PHYSICIAN'S BULLETIN

November 21, 2025: Vol. LXX, ISSUE 7

NOVA SCOTIA MEDICAL SERVICES INSURANCE

CONTENTS

NEW FEES

Effective November 21, 2025 the following health service code is available for billing:

Category	Code	Description	Base Units
DEFT	NHTA1	Nursing Home Telephone Patient Assessment with Regulated Nursing Professional **Description** This service is billable when a physician has a telephone conversation with a Regulated Nursing Professional to provide advice on a patient, with whom thephysician (or physician group) has an established relationship, to determine a management decision. The limited assessment is conducted by a Regulated Nursing Professional who is in the same Nursing Home (LTC/RCF) location as the patient. No direct communication between physician and patient is required. This is a virtual assessment using a Regulated Nursing Professional to assess the patient and who is authorized to speak on the patient's behalf. **Billing Guidelines** All interactions must be recorded in the patient's chart, including, but not limited to: • The time of the call if claiming TI=GPEW • The documentation should be clear that the conversation/ assessment occurred with a Regulated Nursing Professional • The history of the presenting problem, review of relevant body systems or investigations, diagnosis and treatment plan • The name of the nursing professional is recommended Physicians may use a copy of the documentation from the Nurse to support this HSC claim, but it must be reviewed and 'signed off' by the physician prior to submitting the claim to MSI. The physician may add any needed clarifications or corrections to this documentation as an addendum as per CMPA Guidelines.	16.5 MSU

Category	Code	Description	Base Units
		• This fee code may not be billed with, TPR1 Telephone Prescription Renewal, AHCP1 or LTC Medical Chart Review for the same patient, same day, same provider. • This code may not be billed if the call is to arrange an in-person Nursing Home visit or appointment, a prescription renewal, or for calls with other allied health care professionals. • This code may not be billed if the physician is present in the LTC facility. • Only billable once per patient per day. • 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 is a visit on the same day, text is required on the visit claim regarding the intervention. **Premium** TI=GPEW **Specialty** SP=GENP **Location** LO=OFFC	

FEE UPDATES

Effective November 21, 2025, the following health service code has been updated to **Location Office:**

Category	Code	Description	Base Units
VIST	03.03 RO=NHCR	Nursing Home Medical Chart Review with telephone call/email/fax advice communicated to a regulated health care professional for patients in licensed, provincially registered nursing homes and residential care facilities. Groups of up to three telephone calls, faxes or e-mails per day per patient. Note: each additional group of three telephone calls, faxes or e-mails per day per patient can be claimed at 11.5 units. **Description** Physicians may claim for medical chart review with telephone call/email/fax advice provided for patients in licensed, provincially registered nursing homes and residential care facilities. Only advice provided to regulated health care professionals within the patient's circle of care at the nursing home or residential care facility is eligible for this reimbursement. Telephone calls/faxes/e-mails between by the patient, their SDM, or their family members are not eligible. Physicians and nursing home staff involved are advised to keep a detailed record of telephone call/email/fax advice requested and provided. Medical chart review with telephone call/email/fax advice may be claimed in groups of three interactions per day for the same patient at a total of 11.5 MSU. Each additional group of three interactions either for the same patient or a different patient per day can be claimed at 11.5 MSU. **Billing Guidelines** • Communication must be with a regulated health care professional within the patients circle of care.	11.5 MSU

BACK TO CONTENTS

Category	Code	Description	Base Units
		• Not for discussions with the patient, their SDM, or family members. • Detailed record of the chart review and advice provided to be available upon request. • Payable for groups of up to three services per claim. • Additional groups of three services may be claimed at the same value. **Specialty Restriction:** SP=GENP **Location:** **LO=OFFC**	

PREAMBLE UPDATE

Effective November 21, 2025, the following preamble has been updated.

