PHYSICIAN'S BULLETIN
November 17, 2017: Vol. LVIII, ISSUE 11

NOVA SCOTIA MEDICAL SERVICES INSURANCE

CONTENTS

★ Fees New Fees and Highlighted Fees

NEW FEES

Effective November 17, 2017 the following health service code will be available for billing:

Category	Code	Description	Base Units
MAAS	50.77C	**Portal Vein Embolisation** Vascular embolization or occlusion of the portal vein (s), inclusive of percutaneous portal vein catheterization and all radiological supervision and interpretation, intra-procedural road mapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction. **Billing Guidelines** • Each case to be evaluated based on active physician skin to skin time defined as the time of first incision for placement of percutaneous catheter until the completion of embolization and removal of the venous catheter by the physician. • Time must be documented in the patient's health record. • Procedural time sheets to be submitted with claim. **Specialty Restriction** Interventional Radiology Fellowship with additional training in PVE **Location** HOSP	IC 140 MSU/hr

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The following codes were made effective November 1, 2017. Physicians were previously advised to hold these claims until November 17, 2017; codes are now available for billing.

Health Service Codes with fee value adjustments; physicians are asked to continue billing these codes, and a retroactive payment will be provided at a later date for claims billed between November 1, 2017 and November 17, 2017.

Category	Code	Description	Base Units
DEFT	CPO1	**Care Plan Oversight (CPO) Nursing Home, Residential Care Facility, or Hospice**	
		A) CPO 15 to 29 minutes within a calendar month	15 MSU
		B) CPO greater than 30 minutes within a calendar month	30 MSU
		Supervision of care for a nursing home, residential care facility, or hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by the physician most responsible for providing definitive or comprehensive care for that particular patient, review of subsequent reports of patient status, review of related laboratory and other studies not generated in a face to face encounter, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s) outside of that physician's practice, family member(s), surrogate decision maker(s) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; a) 15 to 29 minutes or b) 30 minutes or more.	
		Billing Guidelines • Reportable for the calendar month when greater than 15 minutes of physician time is spent on the duties listed above. Anything less than 15 minutes is considered to be included in the visit encounter service. • Maximum reporting six times per calendar year. • Only one physician may report for any given patient in a calendar month. • The physician claiming the service must be the most responsible physician who provides definitive or comprehensive care for that particular patient. • The physician must have seen the patient for a face to face visit at least once in the six months prior to reporting CPO. • The physician must personally document the date, the time spent and a brief description of the activities provided in the patient's health record. Given that this service may be reported when the physician is not physically present in the nursing home, RCF or hospice, the initial documentation should be made in either the physician's EMR or the patient's nursing home, RCF or hospice health record. This information **must** be documented in the nursing home, RCF or hospice health record when the physician next visits the nursing home, RCF or hospice. • For reporting purposes, activities must be documented in the Care Plan Oversight Reporting Table (or similar format that includes all of the same service elements, times and dates) in the patient health record. • Do not report with other telephone service or non face to face codes such as: o 13.99C Supervision of long-term anticoagulant therapy - in the same calendar month. o ENH1 Long Term Care Medication Review - in the same calendar year.	
		When CPO has been reported, only one CGA1 (Long Term Care Geriatric Assessment)	

		may be reported in the same calendar year. If a nursing home patient's condition is declining such that a second CGA1 is deemed necessary within a calendar year this may be reported. However it may not be reported in the same month that CPO is reported. In addition, text is required on the claim to indicate the reasons for a second CGA1 in the same year. **Specialty Restriction** GENP **Location** LO=NRHM, Residential Care Facility, or Hospice Please note: When submitting claims for a service provided at a Residential Care Facility (RCF), please use LO=NRHM and select the applicable facility code for the RCF location.

