sessional Payments and Locum Claim Forms. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut-off date to ensure processing for that payment period.

PLEASE NOTE, THE ** INDICATES A DATE VARIATION

2022 HOLIDAY DATES

Please make a note in your schedule of the following dates MSI will accept as "Holidays".	
NEW YEAR'S DAY	MONDAY, JANUARY 3, 2022
HERITAGE DAY	MONDAY, FEBRUARY 21, 2022
GOOD FRIDAY	FRIDAY, APRIL 15, 2022
EASTER MONDAY	MONDAY, APRIL 18, 2022
VICTORIA DAY	MONDAY, MAY 23, 2022
CANADA DAY	FRIDAY, JULY 1, 2022
CIVIC HOLIDAY	MONDAY, AUGUST 1, 2022
LABOUR DAY	MONDAY, SEPTEMBER 5, 2022
NATIONAL DAY FOR TRUTH AND RECONCILIATION	FRIDAY, SEPTEMBER 30, 2022
THANKSGIVING DAY	MONDAY, OCTOBER 10, 2022
REMEMBRANCE DAY	FRIDAY, NOVEMBER 11, 2022
CHRISTMAS DAY	MONDAY, DECEMBER 26, 2022
BOXING DAY	TUESDAY, DECEMBER 27, 2022
NEW YEAR'S DAY	MONDAY, JANUARY 2, 2023

PHYSICIAN'S BULLETIN
November 24, 2021: Vol. LXVI, ISSUE 16

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Physician Recruiters

Nova Scotia Office of Healthcare Professionals Recruitment

M.D. Recruitment & Retention Lead (4 positions, one in each zone)

Recruitment of physicians is a high touch process. Physicians want to have a sense of both the clinical and the community environments in which they will live and practice. Recruiting physicians should be through a collaborative team effort, to ensure the successful recruitment of physicians, which includes onboarding and ensuring they are settled in their roles and communities.

Working with zone recruiters and other key partners, the **M.D. Recruitment and Retention Lead** will be a central point of contact for supporting the clinical focus of recruiting. Zone physician recruitment will be a collaborative effort with the local recruiters as well as other key partners such as Doctors Nova Scotia. The **M.D. Recruitment and Retention Lead** will meet with potential candidates, coordinate meetings with other clinical personnel, help facilitate the integration of the new recruit into the medical community and connect with the new recruit periodically over the first year of practice.

The **M.D. Recruitment & Retention Lead** will be a licensed physician in Nova Scotia with an interest in physician resource planning. They are viewed as a strong physician leader and community advocate and will maintain regular contact with the other **M.D. Recruitment & Retention Leads**.

This position will be contracted annually and is anticipated to be approximately 1.5 days per week (0.3 full time equivalent). Compensation will be consistent with the Medical Consultant at the Department of Health and Wellness ($160 per hour).

Interested candidates should submit their resume and covering letter to: HealthcareRecruitment@novascotia.ca

Due: Friday December 17, 2021

PHYSICIAN'S BULLETIN
November 18, 2021: Vol. LXVI, ISSUE 15

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Job Title: Medical Consultant (Medicare Programs-Audit)

Job Title:	Medical Consultant
Department:	Nova Scotia Medicare Programs
Competition:	74950
Internal/External:	Internal/ External
Employment	External Consultant: Part-time hours initially, gradually increasing to full-time hours.
Location:	Dartmouth, Nova Scotia
Salary:	Competitive Compensation
Reports To:	Team Leader, NS Medicare Programs
Closing Date:	December 8, 2021

Role Summary:

We are currently accepting applications for an external Medical Consultant to join the Medicare Programs Team. The successful candidate will work with the Medicare Programs Team and will be responsible for supporting the MSI post-payment monitoring function. The Medical Consultant will provide the medical link between paying agency and providers. In collaboration with the MSI Monitoring Team, they also will advise the key stakeholders of Medavie Blue Cross and the Department of Health and Wellness of Nova Scotia on MSI Monitoring related matters including the development of policies and procedures.

This opportunity will be part-time hours initially, gradually increasing to full-time hours.

As a MSI Monitoring Medical Consultant, your key responsibilities will include:

- Conduct fee for service and shadow billing audits in collaboration with the Medicare Auditors.
- Support the evaluation of select alternative funding contracts, includes interviews with providers and other parties.
- Assist in the development of the annual audit plan, procedures to enhance monitoring operations.
- Participate and provide feedback into the development of risk analysis strategies to utilize departmental resources efficiently.
- Communicate with providers, Nova Scotia residents, Department of Health and Wellness, Doctors Nova Scotia, law enforcement, other government agencies in relation to MSI audit.
- Provide feedback and billing guidance to physicians in relation to billing audit results.
- Participate in various meetings with the Department of Health and Wellness and other stakeholders as required.
- Resolve issues and maintain productive, professional relationships with medical provider community and Department of Health and Wellness; inform providers through MSI Physician Bulletin publications of changing audit policies, administrative procedures and billing issues.
- Liaise with and provide support to staff from other MSI departments including the provision of claims assessment support as required.
- Provide support to the Nova Scotia Department of Health and Wellness regarding physician appeals of billing audits.
- Maintain confidentiality, respecting both patients and provider matters.

As the ideal candidate, you possess the following qualifications:
Education: University degree with a Doctor of Medicine with an active medical license in good standing in the current jurisdiction, an active member with the Canadian Medical Protective Association and eligibility for licensure with the College of Physicians and Surgeons of Nova Scotia.

Work Experience: Minimum of 15 years experience as a physician in a range of practice settings. Specialist training and administrative experience would be an asset.

Computer Skills: General computer knowledge, including functional knowledge of Microsoft Office products (Word, Excel, Power Point) and email.

Communication Skills: Excellent written and verbal communication skills are fundamental to the position. Strong interpersonal skills and the ability to build relationships, mentor and support providers and resolve conflicts.

Other Qualifications: Ability to travel throughout the province of Nova Scotia.

You also demonstrate the following core competencies:
Knowledge: Uses knowledge and industry best practices to provide guidance and/or advice to practitioners, leaders, and coworkers on key issues in own area of expertise. Demonstrates a specialized knowledge of all processes, policies, and precedents to do the job and solve day to day issues independently. This includes familiarity with safe prescribing guidelines, as well as relevant standards and expectations as outlined by each licensing authority.

Analytical Thinking: Uses knowledge and experience to solve a variety of routine and complex technical problems. Identifies the cause of problems and implements the most appropriate solution.

Communication: Able to communicate complex information effectively through both oral and written means. Demonstrates the full range of effective verbal communication skills in a variety of settings such as formal meetings, presentations and across disciplines.

Customer Orientation: Able to support, mentor and guide practitioners even when their viewpoint may be different than your own.

Execution and Organizational Skills: Exceptional organizational and time-management skills. Able to prioritize work within a changing work environment under the pressure of deadlines.

Teamwork: Provides professional advice and support to team members, proactively searches for ways to improve work effectiveness and performance.

If you are interested in working with a team of professionals in a challenging role and you possess the necessary qualifications, please follow the instructions for applying via the Medavie Blue Cross corporate website by clicking the link below:

APPLY NOW

We would like to thank all candidates for expressing interest. Please note only those selected for interviews will be contacted.

Medavie Blue Cross is an equal opportunity employer.

PHYSICIAN'S BULLETIN
October 27, 2021: Vol. LXVI, ISSUE 14

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Fee Code Update

INTERIM FEE MADE PERMANENT

Effective November 1, 2021 the Health Service Code 03.04I will be made permanent. Physicians are asked to hold claims with service dates November 1, 2021 onward until the anticipated MSI system update in November. An update will be provided in a future bulletin to advise when physicians can submit their claims. Physicians are reminded of the description for this service:

Category	Code	Description	Base Units
VIST	03.04I	**PSP Mental Health Comprehensive Visit to establish the PSP Mental Health Plan (PSP=Practice Support Program)** **Description** This code is for the complete assessment of the patient with a confirmed mental illness meeting the diagnostic criteria in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of sufficient severity and acuity to cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and warrant the development of a Mental Health care plan. This is not intended for patients with self-limited or short-lived mental health symptoms. The assessment is to be performed by the PSP trained family physician most responsible for the patient's mental health care. The Mental Health Plan and start and stop times must be documented in the health record. This complete assessment is to include **all** of the following elements and be documented in the health record: • The patient's DSM diagnosis, psychiatric history and current mental state including suicide risk assessment as appropriate • Obtaining collateral history and information from caregivers as required • Performance of a complete medication review to include collateral information from pharmacy and assisted living facility as appropriate • Reviewing and documenting results of relevant validated assessment tools, laboratory, and other test results • Documentation of a clinical plan for the patient's care over the next year. Includes advanced care planning where appropriate	50 MSU +MU

- Outline of expected outcomes as a result of the treatment plan
- Outline of linkages with other health care providers and community resources who will be involved in the patient's care.
- Confirmation that the plan has been created jointly and shared with the patient or their medical representative. The plan is to be shared with other care providers as appropriate
- A documented care plan must be in place before access to additional counselling hours is provided

It is recognized that the required elements may require more than one visit to complete. This health service code may be claimed at the final visit only when all of the information is complete and documented in the health record; other visits may be reported at the usual rate.

All elements must be documented in the health record before reporting this PSP MHP visit service.

