PHYSICIAN'S BULLETIN

May 24, 2024: Vol. LXIX, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

Public Health – COVID-19 Vaccines

This fall, physicians will be able to offer COVID-19 vaccines to their patients. Vaccine products will include Moderna for individuals 6 months and older, Pfizer for individuals 12 years and older (no pediatric or infant formulation will be available), and Novavax for individuals 12 years and older. More details will be provided in early September when the provincial publicly funded influenza and COVID-19 immunization programs are finalized.

While pharmacists continue to utilize CANImmunize to assist with appointment booking and documentation, physicians are not required to use this system, and can enter the vaccination record directly into their EMR system. Physicians using CANImmunize can continue to do so or can switch to the EMR for documentation purposes.

As a reminder, the NSH Provincial EMRs & Integrated Solutions website contains helpful guides, tips and templates for EMR use.

Public Health – Measles Vaccination

The publicly funded immunization program eligibility for measles containing vaccines is now updated due to the risk of importation of a case of measles case into Nova Scotia associated with travel.

Please see full eligibility for measles containing vaccines on pages 9 and 10 of the Publicly Funded Vaccine/Immunoglobulin Eligibility Policy.

Physicians who were holding 13.59L RO=MMRT PT=RISK claims for patients born prior to 1970 may now be submitted.

In addition, effective April 3, 2024 the eligibility for 13.59L RO=MMAR also includes:

- Students born before 1970 in post-secondary education settings are eligible for 1 dose of measles-containing vaccine.
- Health care workers regardless of age/year of birth are eligible for 2 doses of measles-containing vaccine.

For MMR vaccine given for travel purposes:
(Infants 6 months to less than 12 months and adults born before 1970)
13.59L RO=MMRT, PT=RISK Measles, Mumps, Rubella vaccine for travel to areas at risk for measles: text required to indicate travel/risk

For MMRV vaccine given in the routine childhood schedule:
13.59L RO=MMRV Measles, Mumps, Rubella and Varicella vaccine

For routine MMR vaccine given in the routine adult schedule:
13.59L RO=MMAR Measles, Mumps, Rubella vaccine

FEE UPDATE

Category	Code	Description	Base Units
ADON	13.59L	Injection for pneumococcal pneumonia, bacteraemia and meningitis (Pneumovax or Prevnar 20) **RO=PNEU** **Billing Guidelines** Maximum doses per lifetime will be increased from 3 to 5. Patient must be minimum 6 weeks old. Text is required when claiming with high-risk modifier (PT=RISK)	6 MSU
ADON	13.59L	Pneumococcal conjugate vaccine (Prevnar 13 or Vaxneuvance) **RO=PNEC** **Billing Guidelines** Maximum 4 doses per lifetime, a 4th dose will no longer require the PT=RISK modifier. Patient must be minimum 6 weeks old. Text is required when claiming with high-risk modifier (PT=RISK)	6 MSU

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NEW FEES

Effective May 24, 2024 the following health service codes are available for billing:

The new HSC must meet the established Facility On-Call billing guidelines for a Level 1 Rota.

Health Service Code	Description	Weekday	Weekend/Holidays (DA=RGE1)
F1040	Inpatient Withdrawal Management	$350	$500

F1040 is not tied to a specific facility/site but must be submitted using facility # 165388
May only be claimed one per day per physician.

Health Service Code	Description	Weekday	Weekend/Holidays (DA=RGE1)	Approved Facility
F1041	Recovery Support Center	$350	$500	Dartmouth Recovery Support Center (165388FACILITY)

INTERIM FEE UPDATES

Category	Code	Description	Base Units
DEFT	NPIV1	**New Patient Intake Visit** **Description** A new patient intake visit may be billed when a family physician accepts a new patient into their office practice and arranges an appointment for the purpose of gathering a detailed medical and social history in order to establish an ongoing patient-physician relationship and to construct the patient's medical record. Includes review of clinical documents prior to the visit and establishment of medical record on the same day. (Includes face to face and non-face to face time) **Billing Guidelines** • Such an encounter shall include documentation of the new patient's current health status, past medical history, relevant social and family history, and a list of current medications and allergies, as well as any physical examination as clinically appropriate. All components of this service must be completed on the same day. • If a medically necessary service is indicated during the initial visit, the time taken to address this can contribute to the multiples claimed. This fee is considered to compensate for a medically necessary service, if required at the initial visit. • Physician must submit ME=CARE declaration letter before billing any NPIV services. • The fee can only be billed once per physician per patient when the physician is first accepting the patient into their attached roster, it cannot be billed for patients already on your roster. For physicians in a collaborative practice, you may bill the NPIV1 when you are accepting a patient from a retiring/relocating physician within your collaborative	34 MSU +MU

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Category	Code	Description	Base Units

practice for whom you may have billed ME=CARE in the past, as long as the patient is new to your panel.