Category	Code	Description	Base Units
VIST	03.03	**Subsequent Daily Hospital Visit (LO=HOSP, FN=INPT, DA= DA23 or DA=DA47)** A) Days 2, 3, and first day out of ICU (DA=DA23) B) Days 4 – 7 (DA=DA47) These adjusted MSU values apply to health service code 03.03 LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, a subsequent limited visit provided to patients admitted to hospital where a family doctor is the most responsible physician. **Billing Guidelines** • May only be claimed once per patient per day by the most responsible physician (MRP). 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 increased code values. **Specialty Restriction** GENP **Location** LO=HOSP, FN=INPT	 23 MSU 19 MSU

Category	Code	Description	Base Units
VIST	03.04F	**Acute Care Hospital Discharge Day Management - Comprehensive**	45 MSU

The comprehensive hospital discharge day management code is intended to be used when 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; the final examination of the patient, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms. Every effort is to be made by the discharge physician to communicate (direct, contact telephone, electronic) with the community physician who will be most responsible for the patient's care after discharge.
It is recognized that for complex comprehensive discharges, the discharge process may occur over 2 days. For example the discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms may be completed on one day and the final examination of the patient and discharge order the following day.
If this situation arises, 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 reported once by the MRP and may not be unbundled to accommodate splitting the workload

- A visit is considered an integral part of this service and is not reportable in addition.
- Documentation of the services provided and time spent must be documented in the health record.

Billing Guidelines

Preamble Rules 5.1.30 - 5.1.31 apply. Not reportable if the patient is admitted and discharged on the same day or 24 hour period.

- Reportable by the Most Responsible Physician only. The Most Responsible Physician (MRP) is defined as the physician in charge of the patient's care for any given day (24 hour period).
- May only be claimed once per patient per inpatient hospital admission.
- The physician claiming this health service may not report any other visit service for the same patient, same day. In addition, HSC 03.02 (Hospital Discharge Free) A may not be claimed as the service is included in the Comprehensive Acute Care Discharge Day Management Health Service Code.
- Efforts made to establish communication with the health care provider who will be most responsible for the patient's care after discharge must be documented in the health record.
- Not reportable for hospital deaths.

Do not count time for services performed outside of the patient's unit or floor e.g., calls to the receiving physician/facility made from the physician's private office) or services performed after the patient physically leaves the hospital.

Specialty Restriction
GENP
Location
LO=HOSP, FN=INPT

Category	Code	Description	Base Units
ADON	03.03S	**First Visit After Acute Care In-Patient Hospital Discharge – Complex Care** This is an additional fee for the first office visit of the patient requiring ongoing complex care within 14 days of acute care in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care. • The physician or their office staff must make every effort to communicate (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge. • Not reportable in the walk-in clinic setting. A complex care patient is defined as: • A patient with multiple (two or more) chronic conditions requiring active management expected to last at least 12 months, or until the death of the patient. • The chronic conditions must place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. **Billing Guidelines** ADON Restricted to: 03.03 Office visit 03.03A Geriatric Office Visit (for patients age 65+) 03.03E Adults with Developmental Disabilities • Reportable only if the visit occurs in the primary care physician's office or the patient's home within 14 calendar days after hospital discharge (consider discharge date as Day zero). • Hospital length of stay must be greater than or equal to 48 hours. • Communication (direct contact, telephone, electronic) with the patient and/or caregiver by the physician or their office staff within 2 business days of discharge must be documented in the health record. If unsuccessful, the reason must be documented in the health record. • Not reportable if the admission to hospital was for the purpose of performing elective surgery (major or minor) or fracture care (major or minor). • Not reportable if the admission to hospital was for the purpose of obstetrical delivery. • Not reportable if the admission to hospital was for the purpose of newborn care. • Not reportable for services rendered in other locations such as Nursing Homes, Residential Care Facilities, or Hospice. • The physician claiming the service must be the provider most responsible for the patient's ongoing complex care. • Claimable once per patient per inpatient admission. • Not reportable for any subsequent discharges within 30 days. • Not reportable in the same month as other monthly care fees - such as 13.99C – Supervision of long-term anticoagulant therapy. • Maximum of 4 claims per physician per patient per year. **Specialty Restriction** GENP **Location** LO=OFFC, HOME	10 MSU

Category	Code	Description	Base Units
ADON	03.03P	**First Visit after In-Patient Hospital Discharge – Maternal and Newborn Care** This is an additional fee for the first maternal/newborn office visit within 14 days of in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care. • The primary care physician or their office staff must make every effort to communicate (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge. • Not reportable in the walk-in clinic setting. **Billing Guidelines** ADON Restricted to: • 03.03 Office visit • 03.03 Well Baby Care Reportable only if the visit occurs in the primary care physician's office or the patient's home within 14 calendar days after hospital discharge (consider discharge date as Day zero). Every effort to establish communication with the patient and/or caregiver by the physician or their office staff (direct contact, telephone, electronic) within 2 business days of discharge must be documented in the health record. If unsuccessful, the reason must be documented in the health record. Only reportable if the reason for admission to hospital was for the purpose of obstetrical delivery. Physician must be the provider most responsible for the mother and child's ongoing care. Claimable once per patient per inpatient admission for obstetrical delivery. Not reportable for any subsequent discharges within 30 days. Maximum of 1 claim per pregnancy (mother) Maximum 1 claim per infant **Specialty Restriction** GENP **Location** LO=OFFC, HOME	10 MSU

