PHYSICIAN'S BULLETIN

March 19 2021: Vol. LXVI, ISSUE: 4

NOVA SCOTIA MEDICAL SERVICES INSURANCE

CONTENTS

MSI News

MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT

Effective April 1, 2021, the Medical Service Unit (MSU) value will increase from $2.58 to $2.63.

ANAESTHESIA UNIT

Effective April 1, 2021, the Anaesthesia Unit (AU) value will increase from $22.71 to $23.88.

PSYCHIATRY FEES

Effective April 1, 2021, the hourly psychiatry rate for General Practitioners will increase to $154.57 while the hourly rate for Specialists increases to $209.59 as per the tariff agreement.

WORKERS COMPENSATION BOARD UNIT VALUE CHANGES

WCB MEDICAL SERVICE UNIT

Effective April 1, 2021, the Workers Compensation Board Medical Service Unit (WCB MSU) value will increase from $2.87 to $2.92.

WORKERS COMPENSATION BOARD ANAESTHESIA UNIT

Effective April 1, 2021, the Workers Compensation Board Anaesthesia Unit (WCB AU) value will increase from $25.23 to $26.53.

WORKERS COMPENSATION BOARD FEE CODE INCREASES

Workers' Compensation Board Fee Code Update

As per the contract between WCB and Doctors Nova Scotia, an annual escalator based on the Consumer Price Index has been calculated for the listed WCB specific fees for fiscal year 2021-22.

Due to the increase in CPI for 2020, all of the WCB specific services listed below will have their values increased by 0.81% effective April 1st, 2021:

CODE	DESCRIPTION	APRIL 2021 VALUE
WCB12	EPS physician assessment Service. Combined office visit and completion of Form 8/10 For complex **initial** assessments exceeding 50 minutes, EPS physicians may bill additional 15-minute increments to a maximum of 1 additional hour	**Initial visit:** $189.42 + $55.39 per 15 minutes to a maximum 4x (RO=EPS1 and RP=INTL) **Subsequent visit:** $189.42 (RO=EPS1 and RP=SUBS)
WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable	GPs…….$46.31 per 15 min EPS(RO=EPS1).. $55.39 per 15 min Specialists…….$62.31 per 15 min
WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable	GPs…….$46.31 per 15 min EPS(RO=EPS1)..$55.39 per 15 min Specialists……....$62.31 per 15 min
WCB17	Photocopies of Chart Notes	10 pgs or less (ME=UP10)……..$27.74 11-25 pgs (ME=UP25)…….$55.39 26-50 pgs (ME=UP50)…….$110.67 Over 50 pgs (ME=OV50)…….$165.94
WCB20	Carpal Tunnel Syndrome (CTS) Assessment Report	$71.04
WCB21	Follow-up visit report	$41.55
WCB22	Completed Mandatory Generic Exemption Request Form	$13.90 per form
WCB23	Completed Non-Opioid Special Authorization Request Form	$13.90 per form
WCB24	Completed Opioid Special Authorization Request Form	$46.57 per form
WCB25	Completed WCB Substance Abuse Assessment Form	$31.04
WCB26	Return to Work Report – Physician's Report Form 8/10	$71.04
WCB27	Eye Report	$62.31

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CODE	DESCRIPTION	APRIL 2021 VALUE
WCB28	Comprehensive Visit for Work Related Injury or Illness	$71.48
WCB29	Initial Request Form For Medical Cannabis	$77.12
WCB30	Extension Request Form For Medical Cannabis	$46.31
WCB31	WCB Interim Fee – Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed	$71.48

FEE CODE INCREASES

INCREASES IN COMPREHENSIVE PRIMARY CARE FEE CODES

As per the master agreement, the following fees shall have their values increased for family physicians. (New Value is the value effective April 1, 2021)