Billing Guidelines

- Reportable by the patient's PSP trained physician only
- Not reportable with any other visit fee for the same physician, same patient, same day
- Not reportable for services provided at walk-in clinics
- Not to be used for patients living in nursing homes, residential care facilities or hospices
- Reportable only once per patient per year
- 50 MSU for first 30 minutes, 25 MSU for each additional 15 minutes, up to a maximum of 1 hour (5 multiples)
- Start and stop times must be reported in the text field of the claim to MSI, as well as in the health record

Specialty Restriction:
SP=GENP with PSP training

May be claimed by physicians in episodic care clinics (walk-in) if the patient is unattached (must be noted on the health record and text on the claim)

Location:
LO=OFFC, LO=HOME

PHYSICIAN'S BULLETIN

September 22, 2021: Vol. LXVI, ISSUE 13

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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3 Prolonged Consultation 5.1.105
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2 87.98A
3 08.19B

New Fees
4 03.08A

Billing Matters

5 High-Dose Influenza Vaccine 13.59L RO=HDIN
5 Services Provided by non-physicians
5 Holiday Dates 2021

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5 Updated Files
5 Useful Links
5 Contact Information

PREAMBLE CHANGE

Effective September 17, 2021 the rate for detention time is increased:

Current Definition	New Definition
Detention Time (5.1.75) …This may include time spent with the patient travelling from one location to another. However, travel time to transport donor organs from a donor site to the recipient site for transplantation begins at the time the retrieving surgeon accompanied by the donor organs leave the donor site. Where any service is performed during the time spent with the patient, either the service or the detention time, but not both, should be claimed. The circumstances in each case, and the time involved, should be documented with the service encounter. *(5.1.77)* The fee for detention is 12.5 units per 15 minutes. The detention modifier RO=DETE must be indicated on the service encounter. *(5.1.78)*…	**Detention Time (5.1.75)** **…**This may include time spent with the patient travelling from one location to another. However, travel time to transport donor organs from a donor **facility** to the recipient **facility** for transplantation begins at the time the retrieving surgeon accompanied by the donor organs leave the donor **facility**. Where any service is performed during the time spent with the patient, either the service or the detention time, but not both, should be claimed. The circumstances in each case, and the time involved, should be documented with the service encounter. *(5.1.77)* The fee for detention is **15 units per 15 minutes for general practitioners and 17.5 units per 15 minutes for specialists**. The detention modifier RO=DETE must be indicated on the service encounter. *(5.1.78)*…

FEE REVISION

Effective September 17, 2021 the following health service code value has been updated:

Category	Code	Description	Base Units
ADON	87.98A	**Detention During Obstetrical Delivery (for attendance beyond three hours)** **RO=DETE** **Description** Detention time for obstetrical delivery performed by a family physician when the physician is required to be in attendance beyond three hours, notwithstanding clause 5.2.75 *(see below)* of the Physicians Manual (2014). Each 15-minute time increment beyond three hours has a rate of **15** MSU to a maximum of 8 hours. **Billing Guidelines** May only be claimed as an add-on for HSC 87.98 Delivery NEC. 1 multiple = 3 hours with patient 2 multiples = 3 hours, 15 minutes 3 multiples = 3.5 hours 4 multiples = 3.75 hours 5 multiples = 4 hours etc. to a maximum of: 21 multiples = 8 hours **Specialty Restriction** SP=GENP {ATTENDANCE AT LABOUR AND DELIVERY *(5.2.75)}* This is a service involving constant or periodic attendance on a patient during the period of labour to provide all aspects of care. This includes the initial assessment, and such subsequent assessment as may be indicated, including ongoing monitoring of the patient's condition. Obstetrical delivery covers services rendered during delivery, including medical or surgical inductions by the attending physician, suturing of minor lacerations, hypnosis, detention time during labour, local or regional anesthesia and manual removal of placenta by the attending physician, and all obstetrical manoeuvers that may be required, e.g. use of forceps.}	**15** MSU per 15 minutes

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PREAMBLE CHANGES

Current Definition	New Definition
Prolonged Consultation A prolonged consultation may be claimed only by the following specialties: a) Anesthesia 15 units per 15 minutes b) Internal Medicine 13.5 units per 15 minutes c) Neurology 13.5 units per 15 minutes d) Physical Medicine 13.5 units per 15 minutes e) Paediatrics 16.3 units per 15 minutes f) Psychiatry 18.22 units per 15 minutes g) Obstetrics and Gynaecology 13.5 units per 15 minutes h) Palliative Care 15.5 units per 15 minutes *(5.1.105)*	**Prolonged Consultation** A prolonged consultation may be claimed only by the following specialties: a) Anesthesia 15 units per 15 minutes b) Internal Medicine 13.5 units per 15 minutes c) Neurology 13.5 units per 15 minutes d) Physical Medicine 13.5 units per 15 minutes e) Paediatrics 16.3 units per 15 minutes f) Obstetrics and Gynaecology 13.5 units per 15 minutes g) Palliative Care 15.5 units per 15 minutes *(5.1.105)*
Psychiatric Care (5.2.122) Psychiatric care is any form of assessment or treatment by a psychiatrist on the register of specialists of the Province of Nova Scotia, in which there is consideration and attempted alteration of the patient's biopsychosocial functioning. *(5.2.123)*	**Psychiatric Care (5.2.122)** Psychiatric care is any form of assessment or treatment by a psychiatrist on the register of specialists of the Province of Nova Scotia, in which there is consideration and attempted alteration of the patient's biopsychosocial functioning. **When psychiatric care extends beyond six months, the psychiatrist must document the rationale for continued specialist care in the patient's health record, and in a brief written report to the patient's primary care provider at least every six months.** *(5.2.123)*
Therapeutic/Diagnostic Interview (5.1.126) This service relates to a specific child and may take place with allied health professionals, education, correction, or other community resources. This applies to interviews by psychiatrists but does not preclude resident involvement. *(5.2.127)*	**Therapeutic/Diagnostic Interview (5.2.126)** This service relates to a specific child and may take place with **parents and/or caregivers,** allied health professionals, education, correction, or other community resources. This applies to interviews by psychiatrists but does not preclude resident involvement. *(5.2.127)*

FEE REVISION

Category	Code	Description	Base Units
PSYC	08.19B	Therapeutic/diagnostic interview - relating to a child with **parents and/or caregivers,** allied health professionals, education, correction, and other community resources **Specialty Restriction** SP=PSYC	44.44 MSU 22.22 units per 15 min. thereafter

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NEW FEE

Effective September 17, 2021 the following health service code is available for billing:

Category	Code	Description	Base Units
CONS	03.08A	**Extended Comprehensive Psychiatry Consultation - When direct physician to patient time exceeds 60 minutes**	132.19 MSU + MU

Description
The extended comprehensive psychiatry consultation follows all of the preamble rules pertaining to comprehensive visits and consultations. After the initial 60 minutes of direct physician to patient time, the psychiatrist must spend at least 80% of the time in direct physician to patient contact (in person or synchronous PHIA compliant virtual care platform).

Multiples may be claimed after 75 minutes and are calculated in 15-minute intervals, or portion thereof. 80% of the time must be in direct physician to patient contact (in person or synchronous PHIA compliant virtual care platform). Multiples will be paid at ¼ of the current negotiated MSU value for the 03.08 psychiatry comprehensive consultation. If service time extends beyond 180 minutes, the claim must be submitted for manual assessment with clinical documentation.

Billing Guidelines
- Start and stop times must be recorded in the health record.
- Direct physician to patient time must be 61 minutes or greater.
- Consultations of 60 minutes or less to be reported as 03.08 at the current rate.
- No other services may be claimed for the same patient during that time period.
- If clinical service exceeds maximum time of 9 multiples (180 minutes) submit as EC for manual assessment with clinical documentation and electronic text.

Multiples
MU per 15 minutes, or portion thereof beyond 75 minutes.
Maximum 9MU (total service time 180 minutes)

Multiples	Time Claimed	Time Spent with Patient
1 multiple	61 minutes	61-71 minutes
2 multiples	75 minutes	72-86 minutes
3 multiples	90 minutes	87-101 minutes
4 multiples	105 minutes	102-116 minutes
5 multiples	120 minutes	117-131 minutes
6 multiples	135 minutes	132-146 minutes
7 multiples	150 minutes	147-161 minutes
8 multiples	165 minutes	162-176 minutes
to a maximum of:		
9 multiples	180 minutes	177-180 minutes

Specialty Restriction:
SP=PSYC

Location:
LO=OFFC, LO=HOSP

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Billing Matters Billing Reminders, Updates, New Explanatory Codes

Expanded eligibility for High-Dose Influenza Vaccine during 2021/22 flu season

Initially expanded in fall 2020, the high-dose influenza vaccine 13.59L RO=HDIN will again be available to patients equal to or greater than 65 years of age who are also hospitalized and designated alternate level of care awaiting long-term care facility placement. This extended eligibility will expire once the 2021/22 influenza season ends.

Services provided by non-physicians

Physicians are reminded that services provided by non-physicians, including nurses, nurse practitioners and other groups are not insured by MSI. The only exception to this is that community-based family physicians who directly employ a nurse may claim for the following procedures done by the nurse, provided the physician is physically on the premises: Paps, provincial immunizations and other simple injections. If the nurse is not employed by the physician, such as in instances in which the nurse is an employee of Nova Scotia Health or the IWK, no services rendered by the nurse may be claimed by the physician. Other services, including but not limited to, procedures, visit services, and counselling services may not be claimed by a physician when they are rendered by non-physicians.

Physicians are reminded they may not claim for injections, immunizations and other services provided by pharmacists.

2021 Holiday Dates

Physicians are advised that September 30, 2021, National Day for Truth and Reconciliation is considered as a recognized holiday by MSI with respect to billing. Physicians may claim the holiday premium rate for certain services provided on an emergency basis. An emergency basis is defined as services that must be performed without delay because of the medical condition of the patient (Preamble 5.1.81). If a physician chooses to provide routine, scheduled services during a statutory holiday, they are not entitled to payment at the holiday rate.

The designated times where premium fees may be claimed and the payment rates are: (5.1.84)

Time Period	Time	Payment Rate
Monday to Friday	17:00 – 23:59	US = PREM (35 percent)
Tuesday to Saturday	00:00 – 07:59	US = PR50 (50 percent)
Saturday	08:00 – 16:59	US = PREM (35 percent)
Saturday to Monday	17:00 – 07:59	US = PR50 (50 percent)
Recognized Holidays	08:00 – 23:59	US = PR50 (50 percent)

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 17th, 2021. The files to download are:
Health Service (SERVICES.DAT), and Health Service Description (SERV_DSC.DAT).

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

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

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

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PHYSICIAN'S BULLETIN
September 10, 2021: Vol. LXVI, ISSUE 12

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Provision of Publicly Funded Virtual Health Services

The policy for publicly funded virtual health services has been published on the NS Department of Health and Wellness website. This policy applies to all publicly funded services funded by the Department of Health and Wellness (DHW), the Nova Scotia Health Authority (NSHA), and the IWK Health Centre (IWK) as they exercise their interdependent statutory mandates, as outlined under the Public Service Act, the Health Services Insurance Act, and the Health Authorities Act.

