PHYSICIAN'S BULLETIN

February 8th, 2019: Vol. LXIV, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

CONTENTS

MSI News

1 NS Health Card Changes

1 Documentation Reminder

Fees

2 Fee Revision
- Enhanced Newborn Visit
- Enhanced Post-Partum Visit

3 Fee Revision
- 78.39A

3 Fee Revision
- 03.03J,K,L (formerly methadone fees)

5 New Fees
- Opioid Agonist Treatment

7 New Fee
- OFI1 (Official Interpreter Services)

7 Preamble Change
- TI=GPEW

Billing Matters

Bulletin Reminders

8 Routine Prenatal care 5.2.72

8 Hypnotherapy 5.2.145

8 New Explain Codes

In Every Issue

9 Updated Files
9 Useful Links
9 Contact Information

Appendices

10 2019 Cut-off Dates

MSI News

CHANGES TO NOVA SCOTIA HEALTH CARDS

Beginning February 11th 2019, Nova Scotia Residents will have the option to remove their sex designation from the front of their health card. A resident's sex designation will still be contained on the health card's magnetic stripe and in the MSI Registration files. A resident's sex designation is still required as part of the claims submission process. If you have any questions concerning the change or require assistance, please contact the MSI Resident Services Department at 902-496-7008 or 1-800-563-8880.

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 will 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.

BACK TO CONTENTS

HIGHLIGHTED FEES

The Master Agreement Management Group increased newborn and post-partum inpatient fees, applicable to all relevant providers. The following adjustments complete that increase, first published for family physicians in the November 30th 2018 bulletin. This increase for post-partum and newborn inpatient fees is interim, pending Fee Committee review of inpatient fees for all specialties: Effective February 8th, 2019 the adjusted MSU values apply to the following health service codes.

Category	Code	Description	Base Units
VIST	03.03	**Subsequent Care – Newborn Healthy Infant (LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS, SP=PEDI)** **Days 2, 3 (DA=DA23)** **Days 4-5 (DA=DA45)** **Description** These adjusted MSU values apply to the following health service codes: 03.03 LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS, SP=PEDI – Subsequent Care – Newborn Healthy Infant When the visit is provided to patients admitted to hospital where the pediatrician is the most responsible physician. **Billing Guidelines** May only be claimed once per patient per day by the most responsible physician (MRP) **Specialty Restriction** SP=PEDI **Location** LO=HOSP, FN=INPT **Notes:** First day out of ICU should be considered equivalent to day 2 and subsequent inpatient days as 3,4,5 for the purpose of reporting these increased code values.	 23 MSU 19 MSU

Category	Code	Description	Base Units
VIST	03.03	**Post-Partum Visit (LO=HOSP, FN=INPT, RO=PTPP, SP=OBGY)** **Days 2, 3 (DA=DA23)** **Days 4-7 (DA=DA47)** **Description** These adjusted MSU values apply to the following health service codes: 03.03 LO=HOSP, FN=INPT, RO=PTPP, SP=OBGY – Post-Partum Visit When the visit is provided to post-partum patients admitted to hospital where the obstetrician or gynecologist is the most responsible physician. **Billing Guidelines** May only be claimed once per patient per day by the most responsible physician (MRP). **Specialty Restriction** SP=OBGY **Location** LO=HOSP, FN=INPT **Notes:** 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.	 23 MSU 19 MSU

BACK TO CONTENTS

FEE REVISIONS

As announced in the November 30, 2018 bulletin, HSC **78.39A – Interruption or removal of fallopian tubes for purposes of sterilization: abdominal, vaginal, laparoscopic-not hysteroscopic (unilateral or bilateral**) will now accept a Surgical Assistant modifier.
Effective February 8th, 2019, offices may now bill their Surgical Assist claims for services provided since November 30th, 2018.