	Old Value	New Value
Description	**MSU**	**MSU**
Office Visit (ME=CARE)	15.95	16.96
Geriatric Office Visit (ME=CARE)	19.73	20.99
Office Visit After-Hours (ME=CARE)	19.94	21.20
Geriatric Office Visit After-Hours (ME=CARE)	24.67	26.24
Office Visit – Well Baby Care (ME=CARE)	15.95	16.96
Office Visit Well Baby Care After-Hours (ME=CARE)	19.94	21.20
Office Visit Prenatal Care (ME=CARE)	15.95	16.96
Office Visit Prenatal Care After-Hours (ME=CARE)	19.94	21.20
Office Visit Postnatal Care After-Hours (ME=CARE)	25.67	27.30
Subsq. Inpatient Care Visit (Days 2, 3)	24.85	26.43
Subsq. Inpatient Care Visit – Newborn (Days 2, 3)	24.85	26.43
Subsq. Inpatient Care Visit – Post-Partum (Days 2, 3)	24.85	26.43
Subsq. Inpatient Care Visit (Days 4-7)	20.53	21.84
Subsq. Inpatient Care Visit – Post-Partum (Days 4-7)	20.53	21.84
Subsq. Inpatient Care Visit (Daily to 56 days)	17.29	18.39
Subsq. Inpatient Care Visit (Weekly after Day 56)	17.29	18.39

INCREASES IN PSYCHIATRY FEE CODES

As per the master agreement, the following fees shall have their values increased for psychiatrists. (New Value is the value effective April 1, 2021) *Note: these increases are for psychiatrists only.*

	Old Value	New Value
Description	**MSU**	**MSU**
Routine Psychiatric Visit (08.5B)	42.68	43.41
Psychotherapy (08.49B)	43.25	44.46
Comprehensive Consultation (03.08)	94.85	103.24
Child Psychiatric Assessment (08.19A)	48.87	50.23
Group Therapy (08.44)	11.66	11.99
Therapeutic/Diagnostic Interview Relating to a child (08.19B)	43.23	44.44

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FEE CODE INCREASES (CONTINUED)

INCREASES IN OBSTETRIC AND GYNECOLOGY FEE CODES

As per the master agreement, the following fees shall have their values increased for obstetrics and gynecology services. (New Value is the value effective April 1, 2021)

Gynecology Fee Code Changes

HSC	Description	Old Value MSU	New Value MSU
03.03V	Medical Abortion/Termination of early pregnancy	62.63	67.03
80.89A	Abortion – Incomplete; examination of the uterus without D&C or anaes.	32.96	35.28
79.1	Conization of cervix including colposcopy	67.24	71.97
87.21	Dilation and Curettage for termination of pregnancy	93.61	100.19
81.09	Other Dilation and Curettage	56.04	59.98
81.09A	Endocervical Curettage	13.19	14.11
98.12V	Curettage of warts, including papillomata, keratosis, nevi, moles, pyogenic granulomata, etc., for malignant or recognized pre-malignant condition	15.82	16.93
81.69A	Endometrial Biopsy	25.05	26.81
80.4C	Laparoscopic Hysterectomy	395.55	423.36
80.3	Total Abdominal Hysterectomy	316.44	338.69
80.4A	Vaginal Hysterectomy – uterus-total vaginal w/ rectocoele / cystocoele repair	378.41	405.01
80.4	Vaginal Hysterectomy (subtotal)	316.44	338.69
80.2A	Subtotal Abdominal Hysterectomy	316.44	338.69
80.3A	Uterus – total abdominal w/ rectocoele / cystocoele repair	378.41	405.01
80.3C	Abdominal hysterectomy with salpingo-oophorectomy including bilateral selective pelvic lymphadenectomies, omental biopsy / selective periaortic	527.40	564.48
77.19C	Laparoscopic ovarian cystectomy	197.78	211.68
86.3A	Surgical removal of extrauterine (ectopic) preg. by any means (incl. tubal)	171.41	183.45
78.1A	Salpingectomy for morbidity, not for sterilization	171.41	183.45
10.16	Insertion of vaginal pessary	30.98	33.16
80.19A	Endometrial ablation including D&C	210.96	225.79
82.81A	Colposcopy	11.21	12.00
78.39A	Interruption or removal of fallopian tubes for sterilization purposes	138.44	148.18
77.51	Removal of both ovaries and tubes	257.11	275.18
80.81	Hysteroscopy	56.04	59.98
77.19A	Salpingectomy and salpingo-oophorectomy	171.41	183.45