Current Definition	New Definition
5.2.114 **PAEDIATRIC CARE OF OVERAGE PATIENTS AGE 16 UP TO AND INCLUDING 18 YEARS OF AGE** a) Services associated with the care of overage patients in hospital by a paediatrician are to be paid at paediatric rates. b) Paediatric consultations, whether comprehensive or limited, at any location for overage patients are to be paid at paediatric rates. c) Visits, excluding paediatric consultations, outside hospital for overage patients are not to be paid at paediatric rates except for: i) Behavioral management. ii) Follow-up visits in a paediatrician's office for approved overage patients with complex multi-system medical problems. Application must be made in writing to the MSI Medical Consultant and prior approval obtained for each patient. Application for approval must clearly state the diagnosis and provide sufficient clinical information to support complex multi-system medical problems.	5.2.114 **A. PAEDIATRIC CARE OF PATIENTS 0-18 YEARS OF AGE INCLUSIVE. (UP TO 19TH BIRTHDAY)** • Paediatric fee codes apply to patients 0-18 years of age inclusive. This includes services provided in the hospital or office for consultations and visits, provided all other health service code requirements are met. *(5.2.115)* **B. PAEDIATRIC CARE OF OVERAGE PATIENTS 19 YEARS OF AGE AND OLDER** *(5.2.116)* • Overage is defined as the day of the 19th birthday and over. • Services associated with the care of overage patients in hospital by a paediatrician are to be paid at paediatric rates. • Paediatric consultations, whether comprehensive or limited, at any location for overage patients are to be paid at paediatric rates. • Visits, excluding paediatric consultations, outside hospital for overage patients are not to be paid at paediatric rates except for: o Behavioral management. o Follow-up visits in a paediatrician's office for approved overage patients with complex multi-system medical problems. Application must be made in writing to the MSI Medical Consultant and prior approval obtained for each patient. Application for approval must clearly state the diagnosis and provide sufficient clinical information to support complex multi-system medical problems. *(5.2.117)*

BACK TO CONTENTS

BILLING QUESTIONS – HEALTH CARD Q&A

Providers and their staff should ensure they are gathering patient information prior to the appointment/procedure (or after the procedure in an emergency) and make every attempt to contact the patient if the claim submitted to MSI has been rejected due to ineligibility.

Please take special care to review the patient's personal health card the first-time treatment is provided. Additional identification must be requested to ensure the patient's identity. *(Preamble 2.3.35)* The existence of a health card is not a guarantee of coverage. It is the service provider's responsibility to try and contact the patient *(Preamble 2.3.36)*

Prior to the appointment with the patient (or after, if emergency), the following information should be collected, and questions considered:

- Do they have a valid NS Health Card? What is the number and expiry date?
- Do they currently have, or have they ever had, coverage in another Canadian province? What is that Health Card Number and information? (Just because they have a NS card, does not mean their NS card is the active/appropriate card to use, and vise versa with an OOP health card.)
- Do they have private insurance?
- Have they moved in the previous 4 years?
- Is their contact information correct? i.e., phone number and address.

If a patient does not have MSI coverage (or coverage from another Canadian province) providers may charge patients fees for clinical services. It is important providers are aware of the patient's current coverage and have their contact information prior to them leaving the facility.

Q&A

Q. Sometimes a claim is rejected with an error code. What does that mean?

A. If the provider receives the error code **ED103** (service recipient birth date does not match date of birth on health card) this is typically a clerical error. They should confirm they entered the claim accurately and used the correct date of birth, and/or try to contact the patient to confirm the health card details. Often the month and day have been switched which will result in this error.

If the provider receives the error code **ED049** (invalid service recipient health card number for date of service or recipient is ineligible for the program), try to contact the patient to confirm the health card details and verify if the patient is eligible for health care with another Canadian province.

The following new explain codes have also been developed to help clarify health card rejections:

ED130: Patient health card number is missing and cannot be 000 000 000.

A: This code is a result of the health card number field being blank or zero filled. Please check your submission and submit a new claim with the proper health card number.

ED131: Patient health card number submitted was not recognized by MSI; please check number for errors.

A: This code is a result of the health card number attached to the claim does not exist. I.e., the number submitted is incorrect and is not a recognized health card number. This could be a result of a claim being submitted prior to the health card number registration or effective/eligibility date.

BACK TO CONTENTS

ED132: Ineligible patient health card number. Patient did not have MSI coverage on the date of service, please contact patient.

A: This code is a result of the patient not having coverage on the date of service. This means that it is a valid health card number, however the patient does not have MSI coverage on the date of service. You will need to contact to patient to determine appropriate payment.

Q. What if it is known that the patient is unhoused and is unable to confirm details of their health card number?

A. Providers can call MSI at 902-496-7008 or 1800-563-8880 to receive assistance with patient's health card eligibility. MSI can search the system and troubleshoot issues over the phone. Please have the following information ready to provide to MSI:

- The provider name/number
- Patient details: name, date of birth, etc.

Q. The claim was rejected after the information was confirmed to be correct. What should we do now?

If clarification is required, the first point of contact should be the patient as this information should be collected at the time of the appointment. If you are not successful contacting the patient, please call MSI at 902-496-7008 or 1-800-563-8880 to confirm the patient's date of birth and/or eligibility for MSI coverage. Please have the following information ready to provide to MSI:

- The provider name/number
- Patient details: health card number, name, date of birth, address and phone number, if available

If the provider has attempted the steps above to contact the patient and MSI and has been unsuccessful in obtaining the required information due to extenuating circumstances, MSI can review a request to determine if payment of service can be made. This would be considered in limited circumstances such as:

- Residents unable to complete the application/renewal process for a health card due to circumstances outside of existing eligibility, e.g., homelessness, mental health capacity, etc.
- Patient passed away before they could update their health card.