Category	Code	Description	Base Units
ADON	HOVM1	**Blended Mileage and travel detention for Home Visits (1 multiple = 1 km)** This health service code is added on to a home visit health service code when the physician must travel to the patient's home in order to provide clinical services to a homebound patient. **Billing Guidelines** Text for the claim must include: • the start and finish time of the visit • point of origin • destination address • the distance in kilometers maximum MU=70 **Specialty Restriction** GENP **Multiples** 1 MU = 1 km, maximum multiples = 70 **Location** LO=HOME	0.46 MSU + MU

BILLING REMINDERS

Endoscopy transurethral electro-resection (HSC 72.1B)
Physicians are reminded that health service codes 69.0A cystoscopy with removal of foreign body/calculus, 01.34A cystoscopy with or without catheterization of ureters, and 01.34B cystoscopy with urethral dilation, cannot be claimed in the same encounter as 72.1B –endoscopy transurethral electro-resection, and vice versa.

Insertion of indwelling urinary catheter by Urologist
Health service code 69.94 – Insertion of indwelling urinary catheter performed by urologists cannot be claimed with any other procedures during the same encounter.

Clarification Health Service Codes 03.03Q Scheduled Specialist Telephone Management/Follow-up with Patient and 03.03R Scheduled Family Physician Telephone Management/Follow-Up with Patient

HSC 03.03Q and 03.03R were introduced earlier this year.

HSC 03.03Q may be reported for a scheduled 15 minute telephone communication between the specialist physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face consultation, visit or procedure by the same physician within the last 9 months and has not been seen within the last 7 days **for the same condition by the same provider or another provider within the same group practice**.

This service is not reported if the outcome of the scheduled call is to see the patient at the next available appointment in the office. This communication is intended to take the place of an office follow up visit that would have otherwise been scheduled, when a physical examination of the patient is not required.

A group practice is defined as the arrangement whereby two or more physicians are in practice, and each physician maintains and has access to medical records and histories of the patients.

HSC 03.03R may be reported for a scheduled 15 minute telephone communication between the family physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face visit by the same physician within the last 9 months and has not been seen within the last 7 days **for the same condition by the same provider or another provider within the same group practice.**

A group practice is defined as the arrangement whereby two or more physicians are in practice, and each physician maintains and has access to medical records and histories of the patients.

This telephone communication is intended to take the place of an office visit initiated by the patient (or the patient's parent, guardian or proxy as established by written consent) for a new condition or an exacerbation of an existing condition, or a follow up visit that would have
otherwise been scheduled by either the physician or the patient, when a physical examination of the patient is not required.

The patient population eligible must be either 65 years and older or be suffering from mental illness or multiple (two or more) chronic diseases.

Chronic disease is defined as:
• A condition expected to last at least 12 months or until the death of the patient
• The chronic condition must place the patient at significant risk of acute exacerbation/decompensation, functional decline, or death

Mental illness is defined as:
• A condition that meets criteria for a DSM diagnosis

The service is not reported if the decision is to see the patient at the next available appointment in the office.

Both HSC 03.03Q and 03.03R have complex billing guidelines and documentation requirements and physicians are urged to review the May 18, 2017 MSI Bulletin to familiarize themselves with these before claiming these HSCs.

Scenarios:

Q: I am a cardiologist whose office practice is co-located with another cardiologist. My colleague saw Mrs. Green two days ago with increasing dyspnea due to congestive heart failure. May I claim HSC 03.03Q for a follow-up telephone call with her?
A: As noted above, you may only claim this HSC if she has not been seen by you or another physician in your group within the past 7 days. As your office colleague saw her two days ago, you may not claim HSC 03.03Q for a follow-up telephone call.