Effective February 8th, 2019, HSC **03.03J, 03.03K, 03.03L** have been updated:

Category	Code	Description	Base Units
VIST	03.03J	**Initial Opioid Use Disorder Assessment for Initiation of Opioid Agonist Treatment (OAT) Community Primary Care Setting Only (30 minutes)**	50MSU + MU

Description
This is a time based fee for the complete assessment of the patient entering into opioid agonist treatment (OAT) for the first time as prescribed by their primary care provider. The required elements of this service are outlined below and must be documented in the patient's health record. Required elements include:

i. A complete substance use history including illicit, prescription and OTC medications with a risk of abuse and a DSM diagnosis for each problematic drug;
ii. A complete addiction treatment history;
iii. Past medical and surgical history;
iv. Family history;
v. Psychosocial history, including living situation, source of income and education;
vi. Review of systems;
vii. A focused physical examination;
viii. Review of treatment options;
ix. Formulation of a treatment plan;
x. Communication with the patient and/or family to obtain information for the assessment as well as with support staff working in the treatment environment;
xi. Communication with previous care providers, including family doctors, pharmacists, Mental Health and Addictions staff, etc. as necessary.
xii. Obtain a patient profile for the previous 12 months through the Nova Scotia Prescription Monitoring Program (NSPMP) or Drug Information System (DIS)
xiii. Obtain a urine drug screen;
xiv. The health care provider should request blood work serology (screening for HIV, and Hepatitis A, B, and C) if not done recently by a previous provider.
xv. Consider obtaining an ECG if indicated.

- Start and stop times are to be documented in the health record.
- It is recognized that the required elements may be gathered over several visits with the patient. This fee is for the initial visit only

Billing Guidelines

- Billable only by the health care provider who is most responsible for the patient's ongoing OAT in the community primary care setting.
- Not reportable for care provided in an Opioid Use Disorder Treatment Program
- Multiples of 15 minutes may be billed in addition to the base fee code to a maximum of 60 minutes in total.
- 80% of the time must be spent in face to face contact with the patient and/or family.
- If time less than 25 minutes, bill as regular visit.
- Once per health care provider per patient.

Specialty Restriction
SP=GENP

Premium
TI=GPEW

Location
LO=OFFC

BACK TO CONTENTS

Category	Code	Description	Base Units
VIST	03.03K	**Initial Opioid Use Disorder Assessment for Opioid Agonist Treatment (OAT) – Transfer from Opioid Use Disorder Treatment Program to community Primary Care Provider**	50MSU

Description

This is a fixed fee for the complete assessment of the patient being transferred from an established Opioid Use Disorder Treatment Program to the primary health care provider who will be most responsible for that patient's ongoing OAT. The required elements of this service are outlined below and must be documented in the patient's health record. Required elements include:

i. A complete substance use history including illicit, prescription and OTC medications with a risk of abuse and a DSM diagnosis for each problematic drug;
ii. A complete addiction treatment history;
iii. Past medical and surgical history;
iv. Family history;
v. Psychosocial history, including living situation, source of income and education;
vi. Review of systems;
vii. A focused physical examination;
viii. Review of treatment options;
ix. Formulation of a treatment plan;
x. Communication with the patient and/or family to obtain information for the assessment as well as for support staff working in the treatment environment;
xi. Communication with previous care providers, including family doctors, pharmacists, Mental Health and Addictions staff, etc. as necessary;
xii. Obtain a patient profile for the previous 12 months through the Nova Scotia Prescription Monitoring Program (NSPMP) or Drug Information System (DIS);
xiii. Obtain a urine drug screen;
xiv. The physician should request blood work serology (screening for HIV, and Hepatitis A, B and C) if not done recently by a previous provider;
xv. Consider obtaining an ECG if indicated.

It is recognized that the required elements may be gathered over several visits with the patient. This fee is for the initial visit only.