Obstetric Fee Code Changes

HSC	Description	Old Value MSU	New Value MSU
87.98	Delivery (RF=REFD, SP=OBGY)	342.81	366.91
87.98	Delivery (SP=OBGY or SP=GENP)	263.70	282.24
86.1	Cervical Caesarean Section	342.81	366.91
84.79	Other Vacuum Extraction	342.81	366.91
86.1A	Caesarean section with tubal ligation	369.18	395.13
84.71	Vacuum extraction with episiotomy	342.81	366.91
84.0	Low forceps delivery without episiotomy	342.81	366.91
84.1	Low forceps delivery (with episiotomy)	342.81	366.91
84.8	Other specified instrumental delivery	342.81	366.91
84.29	Other mid forceps delivery	342.81	366.91
84.21	Mid forceps delivery (with episiotomy)	342.81	366.91
84.53	Total breech extraction	342.81	366.91
84.51	Breech extraction, unqualified	342.81	366.91
84.31	High forceps delivery with episiotomy	342.81	366.91
84.39	Other high forceps delivery	342.81	366.91
84.52	Partial breech extraction	342.81	366.91
84.61	Partial breech extraction with forceps to aftercoming head	342.81	366.91
84.62	Total breech extraction with forceps to aftercoming head	342.81	366.91
84.9	Unspecified instrumental delivery	342.81	366.91

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FEE CODE INCREASES (CONTINUED)

INCREASES IN OBSTETRIC AND GYNECOLOGY FEE CODES *(continued)*

As per the master agreement, the following fees shall have their values increased for obstetrics and gynecology services. (New Value is the value effective April 1, 2021)

Gynecology and Obstetrics Fee Code Changes

HSC	Description	Old Value MSU	New Value MSU
81.8	Insertion of intra-uterine contraceptive device	42.19	45.16
81.01	Dilation and curettage following delivery or abortion	75.15	80.44
86.61	Aspiration curettage following delivery or abortion	75.15	80.44

OB/GYN Consultation Fee Code Changes

HSC	Description	Old Value MSU	New Value MSU
03.08	Comprehensive Consultation (Prolonged)	37.60	40.10
03.07	Limited Consultation	27.00	29.50
03.07	Repeat Consultation (Prolonged)	25.00	27.50

UPDATED FEES

Teaching Stipend

Health service code TESP1 and TESP2 have been retroactively revised to daily rate fees for both fee for service and shadow billing. Any physicians who have claimed these fees since April 2020 will be contacted and directed to update their claims once an approved list of physicians is confirmed with Dalhousie University.

Category	Code	Description	Base Units
DEFT	TESP1	TEACHING STIPEND FOR MEDICAL STUDENT	$90 per day
DEFT	TESP2	TEACHING STIPEND FOR RESIDENT ELECTIVE	$90 per day

TESP1 and TESP2 revised to daily fees with a value of $90 each.

A claim for these services is designated to remunerate for any teaching responsibilities incurred during the service date.

These daily codes are available as both FFS and APP claims for physicians that meet the eligibility criteria outlined below.

Not eligible for any premiums

Maximum claimable amount of $450 per weekly period (i.e. only 5 teaching stipend claims per physician per week will be accepted)

Eligibility restrictions:

- Only available for those who have an academic appointment and are teaching Dalhousie residents and students
- FFS family physicians are eligible
- FFS royal college specialists are eligible
- APP physicians are able to shadow bill at the $90 daily rate

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- AFP physicians are not eligible for this fee code for work done in the AFP, likewise FFS physicians working within one of the FFS Academic Departments are not eligible
- Physicians (part time Academic Department and part time FFS) are eligible for work done outside the Academic Health Centre/IWK and not otherwise compensated through their clinical department or AFP (for example a physician in their private clinic teaching a student/resident).

Dalhousie will confirm the list of physicians approved to claim the teaching stipend to MSI, as well as any updates to the list as they occur.

Electronic claims for TESP1 and TESP2 should be claimed using health card number 0000002352 with date of birth April 1, 1969. Diagnostic code V623 is also required.

FEE REVISIONS

The effective period for interim health service code 03.04I – PSP Mental Health Comprehensive Visit to Establish the PSP Mental Health Plan (Practice Support Program) has been extended to October 31, 2021.

Physicians are reminded of the description for this service:
*Based on these requirements it is expected that a physician would have no more than 5 eligible patients per year.