Virtual Health Care

Virtual health care is defined in the policy to be any interactions between patients and/or members of their circle of care, occurring remotely, using synchronous or asynchronous forms of communication.

Synchronous methods of virtual care (e.g., real-time telephone or *Personal Health Information Act* (PHIA, 2010) compliant video platforms such as Telehealth or Zoom for Healthcare) are permitted for the use and billing in accordance with the policy. Asynchronous methods of virtual care, such as secure messaging through an Electronic Medical Record (EMR) are permitted for use in accordance with the policy. However, asynchronous methods of virtual care are not approved for billing within Nova Scotia at this time.

The full policy can be accessed here:
https://novascotia.ca/dhw/publications/Provision-of-Publicly-Funded-Virtual-Health-Services.pdf

Please read the policy carefully- Appendix 2 includes some provisions specific to physicians providing virtual services. While this policy has been in effect since March 2021, physician adherence to this policy is effective September 16, 2021.

PHYSICIAN'S BULLETIN
July 23, 2021: Vol. LXVI, ISSUE 11

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2 Transcutaneous Aortic Valve Implantation (TAVI)

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MSI DOCUMENTATION REMINDER

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the 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), the working diagnosis and the treatment prescribed, and start and stop times for time based codes.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptation's, or emotional problems, 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." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional wellbeing of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy," etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule. Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim. Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service on that date, then the service is not paid for or a lesser benefit is given. When the clinical record does not support the service claimed, there may be a recovery to MSI at the time of audit. Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

NEW INTERIM FEE

The following interim fee is effective July 23, 2021:

Category	Code	Description	Base Units	Anaes Units
VEDT	47.25C	**Transcutaneous Aortic Valve Implantation (TAVI)**		15+T
		First Physician (RO=FPHN)	611 MSU	
		Second Physician (RO=SPHN)	611 MSU	

Description
This comprehensive health service code includes all physician work required to perform a transcutaneous aortic valve implantation. This work includes, when performed percutaneous and/or open arterial cardiac access, placement of any sheath required, balloon aortic valvuloplasty, delivery, deployment and placement of the valve, temporary pacemaker insertion and closure of access sites. All means used to guide the procedure such as contrast injections, angiography, fluoroscopy, right and left cardiac catheterization, supravalvular aortography, aortic and left ventricular outflow tract measurements are included such that any radiological supervision and interpretation should not be reported or claimed.

Billing Guidelines
Do not report with the following same patient same day:

- 47.03 - Closed heart valvotomy, aortic valve
- 47.25 - Other replacement of aortic valve
- 47.52A - Closure of arterial septal defect
- 49.73 - Implantation of endocardial electrodes
- 50.82 - Aortography
- 50.82C - Aortic arch study
- 50.91 - Arterial catheterization
- 50.99C - Femoral vein puncture
- 51.61B - Off pump coronary artery bypass surgery

Do not report with:
R1071 - Aortic root (cardiac)

Specialty Restriction:
SP=CASG, SP=CARD, SP=GNSG

Location:
LO=HOSP (QEII only)

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NEW AND UPDATED EXPLANATORY CODES

Code	Description
VE033	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED A SEPARATE FEE FOR A PORTION OF THIS SERVICE ON THE SAME DATE.
VE034	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED THE COMPREHENSIVE TRANSCUTANEOUS AORTIC VALVE IMPLANTATION (TAVI) FEE FOR THIS PATIENT ON THIS DAY.
VE035	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS THIS INTERPRETATION IS INCLUDED IN THE COMPREHENSIVE FEE FOR TRANSCUTANEOUS AORTIC VALVE IMPLANTATION PERFORMED ON THAT DATE.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday July 23rd, 2021. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

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

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

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PHYSICIAN'S BULLETIN
July 2, 2021: Vol. LXVI, ISSUE 10

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

FACILITY ON-CALL, PMC, CHIP – TRANSITION TO ELECTRONIC BILLING

Effective July 1, 2021 Facility On-Call payments are transitioning to electronic billing and will be made directly by MSI to physicians as Fee-for-Service (FFS) claims. All other components of the program (i.e., established rotas, eligibility or rates) remain unchanged.

New health service codes (i.e., fee codes) have been established for each existing rota. As of July 1, physicians will submit their Facility On-Call claims directly to MSI. All shifts will be directly paid to the on-call physicians through either an individual or group FFS Business Arrangement (BA). If you do not have a FFS BA, please contact MSI at 902-496-7011 (HRM local), 1-866-553-0585 (toll free) or msiproviders@medavie.bluecross.ca.

Physicians will continue to be paid per the categories as specified in the Nova Scotia Facility On-Call Program Guidelines. Categories of the Program are based on different levels of service and apply to physicians providing on-call services in approved regional and tertiary hospitals and/or participating Community Hospital Inpatient Program (CHIP) and Primary Maternity Care (PMC) program sites.

Where rotas have organized themselves to share in the call payments for any given shift(s), the following options exist:

1. Physicians share a call shift equally:
   - Use the 50% modifier when billing; both physicians would claim the Facility On-Call fee and use the modifier PO=HALF.
2. Multiple physicians regularly share in the daily call stipend:
   - Using a group BA; the most responsible physician would claim the stipend for the shift. MSI will make the payment to the group bank account. It is left to the group administrator to disburse funding to the participating physicians.

When submitting claims for Facility On-Call:

- Use the generic health card number **0000002352**, date of birth **April 1, 1969** and diagnostic code **V689** for billing purposes.
- Use the **service date that aligns with the beginning time of the shift covered** (for both normal coverage and call-backs). For a weekday coverage running from 1700 to 0800 hours the following day, the claim should include the service date that aligns with the 1700 start time.

For more examples or information, please refer to the FAQs below.

Note: Where on-call services are remunerated within program funding (e.g., AFP, ICU-APP Option Levels 1-3) there will be no change; these physicians will continue to be remunerated through existing processes.

Q: What is the intent of the Facility On-Call Program?

A: Although the Facility On-Call Program is for 24-hours, the funding being provided is intended to recognize "after hours" emergency calls/services, not routine consultation, or the routine care of inpatients. "After-hours" is defined as weekday evenings/nights (1700 - 0800), weekends (24 hours) and holidays (24 hours) beginning at 0800. It is meant to provide remuneration for the physician where personal time is disrupted by having to provide on-call services.

Q: How do I know which category I am in or which health service code to bill?

A: Physicians should use the health service code appropriate to their category, specialty, and location. Please see the Fee Code Table below to clarify the locations for each health service code. Physicians will continue to be paid per the categories as specified in the Nova Scotia Facility On-Call Program Guidelines. Only the submission and payment processes are changing.

Q: Can I bill regular health service codes in addition to the Facility On-Call health service codes?

A: Eligible physicians who are called into the facility can claim services rendered in addition to receiving on-call funding where applicable with their funding (e.g. specialists with APP may claim after hours services as fee for service with the implementation of the current Master Agreement). Providers should confirm what services are appropriate for billing purposes before attempting to do so. Note: all after-hours claims should be billed using appropriate health card numbers and after-hours modifiers.

Q: How do I bill the Facility On-Call health service codes?

A: The health services codes are available for download in the vendor software.

Q: What if I do not have the ability to submit electronic claims?

A: If you do not have a FFS or Group FFS Business Arrangement (BA) you will need to obtain one by contacting MSI at 902-496-7011 (HRM local), 1-866-553-0585 (toll free) or msiproviders@medavie.bluecross.ca. Physicians who do not have billing software often engage the services of a Service Bureau. Service Bureaus are independent billing providers who do complete billing for physicians for a fee. *Prices vary and are set by the independent Service Bureaus; physicians should choose the Service Bureau which best suits their needs.*

Q: What about my Facility On-Call coverage for service dates up to June 30?

A: All claims up to June 30, 2021, will continue to be paid via the invoice method through NSHA/IWK. As of July 1, 2021, Facility On-Call claims should be submitted as FFS using the new health service codes.

Q: How often can I bill the Facility On-Call health service code?

A: The health service code can be billed once per eligible physician per rota per 24-hour period.

Q: Can I bill for covering two facilities or two rotas in the same facility at the same time?

A: Physicians cannot claim for more than one on-call payment on the same day. For example, an OBGYN cannot claim separate call shifts when covering the Dartmouth General (as primary) and IWK (as secondary) on the same day. The physician would claim the call which provides the higher compensation – typically the primary call rota. Similarly, if a physician who is on-call for PMC was requested to also cover hospitalist, the physician would claim the on-call for PMC as there is no difference in the category between those two programs.

Q: When do I use the US=CALL modifier?

A: A physician may also claim a callback rate in addition to the Category 3 daily rate if they are required to return to the hospital while providing call services. To claim, first submit for the appropriate daily rate, followed by a second claim for the same health service code using the US=CALL modifier. Physicians not scheduled to provide Facility On-Call services may not claim a callback. Facility On-Call Category 4 callback fee can only be claimed once per 24 hours. It is available to physicians whose specialty or subspecialty does not have a designated on-call rota.

Q: How do I bill when I am on call for a half shift?

A: If you provide coverage for a half shift, use the PO=HALF modifier to indicate the partial coverage. A separate physician providing coverage for the remainder of the rota is to claim the other half. Total claims for each day cannot exceed 100% of the Facility On-Call Category daily value. For example, if two Anaesthesiologists are sharing a Saturday call – one is doing daytime, the other is doing nighttime – they would both bill the fee code F1001, use the weekend modifier DA-RGE1 and use the additional modifier PO=HALF. Each physician will be paid half the call rate for that shift ($200 each).

Q: How will this work for group payments?

A: For physicians who receive remuneration through group funding, the Facility On-Call code can be billed to the Group FFS Business Arrangement. Using this group BA, one physician will claim the stipend for the shift. MSI will make the payment to the group bank account. It is left to the group administrator to disburse funding to the participating physicians.

Q: What documentation is required to substantiate my Facility On-Call claims?

A: For quarterly and annual review purposes, DHW will require documentation. This will include written on-call schedules and, for callback claims, documentation of the reason for each callback. Physicians should keep records of their call participation and what portion of call shifts are fulfilled. Additionally, all service claims made while on-call should use the appropriate modifiers where applicable (e.g. nighttime claims should use nighttime and/or urgent modifiers).

Q: How does this transition to electronic billing affect CHIP and PMC workbooks?