Note: Providers should take special attention to identify noninsured situations prior to delivery of services. These scenarios could include:

- A non-Canadian who is vacationing in Nova Scotia,
- Refugee Claimants that are not eligible for MSI coverage but could have the Interim Federal Health Program (IFHP) coverage. Physicians must register as a health-care provider under this program to receive payment for these services Interim Federal Health Program (canada.ca),
- Canadian citizens who live out of country and are here visiting or passing through Nova Scotia on their way to reside in another Canadian province. They do not meet Nova Scotia's residency requirements,
- International students during the 12-month waiting period. They should have insurance through the university,
- Non-Canadians who specifically travel to Nova Scotia or another Canadian province for medical services.
- Quebec does not participate in reciprocal medical billing. When providing services to Quebec residents you can bill them directly and provide a detailed invoice/receipt which they can submit to the RAMQ for reimbursement of insured services.

BACK TO CONTENTS

Billing Matters Billing Reminders, Updates, New Explanatory Codes

RETIREMENT FUND WEBPAGE

Physicians are advised of a new page on the MSI website dedicated to the Physician Retirement Fund, where you will find the program overview and updates, resources, and key dates. MSI - Physician Retirement Fund –

LFM SER UPDATE

Physicians are advised encounter claims of the Telephone Prescription Renewal (TPR1) fee code now qualify as one service encounter to LFM physicians.

MULTIPLES FOR SERVICES PROVIDED BY A MEDICAL LEARNER

Physicians are allowed to submit claims for prolonged visits and other health service codes with multiples when rendered by the learner, provided the claim reflects the length of time it would take for the physician to provide the service themselves. It is not appropriate to claim extra multiples to reflect the additional time taken by the learner. As always, documentation of the visit must reflect the complexity of the visit when billing a prolonged visit.

MEET AND GREET REMINDER (Preamble 2.2.54)

Physicians are reminded that all services billed to MSI must be medically necessary. There must be a specific health related concern/complaint that has led the patient to seek medical attention. It is not appropriate to bill MSI for a 'meet and greet' visit with a new patient unless a health-related concern/complaint has been addressed at the visit.
When **accepting a patient into your practice**, the NPIV1 new patient intake visit can be claimed for the purpose of gathering a detailed patient history **to establish an ongoing patient-physician relationship** and to construct the patient's medical record. (see full guidelines in the interim fee guide Interim-Fee-Reference-Guide-May-2025.pdf)
The NPIV1 is an initial visit with the patient and cannot be done virtually.

LOCATION OF PHYSICIAN DURING VIRTUAL ENCOUNTERS

Physicians should be aware of the location code they are using on claims when providing phone or virtual video encounters to patients. Physicians should not use the location of the patient. Physicians should use the location of 'office' (LO=OFFC). As currently defined in section 5.0.11 of the preamble, an office refers to the location where a physician is practicing their profession. An office may be located in the physician's home, in a hospital, in an institution, or in other facilities or buildings.

A location of 'home' (LO=HOME) should not be used for phone/virtual encounters if the physician was in their 'office' and the patient was in their home. Use of location of home, as outlined in preamble 5.1.48 indicates the service was rendered by a physician following travel to the patient's home. If the physician does not travel to the patients home, a location of home should not be used.

Additionally, locations of outpatient or emergency departments (LO=HOSP, FN=EMCC/FN=OTPT) are to be used when physicians provide medical treatment to a patient presenting to an OPD emergency department (5.1.28). To use a location other than office, the physician must be physically present at that location when they render services to the patient.

PHYSICIAN CONTACT

Physicians are reminded of the importance of keeping their contact information (email address, telephone, and mailing address) current with MSI. To update your contact information, you may reach out to MSIProviders@medavie.ca or 902- 496-7011 (toll-free 1-877-910-4674)

PHYSICIAN'S MANUAL

Applicable updates in the Physician's Bulletin's will be reflected in the Physician's Manual within 3 weeks; however, it may be necessary to refer to Physician's Bulletins for additional detailed information and any billing clarifications or reminders.