Billing Guidelines

- Reportable only by the health care provider who is most responsible for the patient's ongoing OAT in the community primary care setting
- Once per patient per health care provider
- Applies only to patients transferred from a recognized Opioid Use Disorder Treatment Program
- Not reportable by health care providers who have previously seen the patient in a recognized Opioid Use Disorder Treatment Program

Specialty Restriction
SP=GENP

Premium
TI=GPEW

Location
LO=OFFC

Category	Code	Description	Base Units
VIST	03.03L	**Permanent Transfer of a patient on active Opioid Agonist Treatment (OAT) for opioid use disorder-Full acceptance of responsibility for ongoing care –Initial visit with accepting health care provider**	50MSU

Description

This is a fixed fee available to the primary care provider accepting full and ongoing responsibility for OAT for the patient's substance use disorder from the community health care provider currently providing care, due to a patient's relocation or desire for permanent change in health care provider. The required elements of this service are outlined below and must be documented in the patient's health record. Required elements include:

- A complete substance use history including illicit, prescription and OTC medications with a risk of abuse and a DSM diagnosis for each problematic drug;
- A complete addiction treatment history;
- Past medical and surgical history;
- Family history;
- Psychosocial history, including living situation, source of income and education;

BACK TO CONTENTS

- Review of systems;
- A focused physical examination;
- Review of treatment options;
- Formulation of a treatment plan;
- Communication with the patient and/or family to obtain information for the assessment as well as for support staff working in the treatment environment;
- Communication with previous care providers, including family doctors, pharmacists, Mental Health and Addictions staff, etc. as necessary;
- Obtain a patient profile for the previous 12 months through the Nova Scotia Prescription Monitoring Program (NSPMP) or Drug Information System (DIS);
- Obtain a urine drug screen;
- The physician should request blood work serology (screening for HIV, and Hepatitis A, B and C) if not done recently by a previous provider;
- Consider obtaining an ECG if indicated.

It is recognized that the required elements may be gathered over several visits with the patient. This fee is for the initial visit only. Regular visit fees may be billed for subsequent visits.

Billing Guidelines

- Reportable only by the health care provider who is most responsible for the patient's ongoing OAT
- Once per patient per health care provider
- Reportable only by the accepting health care provider
- Not reportable for health care providers within the same group practice
- Not reportable by health care providers who have previously seen the patient in a recognized Opioid Use Disorder Treatment Program

Specialty Restriction
SP=GENP

Premium
TI=GPEW

Location
LO=OFFC

NEW FEES

Effective February 8th, 2019, HSC **MMM1 and MMM2** have been terminated and replaced with **OAT1 and OAT2**:

Category	Code	Description	Base Units
DEFT	OAT1	**Opioid Agonist Treatment (OAT) Monthly Management Fee for the Comprehensive Primary Care Provider Only** **ME=CARE**	60MSU

Description
This fee may be billed once per month by the comprehensive primary care provider, outside of the Opioid Use Disorder Treatment Program, who is most responsible for providing opioid agonist treatment (OAT) as defined by current DSM-criteria. The patient will be seen by the health care provider for a face to face visit or counselling session at least once per month (not including visits for urine drug screening alone). The following items are considered to be included in this service:

- All medication reviews and OAT dosage adjustments as required;
- Communicating on a regular timely basis with the pharmacy responsible for administering the patient's opioid agonist dose for the provision of safe and effective OAT: managing missed doses, checking on daily presentation at the pharmacy, helping coordinate prescriptions going to multiple pharmacies if there are Sunday or holiday closures or if a patient is travelling;
- Providing and/or coordinating care for the patient's concurrent physical and mental health conditions;
- Counselling the patient on issues related to their opioid use disorder;
- Connecting the patient to appropriate community resources;
- Providing case management and coordination of care functions, and facilitating connection with other addiction care providers;
- Arranging **random** point of care (POC) urine drug screening (UDS) appropriate to the patient's phase of treatment; To include generation of **random** UDS encounters, collection of urine, interpretation of results, documentation of the process of **randomization** and results of the screen in the health care record, and provision of feedback to the patient based on the results.
- A visit may not be claimed if the sole purpose of the patient's office encounter is to provide a urine sample.