A: The sessional-paid Community Hospital Inpatient Program (CHIP) or Primary Maternity Care (PMC) Program will also transition to the new health service codes after June 30, 2021. All CHIP and PMC workbooks have been revised to remove the Facility On-Call claims. MSI has sent these workbook templates to each site lead.

Facility On-Call Category 1 (with PMC)

Health Service Code	Description	Weekday	Weekend/ Holidays (DA=RGE1)	Approved Regional and Tertiary Hospitals
F1001	Facility on Call Category 1 – Anaestheia	$300	$400	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Cumberland Regional, Aberdeen, St. Martha's, Cape Breton Regional, Dartmouth General.
F1002	Facility on Call Category 1 – General Surgery	$300	$400	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Cumberland Regional, Aberdeen, St. Martha's, Cape Breton Regional, Dartmouth General.
F1003	Facility on Call Category 1 – Internal Medicine	$300	$400	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Cumberland Regional, Aberdeen, St. Martha's, Cape Breton Regional, Dartmouth General.
F1004	Facility on Call Category 1 – Obstetrics/Gynecology RO=OBS1 (Yarmouth and IWK only) RO=OBS2 (IWK only) RO=GYN1 (Dartmouth and IWK only)	$300	$400	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Aberdeen, St. Martha's, Cape Breton Regional, Dartmouth General, IWK/Grace.
F1005	Facility on Call Category 1 – Family Medicine-Primary Maternity Care	$300	$400	South Shore Regional, Yarmouth Regional, Valley Regional, Cumberland Regional, St. Martha's, Cape Breton Regional.
F1006	Facility on Call Category 1 – Hospitalist	$300	$400	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Cumberland Regional, Aberdeen, St. Martha's, Cape Breton Regional, Glace Bay, Dartmouth General, QEII, IWK/Grace.
F1007	Facility on Call Category 1 – Diagnostic Imaging	$300	$400	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Aberdeen, St. Martha's, Cape Breton Regional, Dartmouth General, QEII.
F1008	Facility on Call Category 1 – Family Medicine O.R. Call Assists	$300	$400	Valley Regional, St. Martha's, Cape Breton Regional, Dartmouth General.
F1009	Facility on Call Category 1 – Family Medicine (Mental Health)	$300	$400	Cape Breton Regional
F1010	Facility on Call Category 1 – Orthopedics	$300	$400	Valley Regional, Aberdeen, Cape Breton Regional
F1011	Facility on Call Category 1 – Pediatrics	$300	$400	Valley Regional, Colchester East Hants, St. Martha's, Cape Breton Regional,
F1012	Facility on Call Category 1 – Psychiatry	$300	$400	Colchester East Hants, St. Martha's, Cape Breton Regional,
F1013	Facility on Call Category 1 – Urology	$300	$400	Valley Regional, Cape Breton Regional, Dartmouth General, QEII.
F1014	Facility on Call Category 1 – Ophthalmology	$300	$400	St. Martha's, Cape Breton Regional, QEII.
F1015	Facility on Call Category 1 – Palliative Care	$300	$400	Cape Breton Regional
F1016	Facility on Call Category 1 – Nephrology	$300	$400	Cape Breton Regional, QEII, IWK/Grace.

Facility On-Call Category 2

Health Service Code	Description	Weekday	Weekend/ Holidays (DA=RGE1)	Approved Regional and Tertiary Hospitals
F2010	Facility on Call Category 2 – Orthopedics	$250	$300	Dartmouth General
F2011	Facility on Call Category 2 – Pediatrics	$250	$300	Yarmouth Regional, Aberdeen
F2013	Facility on Call Category 2 – Urology	$250	$300	Colchester East Hants
F2014	Facility on Call Category 2 – Ophthalmology	$250	$300	Yarmouth Regional
F2017	Facility on Call Category 2 – Otolaryngology	$250	$300	Valley Regional, St. Martha's, Cape Breton Regional
F2018	Facility on Call Category 2 – Vascular Surgery	$250	$300	Valley Regional, Cape Breton Regional
F2004	Facility on Call Category 2 – Obstetrics/Gynecology	$250	$300	Cumberland Regional
F2019	Facility on Call Category 2 – Plastic Surgery	$250	$300	St. Martha's, Cape Breton Regional
F2020	Facility on Call Category 2 – Neonatology	$250	$300	Cape Breton Regional
F2021	Facility on Call Category 2 – Neurosurgery	$250	$300	Cape Breton Regional
F2022	Facility on Call Category 2 – Neurology	$250	$300	Cape Breton Regional

Facility On-Call Category 3

Health Service Code	Description	Weekday	Weekend/ Holidays (DA=RGE1)	Callback (US=CALL)	Approved Regional and Tertiary Hospitals
F3012	Facility on Call Category 3 – Psychiatry	$150	$200	$100	South Shore Regional, Yarmouth Regional, Valley Regional
F3023	Facility on Call Category 3 – Pathology	$150	$200	$100	South Shore Regional, Colchester East Hants, St. Martha's, Cape Breton Regional
F3024	Facility on Call Category 3 – Child Psychiatry	$150	$200	$100	Colchester East Hants
F3017	Facility on Call Category 3 – Otolaryngology	$150	$200	$100	Cumberland Regional
F3025	Facility on Call Category 3 – Radiation Oncology	$150	$200	$100	Cape Breton Regional
F3026	Facility on Call Category 3 – Medical Oncology	$150	$200	$100	Cape Breton Regional
F3027	Facility on Call Category 3 – Tissue Bank	$150	$200	$100	QEII
F3028	Facility on Call Category 3 – Hyperbaric Unit	$150	$200	$100	QEII
F3029	Facility on Call Category 3 – Urology Transplant	$150	$200	$100	QEII
F3030	Facility on Call Category 3 – Ophthalmology - Orbital Reconstruction	$150	$200	$100	QEII

Facility On-Call Category 4

Health Service Code	Description	Callback (US=CALL)	Approved Regional and Tertiary Hospitals
F4CB1	Facility on Call Category 4 – Callback (US=CALL modifier required)	$300	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Cumberland Regional, Aberdeen, St. Martha's, Cape Breton Regional, Dartmouth General, QEII, IWK/Grace

Community Hospital Inpatient Program (CHIP)

Health Service Code	Description	Weekday	Weekend/ Holidays (DA=RGE1)	Approved CHIP Hospitals
FCHP1	Facility on Call – Community Hospital Inpatient Program	$300	$400	Strait-Richmond Hospital, Northside General Hospital, Fishermans Memorial Hospital, Soldiers Memorial Hospital, Queens General Hospital, Roseway Hospital, New Waterford Consolidated

Code	Description
GN109	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS ROTA HAS ALREADY BEEN CLAIMED AT EITHER HALF OR FULL VALUE FROM THIS FACILITY FOR THE SAME SERVICE DATE.
GN110	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS ROTA HAS ALREADY BEEN CLAIMED AT FULL VALUE FROM THIS FACILITY FOR THE SAME SERVICE DATE.
GN111	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED A FACILITY ON-CALL CALLBACK RATE FOR THIS SERVICE DATE.
GN112	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE COMMUNITY HOSPITAL INPATIENT PROGRAM HAS ALREAD BEEN CLAIMED FROM THE SAME HOSPITAL ON THIS DATE.
GN113	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST CLAIM A CATEGORY 3 FACILITY ON-CALL DAILY RATE PRIOR TO CLAIMING THE ASSOCIATED CALLBACK FEE.
GN114	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM OF 2 OPHTHALMOLOGY ROTAS HAVE ALREADY BEEN CLAIMED FROM THIS FACILITY ON THIS DATE.
GN115	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM OF 4 DIAGNOSTIC IMAGING ROTAS HAVE ALREADY BEEN CLAIMED FROM THIS FACILITY ON THIS DATE.
GN116	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR THE FACILITY ON-CALL OBSTETRICS/GYNECOLOGY ROTA USING THE SAME ROLE MODIFIER HAS ALREADY BEEN CLAIMED FROM THE IWK FOR THIS DATE.
GN117	SERVICE ENCOUNTER HAS BEEN REFUSED AS CLAIMS FOR HSC F1004 FROM THIS FACILITY SHOULD NOT INCLUDE A ROLE MODIFIER.
GN118	SERVICE ENCOUNTER HAS BEEN REFUSED AS CLAIMS FOR HSC F1004 FROM YARMOUTH SHOULD BE MADE USING THE RO=OBS1 MODIFIER.
GN119	SERVICE ENCOUNTER HAS BEEN REFUSED AS CLAIMS FOR HSC F1004 FROM DARTMOUTH GENERAL SHOULD BE MADE USING THE RO=GYN1 MODIFIER.
GN120	SERVICE ENCOUNTER HAS BEEN REFUSED AS CLAIMS FOR HSC F1004 FROM THE IWK SHOULD BE MADE USING THE APPROPRIATE RO MODIFIER FOR 1ST OR 2ND OBSTETRICS, OR 1ST GYNECOLOGY.

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NOVA SCOTIA MEDICAL SERVICES INSURANCE

Physician Reminder

ELECTIVE OUT OF PROVINCE AND OUT OF COUNTRY SERVICES

ELECTIVE OUT OF PROVINCE SERVICES (WITHIN CANADA)

Prior approval is required from the Nova Scotia Department of Health and Wellness before referring a patient out of province for insured health services unavailable in Nova Scotia if the patient wishes to be considered for travel and accommodation assistance. Approval must be sought through the Medical Consultant, MSI.

The referral must be from a specialist registered in Nova Scotia, who is actively involved in the eligible resident's care. The referral must include the following:

- A description of the eligible resident's relevant medical history.
- A description of the health services requested as well as an estimation of the expected benefit to the patient.
- Confirmation that the health service(s) are provided in a publicly funded facility and are covered by the medical insurer in the proposed province.
- Written confirmation of the medical evidence supporting the requested health service.
- When the proposed health service is a new or emerging health service, documentation must be included of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.
- Information on the available health services in Nova Scotia and an explanation of why these are not sufficient for the resident's needs.
- The contact information of the physician who will be treating the patient so a copy of the approval documentation can be forwarded to their office.
- A description of any follow-up requirements.
- A written recommendation in support of the out-of-province health services, confirming that this is the specialist's recommendation and that the referral is not being provided solely at the request of the patient.
- Written confirmation of, the patient's medical requirement for travel with an escort, if required.
- The costs for an escort will not be covered by DHW if there is no medical evidence to support the need for an escort. Evidence of medical need for an escort is not required if the resident is under 19 years of age.