Category	Code	Description	Base Units
VIST	03.04I	**PSP Mental Health Comprehensive Visit to establish the PSP (PSP= Practice Support Program) Mental Health Plan** This code is for the complete assessment of the patient with a confirmed mental illness meeting the diagnostic criteria in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of sufficient severity and acuity to cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and warrant the development of a Mental Health care plan. This is not intended for patients with self-limited or short-lived mental health symptoms. The assessment is to be performed by the PSP trained family physician most responsible for the patient's mental health care. The Mental Health Plan and start and stop times must be documented in the health record. This complete assessment is to include **all** of the following elements and be documented in the health record: • The patient's DSM diagnosis, psychiatric history and current mental state including suicide risk assessment as appropriate • Obtaining collateral history and information from caregivers as required • Performance of a complete medication review to include collateral information from pharmacy and assisted living facility as appropriate • Reviewing and documenting results of relevant validated assessment tools, laboratory, and other test results • Documentation of a clinical plan for the patient's care over the next year. Includes advanced care planning where appropriate • Outline of expected outcomes as a result of the treatment plan • Outline of linkages with other health care providers and community resources who will be involved in the patients care. • Confirmation that the plan has been created jointly and shared with the patient or their medical representative. The plan is to be shared with other care providers as appropriate	50 MSU +MU

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Category	Code	Description	Base Units
		• A documented care plan must be in place before access to additional counselling hours is provided It is recognized that the required elements may require more than one visit to complete. This health service code may be claimed at the final visit only when all of the information is complete and documented in the health record; other visits may be reported at the usual rate. **All** elements must be documented in the health record before reporting this PSP MHP visit service. **Billing Guidelines** • Reportable by the patient's PSP trained physician only • Not reportable with any other visit fee for the same physician, same patient, same day • Not reportable for services provided at walk-in clinics • Not to be used for patients living in nursing homes, residential care facilities or hospices • Reportable only once per patient per year • 50 MSU for first 30 minutes, 25 MSU for each additional 15 minutes, up to a maximum of 1 hour (5 multiples) • Start and stop times must be reported in the text field of the claim to MSI, as well as in the clinical record **Specialty Restriction** GENP with PSP Training **Location** OFFC, HOME	

Clarification to Health Service Code 51.95B

Orginally introduced in the October 2020 Physician's Bulletin, HSC 51.95B – Chronic Dialysis, treatment and supervision of care for the patient with end stage kidney disease, in an urban satellite hemodialysis unit as designated by the Health Authority for a 24 hour period have been updated to be consistent with the fee description. Face-to-face clinical assessment should be documented within a 42-day period, not the previously communicated 14-day.

Category	Code	Description	Base Units
VEDT	51.95B	**Chronic Hemodialysis – treatment and supervision of care for the patient with end stage kidney disease, in an urban satellite hemodialysis unit as designated by the Health Authority (for example; Halifax Infirmary, Dartmouth General, and North Sydney hemodialysis units) for a 24 hour period.** **Description** This comprehensive, daily fee (24 hour period beginning at 12:00 am until 11:59 pm of the same calendar day) is for the treatment and supervision of care for a patient with end stage kidney disease who is registered in the Renal Program (NSHA, STARS or PHS, as a series visit for dialysis) and requires chronic dialysis in an urban satellite hemodialysis unit as designated by the Health. The physician is expected to supervise all aspects of the patient's dialysis care and to provide direct, face-to-face clinical assessment of the patient, including a physical examination appropriate to the patient's medical condition, at least once in every 42 day period, and via PHIA compliant, synchronous virtual care platform once in every 14 day period, with additional clinical assessments as required based on concerns related to changes in the patient's medical condition. Each assessment will be documented in the patient's health record. Elements of care include:	12.11 MSU

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A. All management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital in-patients and in-person emergency department visits related to the management of chronic dialysis. It does not include acute dialysis. Acute dialysis is defined as dialysis rendered to a hospital inpatient in an intensive care setting, or to a patient beginning dialysis for the first time in their lifetime through to their 6th treatment at which point the dialysis is defined as chronic. A visit service, consultation or directive care as appropriate, may be claimed for hospital inpatients if the nephrologist is asked by the patient's most responsible physician to render an opinion and furnish advice regarding the patient's ongoing nephrological care during their hospital stay. The most responsible physician requesting the advice may not be another nephrologist.