BACK TO CONTENTS

- An annual discussion of treatment options with rationale for continued OAT must be documented in the health record.

Billing Guidelines

- Only one claim per patient per month
- Billable only by the comprehensive primary care provider working outside of the Opioid Use Disorder Treatment Program who is most actively supervising/ responsible for the patient's use of OAT (ME=CARE)
- If there is no evidence to support randomization of the POC UDS then the fee will not be paid
- Not reportable for care provided in an Opioid Use Disorder Treatment Program.
- Payment stops when the patient stops OAT
- Will not be paid unless at least 1 face to face visit or counselling session has been reported for the same patient by the same health care provider in the previous 30 day period.

Specialty Restriction
RO=GENP

Location
LO=OFFC

Category	Code	Description	Base Units
DEFT	OAT2	**Opioid Agonist Treatment (OAT) Monthly Management Fee for provision of OAT only – patient referred by another health care provider with written progress updates supplied to the primary care provider at least quarterly.**	45MSU

Description
This fee may be billed once per month by the health care provider, outside of the Opioid Use Disorder Treatment Program, who is most responsible for providing opioid agonist treatment (OAT) as defined by current DSM-criteria. The patient will be seen by the health care provider for a face to face visit or counselling session at least once per month (not including visits for urine drug screening alone). The following items are considered to be included in this service:

- All medication reviews and OAT dosage adjustments as required;
- Communicating on a regular timely basis with the pharmacy responsible for administering the patient's opioid agonist dose for the provision of safe and effective OAT: managing missed doses, checking on daily presentation at the pharmacy, helping coordinate prescriptions going to multiple pharmacies if there are Sunday or holiday closures or if a patient is travelling;
- Providing and/or coordinating care for the patient's concurrent physical and mental health conditions;
- Counselling the patient on issues related to their opioid use disorder;
- Connecting the patient to appropriate community resources;
- Providing case management and coordination of care functions, and facilitating connection with other addiction care providers;
- Arranging **random** point of care (POC) urine drug screening (UDS) appropriate to the patient's phase of treatment; To include generation of **random** UDS encounters, collection of urine, interpretation of results, documentation of the process of **randomization** and results of the screen in the health care record, and provision of feedback to the patient based on the results.
- A visit may not be claimed if the sole purpose of the patient's office encounter is to provide a urine sample.
- An annual discussion of treatment options with rationale for continued OAT must be documented in the health record.
- Written progress updates will be supplied to the patient's comprehensive primary care provider at least quarterly and documented in the health record.

Billing Guidelines

- Only one claim per patient per month
- Billable only by the comprehensive primary care provider working outside of the Opioid Use Disorder Treatment Program who is most actively supervising/ responsible for the patient's use of OAT
- If there is no evidence to support randomization of the POC UDS then the fee will not be paid
- Not reportable for care provided in an Opioid Use Disorder Treatment Program.
- Payment stops when the patient stops OAT
- Will not be paid unless at least 1 face to face visit or counselling session has been reported for the same patient by the same health care provider in the previous 30 day period.

Specialty Restriction
N/A

Location
LO=OFFC

BACK TO CONTENTS

Effective February 8th, 2019, HSC OFI1 is available for billing:

Category	Code	Description	Base Units
ADON	OFI1	**Incentive for use of Official Interpreter services when caring for a patient of limited English proficiency (LEP)**	5MSU

Description
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.

Billing Guidelines
This incentive may be added on to the appropriate visit code when the services of an official interpreter are required to facilitate a clinical encounter with a patient of Limited English Proficiency (LEP).
Available only for face to face or real time PHIA compliant technology encounters.

Documentation Requirements
The official identification number of the interpreter must be documented in the health record.

