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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 | Base Units |
|---|---|---|---|
| CONS | 03.09K | **Specialist Telephone Advice – Consultant Physician – providing advice** | 25 MSU |
| | 03.09L | **Specialist Telephone Advice – Referring Physician – requesting advice** | 11.5 MSU |

**Description**

This health service code may be reported for a two-way telephone (or other synchronous electronic verbal communication) regarding the assessment and management of the patient but without the consulting physician seeing the patient.
The referring physician may be a family physician or other specialist seeking an expert opinion from the consulting physician due to the complexity and severity of the case and with the intent of continuing to provide the patient's care closer to home. The consultant specialist may also receive requests for advice from a nurse practitioner.
The referring physician (or NP) must communicate to the specialist the reason for the consultation and relevant patient information through verbal, written or electronic communication, either before or within four business days after the telephone call. The referring physician must document that this information was supplied to the specialist.
There must be a two-way verbal communication discussing the clinical situation followed by a management decision and a written report from the specialist to the referring provider.
The formal consultation report must be available in the patient's medical record, both the referring physician (or NP) and the specialist must maintain copies of this document, both medical records must include the date and time of the service and any contemporaneous notes, in addition to the written documents.
The service is reportable by the specialist for a new patient or an established patient with a new condition or an exacerbation of an existing condition.

**Billing Guidelines**

The HSC includes a review of the patient's relevant history, relevant family history and relevant history of present complaint, and a review of any laboratory data, PACS images, medical records or other data as needed to provide advice. The health service includes a discussion of the relevant physical findings as reported by the referring provider.
If subsequent phone calls are necessary within 14 days to complete the consultation, they are considered included in the HSC for the telephone consultation.
The Consultant Physician HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.
The Referring Physician HSC may be reported when the telephone call for an urgent consultation occurs on the same day as the patient visit that generated the consultation.

The HSC is not reportable when the purpose of the communication is to:

- Arrange transfer
- Arrange a hospital bed for the patient
- Arrange a telemedicine consultation
- Arrange an expedited face to face consultation
- Arrange a laboratory, other diagnostic test or procedure

- Inform the referring physician of the results of diagnostic investigations
- Decline the request for a consultation or transfer the request to another physician

The service is not reportable for other forms of communication such as:
- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant

The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another health professional such as:
- Nurse practitioner
- Resident in training
- Clinical fellow
- Medical student

The service is not reportable by the consulting physician if the patient has had a face to face visit with the consultant or any member of his/her call group within the previous 14 days for the same condition or if the telephone consultation results in a face to face service within the next 14 days or the next available appointment of the consultant.
The service is not reportable for telephone calls of less than 5 minutes of two-way medical discussion. The service is not reportable for calls between a referring provider and specialist in the same institution or practice location.

**Documentation Requirements**
- The referring physician must document that s/he has communicated the reason for the consultation and relevant patient information to the specialist
- Both the specialist consultant and the referring provider must document the patient name, identifying data, date and start and stop time of the call in their respective charts or EMRs.
- The names of the referring physician (or NP) and the consultant physician must be documented by both physicians.
- The diagnosis, reason for referral, elements of the history and physical as relayed by the referring provider, the opinion of the consultant physician and the plan for future management must be documented.
- A written report must be sent to the referring provider by the specialist consultant.
- The referring physician's billing number must be noted on the electronic claim.
- Both physicians must submit the start and stop time of the call in the text field on the MSI service report.

**Specialty Restriction**
N/A

**Location**
LO=OFFC

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03R | **Family Physician Telephone Management/Follow Up with Patient**<br><br>**Description:**<br>This health service code may be reported for a 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. 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 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 is not required. The patient population eligible must be either 65 years and older or be suffering from mental illness or suffering from at least one chronic disease.<br><br>Chronic disease is defined as:<br>o A condition expected to last one year or more<br>o This condition requires ongoing medical management<br>Mental illness is defined as:<br>o A condition that meets criteria for a DSM diagnosis. | 11.5 MSU |

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

**Billing Guidelines:**
This health service is reportable for a synchronous communication by telephone (or other PHIA compliant synchronous electronic verbal communication) between the family physician and the patient (or the patient's parent, guardian or proxy as established by written consent)
Telephone management requires synchronous communication between the patient and physician on a clinical level; the HSC is not reportable for administrative tasks.
The call must include a discussion of the clinical problem and management decision.
The family physician must have seen and examined the patient within the preceding 9 months.
The HSC is reportable for a maximum of 4 times per patient per year by the family physician and/or the practice providing ongoing comprehensive care to the patient.
The HSC is not reportable by walk-in clinics. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no requirement for an appointment, and episodic care with little or no follow-up. There is no standard patient roster and the patient list is constantly changing.
The HSC is not reportable for facility-based patients.
The HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.
The service is not reportable when the purpose of the communication is to:

- Arrange a face-to-face appointment
- Notify the patient of an appointment
- Prescription renewal
- Arranging to provide a sick note
- Arrange a laboratory, other diagnostic test or procedure
- Inform the patient of the results of diagnostic investigations with no change in management plan

This service is not reportable for other forms of communication such as:

- Written, e-mail or fax communication
- Electronic verbal forms of communication that are not PHIA compliant.