Q: I am a family physician. My longstanding patient, Mr. Blue, was recently admitted to our local hospital with pneumonia. I was away and one of my office colleagues cared for him and discharged him 5 days ago. Today, he has called looking to discuss some new GI symptoms. May I claim HSC 03.03R?
A: As this is a different problem from the one your office colleague provided care for 5 days ago, you may claim HSC 03.03R provided all other billing guidelines and documentation requirements have been satisfied.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
AD068	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE HSC 03.03P HAS PREVIOUSLY BEEN PAID.
AD069	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST CLAIM AN APPROPRIATE OFFICE VISIT BEFORE CLAIMING THIS ADD ON FEE FOR THE SAME ENCOUNTER.
AD070	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED THIS FIRST VISIT AFTER DISCHARGE ADD ON FEE FOR THIS PERIOD.
AD071	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED THIS FIRST VISIT AFTER DISCHARGE ADD ON FEE THE MAXIMUM OF FOUR TIMES IN THE PAST YEAR.
AD072	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED A MONTHLY CARE FEE IN THE SAME CALENDAR MONTH.
AD073	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED HSC 03.03S IN THE SAME CALENDAR MONTH.
AD076	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE HSC 03.03P CANNOT BE CLAIMED FOR PATIENT AGES 1-10.
DE029	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CLAIM FOR CARE PLAN OVERSIGHT OR LONG TERM CARE CLINICAL GERIATRIC ASSESSMENT HAS PREVIOUSLY BEEN MADE FOR THIS PATIENT DURING THE SAME CALENDAR MONTH.
DE030	SERVICE ENCOUNTER HAS BEEN REFUSED A CLAIM FOR CARE PLAN OVERSIGHT HAS PREVIOUSLY BEEN MADE FOR THIS PATIENT DURING THE SAME CALENDAR MONTH.
DE031	SERVICE ENCOUNTER HAS BEEN DISALLOWED. WHEN BOTH A CLINICAL GERIATRIC ASSESSMENT AND CARE PLAN OVERSIGHT FEE HAVE BEEN CLAIMED FOR A PATIENT IN THE SAME CALENDAR YEAR, THE SECOND CGA FEE REQUIRES TEXT EXPLAINING NECESSITY. PLEASE RESUBMIT THIS CLAIM WITH TEXT REFERRING TO THE NECESSITY OF THIS SERVICE.

Code	Description
GN099	SERVICE HAS BEEN DISALLOWED, INSERTION OF THE INWELLING URINARY CATHETER CAN NOT BE CLAIMED WITH ANY OTHER PROCEDURE FEES DURING THE SAME ENCOUNTER
MJ060	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS A CLAIM FOR CYSTOSCOPY HAS ALREADY BEEN SUBMITTED FOR THIS PATIENT AT THE SAME ENCOUNTER. IF AN ADDITIONAL CYSTOSCOPIC PROCEDURE IS REQUIRED PLEASE RESUBMIT WITH SUPPORTING TEXT.
MJ061	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED HSC 72.1B AT THE SAME ENCOUNTER. IF AN ADDITIONAL CYSTOSCOPIC PROCEDURE IS REQUIRED PLEASE RESUBMIT WITH SUPPORTING TEXT.
VA045	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS HSC 50.99A AND 69.94 REQUIRE TEXT INDICATING WHY THE INTRAVENOUS/CATHETER INSERTION WAS PERFORMED BY THE PHYSICIAN
VA082	SERVICE HAS BEEN DISALLOWED, INSERTION OF THE INWELLING URINARY CATHETER CAN NOT BE CLAIMED WITH ANY OTHER PROCEDURE FEES DURING THE SAME ENCOUNTER
VA083	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY BILLED HSC 72.1B AT THE SAME ENCOUNTER. IF AN ADDITIONAL CYSTOSCOPIC PROCEDURE IS REQUIRED PLEASE RESUBMIT WITH SUPPORTING TEXT.
VT142	SERVICE ENCOUNTER HAS BEEN REFUSED AS A DAILY HOSPITAL VISIT RATE FOR THE MOST RESPONSIBLE PHYSICIAN HAS ALREADY BEEN CLAIMED FOR THE PATIENT ON THIS DAY.
VT143	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE DA=DA23 MODIFIER MAY ONLY BE USED ON THE 2ND AND 3RD ADMISSION DATES (OR DAYS OUT OF ICU).
VT144	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE DA=DA47 MODIFIER MAY ONLY BE USED ON THE 4TH TO 7TH ADMISSION DATES (OR DAYS OUT OF ICU).
VT145	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED A VISIT SERVICE FOR THIS PATIENT ON THE SAME DAY.
VT146	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED THE ACUTE CARE HOSPITAL DISCHARGE DAY MANAGEMENT VISIT FEE FOR THIS PATIENT ON THE SAME DAY.
VT154	SERVICE HAS BEEN DISALLOWED, RESUBMIT AS A LIMITED VISIT, A SUBSEQUENT COMPREHENSIVE VISIT OR RESUBMIT PROVIDING ELECTRONIC TEXT EXPLAINING THE MEDICAL NECESSITY OF AN INITIAL COMPREHENSIVE VISIT WITHIN 30 DAYS OF A PREVIOUS VISIT

