PHYSICIAN'S BULLETIN

May 17, 2018: Vol. LXI, ISSUE 14

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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PRIMARY CARE INVESTMENTS

The investments represent a significant increase to the fees for services commonly provided by family physicians. With the input of Doctors Nova Scotia, the investments are structured with the intent that Nova Scotians will see an increase in physicians who are able to establish new relationships with patients who currently either do not have or are seeking a new family doctor. Highlights of the investment package include:

COMPREHENSIVE AND CONTINUOUS CARE

Effective April 1st, 2018 there is an increase of 13.5% to the fee paid for health service code 03.03 (office visit and geriatric office visit) for family physicians who are delivering comprehensive and continuous care to patients with whom they have an ongoing relationship. It does not include episodic care provided to walk-in patients. The enhanced fees are only available to family physicians who attest, via confirmation letter, that they are providing comprehensive and continuous care to patients. The MSI system will not be updated until May 17th. To claim the new enhanced fees, physicians should begin to use the new ME=CARE modifier on applicable claims submitted on May 17th or after, even if the service date was prior to May 17th. A confirmation letter must be filled out and returned directly to MSI no later than May 25th, 2018. Any claims eligible for the enhanced fee value that were submitted between April 1st and May 25th will later be identified, and a retroactive payment will be provided to physicians. Letters received after May 25th, 2018 will still be processed and eligibility will commence as of that date, no retroactive payments will be made for letters received after May 25th, 2018. All physicians who intend to use, or have been using, the enhanced fees, are required to submit the letter in order to continue to be eligible to bill these enhanced fees. The letter can be found here and must be sent to: primary_care_investments@medavie.bluecross.ca.

ENROLMENT FEE

Effective April 1st 2018, a one-time flat enrolment fee of $7.50 per current patient to enable family physicians to identify panels of patients for whom they are providing comprehensive and continuing care. However, it will take some time to define the enrolment process and for the initial/preliminary patient panel lists to be developed and distributed to family physicians for verification. Once these lists are received you will have the opportunity to add and/or remove names from the list based on your own charts. The $7.50 per patient will apply to the final approved and validated roster. More details on this fee, including the process will be shared in the coming weeks.

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UNATTACHED PATIENTS

Effective April 1st 2018, the rules for the $150 unattached patient bonus have been expanded. The fee will be available to APP, FFS, and eligible AFP family physicians for taking on patients from the 811 Find a Family Practice list as well as other patients who were previously unattached at the time they enrolled or who may become unattached, such as patients referred from the Emergency Department and patients from a practice where the physician is retiring or relocating and who no longer have a family physician. The criteria for the existing UPB1 will be broadened and the process for claiming the fee simplified. The fee should be billed at the time of your initial visit. You are required to keep the patient in your practice and to maintain an open chart for at least a year, but you should still bill the incentive at the time of the initial visit. (Note that this is a change from the instructions first communicated, which suggested that you should hold your billing until the unattached patient has been in your practice for a year.)

ALTERNATIVE PAYMENT PLAN (APP) CONTRACTS

Family practitioners compensated through APP contracts will have the opportunity to increase their compensation by 5.6%. It applies to APPs regardless of the full or part-time nature of the arrangement, based on volume of shadow billing. APP physicians who shadow bill a minimum 80% of their contract's payment will receive the 5.6% bonus.

Click here for FAQs regarding the Primary Care Investments.

TECHNOLOGY STIPEND - VIRTUAL CARE PILOT (MyHealthNS)

A working group, chaired by Dr. Stewart Cameron and with Doctors Nova Scotia representation, is working on the MyHealthNS Virtual Care Pilot criteria where physicians can receive up to $12,000 a year. This pilot will look at the benefits and impacts of using the secure e-messaging function and telephone to improve access to primary health care. When information is available, it will be added to the Physician's Bulletin. Meanwhile, to schedule a demo of MyHealthNS you can reach DHW at 902-424-3951 or email MyHealthNS@novascotia.ca.