MSI will review the application and provide a response to the appropriate specialist within 30 days of receiving a complete application.

Upon approval of the application, the Department of Health and Wellness will contact the eligible resident and provide the appropriate application forms for travel and accommodation assistance.

ELECTIVE OUT OF COUNTRY SERVICES

Individuals requiring elective, insured health services that are not available within Canada must be authorized by the DHW prior to making any medical and/or travel arrangement to ensure the service will be insured and in order for the DHW/MSI to negotiate a reasonable and fair compensation with out of country providers prior to the provision of services. In order for a patient to be referred outside Canada for treatment, prior written approval is required from the Medical Consultant, MSI.

The referral must be from a specialist registered in Nova Scotia, who is actively involved in the eligible resident's care. The referral must include the following:

- A description of the eligible resident's relevant medical history.
- A description of the health services requested as well as an estimation of the expected benefit to the patient.
- The contact information of the physician who will be treating the patient so a copy of the approval documentation can be forwarded to their office.
- Written confirmation of the medical evidence supporting the requested health service.
- When the proposed health service is a new or emerging health service, documentation must be included of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.
- Information on the available health services in Canada and an explanation of why these are not sufficient for the resident's needs.
- A description of any follow-up requirements.
- A written recommendation in support of the out-of-country health services, confirming that this is the specialist's recommendation and that the referral is not being provided solely at the request of the patient.
- Written confirmation of the patient's medical requirement for travel with an escort, if required.
- The costs for an escort will not be covered by DHW if there is no medical evidence to support the need for an escort. Evidence of medical need for an escort is not required if the resident is under 19 years of age.

MSI will review the application and provide a response to the appropriate specialist within 30 days of receiving a complete application.

Upon approval of the application, the Department of Health and Wellness will contact the eligible resident and provide the appropriate application forms for travel and accommodation assistance.

MEDICARE PAYMENT STATEMENT REMINDER

Prior to June 2021, MSI distributed the following pay statements:

- Electronic statement associated with the biweekly payment of FFS patient specific claims. There are two versions: a preformatted report and an extract of the data on the statement. This statement is accessible via an electronic request often submitted through your practice management software.
- Paper statement associated with the payment of non-FFS patient specific claims, e.g., AFP, APP, sessional, psychiatric hourly, CMPA and incentives.

Effective June 2, 2021 onward, the paper statement noted above has been replaced with an electronic statement. You are able to view and print this statement through a new web-based user interface. The statement is identical to the previous preformatted report.

The existing process that submitters utilize to download the statement associated with FFS patient specific claims has not changed.

If you have any questions regarding this change, please do not hesitate to contact us. We can be reached at msi_assessment@medavie.bluecross.ca or 902-496-7011/toll-free 1-866-553-0585.

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NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

MEDICARE PAYMENT STATEMENT DISTRIBUTION CHANGE – JUNE 2, 2021

Currently MSI distributes the following pay statements:

- Electronic statement associated with the biweekly payment of FFS patient specific claims. There are two versions: a preformatted report and an extract of the data on the statement. This statement is accessible via an electronic request often submitted through your practice management software.
- Paper statement associated with the payment of non-FFS patient specific claims, e.g., AFP, APP, sessional, psychiatric hourly, CMPA and incentives. This statement is mailed to the address that the physician or group has provided to MSI.

Effective June 2, 2021 onward, the paper statement noted above will be replaced with an electronic statement. You will be able to view and print this statement through a new web-based user interface. The statement will be identical to the current preformatted report.

You should have received a letter within the past week providing you with your login instructions. For physicians, the instructions indicate that you are to log in using your MSI Provider Number as your username. Your MSI provider number is a unique 6-digit number provided to you during the MSI registration process and used during claims' submission. Enter only the 6-digit number. Do not include 'PH' or 'PH-' in front of or following the 6-digit number.

The existing process that submitters utilize to download the statement associated with FFS patient specific claims will not change.

If you have any questions regarding this change, please do not hesitate to contact us. We can be reached at msi_assessment@medavie.bluecross.ca or 902-496-7011/toll-free 1-866-553-0585.

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Billing Matters Billing Reminders, Updates, New Explanatory Codes

COVID-19 VACCINATION (1ST AND 2ND DOSES) PHYSICIAN CLINIC REMUNERATION

The various payment methods for COVID-19 Vaccination indicated below are available for **Physician Clinics coordinated by Doctors Nova Scotia**. These do not apply to NSHA 'community' or 'public health' clinics (e.g. large arenas, First Nations Reserves, mobile units, longterm care facilities) nor does it apply to physicians who are independently participating in pharmacy or other clinics where remuneration has been pre-arranged.

For immunizations, tray fees (health service code 13.59M) may only be claimed if a physican incurs costs and may not be claimed when the supplies are provided by the government. For the current provincial rollout (doses 1 and 2), supplies will be provided by Nova Scotia and, therefore, cannot be claimed.

Physicians seeking to claim for immunizations rendered by nurses and nurse practitioners in their practice can only do so when the physicians are onsite during the time of immunization and those healthcare personnel are directly employed by the physician, and not when they are employed by the Nova Scotia Health Authority. Note: for the sessional payment option, physicians must provide the services themselves and cannot claim for any immunizations administered by other healthcare personnel.

1. **Fee for Service**
   For individual physicians who are providing COVID-19 immunizations as Fee for Service (FFS), these injections are to be claimed under the existing FFS business arrangement. These services will be claimed using the health service code 13.59L, following the rules set in Preamble 5.3.26 concerning provincial immunizations. A modifier has been developed for COVID-19 vaccines and must be used in conjunction with the 13.59L: **RO=CO19**.

Category	Code	Description	Base Units
ADON	13.59L	**Provincial Immunization for COVID-19** RO=CO19 **Description** COVID-19 vaccination	6 MSU

COVID-19 VACCINATION PHYSICIAN CLINIC REMUNERATION (CONTINUED)

2. **Alternative Funding (e.g., APP, CEC, C/AFP)** – No shadow billing requirement
Physicians who are providing COVID-19 immunizations as part of their Alternative Funding agreement deliverables (e.g., APP, CEC, C/AFP) will have the option to integrate any COVID-19 work into their existing contracted hours and be paid through their existing business arrangement. Although shadow billing is not required for immunizations, the shadow billing could make a positive difference to overall shadow billing for the year (e.g., eligibility for the APP 5.6% bonus). These injections would be shadow billed using health service code 13.59L following the rules set in Preamble 5.3.26 concerning provincial immunizations. A modifier has been developed for COVID-19 vaccines and must be used in conjunction with the 13.59L: **RO=CO19**.

   Alternatively, physicians may request an exclusion from the Department of Health and Wellness (DHW) to deliver the vaccination services over and above their regular contracted hours. A request for exclusion must be approved by DHW by emailing: alternate.funding@novascotia.ca.

3. **Individual Sessional** – No shadow billing requirement
Physicians receiving remuneration via sessional funding for the hours administering the vaccine are paid at the GP rate of $157.80 per hour (2021-22 rate). Sessional funding claims should be submitted to Medavie on a weekly basis; however, all claims must be submitted within 90 days of service per the Physician Manual. Any claims submitted outside this 90-day approval period are not payable. The claim must be reviewed and approved by an immunization clinic site manager or designate. Once approved, the claim should be submitted to Medavie for payment: email afpclaims@medavie.bluecross.ca and copy alternate.funding@novascotia.ca. If a physician requries a sessional form, they should contact alternate.funding@novascotia.ca.

   NOTE:
   Each clinic must be remunerated in the same method; sessional and FFS cannot be combined in a clinic. The only exception would be if an APP, CEC or C/AFP physician is including immunization into their scheduled hours for any given week; these physicians can do so while their collegues are receiving FFS or individual sessional payment.

REMINDERS

CMPA Rebate

The Department of Health and Wellness (through MSI) will continue to provide reimbursement of all eligible Canadian Medical Protective Association (CMPA) fees directly to physicians. Payments will be issued on a quarterly payment schedule and deposited through an electronic funds transfer. Medavie and DHW are working on options to better enable appropriate payment and better accountability. Stay tuned for changes.

These payments are deposited through an electronic funds transfer. If you do not already have a CMPA Business Arrangement set up to receive these deposits, you may fill out the MSI Provider Business Arrangement Form with a void cheque and email to msiproviders@medavie.ca or fax to 902-469-4674.

Should you have any questions regarding your CMPA rebate, please contact: CMPA@medavie.ca

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NEW AND UPDATED EXPLANATORY CODES

Code	Description
AD088	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR 13.59L RO=CO19 HAS BEEN APPROVED IN THE PREVIOUS 18 DAYS.
MA008	SERVICE ENCOUNTER HAS BEEN REFUSED. INTERIM SERVICE CODE HAS EXPIRED. APPLICATION MUST BE SUBMITTED TO THE FEE COMMITTEE FOR ESTABLISHING A PERMANENT HEALTH SERVICE CODE.
VE029	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS AN OUTPATIENT VISIT OR CONSULT FROM A RELATED SPECIALTY HAS BEEN CLAIMED FOR THIS PATIENT ON THAT DATE.
VT172	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A CHRONIC DIALYSIS MANAGEMENT DAILY TREATMENT AND SUPERVISION FEE HAS BEEN CLAIMED FOR THIS PATIENT ON THAT DATE.
PC036	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE NOT INDICATED THAT PRIOR APPROVAL HAS BEEN ISSUED. MAXIMUM LIMIT OF 9 HOURS FOR A PSP PHYSICIAN PER YEAR FOR COUNSELLING HAS PREVIOUSLY BEEN APPROVED.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday May 14th, 2021. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), Modifiers (MODVALS.DAT) and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

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

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

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NOVA SCOTIA

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PHYSICIAN'S BULLETIN
May 11, 2021: Vol. LXVI, ISSUE 6

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Physician Advisor Opportunity

The Department of Health and Wellness (DHW) is seeking an inaugural Physician Advisor, Quality and Patient Safety (QPS) on a part time basis (approximately up to 45 hours per month).