- For New Patient Intake Visits that are less than 30 minutes (including both the face to face and non-face to face time), the physician should bill fee code NPIV1 with one multiple. For New Patient Intake Visits that are greater than 30 minutes the physician can bill a maximum of 5 multiples, i.e., 90 minutes. Prolonged office visits are paid in 15-minute time blocks or portion thereof. When billing multiples, start and stop times of the encounter time must be documented in the health record and on the text field of the claim.
- The NPIV fee code can only be billed once per patient per physician.
- May not be billed with any other visit code or procedure code at the same encounter.
- Not applicable for virtual care.
- **When billed in the Nursing Home location (LO=NRHM), the following rules apply:**
  - **Only the physician most responsible for the ongoing primary care of the patient may use this code**
  - **Physicians on the LFM payment model must have Nursing Home/ Long Term Care included in their LFM hours to use this code; LFM physicians who see patients in Nursing Home / Long Term Care outside of their LFM hours may not use this code.**

Multiples:
17 MSU per 15 minutes to a maximum of 5 multiples (90 minutes)

Premium Eligible:
TI=GPEW

Specialty Restriction:
SP=GENP

Location:
LO=OFFC, LO=NRHM, **LO=HOME**

Nursing Home Attachment Initiative

Until July 31, 2024, family physicians providing comprehensive and continuous primary care to their patients in long-term care may bill 1(one) NPIV1 encounter with 1(one) multiple for the purpose of formally rostering an existing patient. This type NPIV1 billing is available in the long-term care/nursing home setting only (LO=NRHM).

When billing NPIV1 for an existing patient, the requirements for an office visit must be met. The text field of the claim must include the text “Existing Patient Nursing Home Attachment.” After July 31, 2024, NPIV1 claims for existing patients will no longer be accepted and NPIV1 shall be used for new patients only.

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The following interim health service codes have been made **permanent:**

Category	Code	Description	Base Units	Anaes Units
VEDT	47.25C	**Transcutaneous Aortic Valve Implantation/Replacement (TAVI)** **First Physician (RO=FPHN)** **Second Physician (RO=SPHN)** **Description** 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. **Billing Guidelines** Do not report with the following same patient same day: • 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) ADON 99.09A Morbid Obesity Surgical Add on is not applicable as this is a transcutaneous procedure **Specialty Restriction:** SP=CASG, SP=CARD, SP=GNSG, SP=INMD **Location:** LO=HOSP (QEII only)	611 MSU 611 MSU	20+T

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Category	Code	Description	Base Units	Anae Units
MASG	97.79B	**Masculinization of Chest Wall** **Prior Approval/Preauthorization required (PA)** **Description** 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. **Billing Guidelines** • 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/ • May not be claimed with: ○ Mastectomy HSC's: 97.12, 97.13, 97.14, 97.15, 97.31A, 97.31C, 97.32, 97.32B ○ Reconstruction of nipple HSC: 97.77 ○ Tissue shift/graft HSC's to include, but not limited to: 98.51B, 98.51C, 98.51D, 98.51E • Once per patient per lifetime RO=SRAS applicable **Specialty Restriction:** SP=PLAS **Location:** LO=HOSP	425 MSU	4+T

Category	Code	Description	Base Units	Anae Units
MASG	97.44A	**Feminization of chest wall** **Prior Approval/Preauthorization required (PA)** **Description** 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. **Billing Guidelines** • 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/	350 MSU	4+T

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Category	Code	Description	Base Units	Anae Units

		• May not be claimed with:
		  ○ Augmentation Mammoplasty HSC's: 97.43, 97.44
		  ○ Insertion of tissue expander HSC: 98.98
		  ○ Breast Reconstruction HSC's: 97.6B, 97.6C, 97.6D, 97.75A
		  ○ Reconstruction of nipple HSC: 97.77
		  ○ Tissue shift/graft HSC's to include, but not limited to: 98.51B, 98.51C, 98.51D, 98.51E
		• Once per patient per lifetime
		
		RO=SRAS applicable
		
		Specialty Restriction:
		SP=PLAS
		
		Location:
		LO=HOSP		

Category	Code	Description	Base Units	Anae Units

MISG	97.99B	**Revision of gender affirming chest surgery**
		Prior Approval/Preauthorization required (PA)
		
		Description
		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.
		