ELECTRONIC MEDICAL RECORD (EMR) INCENTIVE TRUST AND SUPPORT

The DHW Migration Project Office will trigger payment of all incentives after the migration has been completed and all eligibility criteria have been met. Payments will be processed through MSI on a quarterly basis.

The following incentives and supports are available:

- **A one-time migration incentive of $2,300** will be paid to each physician in recognition for time spent by them and their staff to ensure migration of their patient records in accordance with provincial migration project standards, including testing and validating migrated data.

- ***A one-time incentive payment to expedite the required migration from Nightingale On Demand*** (NOD). Eligible physicians currently on Nightingale on Demand may also receive up to a maximum of $3,000 (one-time payment) to compensate them for migrating their patient records from Nightingale On Demand to a Certified EMR. Incentive amounts will be determined as follows:

    - Physicians who, between December 1, 2017 and October 31, 2018, secure a migration date with the vendor and DHW and submit their Consent to Grant Access Form to DHW, shall receive the maximum amount of the NOD Migration Incentive ($3,000). (Note that the migration date may be after October 31st, 2018, but it must be ***secured*** by October 31st, 2018)
    - Physicians who, between November 1, 2018 and March 31, 2019, secure a migration date with the vendor and DHW and submit their Consent to Grant Access Form to DHW, shall receive 75% of the maximum NOD Incentive (actual $2,250). (Note that the migration date may be after March 31, 2019, but it must be ***secured*** by March 31, 2019.)
    - Physicians who, between April 1, 2019 and October 31, 2019, secure a migration date with the vendor and DHW and submit their Consent to Grant Access Form to DHW, shall receive 50% of the maximum NOD Incentive (actual $1,500) (Note that the migration date may be after October 31, 2019, but it must be ***secured*** by October 31, 2019.)
    - Once a migration date is secured, it is expected that the physician will complete the migration as scheduled. If the scheduled migration date is changed by the DHW Migration Project Office, this will not negatively affect the amount of the incentive to be paid to the physician. If the scheduled migration date is changed by the physician, the new migration secured date will be used to determine eligibility for incentive payments.

- To qualify for compensation under the EMR Migration Incentive Program physicians are required to meet specific migration eligibility criteria and must have migrated from a provincial EMR to a Certified EMR between December 1, 2017 and December 31, 2019.

ELECTRONIC MEDICAL RECORD (*EMR) SUBSIDY*

To encourage ongoing EMR use, *existing* provincial EMR users (i.e. Practimax, Accuro and Med Access), who are receiving eResults from provincial information systems, will receive an EMR subsidy of $200 per month. The EMR Subsidy payment will be processed by DHW and paid through MSI on a quarterly basis. No action is required by physicians.

- Nightingale On Demand physicians will qualify for the subsidy in the month after they have completed their migration to a Certified EMR.
- For Accuro, Practimax and Med Access EMR users who meet the eligibility criteria (see FAQ), the subsidy is effective April 1, 2018.
- The end date for the EMR Subsidy is December 31, 2019 or earlier if a new Physician Master Agreement has been ratified.

Click here for the complete DHW EMR Communication and FAQ.

★ Fees New Fees, Fee Revisions, and Highlighted Fees

NEW FEES

Effective May 17th, 2018, the following health service code will be available for billing:

Category	Code	Description	Base Units
VIST	03.03V	**Medical Abortion/Termination of early Pregnancy** This comprehensive fee includes the assessment of the patient requesting termination of an early (first trimester) pregnancy, counselling, ordering and interpretation of laboratory tests and diagnostic imaging as required, prescription of the medication and telephone follow up. Administration/prescription of cytotoxic medication(s) and Rh immune globulin (where required) is included as are all verbal or electronic communications with the patient to relay results of follow up blood work and address questions or concerns. **Billing Guidelines** • May not be reported with any other consultation or visit service same patient same day. • Follow up visits are not included in the comprehensive HSC. **Premium** GPEW **Location** OFFICE	47.5 MSU

Effective April 1, 2018 the following health service premium is available for billing. Physicians holding claims from April 1st - May 16th have 90 days from the date of the bulletin to submit; please refer to this bulletin in electronic text for any claims submitted over 90 days from their date of service.