The Quality and Patient Safety Branch at DHW provides leadership to guide and drive quality improvement across the health care system through policy, legislation, measurement, monitoring and reporting.

A DHW physician resource for QPS is critical to support and enable the Department to fully realize the dual responsibilities of leadership and monitoring and accountability in the areas of quality and patient safety.

The mandate of this exciting new role is to:

- assist in driving continuous quality improvement in health care for Nova Scotia by providing leadership, expertise and advice on current DHW quality and patient safety priorities and
- participating in the development of provincial oversight & reporting mechanisms to improve health-system performance.

Physician engagement is essential for quality and patient safety improvements; this will be a key role for the Physician Advisor.

The inaugural Physician Advisor is an exceptional leader with the vision and scholarly profile to understand and nurture the complex interrelationships required to develop and implement quality improvement that integrates the public, health teams, health leaders, physicians and policy makers to strengthen and improve healthcare patient outcomes.

Please click here to view further details on the scope of work.

To apply, please send a covering letter that highlights your interest and how you meet the qualifications, along with a detailed CV with two references, including contact information to: Krizia.Sadi@novascotia.ca before midnight June 14, 2021.

PHYSICIAN'S BULLETIN
May 10, 2021: Vol. LXVI, ISSUE 5

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians

MEDICARE PAYMENT STATEMENT DISTRIBUTION – UPCOMING CHANGES

Currently MSI distributes the following pay statements:

- Electronic statement associated with the biweekly payment of FFS patient specific claims. There are two versions: a preformatted report and an extract of the data on the statement. This statement is accessible via an electronic request often submitted through your practice management software.
- Paper statement associated with the payment of non-FFS patient specific claims, e.g., AFP, APP, sessional, psychiatric hourly, CMPA and incentives. This statement is mailed to the address that the physician or group has provided to MSI.

Effective June 2, 2021 onward, the paper statement noted above will be replaced with an electronic statement. You will be able to view and print this statement through a new web-based user interface. The statement will be identical to the current preformatted report. In the next few weeks, you will receive a letter providing you with the link to access these statements, your unique login information, and login instructions.

The existing process that submitters utilize to download the statement associated with FFS patient specific claims will not change.

If you have any questions regarding this change, please do not hesitate to contact us. We can be reached at msi_assessment@medavie.bluecross.ca or 902-496-7011/toll-free 1-866-553-0585.

PHYSICIAN'S BULLETIN

March 19 2021: Vol. LXVI, ISSUE: 4

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MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT

Effective April 1, 2021, the Medical Service Unit (MSU) value will increase from $2.58 to $2.63.

ANAESTHESIA UNIT

Effective April 1, 2021, the Anaesthesia Unit (AU) value will increase from $22.71 to $23.88.

PSYCHIATRY FEES

Effective April 1, 2021, the hourly psychiatry rate for General Practitioners will increase to $154.57 while the hourly rate for Specialists increases to $209.59 as per the tariff agreement.

WORKERS COMPENSATION BOARD UNIT VALUE CHANGES

WCB MEDICAL SERVICE UNIT

Effective April 1, 2021, the Workers Compensation Board Medical Service Unit (WCB MSU) value will increase from $2.87 to $2.92.

WORKERS COMPENSATION BOARD ANAESTHESIA UNIT

Effective April 1, 2021, the Workers Compensation Board Anaesthesia Unit (WCB AU) value will increase from $25.23 to $26.53.

WORKERS COMPENSATION BOARD FEE CODE INCREASES

Workers' Compensation Board Fee Code Update

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been calculated for the listed WCB specific fees for fiscal year 2021-22.

Due to the increase in CPI for 2020, all of the WCB specific services listed below will have their values increased by 0.81% effective April 1st, 2021:

CODE	DESCRIPTION	APRIL 2021 VALUE
WCB12	EPS physician assessment Service. Combined office visit and completion of Form 8/10 For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15-minute increments to a maximum of 1 additional hour	**Initial visit:** $189.42 + $55.39 per 15 minutes to a maximum 4x (RO=EPS1 and RP=INTL) **Subsequent visit:** $189.42 (RO=EPS1 and RP=SUBS)
WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable	GPs..... $46.31 per 15 min EPS(RO=EPS1).. $55.39 per 15 min Specialists.....$62.31 per 15 min
WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable	GPs..... $46.31 per 15 min EPS(RO=EPS1)..$55.39 per 15 min Specialists.....$62.31 per 15 min
WCB17	Photocopies of Chart Notes	10 pgs or less (ME=UP10) ..... $27.74 11-25 pgs (ME=UP25)… ..... $55.39 26-50 pgs (ME=UP50)… ..... $110.67 Over 50 pgs (ME=OV50)… $165.94
WCB20	Carpal Tunnel Syndrome (CTS) Assessment Report	$71.04
WCB21	Follow-up visit report	$41.55
WCB22	Completed Mandatory Generic Exemption Request Form	$13.90 per form
WCB23	Completed Non-Opioid Special Authorization Request Form	$13.90 per form
WCB24	Completed Opioid Special Authorization Request Form	$46.57 per form
WCB25	Completed WCB Substance Abuse Assessment Form	$31.04
WCB26	Return to Work Report – Physician's Report Form 8/10	$71.04
WCB27	Eye Report	$62.31

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CODE	DESCRIPTION	APRIL 2021 VALUE
WCB28	Comprehensive Visit for Work Related Injury or Illness	$71.48
WCB29	Initial Request Form For Medical Cannabis	$77.12
WCB30	Extension Request Form For Medical Cannabis	$46.31
WCB31	WCB Interim Fee – Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed	$71.48

FEE CODE INCREASES

INCREASES IN COMPREHENSIVE PRIMARY CARE FEE CODES

As per the master agreement, the following fees shall have their values increased for family physicians. (New Value is the value effective April 1, 2021)

	Old Value	New Value
Description	**MSU**	**MSU**
Office Visit (ME=CARE)	15.95	16.96
Geriatric Office Visit (ME=CARE)	19.73	20.99
Office Visit After-Hours (ME=CARE)	19.94	21.20
Geriatric Office Visit After-Hours (ME=CARE)	24.67	26.24
Office Visit – Well Baby Care (ME=CARE)	15.95	16.96
Office Visit Well Baby Care After-Hours (ME=CARE)	19.94	21.20
Office Visit Prenatal Care (ME=CARE)	15.95	16.96
Office Visit Prenatal Care After-Hours (ME=CARE)	19.94	21.20
Office Visit Postnatal Care After-Hours (ME=CARE)	25.67	27.30
Subsq. Inpatient Care Visit (Days 2, 3)	24.85	26.43
Subsq. Inpatient Care Visit – Newborn (Days 2, 3)	24.85	26.43
Subsq. Inpatient Care Visit – Post-Partum (Days 2, 3)	24.85	26.43
Subsq. Inpatient Care Visit (Days 4-7)	20.53	21.84
Subsq. Inpatient Care Visit – Post-Partum (Days 4-7)	20.53	21.84
Subsq. Inpatient Care Visit (Daily to 56 days)	17.29	18.39
Subsq. Inpatient Care Visit (Weekly after Day 56)	17.29	18.39

INCREASES IN PSYCHIATRY FEE CODES

As per the master agreement, the following fees shall have their values increased for psychiatrists. (New Value is the value effective April 1, 2021) *Note: these increases are for psychiatrists only.*

	Old Value	New Value
Description	**MSU**	**MSU**
Routine Psychiatric Visit (08.5B)	42.68	43.41
Psychotherapy (08.49B)	43.25	44.46
Comprehensive Consultation (03.08)	94.85	103.24
Child Psychiatric Assessment (08.19A)	48.87	50.23
Group Therapy (08.44)	11.66	11.99
Therapeutic/Diagnostic Interview Relating to a child (08.19B)	43.23	44.44

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FEE CODE INCREASES (CONTINUED)

INCREASES IN OBSTETRIC AND GYNECOLOGY FEE CODES

As per the master agreement, the following fees shall have their values increased for obstetrics and gynecology services. (New Value is the value effective April 1, 2021)

Gynecology Fee Code Changes

HSC	Description	Old Value MSU	New Value MSU
03.03V	Medical Abortion/Termination of early pregnancy	62.63	67.03
80.89A	Abortion – Incomplete; examination of the uterus without D&C or anaes.	32.96	35.28
79.1	Conization of cervix including colposcopy	67.24	71.97
87.21	Dilation and Curettage for termination of pregnancy	93.61	100.19
81.09	Other Dilation and Curettage	56.04	59.98
81.09A	Endocervical Curettage	13.19	14.11
98.12V	Curettage of warts, including papillomata, keratosis, nevi, moles, pyogenic granulomata, etc., for malignant or recognized pre-malignant condition	15.82	16.93
81.69A	Endometrial Biopsy	25.05	26.81
80.4C	Laparoscopic Hysterectomy	395.55	423.36
80.3	Total Abdominal Hysterectomy	316.44	338.69
80.4A	Vaginal Hysterectomy – uterus-total vaginal w/ rectocoele / cystocoele repair	378.41	405.01
80.4	Vaginal Hysterectomy (subtotal)	316.44	338.69
80.2A	Subtotal Abdominal Hysterectomy	316.44	338.69
80.3A	Uterus – total abdominal w/ rectocoele / cystocoele repair	378.41	405.01
80.3C	Abdominal hysterectomy with salpingo-oophorectomy including bilateral selective pelvic lymphadenectomies, omental biopsy / selective periaortic	527.40	564.48
77.19C	Laparoscopic ovarian cystectomy	197.78	211.68
86.3A	Surgical removal of extrauterine (ectopic) preg. by any means (incl. tubal)	171.41	183.45
78.1A	Salpingectomy for morbidity, not for sterilization	171.41	183.45
10.16	Insertion of vaginal pessary	30.98	33.16
80.19A	Endometrial ablation including D&C	210.96	225.79
82.81A	Colposcopy	11.21	12.00
78.39A	Interruption or removal of fallopian tubes for sterilization purposes	138.44	148.18
77.51	Removal of both ovaries and tubes	257.11	275.18
80.81	Hysteroscopy	56.04	59.98
77.19A	Salpingectomy and salpingo-oophorectomy	171.41	183.45