Specialty Restriction
N/A

Location
N/A

PREAMBLE CHANGES

GP EVENING AND WEEKEND INCENTIVE (5.1.188)

Current Definition	New Definition
GP EVENING AND WEEKEND INCENTIVE *(5.1.188)*	**GP ENHANCED HOURS PREMIUM**
This incentive program is intended to promote enhanced evening and weekend access to primary care services provided in the offices of fee-for-service family physicians who have an established practice and provide comprehensive and on-going care for their patients. *(5.1.189)* Billing Guidelines: • The eligible time periods for claiming the evening and weekend office visit incentive are 6 – 10p.m. during weekday evenings and 9 a.m. – 5 p.m. on weekends (Saturday and Sunday). • Physicians should offer and book appointments during these time periods in the same manner as they would for other (weekday) office hours. • Evening and weekend services eligible for incentive funding are office visit services provided in a community-based family practice in which the physician maintains a comprehensive patient chart to record all patient encounters, provides all necessary follow-up care for each encounter and takes responsibility for initiation and follow-up on all related referrals. • Eligible physicians may claim an incentive for evening and weekend office services provided for their own patients as well as for patients from the stable patient roster of other eligible physicians within the same practice location, providing the patient's record can be accessed and the encounter is recorded. • Services provided in walk-in clinics are not eligible for the evening and weekend office visit incentive funding program. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no	This premium in 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

BACK TO CONTENTS

Current Definition	New Definition
requirement for an appointment, and episodic care with little or no follow-up. There is no standard patient roster and the patient list is constantly changing.*(5.1.190)*	episodic care with little or no follow-up. Walk in clinics have no standard patient panel and the patient list is constantly changing.
The following office services are eligible for the 25% evening and weekend incentive providing all other eligibility criteria are met. 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. *(5.1.191)* NOTE: For services where the evening and weekend incentive has been claimed, a record must be maintained and readily available to verify that the patient was booked for an appointment during an incentive-eligible time period. The appointment time should be recorded in the patient's record or office appointment books retained. *(5.1.192)* APP contract physicians can shadow bill the GP Evening and Weekend Office Visit Incentive (GPEW) *(5.1.193)* The evening and weekend office visit incentive should not be claimed in circumstances where the patient is booked for an appointment time that is not eligible for the incentive and then the physician "runs late". *(5.1.194)*	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".

Time Period	Time	Payment Rate
Monday to Friday	6:00a.m – 8:00a.m	TI=GPEW (25% premium)
Monday to Friday	5:00p.m – 10:00p.m	TI=GPEW (25% premium)
Saturday and Sunday	9:00a.m – 10:00p.m	TI=GPEW (25% premium)
Recognized Holidays	9:00a.m – 10:00p.m	TI=GPEW (25% premium)

Billing Matters Billing Reminders, Updates, New Explanatory Codes

BILLING REMINDERS

Routine Prenatal Care 5.2.72
Physicians are reminded that any prenatal visit, limited or comprehensive, includes a Pap smear when medically indicated. However, a Pap smear is not required in order to bill a prenatal visit.

Hypnotherapy 5.2.145
Physicians practicing hypnotherapy must have at least 20 hours of training in clinical hypnotherapy and be an active member in good standing of a recognized Canadian Clinical Hypnosis society.

2019 Cut Off Dates
Please be advised there have been some adjustments made to the 2019 cut off dates. See attachment.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
VA093	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS IT IS INCLUDED IN THE REMUNERATION OF ANOTHER SERVICE RECENTLY BILLED FOR THIS PATIENT.

BACK TO CONTENTS

Code	Description
AD082	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE INTERPRETER INCENTIVE MAY ONLY BE CLAIMED AFTER A VISIT OR CONSULT DURING THE SAME SERVICE OCCURRENCE.
DE034	SERVICE ENCOUNTER HAS BEEN REFUSED AS THERE HAVE BEEN NO SERVICES CLAIMED BY YOU FOR THIS PATIENT IN THE PREVIOUS 30 DAYS.
GN100	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST SUBMIT YOUR SIGNED PHYSICIAN CONFIRMATION LETTER IN ORDER TO BILL THE ENHANCED FEES FOR OFFICE AND GERIATRIC VISITS.
GN101	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE IS NOT BILLABLE FROM A HOSPICE FACILITY.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday February 8th, 2019. The files to download are health service (SERVICES.DAT), health service description (SERV_DESC.DAT), modifiers (MODVALS.DAT) and, explanatory codes (EXPLAIN.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

