## CONTENTS



## 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 **+ MU** |
| CONS | 03.09L | Specialist Telephone Advice – Referring Physician – requesting advice | 13 MSU **+ MU** |

**Description**

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

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

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

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

The referring physician or provider must document:

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

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

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

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

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

| Category | Code | Description | Base Units |
|---|---|---|---|
| | | - Inform the referring physician of the results of diagnostic investigations<br>- Decline the request for a consultation or transfer the request to another physician<br><br>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:<br>- Nurse practitioner<br>- Resident in training<br>- Clinical fellow<br>- Medical student<br><br>This service is not reportable for telephone calls or face to face conversations of less than 5 minutes of two-way medical discussion.<br>If the discussion exceeds 24 minutes, multiple units may be claimed in 15-minute increments up to a total of maximum time of 60 minutes for the entire encounter. Where MU are claimed, start and stop times must be recorded in the patient's health record and in the text of the claim. Multiples may not be claimed for asynchronous services.<br><br>**Documentation Requirements**<br>• The referring physician or provider must document that he/she/they have communicated the reason for the consultation and relevant patient information to the consultant physician<br>• Both the consultant physician and the referring health care provider must document the patient's name, identifying data, date and encounter time in their respective charts or EMRs.<br>• The names of the referring health care provider and the consultant physician must be documented by both the referring health care provider and the consultant physician.<br>• The diagnosis, reason for referral, elements of the history and physical as relayed by the referring health care provider, the opinion of the consultant physician and the plan for future management must be documented by the referring health care provider and the specialist consultant. The consulting physician may use a copy of the documentation from the referring health care provider to support this HSC claim, but it must be reviewed and 'signed off' by the consulting physician.<br>• A written report must be sent to the referring health care provider by the specialist consultant. The specialist consultant may satisfy this requirement by returning a copy of the documentation from the referring provider as long as it was reviewed and 'signed off' by the consultant physician.<br>• The referring health care provider's billing number must be noted on the claim from the consultant. This is not required for the referring health care provider's claim.<br><br>**Billing Guidelines**<br>• The consultant physician service is not reportable in addition to any other service for the same patient by the same physician on the same day.<br>• The referring health care provider service may be reported when the communication with the consultant occurs on the same day as the patient visit or other service.<br><br>**Multiples:**<br>03.09K 17.5 MSU per 15 minutes<br>03.09L 13 MSU per 15 minutes<br><br>**Specialty Restriction:**<br>SP=GENP, SP=PSYC, SP=INMD, SP=PEDI, SP=OBGY<br><br>**Location:**<br>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 | 11.5 MSU |

| Category | Code | Description | Base Units |
|---|---|---|---|

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.

Chronic disease is defined as:
- A condition expected to last one year or more
- This condition requires ongoing medical management

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.

**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

| Category | Code | Description | Base Units |
|---|---|---|---|
| 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>**First Physician (RO=FPHN)**<br>**Second Physician (RO=SPHN)**<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>**Billing Guidelines**<br>Do not report with the following same patient same day:<br>• 47.03 – Closed heart valvotomy, aortic valve<br>• 47.25 – Other replacement of aortic valve<br>• 47.52A – Closure of arterial septal defect<br>• 49.73 – Implantation of endocardial electrodes<br>• 50.82 – Aortography<br>• 50.82C – Aortic arch study<br>• 50.91 – Arterial catheterization<br>• 50.99C – Femoral vein puncture<br>• 51.61B – Off pump coronary artery bypass surgery<br>Do not report with:<br>R1071 – Aortic root (cardiac)<br>**Specialty Restriction:**<br>SP=CASG, SP=CARD, SP=GNSG<br>**Location:**<br>LO=HOSP (QEII only) | 611 MSU<br>611 MSU | 15+T |

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>**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>**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>  ○ Mastectomy HSC's: 97.12, 97.13, 97.14, 97.15, 97.31A, 97.31C, 97.32, 97.32B<br>  ○ Reconstruction of nipple HSC: 97.77<br>  ○ 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>RO=SRAS applicable<br>**Specialty Restriction:**<br>SP=PLAS<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<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 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>**Regions (Required)**<br>RG=LEFT, RG=RIGT, RG=BOTH<br><br>**Specialty Restriction:**<br>SP=PLAS<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<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<br><br>**Location:**<br>LO=OFFC | 36 MSU |