Obstetric Fee Code Changes

HSC	Description	Old Value MSU	New Value MSU
87.98	Delivery (RF=REFD, SP=OBGY)	342.81	366.91
87.98	Delivery (SP=OBGY or SP=GENP)	263.70	282.24
86.1	Cervical Caesarean Section	342.81	366.91
84.79	Other Vacuum Extraction	342.81	366.91
86.1A	Caesarean section with tubal ligation	369.18	395.13
84.71	Vacuum extraction with episiotomy	342.81	366.91
84.0	Low forceps delivery without episiotomy	342.81	366.91
84.1	Low forceps delivery (with episiotomy)	342.81	366.91
84.8	Other specified instrumental delivery	342.81	366.91
84.29	Other mid forceps delivery	342.81	366.91
84.21	Mid forceps delivery (with episiotomy)	342.81	366.91
84.53	Total breech extraction	342.81	366.91
84.51	Breech extraction, unqualified	342.81	366.91
84.31	High forceps delivery with episiotomy	342.81	366.91
84.39	Other high forceps delivery	342.81	366.91
84.52	Partial breech extraction	342.81	366.91
84.61	Partial breech extraction with forceps to aftercoming head	342.81	366.91
84.62	Total breech extraction with forceps to aftercoming head	342.81	366.91
84.9	Unspecified instrumental delivery	342.81	366.91

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FEE CODE INCREASES (CONTINUED)

INCREASES IN OBSTETRIC AND GYNECOLOGY FEE CODES *(continued)*

As per the master agreement, the following fees shall have their values increased for obstetrics and gynecology services. (New Value is the value effective April 1, 2021)

Gynecology and Obstetrics Fee Code Changes

HSC	Description	Old Value MSU	New Value MSU
81.8	Insertion of intra-uterine contraceptive device	42.19	45.16
81.01	Dilation and curettage following delivery or abortion	75.15	80.44
81.61	Aspiration curettage following delivery or abortion	75.15	80.44

OB/GYN Consultation Fee Code Changes

HSC	Description	Old Value MSU	New Value MSU
03.08	Comprehensive Consultation (Prolonged)	37.60	40.10
03.07	Limited Consultation	27.00	29.50
03.07	Repeat Consultation (Prolonged)	25.00	27.50

UPDATED FEES

Teaching Stipend

Health service code TESP1 and TESP2 have been retroactively revised to daily rate fees for both fee for service and shadow billing. Any physicians who have claimed these fees since April 2020 will be contacted and directed to update their claims once an approved list of physicians is confirmed with Dalhousie University.

Category	Code	Description	Base Units
DEFT	TESP1	TEACHING STIPEND FOR MEDICAL STUDENT	$90 per day
DEFT	TESP2	TEACHING STIPEND FOR RESIDENT ELECTIVE	$90 per day

TESP1 and TESP2 revised to daily fees with a value of $90 each.

A claim for these services is designated to remunerate for any teaching responsibilities incurred during the service date.

These daily codes are available as both FFS and APP claims for physicians that meet the eligibility criteria outlined below.

Not eligible for any premiums

Maximum claimable amount of $450 per weekly period (i.e. only 5 teaching stipend claims per physician per week will be accepted)

Eligibility restrictions:

- Only available for those who have an academic appointment and are teaching Dalhousie residents and students
- FFS family physicians are eligible
- FFS royal college specialists are eligible
- APP physicians are able to shadow bill at the $90 daily rate

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- AFP physicians are not eligible for this fee code for work done in the AFP, likewise FFS physicians working within one of the FFS Academic Departments are not eligible
- Physicians (part time Academic Department and part time FFS) are eligible for work done outside the Academic Health Centre/IWK and not otherwise compensated through their clinical department or AFP (for example a physician in their private clinic teaching a student/resident).

Dalhousie will confirm the list of physicians approved to claim the teaching stipend to MSI, as well as any updates to the list as they occur.

Electronic claims for TESP1 and TESP2 should be claimed using health card number 0000002352 with date of birth April 1, 1969. Diagnostic code V623 is also required.

FEE REVISIONS

The effective period for interim health service code 03.04I – PSP Mental Health Comprehensive Visit to Establish the PSP Mental Health Plan (Practice Support Program) has been extended to October 31, 2021.

Physicians are reminded of the description for this service:
*Based on these requirements it is expected that a physician would have no more than 5 eligible patients per year.

Category	Code	Description	Base Units
VIST	03.04I	**PSP Mental Health Comprehensive Visit to establish the PSP (PSP= Practice Support Program) Mental Health Plan** This code is for the complete assessment of the patient with a confirmed mental illness meeting the diagnostic criteria in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of sufficient severity and acuity to cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and warrant the development of a Mental Health care plan. This is not intended for patients with self-limited or short-lived mental health symptoms. The assessment is to be performed by the PSP trained family physician most responsible for the patient's mental health care. The Mental Health Plan and start and stop times must be documented in the health record. This complete assessment is to include **all** of the following elements and be documented in the health record: • The patient's DSM diagnosis, psychiatric history and current mental state including suicide risk assessment as appropriate • Obtaining collateral history and information from caregivers as required • Performance of a complete medication review to include collateral information from pharmacy and assisted living facility as appropriate • Reviewing and documenting results of relevant validated assessment tools, laboratory, and other test results • Documentation of a clinical plan for the patient's care over the next year. Includes advanced care planning where appropriate • Outline of expected outcomes as a result of the treatment plan • Outline of linkages with other health care providers and community resources who will be involved in the patients care. • Confirmation that the plan has been created jointly and shared with the patient or their medical representative. The plan is to be shared with other care providers as appropriate	50 MSU +MU

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Category	Code	Description	Base Units
		• A documented care plan must be in place before access to additional counselling hours is provided It is recognized that the required elements may require more than one visit to complete. This health service code may be claimed at the final visit only when all of the information is complete and documented in the health record; other visits may be reported at the usual rate. **All** elements must be documented in the health record before reporting this PSP MHP visit service. **Billing Guidelines** • Reportable by the patient's PSP trained physician only • Not reportable with any other visit fee for the same physician, same patient, same day • Not reportable for services provided at walk-in clinics • Not to be used for patients living in nursing homes, residential care facilities or hospices • Reportable only once per patient per year • 50 MSU for first 30 minutes, 25 MSU for each additional 15 minutes, up to a maximum of 1 hour (5 multiples) • Start and stop times must be reported in the text field of the claim to MSI, as well as in the clinical record **Specialty Restriction** GENP with PSP Training **Location** OFFC, HOME	

Clarification to Health Service Code 51.95B

Orginally introduced in the October 2020 Physician's Bulletin, HSC 51.95B – Chronic Dialysis, treatment and supervision of care for the patient with end stage kidney disease, in an urban satellite hemodialysis unit as designated by the Health Authority for a 24 hour period have been updated to be consistent with the fee description. Face-to-face clinical assessment should be documented within a 42-day period, not the previously communicated 14-day.

Category	Code	Description	Base Units
VEDT	51.95B	**Chronic Hemodialysis – treatment and supervision of care for the patient with end stage kidney disease, in an urban satellite hemodialysis unit as designated by the Health Authority (for example; Halifax Infirmary, Dartmouth General, and North Sydney hemodialysis units) for a 24 hour period.** **Description** This comprehensive, daily fee (24 hour period beginning at 12:00 am until 11:59 pm of the same calendar day) is for the treatment and supervision of care for a patient with end stage kidney disease who is registered in the Renal Program (NSHA, STARS or PHS, as a series visit for dialysis) and requires chronic dialysis in an urban satellite hemodialysis unit as designated by the Health. The physician is expected to supervise all aspects of the patient's dialysis care and to provide direct, face-to-face clinical assessment of the patient, including a physical examination appropriate to the patient's medical condition, at least once in every 42 day period, and via PHIA compliant, synchronous virtual care platform once in every 14 day period, with additional clinical assessments as required based on concerns related to changes in the patient's medical condition. Each assessment will be documented in the patient's health record. Elements of care include:	12.11 MSU

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A. All management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital in-patients and in-person emergency department visits related to the management of chronic dialysis. It does not include acute dialysis. Acute dialysis is defined as dialysis rendered to a hospital inpatient in an intensive care setting, or to a patient beginning dialysis for the first time in their lifetime through to their 6th treatment at which point the dialysis is defined as chronic. A visit service, consultation or directive care as appropriate, may be claimed for hospital inpatients if the nephrologist is asked by the patient's most responsible physician to render an opinion and furnish advice regarding the patient's ongoing nephrological care during their hospital stay. The most responsible physician requesting the advice may not be another nephrologist.

B. All outpatient consultations and visits within the scope of practice of nephrology for the assessment and treatment of complications of chronic dialysis and management of end-stage kidney disease.
Including:
    a. Review of laboratory and diagnostic test results
    b. Management of volume status, ideal body weight and blood pressure
    c. Assessment of dialysis access, such as central venous catheter, arteriovenous fistula and peritoneal catheter, and management of any complications as required.
    d. Complete and document the Ambulatory Medication Reconciliation every six months

C. All related counselling, interviews and family meetings

D. Perform all assessments and consultation requests to refer the chronic dialysis patient to the Multiorgan Transplant Program for determination of kidney transplant eligibility.

E. All related case conferences, such as, but not limited to:
    a. Weekly Morning Program Rounds
    b. Review of laboratory and diagnostic test results with multidisciplinary team

For all patients in all hemodialysis units, the Nephrologist assigned to each unit will provide daily coverage of all dialysis patients to address any dialysis issues by being available to speak with the unit charge nurse or team lead every shift to discuss any problems or concerns with individual patients at any time.

The Nephrologist assigned to each unit will provide additional care and address concerns or problems that arise during the course of a hemodialysis treatment or within the 24 hour period of supervision, such as, but not limited to, changes to dialysis prescription or medications based on laboratory results like serum potassium or INR for patients on oral anticoagulants, when results are received after the treatment time.

A standardized review of the patient's overall status on dialysis will be completed and updated every 6 weeks and documented in the patient's health record.

The document will include:
    a. Review and interpretation of laboratory and diagnostic test results
    b. Volume status, ideal body weight, blood pressure and physical examination appropriate to the patient's medical needs.
    c. Assessment of dialysis access, such as; central venous pressure catheter, arteriovenous fistula, peritoneal catheter, and management of any complications as required.