Category	Code	Description	Base Units	Anaes Units
ADON	AHSP1	**After Hours Service Premium (extended service hours)** This premium applies in circumstances where elective procedures are moved to an eligible premium time period due to factors beyond the control of the physician. The 35% after hours service premium is intended to compensate the physician for the disruption of their personal time while providing extended hours of service in addition to the scheduled workday. Eligible time periods are defined as: • Weekday evenings: Mon-Friday 17:00-23:59 • After midnight: Tuesday-Saturday 00:00-07:59 • Weekend day time: Saturday 08:00-16:59 • Weekend night time and Sunday all day: Saturday to Monday 17:00-07:59 • Official recognized holidays: 08:00-23:59 **Billing Guidelines** • May only be reported for scheduled electively booked interventional procedures that have been moved to a premium eligible time period due to factors beyond the control of the physician. • The premium does not apply to elective procedures that have been intentionally booked during premium hours ex: elective cases booked to start before 0800 hours, scheduled weekend joint replacement OR lists etc. **Specialty Restriction** Surgical specialties, endoscopies and interventional radiology **Location** LO=HOSP **Note** Only one claim for AHSP1 is required for all applicable services billed during the same occurrence. While not a billing requirement, physicians may reference in text the service encounter number(s) or health service code(s) the premium should apply to, as this may expedite processing and reduce wait times.	35% premium	35%

Effective April 1st 2018 the following enhanced office visit fees for GPs is available for billing:

Category	Code	Description	Base Units
VIST	03.03	**Office Visit – comprehensive and continuous care** A) ME=CARE, RP=SUBS (RF=REFD) B) ME=CARE, TI=GPEW, RP=SUBS (RF=REFD)	14.76 MSU 18.45 MSU
VIST	03.03A	**Geriatric Office Visit (for patients aged 65+)** A) ME=CARE, (RF=REFD) B) ME=CARE, TI=GPEW, (RF=REFD) The creation of these new enhanced fees will better remunerate full scope family medicine physicians for services provided, while also allowing physicians who provide episodic care to continue billing the current fees for normal and geriatric office visits. **Billing Guidelines** By “full scope family medicine” it is meant that the physician has an ongoing relationship as a primary care provider to their patients and ensures their patients’ continuity of care. The enhanced fee is not intended for episodic care provided to walk-in patients. The submission of a Physician Confirmation Letter is required to successfully use this enhanced fee. **Specialty Restriction** GENP **Location** OFFICE	18.26 MSU 22.83 MSU

FEE REVISIONS

Effective April 1st, 2018 the billing guidelines associated with the following health service codes have been updated:

Category	Code	Description	Base Units
DEFT	UPB1	**Unattached Patient Bonus** On April 1st, 2018 the Department of Health and Wellness implemented revisions to the criteria for claiming HSC UPB1 — the unattached patient bonus fee. **Billing Guideline Updates** • The UPB1 service will be claimable from an office, nursing home, acute home care, or home location. Previously the service was limited to office claims. • The GP has to have had at least one visit service with the patient prior to claiming the UPB1 fee. This visit can occur at the same encounter in which UPB1 is claimed. • A GP can only claim UPB1 once per patient per lifetime. A physician cannot claim the unattached patient bonus more than once for the same patient. • The UPB1 cannot be claimed for walk-in clinics, for patients who already appear on a physician's patient list (physician validated), for patients who were taken off the 811 list before the establishment of this fee enhancement (i.e. retroactive payment before April 1st, 2018), or for new physicians who are building their practices until that point when their patient panel reaches 1350. **Documentation** The GP must confirm and document at the initial visit with the Unattached Patient that the patient is unattached (i.e., does not already have a regular family physician). Information about the encounter that resulted in the GP taking the Unattached Patient into his/her practice must also be recorded in the patient's record. This can be a patient from the 811 list, referral from the hospital emergency department, for enrolling patients who do not have a physician or are unattached at time of enrolment, for enrolling patients for whom un-attachment is imminent because their family practitioner is retiring/relocating and no new family physician is taking over the practice, an inpatient hospital report or other documentation. (Other documentation may include a note by the physician, documenting their discussion with the patient, confirming the prior hospital encounter.) **Specialty Restriction** GENP **Location** All locations	$150.00 (one time per patient)