BACK TO CONTENTS

NEW AND UPDATED EXPLANATORY CODES

Code	Description
GN141	AHCP1 AND TPR1 MAY NOT BE CLAIMED WITH NHTA1
GN142	NHTA1 MAY NOT BE CLAIMED WITH AHCP1 OR TPR1
GN143	NHAT1 MAY NOT BE CLAIMED WITH NURSING HOME MEDICAL CHART REVIEW
GN144	NHAT1 MAY NOT BE CLAIMED DURING THE SAME SERVICE OCCURRENCE AS A VISIT OR CONSULT
GN145	THIS HEALTH SERVICE CODE MAY NOT BE CLAIMED DURING THE SAME SERVICE OCCURRENCE AS NHTA1
VT182	NURSING HOME MEDICAL CHART REVIEW MAY NOT BE CLAIMED WITH NHTA1

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday November 21, 2025. The files to download are: Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), and Explanatory Codes (EXPLAIN.DAT).

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

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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BACK TO CONTENTS

2026 CUT-OFF DATES FOR RECEIPT OF PAPER AND ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE	CONTRACT PAY PERIOD
December 26, 2025**	January 1, 2026	January 7, 2026	December 19, 2025-January 1, 2026
January 12, 2026	January 15, 2026	January 21, 2026	January 2, 2026-January 15, 2026
January 26, 2026	January 29, 2026	February 4, 2026	January 16, 2026-January 29, 2026
February 9, 2026	February 12, 2026	February 18, 2026	January 30, 2026-February 12, 2026
February 23, 2026	February 26, 2026	March 4, 2026	February 13, 2026-February 26, 2026
March 9, 2026	March 12, 2026	March 18, 2026	February 27, 2026-March 12, 2026
March 23, 2026	March 26, 2026	April 1, 2026	March 13, 2026-March 26, 2026
April 2, 2026**	April 9, 2026	April 15, 2026	March 27, 2026-April 9, 2026
April 20, 2026	April 23, 2026	April 29, 2026	April 10, 2026-April 23, 2026
May 4, 2026	May 7, 2026	May 13, 2026	April 24, 2026-May 7, 2026
May 15, 2026**	May 21, 2026	May 27, 2026	May 8, 2026-May 21, 2026
June 1, 2026	June 4, 2026	June 10, 2026	May 22, 2026-June 4, 2026
June 15, 2026	June 18, 2026	June 24, 2026	June 5, 2026-June 18, 2026
June 26, 2026**	July 2, 2026	July 8, 2026	June 19, 2026-July 2, 2026
July 13, 2026	July 16, 2026	July 22, 2026	July 3, 2026-July 16, 2026
July 27, 2026	July 30, 2026	August 5, 2026	July 17, 2026-July 30, 2026
August 10, 2026	August 13, 2026	August 19, 2026	July 31, 2026-August 13, 2026
August 24, 2026	August 27, 2026	September 2, 2026	August 14, 2026-August 27, 2026
September 4, 2026**	September 10, 2026	September 16, 2026	August 28, 2026-September 10, 2026
September 21, 2026	September 24, 2026	**September 29, 2026****	September 11, 2026-September 24, 2026
October 5, 2026	October 8, 2026	October 14, 2026	September 25, 2026-October 8, 2026
October 19, 2026	October 22, 2026	October 28, 2026	October 9, 2026-October 22, 2026
November 2, 2026	November 5, 2026	**November 10, 2026****	October 23, 2026-November 5, 2026
November 16, 2026	November 19, 2026	November 25, 2026	November 6, 2026-November 19, 2026
November 30, 2026	December 3, 2026	December 9, 2026	November 20, 2026-December 3, 2026
December 14, 2026	December 17, 2026	December 23, 2026	December 4, 2026-Dec 17, 2026
December 22, 2026**	**December 30, 2026****	January 6, 2027	December 18, 2026-December 31, 2026
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

2026 HOLIDAY DATES

Please make a note in your schedule of the following dates MSI will accept as "Holidays".	
NEW YEAR'S DAY	THURSDAY, JANUARY 1 2026
HERITAGE DAY	MONDAY, FEBRUARY 16, 2026
GOOD FRIDAY	FRIDAY, APRIL 3, 2026
EASTER MONDAY	MONDAY, APRIL 6, 2026
VICTORIA DAY	MONDAY, MAY 18, 2026
CANADA DAY	WEDNESDAY, JULY 1, 2026
CIVIC HOLIDAY	MONDAY, AUGUST 3, 2026
LABOUR DAY	MONDAY, SEPTEMBER 7, 2026
NATIONAL DAY FOR TRUTH AND RECONCILIATION	WEDNESDAY, SEPTEMBER 30, 2026
THANKSGIVING DAY	MONDAY, OCTOBER 12, 2026
REMEMBRANCE DAY	WEDNESDAY, NOVEMBER 11, 2026
CHRISTMAS DAY	FRIDAY, DECEMBER 25, 2026
BOXING DAY	MONDAY, DECEMBER 28, 2026
NEW YEAR'S DAY	FRIDAY, JANUARY 1, 2027