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

In partnership with

NOVA SCOTIA

BACK TO CONTENTS

2019 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE	SALARY CONTRACT PAY PERIOD
December 19, 2018**	**December 24, 2018****	January 2, 2019	December 14-27, 2018
January 7, 2019	January 10, 2019	January 16, 2019	December 28, 2018-January 10, 2019
January 21, 2019	January 24, 2019	January 30, 2019	January 11-24, 2019
February 4, 2019	February 7, 2019	February 13, 2019	January 25-February 7, 2019
February 15, 2019**	February 21, 2019	February 27, 2019	February 8-21, 2019
March 4, 2019	March 7, 2019	March 13, 2019	February 22-March 7, 2019
March 18, 2019	March 21, 2019	March 27, 2019	March 8-21, 2019
April 1, 2019	April 4, 2019	April 10, 2019	March 22-April 4, 2019
April 12, 2019**	**April 17, 2019****	April 24, 2019	April 5-18, 2019
April 29, 2019	May 2, 2019	May 8, 2019	April 19-May 2, 2019
May 10, 2019**	**May 15, 2019****	May 22, 2019	May 3-16, 2019
May 27, 2019	May 30, 2019	June 5, 2019	May 17-30, 2019
June 10, 2019	June 13, 2019	June 19, 2019	May 31-June 13, 2019
June 21, 2019**	**June 26, 2019****	July 3, 2019	June 14-27, 2019
July 8, 2019	July 11, 2019	July 17, 2019	June 28-July 11, 2019
July 22, 2019	July 25, 2019	July 31, 2019	July 12-25, 2019
August 2, 2019**	August 8, 2019	August 14, 2019	July 26-August 8, 2019
August 19, 2019	August 22, 2019	August 28, 2019	August 9-22, 2019
August 30, 2019**	September 5, 2019	September 11, 2019	August 23-September 5, 2019
September 16, 2019	September 19, 2019	September 25, 2019	September 6-19, 2019
September 30, 2019	October 3, 2019	October 9, 2019	September 20-October 3, 2019
October 11, 2019**	October 17, 2019	October 23, 2019	October 4-17, 2019
October 28, 2019	October 31, 2019	November 6, 2019	October 18-31, 2019
November 8, 2019**	November 14, 2019	November 20, 2019	November 1-14, 2019
November 25, 2019	November 28, 2019	December 4, 2019	November 15-28, 2019
December 9, 2019	December 12, 2019	December 18, 2019	November 29-December 12, 2019
December 19, 2019**	**December 22, 2019****	December 31, 2019	December 13-26, 2019
January 6, 2020	January 9, 2020	January 15, 2020	December 27, 2019-January 9, 2020
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	TUESDAY, JANUARY 1, 2019
HERITAGE DAY	MONDAY, FEBRUARY 18, 2019
GOOD FRIDAY	FRIDAY, APRIL 19, 2019
EASTER MONDAY	MONDAY, APRIL 22, 2019
VICTORIA DAY	MONDAY, MAY 20, 2019
CANADA DAY	MONDAY, JULY 1, 2019
CIVIC HOLIDAY	MONDAY, AUGUST 5, 2019
LABOUR DAY	MONDAY, SEPTEMBER 2, 2019
THANKSGIVING DAY	MONDAY, OCTOBER 14, 2019
REMEMBRANCE DAY	MONDAY, NOVEMBER 11, 2019
CHRISTMAS DAY	WEDNESDAY, DECEMBER 25, 2019
BOXING DAY	THURSDAY, DECEMBER 26, 2019
NEW YEAR'S DAY	WEDNESDAY, JANUARY 1, 2020