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Interim Health Service Codes

Interim Fees are established in certain circumstances with approval from the Department of Health and Wellness. A Health Service Code is assigned to an interim fee and will be published in the MSI Physician's Bulletin.

The current interim fees are listed below. If an interim fee becomes terminated or made permanent it will be removed from this list and updated in the MSI Physician's Bulletin and/or Manual as applicable.

The following Interim Health Service codes are effective April 1, 2017

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

Category	Code	Description

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

The following Interim Health Service code is effective November 13, 2020

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

The following Interim Health Service codes are effective November 13, 2020

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	75 MSU

Category	Code	Description	Base Units
		includes all services required to remove the device and close the wound. **Specialty Restriction:** SP=NEPH **Location:** LO=HOSP (QEII only)	
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

The following Interim Health Service codes are effective July 24, 2023

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. This can be 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 *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	4 MSU

Category	Code	Description	Base Units
DEFT	AHCP1	Physician Advice Requested by a Regulated Health Professional 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 • 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	7.5 MSU

Category	Code	Description	Base Units
		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 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 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.
			34 MSU
			+MU

Category	Code	Description	Base Units
		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	

The following Prolonged Interim Health Service codes are effective July 24, 2023

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. **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	

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) 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	21.3 MSU +MU

The following Interim Health Service code is effective September 18, 2024

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

The following Interim Health Service code is effective December 1, 2024

Category	Code	Description	Base Units
DEFT	ADCP1	**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

The following Interim Health Service code is effective July 18, 2025

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. • 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.	11.5 MSU

Category	Code	Description	Base Units
		• Additional groups of three services may be claimed at the same value. **Specialty Restriction:** SP=GENP **Location:** LO=OFFC	

The following Interim Health Service code is effective November 21, 2025

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 the physician (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 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. • 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	16.5 MSU

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: o Active participation in structured team meetings at least once per month, o Discussions with other regulated health care providers working in the collaborative practice regarding patient care that are not otherwise billable, o 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. • 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 physicians. • 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 physicians 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 physicians 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	146.7

Category	Code	Description	Base Units
		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	

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.

The following Interim Health Service code is effective July 17, 2026

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). 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	17 MSU +MU

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