Category	Code	Description	Base Units
ADON	03.03S	**First Visit After Acute Care In-Patient Hospital Discharge – Complex Care** This is an additional fee for the first office visit of the patient requiring ongoing complex care within 14 days of acute care in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care. • The physician or their office staff should make every effort to	10 MSU

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communicate (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge to better facilitate the patient being seen within 14 days.
- Not reportable in the walk-in clinic setting.

A complex care patient is defined as:
- A patient with multiple (two or more) chronic conditions requiring active management expected to last at least 12 months, or until the death of the patient.
- The chronic conditions must place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

Billing Guidelines

ADON Restricted to:

03.03 Office visit
03.03A Geriatric Office Visit (for patients age 65+)
03.03E Adults with Developmental Disabilities

- Reportable only if the visit occurs in the primary care physician's office or the patient's home within 14 calendar days after hospital discharge (consider discharge date as Day zero).
- Hospital length of stay must be greater than or equal to 48 hours.
- Not reportable if the admission to hospital was for the purpose of performing elective surgery (major or minor) or fracture care (major or minor).
- Not reportable if the admission to hospital was for the purpose of obstetrical delivery.
- Not reportable if the admission to hospital was for the purpose of newborn care.
- Not reportable for services rendered in other locations such as Nursing Homes, Residential Care Facilities, or Hospice.
- The physician claiming the service must be the provider most responsible for the patient's ongoing complex care.
- Claimable once per patient per inpatient admission.
- Not reportable for any subsequent discharges within 30 days.
- Not reportable in the same month as other monthly care fees - such as 13.99C
- Maximum of 4 claims per physician per patient per year.

Specialty Restriction
GENP
Location
LO=OFFC, HOME

Category	Code	Description	Base Units
ADON	03.03P	**First Visit after In-Patient Hospital Discharge – Maternal and Newborn Care** This is an additional fee for the first maternal/newborn office visit within 14 days of in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care. • The primary care physician or their office staff should make every effort to communicate (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge to better facilitate the patient being seen within 14 days of discharge. • Not reportable in the walk-in clinic setting. **Billing Guidelines** ADON Restricted to: 03.03 Office visit 03.03 Well Baby Care • Reportable only if the visit occurs in the primary care physician's office or	10 MSU

the patient's home within 14 calendar days after hospital discharge (consider discharge date as Day zero).
- Only reportable if the reason for admission to hospital was for the purpose of obstetrical delivery.
- Physician must be the provider most responsible for the mother and child's ongoing care.
- Claimable once per patient per inpatient admission for obstetrical delivery.
- Not reportable for any subsequent discharges within 30 days.
- Maximum of 1 claim per pregnancy (mother)
- Maximum 1 claim per infant

Specialty Restriction
SP=GENP

Location
LO=OFFC, HOME

Please note the removal of the requirement for a written referral to be sent to the specialist and available in the patient's medical record only applies to the following health service codes:

Category	Code	Description	Base Units
VIST	03.09K	**Specialist Telephone Advice – Consultant Physician – Providing Advice**	25 MSU
VIST	03.09L	**Specialist Telephone Advice – Referring Physician – Requesting Advice**	11.5 MSU

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 by 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 relevant patient's 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 and 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 claim.
- There must be text on the MSI service report (claim) to indicate whether or not this service replaced a face to face service.