		Billing Guidelines
		• Original chest surgery must have had prior approval from MSI for gender affirming surgery based on a complete and approved GAS application.
		• Only one per patient per lifetime
		• Requires a formal request for prior approval/ preauthorization from MSI by the physician proposing the procedure.
		• May not be claimed with:
		  ○ Reconstruction of nipple HSC: 97.77
		  ○ Tissue shift/graft HSC's to include, but not limited to:
		  • 98.51B, 98.51C, 98.51D, 98.51E
		
		RO=SRAS applicable
		
		Regions (Required)
		RG=LEFT, RG=RIGT, RG=BOTH
		
		Specialty Restriction:
		SP=PLAS
		
		Location:
		LO=HOSP
			150 MSU	4+T

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Category	Code	Description	Base Units
CONS	03.09M	**Preoperative comprehensive assessment for gender affirming surgery** **Description** 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. The assessment must be documented in the health record and include, but is not limited to: • History and physical examination • Discussion of surgical care • Documentation that the current WPATH (World Professional Association for Transgendered Health) standards for care for surgical readiness have been met • Review of psychological assessment to ensure patient is a candidate for reconstructive surgery and discussion with other health professionals concerning patient eligibility as required • Discussion with patient support person(s) as required **Billing Guidelines** Once per patient per lifetime **Specialty Restriction:** SP=PLAS **Location:** LO=OFFC	62 MSU

Category	Code	Description	Base Units
VIST	03.03Y	**Post operative care – gender affirming chest surgery** **Description** 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. **Billing Guidelines** May be claimed once per patient within 18 months post gender affirming surgery by the physician who claimed the original gender affirming surgery. **Specialty Restriction:** SP=PLAS **Location:** LO=OFFC	36 MSU

For a full listing of current Interim Health Service Codes please see the Interim Fee Reference Guide (PDF) available on the MSI website.

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PREAMBLE UPDATE

Effective July 24, 2023, TI=GPEW was made available to walk-in clinics. Please note, the preamble requirements must be met for any office claiming TI=GPEW, and greater clarity has been added for walk-in clinics:

New Definition

This premium is intended to promote enhanced patient access to primary care outside of traditional office hours. This premium is available for select services to physicians who have an ongoing relationship with their patients and select services for physicians providing care at walk-in clinics. *(5.1.189)*

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 should offer and book appointments during these time periods.
- Select services provided in walk-in clinics are eligible for the Enhanced Hours Premium during premium eligible time periods. *(5.1.190)*

The following visit services are eligible for the 25% Enhanced Hours Premium:

- 03.03 Office visits – includes WBCR, ANTL, PTNT etc.
- 03.03A Geriatric office visits
- 03.03C Palliative care support
- 03.03E Adults with developmental disabilities
- 03.03J OAT initial visit
- 03.03K OAT transfer of care from program
- 03.03L OAT transfer of care
- 03.03V Medical abortion
- 03.04 Comprehensive visit
- 03.04I PSP Mental health visit
- 03.09C Palliative care consultation
- 08.41 Hypnotherapy
- 08.44 Group therapy
- 08.45 Family therapy
- 08.49A Counselling
- 08.49B Psychotherapy

The following visit services are eligible for the 25% Enhanced Hours Premium when billed by the patient's family physician only. Walk-in clinics may not bill the following services:

- 03.03B Complex care
- 08.49C Lifestyle counselling *(5.1.229)*

Only one premium 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 Enhanced Hours Premium has been claimed, a record must be maintained and readily available to verify that the patient was booked, **registered, or intended to be seen** 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. *(5.1.192)*

Contract physicians may shadow bill the GP Enhanced Hours Premium **as appropriate** *(5.1.193)*