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

- Nurse Practitioner
- Resident in training
- Clinical fellow
- Medical student
- Clerical staff

The service is not reportable for telephone calls of less than 5 minutes of synchronous medical discussion

**Documentation Requirements:**

- The date, start and stop times of the conversation must be noted in the medical record
- The medical record must indicate the content of the discussion, the management plan and that the patient (or the patient's parent, guardian or proxy as established by written consent) understands and acknowledges the information provided.
- The start and stop time of the call must be included in the text field of the MSI claim

**Specialty Restriction:**
SP=GENP

**Location:**
LO=OFFC

| | | | |
|---|---|---|---|
| VIST | 03.03Q | **Specialist Telephone Management/Follow Up with Patient** | 11.5 MSU |

**Description:**
This health service code may be reported for a 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.
This service is not reported if the outcome of the 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.

**Billing Guidelines:**
This health service is reportable for a synchronous communication by telephone (or other PHIA compliant synchronous electronic verbal communication) between the specialist physician and the patient (or the patient's parent, guardian or proxy as established by written consent)
Telephone management requires synchronous communication between the patient and physician on a clinical level; the HSC is not reportable for administrative tasks.
The call must include a discussion of the clinical problem and management decision.
The specialist physician must have seen and examined the patient within the preceding 9 months.
The HSC is reportable for a maximum of 4 times per patient per physician per year.
The HSC is not reportable for facility-based patients.
The HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.
The service is not reportable when the purpose of the communication is to:

- Arrange a face-to-face appointment
- Notify the patient of an appointment
- Prescription renewal
- Arrange a laboratory, other diagnostic test or procedure
- Inform the patient of the results of diagnostic investigations with no change in management plan

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

- Nurse Practitioner
- Resident in training
- Clinical fellow
- Medical student
- Clerical staff

The service is not reportable for telephone calls of less than 5 minutes of synchronous medical discussion.

**Documentation Requirements:**

- The date, start and stop times of the conversation must be noted in the medical record
- The medical record must indicate the content of the discussion, the management plan and that the patient (or the patient's parent, guardian or proxy as established by written consent) understands and acknowledges the information provided.
- A written report must be sent to the referring physician or family physician by the specialist consultant
- The start and stop time of the call must be included in the text field of the MSI claim

**Location:**
LO=OFFC

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)**<br><br>**Description**<br>This is a comprehensive code for the removal of neurostimulator electrodes such as stereoelectroencephalography (SEEG) electrodes.<br><br>**Specialty Restriction:**<br>SP=NUSG, SP=PEDI<br><br>**Location:**<br>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.**<br><br>**Description**<br>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.<br><br>**Specialty Restriction:**<br>SP=NEPH<br><br>**Location:**<br>LO=HOSP (QEII only) | 125 MSU |
| VEDT | 66.98F | **Removal of Tunneled Intraperitoneal Catheter (for use in dialysis)**<br><br>**Description**<br>This is a comprehensive code for the removal of tunneled intraperitoneal catheter, it includes all services required to remove the device and close the wound.<br><br>**Specialty Restriction:**<br>SP=NEPH<br><br>**Location:**<br>LO=HOSP (QEII only) | 75 MSU |
| VEDT | 66.98G | **Repositioning of Tunneled Intraperitoneal Catheter for use in dialysis**<br><br>**Description**<br>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.<br><br>**Specialty Restriction:**<br>SP=NEPH<br><br>**Location:**<br>LO=HOSP (QEII only) | 75 MSU |

The following Interim Health Service code is effective July 23, 2021

| Category | Code | Description | Base Units | Anaes Units |
|---|---|---|---|---|
| VEDT | 47.25C | **Transcutaneous Aortic Valve Implantation (TAVI)**<br><br>**First Physician (RO=FPHN)**<br>**Second Physician (RO=SPHN)**<br><br>**Description**<br>This comprehensive health service code includes all physician work required to perform a transcutaneous aortic valve implantation. This work includes, when performed percutaneous and/or open arterial cardiac access, placement of any sheath required, balloon aortic valvuloplasty, delivery, deployment and placement of the valve, temporary pacemaker insertion and closure of access sites. All means used to guide the procedure such as contrast injections, angiography, fluoroscopy, right and left cardiac catheterization, supravalvular aortography, aortic and left ventricular outflow tract measurements are included such that any radiological supervision and interpretation should not be reported or claimed.<br><br>**Billing Guidelines**<br>Do not report with the following same patient same day: | 611 MSU<br>611 MSU | 15+T |