Billing Guidelines

- Claimable by the Most Responsible Nephrologist once per patient per 24-hour period beginning at 12:00 am (midnight) and ending at 11:59 pm.
- May not claim any other chronic dialysis HSCs for the same patient, same 24-hour period.
- May not claim any other outpatient visit HSCs same physician, same patient, same 24-hour period.

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- A Nephrologist providing coverage for care of the chronic dialysis patient on behalf of the most responsible nephrologist may not claim any outpatient visit HSCs or chronic dialysis HSCs.
- Emergency hospital visits to attend the patient for a condition unrelated to the management of dialysis, its complications and end stage kidney disease may be claimed but must be submitted for manual assessment with supporting information in the text (clinical documentation may be required). Should the patient be admitted to hospital under the care of the nephrologist, who is acting as the most responsible physician, inpatient visits may be claimed.
- First claim may be made on the date of the patient's first chronic dialysis treatment.
- May not be claimed after the treatment terminates by, for example, successful transplantation, loss of resident status, or death.
- When a face-to-face clinical assessment is not documented in the patient's health record in the **42** day period, payment will be recovered from the Most Responsible Physician who claimed for the service for the majority of days in the preceding seven day period at the end of which the examination was to have occurred.

Specialty Restriction:
SP=NEPH

Location:
LO=HOSP

Billing Matters Billing Reminders, Updates, New Explanatory Codes

2019/2020 Provider Profiles

As announced in 2019, provider profiles will only be sent out by request. If you would like to receive your provider profile for 2019/20 please send your request by email to msi_assessment@medavie.bluecross.ca. In the email please include: your name and provider number, and the profile will be mailed to the address on file.

COVID-19 Immunization

As announced in February, all physician work for COVID-19 immunization will be remunerated via sessional funding for the hours worked. Please refer to the February 19, 2021 Physicians Bulletin for full details on sessional funding.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
GN107	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED A TEACHING STIPEND ON THIS DATE.
GN108	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU ARE NOT AUTHORIZED TO CLAIM THE TEACHING STIPEND.
VA100	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED ONE OF THE FOLLOWING HEALTH SERVICE CODES: 50.99C, 50.91, 50.06C, OR 50.08B. THESE SERVICES ARE CONSIDERED TO BE INCLUSIVE OF THE CURRENT CLAIM.
VA101	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED ONE OF THE FOLLOWING HEALTH SERVICE CODES: 50.82, 50.82C, OR 50.88A. THESE SERVICES ARE CONSIDERED TO BE INCLUSIVE OF THE CURRENT CLAIM.

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Code	Description
VA102	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED ONE OF THE FOLLOWING COMPREHENSIVE HEALTH SERVICE CODES: 48.0A, 48.0C, or 48.0F.
VA103	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED ONE OF THE FOLLOWING COMPREHENSIVE HEALTH SERVICE CODES: 48.0A, 48.0C, or 48.0F.
VA104	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED HSC 48.0A PERCUTANEOUS CORONARY ANGIOPLASTY DURING THIS ENCOUNTER. THE CLAIM FOR CORONARY ANGIOPLASTY INCLUDES SELECTIVE CORONARY ANGIOGRAPHY.
VA105	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED A PORTION OF THIS FEE (HSC 48.98B SELECTIVE CORONARY ANGIOGRAPHY) DURING THIS ENCOUNTER. PLEASE SUBMIT A REVERSAL FOR THE PRIOR 48.98B BEFORE SUBMITTING A REASSESSMENT REQUEST FOR THIS COMPREHENSIVE CLAIM.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday March 19th, 2021. The files to download are:
Health Service (SERVICES.DAT),
Health Service Description (SERV_DSC.DAT),
Modifiers (MODVALS.DAT) and,
Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

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

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

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Master Agreement - Program Payment Schedule (2021/22)

Program	Payment
EMR (Envelope "A" Payments) EMR Envelope "A" payments continue monthly to eligible physicians	Monthly
CME (GP & Specialist) Payment for 2020/21 fiscal year (eligible billings based on 2020 calendar year)	Issued by May 31, 2021
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from April 1, 2021 – June 30, 2021	Issued by July 31, 2021
CMPA Premium Reimbursement Covering April - June 2021	Issued by August 31, 2021
Electronic Medical Records (EMR – B&C) Payments for 2020/21 Fiscal Year	Issued by August 31, 2021
Family Physician Alternative Payment Plan 5.6% Incentive	Issued by September 30, 2021
Surgical Assist Payments Payment based on eligible billings from April 1, 2020 – March 31, 2021	Issued by September 30, 2021
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from July 1, 2021 – September 30, 2021	Issued by October 31, 2021
Collaborative Practice Incentive Program Payments for 2020/21 Fiscal Year	Issued by October 31, 2021
CMPA Premium Reimbursement Covering July -September 2021	Issued by December 31, 2021
Rural Specialist Incentive Program Measurement period April 1st, 2020 – March 31st, 2021 / Payment for 2020/21 fiscal year	Issued by December 31, 2021
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from October 2021 – December, 2021	Issued by January 31, 2022
CMPA Premium Reimbursement Covering October -December 2021	Issued by March 31, 2022
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from January 2022 – March, 2022	Issued by April 30, 2022
CMPA Premium Reimbursement Covering January - March 2022	Issued by May 31, 2022

*Please be advised payment dates noted are the **anticipated** payments for these programs.

Payments for fiscal 2020/21	Continuing payments

PHYSICIAN'S BULLETIN
February 19 2021: Vol. LXVI, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

Notice to Physicians: COVID-19 Immunization

At the present time, all physician work for COVID-19 immunization will be remunerated via sessional funding for the hours worked (at the GP rate of $154.80 per hour presently). This includes vaccinations delivered in healthcare worker clinics, community clinics delivered by the NSHA or IWK, long term care facilities and any prototype clinics in physicians' offices.

Sessional funding claims should be submitted to Medavie on a weekly basis; however, all claims must be submitted within 90 days of service per the Physician Manual. Any claims submitted outside of this 90-day approval period are not payable. The claims must be reviewed and approved by an immunization clinic site manager or designate, or long-term care administrator or designate. Once approved, please submit the claim to Medavie for payment: afpclaims@medavie.bluecross.ca with alternate.funding@novascotia.ca copied. If you require the sessional form please send a request to afpclaims@medavie.bluecross.ca.

Work is underway to pilot immunization that is similar to the flu vaccine. At that time, payment will be fee for service and a bulletin will be provided with additional information.

Alternate Payment Plan (APP), Collaborative Emergency Centre (CEC) and Clinical/Academic Funding Plan (C/AFP) physicians will have the option to integrate any COVID-19 vaccination work into their existing contracted hours and be paid through their existing arrangement. Alternatively, they may request an exclusion from the Department of Health and Wellness (DHW) to deliver the vaccination services over and above their regular contracted hours. A request for exclusion must be approved by DHW by emailing: alternate.funding@novascotia.ca.

PHYSICIAN'S BULLETIN
January 29 2021: Vol. LXVI, ISSUE 2

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

ORGAN AND TISSUE DONATION

The new *Human Organ and Tissue Donation Act (HOTDA)* is now in effect as of January 18, 2021.

MSI Health card renewal forms have been updated to reflect this change.

For more information please see the January 18, 2021 Physicians Bulletin or visit https://novascotia.ca/DHW/msi/health_cards.asp

Fees New Fees and Fee Revisions

NEW INTERIM FEE

Category	Code	Description	Base Units
VEDT	02.75C	**Coronary Computed Tomographic (CT) Angiography for the preoperative evaluation of paediatric patients with congenital heart disease** **Description** Coronary CT angiography with reconstruction of coronary arteries and related vascular structures under the direct supervision of the radiologist for the purpose or evaluating cardiac structure for pre-operative assessment of the paediatric patient with congenital heart disease. This fee includes the performance and interpretation of the scan with administration of contrast material and medication, as required, to control the heart rate along with necessary work station processing. **Billing Guidelines:** Not billable with: • R1135 CT Thorax without contrast • R1141 CT Thorax with contrast • R1145 CT Thorax with and without contrast • R1180 3D Reconstruction **Specialty Restriction:** Sub-specialty trained cardiac paediatric radiologist at the IWK Health Centre (credentials and list of physicians eligible to report this service must be submitted to MSI) **Location:** LO=HOSP (IWK only)	120 MSU

Billing Matters Billing Reminders, Updates, New Explanatory Codes

BILLING REMINDERS

Enhanced office and geriatric visit fees (03.03/03.03A; ME=CARE)

Please click here to view the updated FAQ for billing ME=CARE.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
BK062	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 02.75C HAS ALREADY BEEN CLAIMED FOR THIS PATIENT AT THE SAME ENCOUNTER.
VE032	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC R1135, R1141, R1145 OR R1180 HAS ALREADY BEEN CLAIMED FOR THIS PATIENT AT THE SAME ENCOUNTER.

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January 18 2021: Vol. LXVI, ISSUE 1

NOVA SCOTIA MEDICAL SERVICES INSURANCE

MSI HEALTH CARD RENEWAL FORM AND ORGAN/TISSUE DONATION

Revised Health Card Renewal Form

Please be advised there is an updated version of the Nova Scotia MSI health card renewal form. This form has been updated as a result of the new *Human Organ and Tissue Donation Act* (HOTDA) that is effective January 18, 2021. This form should be used when a Nova Scotia resident's health card has expired. If the card has been expired for more than one year instruct the resident to contact the MSI office to confirm eligibility. The updated form can also be found online at https://novascotia.ca/DHW/msi/health_cards.asp

This form cannot be used for new residents moving to Nova Scotia, to make changes to a residents file such as name, date of birth or gender changes and cannot be used to request duplicate or replacement health cards if lost or stolen. This form cannot be used to renew cards for international students or foreign workers.

Helpful tips to ensure completeness of the renewal form and timely processing:

- Resident must sign the form to confirm they are ordinarily present in NS and to authorize the release of information for payment and audit purposes, this is mandatory to issue a health card.
- A parent or guardian must sign for children under the age of 16.

With implementation of the new legislation, Nova Scotians 19 and over, who are not exempt, will be considered for organ and tissue donation, unless they register their decision to opt out of donation. Nova Scotians can register their decision to opt out of donation by visiting www.novascotia.ca/organtissuedonation.

If you have any questions, please contact MSI Resident Services at 902-496-7008 or toll free at 1-800-563-8880.