Location
LO=OFFC

Category	Code	Description	Base Units
VIST	03.03Q	**Specialist Telephone Management/Follow Up with Patient** 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 lasts 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 two-way telephone (or synchronous electronic verbal communication) between the specialist physician and the patient, or the patient (or the patient's parent, guardian or proxy as established by written consent). • Telephone management requires two-way 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 a management decision. • The specialist physician must have seen and examined the patient within the preceding 9 months. • The HSC is reportable 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 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 two way 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 on the MSI service report. • There must be text on the MSI service report to indicate whether or not this service replaced a face to face service. **Location** LO=OFFC	11.5 MSU

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Category	Code	Description	Base Units
VIST	03.03R	**Family Physician Telephone Management/Follow Up with Patient** 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 an 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 of the patient is not required. The patient population eligible must be either 65 years and older or be suffering from mental illness or multiple (two or more) chronic diseases. Chronic disease is defined as: • A condition expected to last at least 12 months or until the death of the patient • The chronic condition must place the patient at significant risk of acute exacerbation/decompensation, functional decline, or death 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 two-way telephone (or 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 two-way 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 a management decision. • The family physician must have seen and examined the patient within the preceding 9 months. • The HSC is reportable a maximum of 4 times per patient per physician 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 • Time spent providing this service to a patient participating in a Chronic Care Management Plan may not be included in the time requirements of HSC *Chronic Care Management Service – per month*[1] • 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	11.5 MSU

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 two way 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.
- For patient initiated appointment requests that result in a telephone management service on the same day, the following text should be entered in the MSI text field:
  - Same day access
- The start and stop time of the call must be included in the text field on the MSI service report.
- There must be text on the MSI service report to indicate whether or not this service replaced a face to face service.

Location

LO=OFFC

[1]HSC Chronic Care Management Service – per month is currently under development

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Billing Matters Billing Reminders, Updates, New Explanatory Codes

BILLING REMINDERS

Travel for HSC HOVM1

Physicians are reminded that they cannot bill for travel from personal home location to patient home, only for travel from office to patient home (unless the physician has an at-home office registered with MSI).

UPDATES

Methadone Exemption

Effective May 2018 the federal government will permit health care practitioners to prescribe and administer methadone without requiring an exemption from federal law. Due to this policy change, physicians no longer need to provide proof of a valid Health Canada exemption to prescribe methadone in order to claim the following fees through MSI:

- **03.03J** – Initial Opioid Use Disorder Assessment in a community setting for initiation of Methadone Treatment
- **03.03K** – Initial Opioid Use Disorder Assessment for Methadone Treatment – Transfer from Methadone Maintenance Treatment Clinic to community physician
- **03.03L** – Permanent Transfer of patient on active Methadone Treatment for substance use disorder – Full acceptance of responsibility for ongoing care – Initial visit with accepting physician
- **MMM1** – Methadone Treatment Monthly Management fee: Intensive
- **MMM2** – Methadone Monthly Management Fee: Maintenance

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NEW AND UPDATED EXPLANATORY CODES

Code	Description
DE032	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED THE UNATTACHED PATIENT BONUS PAYMENT FOR THIS PATIENT.
DE033	SERVICE ENCOUNTER HAS BEEN REFUSED AS THERE HAVE BEEN NO VISIT SERVICES CLAIMED BY YOU FOR THIS PATIENT IN THE PREVIOUS 365 DAYS.
VT162	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.03V MAY NOT BE BILLED IN ADDITION TO OTHER SERVICES FOR THIS PATIENT ON THE SAME DAY.
VT163	SERVICE ENCOUNTER HAS BEEN REFUSED AS A CONSULT MAY NOT BE BILLED IN ADDITION TO 03.03V FOR THIS PATIENT ON THE SAME DAY.

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

UPDATED FILES

Updated files reflecting changes are available for download on Thursday May 17, 2018. The files to download are health service (SERVICES.DAT), modifier values (MODVALS.DAT), health service description (SERV_DESC.DAT) and, explanatory codes (EXPLAIN.DAT).

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)

http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

www.novascotia.ca/dhw/

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

Phone: 902-496-7011
Toll-Free: 1-866-553-0585
Fax: 902-490-2275
Email:
MSI_Assessment@medavie.bluecross.ca

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

Phone: 902-424-5818
Toll-Free: 1-800-387-6665
(in Nova Scotia)
TTY/TDD: 1-800-670-8888

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