The Enhanced Hours Premium should not be claimed in circumstances where the patient is booked, **registered or intended to be seen** for an appointment time that is not eligible for the premium and then the physician "runs late". *(5.1.194)*

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PROLONGED VISIT CLARIFICATION

Please be advised of the clarifying language with regards to the 03.03 and 03.03A Prolonged Office Visit & Prolonged Geriatric Office Visit for ME=CARE:

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

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

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

As with all medical chart documentation, the clinical encounter should be documented as outlined in the CPSNS Professional Standards and Guidelines Regarding Charting, and should capture enough detail to support the rationale for billing a prolonged visit. It should be evident from the patient record that it was a face-to-face ('in-person') encounter. The start and stop time of the face-to-face encounter must be recorded in the patient record and in the text of the MSI claim.

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

Documentation
Documentation of the following provides a clear indication that a prolonged visit has taken place:
- It is evident from the patient record that it was a face-to-face ('in person') encounter.
- Start and stop times of the encounter are recorded in the patient record and the text of the MSI claim.

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

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TELEPHONE PRESCRIPTION RENEWAL (TPR1) REMINDER

Physicians are reminded that the documentation required when billing for TPR1 must include the name of the pharmacy, drug, dose, and amount prescribed. If using the EMR as documentation, it must indicate all of the required elements listed. Full details can be found in the Interim Fee Reference Guide (PDF)

ALLIED HEALTH CARE PROVIDER TO PHYSICIAN (AHCP1) REMINDER

Physicians are reminded that with regards to pharmacists, this code is for discussion of patient care. It is not for prescription renewal, clarifying ineligible prescriptions or switching to a generic form of drug. With regards to documentation, 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. Full details can be found in the Interim Fee Reference Guide (PDF)

NEW PATIENT INTAKE VISIT (NPIV1) REMINDER

When submitting multiples greater than 1, start and stop times are required to be documented in the patients health record and the text field of the MSI claim.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
AD096	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE DATE OF BIRTH OF THE PATIENT IS PRIOR TO JANUARY 1, 1970. PLEASE RESUBMIT WITH TEXT INDICATING IF THE PATIENT IS A HEALTHCARE WORKER OR POST SECONDARY STUDENT.
AD097	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF DOSES OF 13.59L RO=PNEU IMMUNIZATIONS HAVE PREVIOUSLY BEEN PAID.
GN135	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED A FACILITY ON-CALL INPATIENT WITHDRAWAL MANAGEMENT ROTA FOR THIS SERVICE DATE.
GN136	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED A FACILITY ON-CALL RECOVERY SUPPORT CENTER ROTA FOR THIS SERVICE DATE.

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

UPDATED FILES

Updated files reflecting changes are available for download on May 24, 2024. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

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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

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)
http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS
www.novascotia.ca/dhw/

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Physician Agreement - Program Payment Schedule (2024/25)

Program	Payment*
EMR (Envelope "A" Payments) EMR Envelope "A" payments continue monthly to eligible physicians	Monthly
CME (GP & Specialist) Payment for 2023/24 Fiscal Year (eligible billings based on 2023 calendar year)	Issued by May 31, 2024
CMPA Premium Reimbursement Covering April - June 2024	Issued by August 31, 2024
Electronic Medical Records (EMR – B&C) Payments for 2023/24 Fiscal Year	Issued by August 31, 2024
Surgical Assist Payments Payment based on eligible billings from April 1, 2023 – March 31, 2024	Issued by September 30, 2024
Collaborative Practice Incentive Program Payment for 2023/24 Fiscal Year	Issued by October 31, 2024
CMPA Premium Reimbursement Covering July – September 2024	Issued by November 30, 2024
Rural Specialist Incentive Program Measurement period April 1, 2023 – March 31, 2024	Issued by December 31, 2024
CMPA Premium Reimbursement Covering October – December 2024	Issued by February 28, 2025
Rostering Grant (FFS ME=CARE Family Physicians) Payment for 2024/25 Fiscal Year	Issued by May 31, 2025
CME (GP & Specialist) Payment for 2024/25 Fiscal Year (eligible billings based on 2024 calendar year)	Issued by May 31, 2025
CMPA Premium Reimbursement Covering January – March 2025	Issued by May 31, 2025

***Please be advised payment dates noted are anticipated payments for these programs**