- 47.03 - Closed heart valvotomy, aortic valve
- 47.25 - Other replacement of aortic valve
- 47.52A - Closure of arterial septal defect
- 49.73 - Implantation of endocardial electrodes
- 50.82 - Aortography
- 50.82C - Aortic arch study
- 50.91 - Arterial catheterization
- 50.99C - Femoral vein puncture
- 51.61B - Off pump coronary artery bypass surgery

Do not report with:

R1071 - Aortic root (cardiac)

**Specialty Restriction:**
SP=CASG, SP=CARD, SP=GNSG

**Location:**
LO=HOSP (QEII only)

The following Interim Health Service codes are effective May 1, 2022

| Category | Code | Description | Base Units |
|---|---|---|---|
| VADT | 09.13C | **Ophthalmic Ultrasound of the anterior segment by High Resolution Biomicroscopy or immersion B-scan (water bath) for the assessment of the anterior chamber, unilateral or bilateral.**<br><br>**Description**<br>Assessment of one or both anterior chambers by high resolution ultrasound. If a complete ophthalmic US (A-scan or B-scan) is provided by the same physician, claim for only one or the other but not both. Not to be used for glaucoma screening. May be claimed only when the service is personally rendered by the physician.<br><br>**Billing Guidelines**<br>Not billable with:<br>• 09.13A real time (eye) ultrasound<br><br>**Specialty Restriction:**<br>SP=OPHT with training in ocular oncology<br><br>**Location:**<br>LO=OFFC | 38.7 MSU |

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

The following Interim Health Service codes are effective May 11, 2022

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

| Category | Code | Description | Base Units | Anae Units |
|---|---|---|---|---|
| MASG | 97.44A | **Feminization of chest wall**<br>**Prior Approval/Preauthorization required (PA)**<br><br>**Description**<br>Complete feminization of the chest wall for the surgical treatment of well documented persistent gender dysphoria to include bilateral augmentation mammoplasty with insertion of prosthesis or prostheses, nipple-areolar reconstruction, advancement flaps, tissue shifts, complex wound closure and initial scar camouflage as required. No additional uninsured services may be performed or charged to the patient during this surgical encounter.<br><br>**Billing Guidelines**<br>• Must have prior approval from MSI for gender affirming surgery (GAS) based on a complete and approved GAS application which is available online: https://novascotia.ca/dhw/gender-affirming-surgery/<br>• May not be claimed with:<br>o Augmentation Mammoplasty HSC's: 97.43, 97.44<br>o Insertion of tissue expander HSC: 98.98<br>o Breast Reconstruction HSC's: 97.6B, 97.6C, 97.6D, 97.75A<br>o Reconstruction of nipple HSC: 97.77<br>o Tissue shift/graft HSC's to include, but not limited to: 98.51B, 98.51C, 98.51D, 98.51E<br>• Once per patient per lifetime<br><br>RO=SRAS applicable<br><br>**Specialty Restriction:**<br>SP=PLAS (non fee for service)<br><br>**Location:**<br>LO=HOSP | 350 MSU | 4+T |

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

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

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

The following Interim Health Service code is effective November 25, 2022

| Category | Code | Description | Base Units | Anae Units |
|---|---|---|---|---|
| MASG | 26.29F | **Glaucoma surgery (such as stent insertion) ab interno approach, for the relief of intraocular pressure**<br><br>**Description**<br>This fee is for the surgical treatment of glaucoma via the ab interno approach for procedures such as stent insertion<br><br>**Billing Guidelines:**<br>May be claimed once per eye per surgical encounter<br>Not billable with the following MASG codes:<br>• 26.25 – Trabeculectomy on an eye with a previous major ocular procedure with or without post op laser suture lysis<br>• 26.25D – Trabeculectomy with the use of anti-metabolites with or without post op laser suture lysis<br>• 26.29D – Trabeculoplasty<br>• 26.29E – Placement of glaucoma tube shunt<br>• 26.34 – Trabeculectomy ab externo<br><br>**Modifiers (regions required):**<br>RG=RIGT, RG-LEFT, RG=BOTH<br><br>**Premium Eligible:**<br>Yes<br><br>**Specialty Restriction:**<br>SP=OPHT<br><br>**Location:**<br>LO=HOSP | 175 MSU | 6+T |