UPDATED FILES

Updated files reflecting changes are available for download on Friday November 17, 2017. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT), explanatory codes (EXPLAIN.DAT), and modified values (MODVALS.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

CONTACT INFORMATION

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NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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TTY/TDD: 1-800-670-8888

In partnership with

2018 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE	SALARY CONTRACT PAY PERIOD
December 20, 2017**	**December 27, 2017****	January 3, 2018	December 15-28, 2017
January 8, 2018	January 11, 2018	January 17, 2018	December 29, 2017 – January 11, 2018
January 22, 2018	January 25, 2018	January 31, 2018	January 12-25, 2018
February 5, 2018	February 8, 2018	February 14, 2018	January 26-February 8, 2018
February 16, 2018**	February 22, 2018	February 28, 2018	February 9-22, 2018
March 5, 2018	March 8, 2018	March 14, 2018	February 23-March 8, 2018
March 19, 2018	March 22, 2018	March 28, 2018	March 9-22, 2018
April 2, 2018	April 5, 2018	April 11, 2018	March 23-April 5, 2018
April 16, 2018	April 19, 2018	April 25, 2018	April 6-19, 2018
April 30, 2018	May 3, 2018	May 9, 2018	April 20-May 3, 2018
May 11, 2018**	**May 16, 2018****	May 23, 2018	May 4-17, 2018
May 28, 2018	May 31, 2018	June 6, 2018	May 18-31, 2018
June 11, 2018	June 14, 2018	June 20, 2018	June 1-14, 2018
June 22, 2018**	**June 27, 2018****	July 4, 2018	June 15-28, 2018
July 9, 2018	July 12, 2018	July 18, 2018	June 29-July 12, 2018
July 23, 2018	July 26, 2018	August 1, 2018	July 13-26, 2018
August 3, 2018**	August 9, 2018	August 15, 2018	July 27-August 9, 2018
August 20, 2018	August 23, 2018	August 29, 2018	August 10-23, 2018
August 31, 2018**	September 6, 2018	September 12, 2018	August 24-September 6, 2018
September 17, 2018	September 20, 2018	September 26, 2018	September 7-20, 2018
September 28, 2018**	**October 3, 2018****	October 10, 2018	September 21-October 4, 2018
October 15, 2018	October 18, 2018	October 24, 2018	October 5-18, 2018
October 29, 2018	November 1, 2018	November 7, 2018	October 19-November 1, 2018
November 9, 2018**	November 15, 2018	November 21, 2018	November 2-15, 2018
November 26, 2018	November 29, 2018	December 5, 2018	November 16-29, 2018
December 10, 2018	December 13, 2018	December 19, 2018	November 30-December 13, 2018
December 19, 2018**	**December 24, 2018****	January 2, 2019	December 14-27, 2018
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.

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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	MONDAY, JANUARY 1, 2018
HERITAGE DAY	MONDAY, FEBRUARY 19, 2018
GOOD FRIDAY	FRIDAY, MARCH 30, 2018
EASTER MONDAY	MONDAY, APRIL 2, 2018
VICTORIA DAY	MONDAY, MAY 21, 2018
CANADA DAY	MONDAY, JULY 2, 2018
CIVIC HOLIDAY	MONDAY, AUGUST 6, 2018
LABOUR DAY	MONDAY, SEPTEMBER 3, 2018
THANKSGIVING DAY	MONDAY, OCTOBER 8, 2018
REMEMBRANCE DAY	MONDAY, NOVEMBER 12, 2018
CHRISTMAS DAY	TUESDAY, DECEMBER 25, 2018
BOXING DAY	WEDNESDAY, DECEMBER 26, 2018
NEW YEAR'S DAY	TUESDAY, JANUARY 1, 2019

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Season's
Greetings
From the staff of MSI Programs