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

| Category | Code | Description | Base Units |
|---|---|---|---|
| DEFT | TPR1 | **Telephone Prescription Renewal**<br><br>**Description**<br>This service is billable by a family physician when the physician is requested by a patient to communicate a prescription renewal by telephone, fax, or email without seeing the patient.<br><br>**Billing Guidelines**<br>• Documentation on the patient's chart must include the name of the pharmacy, as well as the drug, dose, and amount prescribed.<br>• This HSC is not to be billed for writing new prescriptions.<br>• This HSC may not be billed if the physician sees the patient (face to face or virtually) on the same day.<br>• May not be billed more than 4 times per year per patient per provider.<br><br>**Specialty Restriction:**<br>SP=GENP | 4 MSU |

| Category | Code | Description | Base Units |
|---|---|---|---|
| DEFT | AHCP1 | **Allied Health Care Provider to Physician**<br><br>**Description**<br>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.<br><br>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.<br><br>**Billing Guidelines**<br>• The allied health care providers must work outside of the physician's practice<br>• Telephone calls initiated by the patient, or patient's family member may not be billed under this code<br>• All interactions must be recorded in the patient's chart, including the time of the call, the name and professional capacity of the allied healthcare worker involved, the medical issue addressed, and the advice given<br>• 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<br>• Claims, outside the pharmacy pilot, can only be made for physician interaction and not for staff (clerks, nurses etc.) of the physician<br>• 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<br>• This fee code may not be billed with the Telephone Prescription Renewal<br>• Only billable once per patient per day per physician<br>• May not be billed more than 15 times per physician per week<br>• 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<br><br>**Specialty Restriction:**<br>SP=GENP<br><br>**Location:**<br>LO=OFFC | 7.5 MSU |

| Category | Code | Description | Base Units |
|---|---|---|---|
| DEFT | NPIV1 | **New Patient Intake Visit**<br><br>**Description**<br>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)<br><br>**Billing Guidelines**<br>• 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.<br>• 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.<br>• Physician must submit ME=CARE declaration letter before billing any NPIV services.<br>• 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.<br>• 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.<br>• The NPIV fee code can only be billed once per patient per physician.<br>• May not be billed with any other visit code or procedure code at the same encounter.<br>• Not applicable for virtual care.<br><br>**Multiples:**<br>17 MSU per 15 minutes to a maximum of 5 multiples (90 minutes)<br><br>**Premium Eligible:**<br>TI=GPEW<br><br>**Specialty Restriction:**<br>SP=GENP<br><br>**Location:**<br>LO=OFFC, LO=NRHM*<br>*For physicians who have Nursing Home incorporated in their LFM hours | 34 MSU<br>+MU |

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

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

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

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

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

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

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

**Premium Eligible:**
TI=GPEW

**Specialty Restriction:**
SP=GENP

**Location:**
LO=OFFC

| Category | Code | Description | Base Units |
|---|---|---|---|
| VIST | 03.03 | **Prolonged Nursing Home Visit**<br><br>**Description**<br>This service is paid to physicians who are delivering patient care to residents in nursing homes. This fee is to be billed for all residents of the nursing home, whether the first patient or extra patient. Prolonged nursing home visits are paid in 15-minute time blocks or portion thereof, 80% of the time must be direct physician to patient contact. Prolonged nursing home visits are not to be confused with active treatment associated with detention.<br><br>**Billing Guidelines**<br>• Each nursing home visit can be billed up to a maximum of 60 minutes per patient per day. This would include a base visit plus up to 3 additional multiples of 15 minutes each.<br>• 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.<br>• Multiples are not applicable for virtual care.<br><br>**Multiples:**<br>17 MSU per 15 minutes to a maximum of 4 multiples (60 minutes) per day<br><br>**Modifiers:**<br>TI=EVNT = Time 1701-2000 – 28.3 MSU + MU (22.95 MSU per 15 minutes)<br>TI=ETMD = Time 2001-2359 – 28.3 MSU + MU (22.95 MSU per 15 minutes)<br>TI=MDNT = Time 0000-0800 – 38.3 MSU + MU (25.5 MSU per 15 minutes)<br>DA=RGE1, TI=AMNN = Time 0801 – 1200, Sat., Sun., Holidays – 28.3 MSU + MU<br>DA=RGE1, TI=NNEV= Time 1201 – 1700, Sat., Sun., Holidays – 28.3 MSU + MU<br><br>**Specialty Restriction:**<br>SP=GENP<br><br>**Location:**<br>LO=NRHM | 21.3 MSU +MU |