B. All outpatient consultations and visits within the scope of practice of nephrology for the assessment and treatment of complications of chronic dialysis and management of end-stage kidney disease.
Including:
    a. Review of laboratory and diagnostic test results
    b. Management of volume status, ideal body weight and blood pressure
    c. Assessment of dialysis access, such as central venous catheter, arteriovenous fistula and peritoneal catheter, and management of any complications as required.
    d. Complete and document the Ambulatory Medication Reconciliation every six months

C. All related counselling, interviews and family meetings

D. Perform all assessments and consultation requests to refer the chronic dialysis patient to the Multiorgan Transplant Program for determination of kidney transplant eligibility.

E. All related case conferences, such as, but not limited to:
    a. Weekly Morning Program Rounds
    b. Review of laboratory and diagnostic test results with multidisciplinary team

For all patients in all hemodialysis units, the Nephrologist assigned to each unit will provide daily coverage of all dialysis patients to address any dialysis issues by being available to speak with the unit charge nurse or team lead every shift to discuss any problems or concerns with individual patients at any time.

The Nephrologist assigned to each unit will provide additional care and address concerns or problems that arise during the course of a hemodialysis treatment or within the 24 hour period of supervision, such as, but not limited to, changes to dialysis prescription or medications based on laboratory results like serum potassium or INR for patients on oral anticoagulants, when results are received after the treatment time.

A standardized review of the patient's overall status on dialysis will be completed and updated every 6 weeks and documented in the patient's health record.

The document will include:
    a. Review and interpretation of laboratory and diagnostic test results
    b. Volume status, ideal body weight, blood pressure and physical examination appropriate to the patient's medical needs.
    c. Assessment of dialysis access, such as; central venous pressure catheter, arteriovenous fistula, peritoneal catheter, and management of any complications as required.

Billing Guidelines

- Claimable by the Most Responsible Nephrologist once per patient per 24-hour period beginning at 12:00 am (midnight) and ending at 11:59 pm.
- May not claim any other chronic dialysis HSCs for the same patient, same 24-hour period.
- May not claim any other outpatient visit HSCs same physician, same patient, same 24-hour period.

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- A Nephrologist providing coverage for care of the chronic dialysis patient on behalf of the most responsible nephrologist may not claim any outpatient visit HSCs or chronic dialysis HSCs.
- Emergency hospital visits to attend the patient for a condition unrelated to the management of dialysis, its complications and end stage kidney disease may be claimed but must be submitted for manual assessment with supporting information in the text (clinical documentation may be required). Should the patient be admitted to hospital under the care of the nephrologist, who is acting as the most responsible physician, inpatient visits may be claimed.
- First claim may be made on the date of the patient's first chronic dialysis treatment.
- May not be claimed after the treatment terminates by, for example, successful transplantation, loss of resident status, or death.
- When a face-to-face clinical assessment is not documented in the patient's health record in the **42** day period, payment will be recovered from the Most Responsible Physician who claimed for the service for the majority of days in the preceding seven day period at the end of which the examination was to have occurred.

Specialty Restriction:
SP=NEPH

Location:
LO=HOSP

Billing Matters Billing Reminders, Updates, New Explanatory Codes

2019/2020 Provider Profiles

As announced in 2019, provider profiles will only be sent out by request. If you would like to receive your provider profile for 2019/20 please send your request by email to msi_assessment@medavie.bluecross.ca. In the email please include: your name and provider number, and the profile will be mailed to the address on file.

COVID-19 Immunization

As announced in February, all physician work for COVID-19 immunization will be remunerated via sessional funding for the hours worked. Please refer to the February 19, 2021 Physicians Bulletin for full details on sessional funding.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
GN107	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY CLAIMED A TEACHING STIPEND ON THIS DATE.
GN108	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU ARE NOT AUTHORIZED TO CLAIM THE TEACHING STIPEND.
VA100	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED ONE OF THE FOLLOWING HEALTH SERVICE CODES: 50.99C, 50.91, 50.06C, OR 50.08B. THESE SERVICES ARE CONSIDERED TO BE INCLUSIVE OF THE CURRENT CLAIM.
VA101	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED ONE OF THE FOLLOWING HEALTH SERVICE CODES: 50.82, 50.82C, OR 50.88A. THESE SERVICES ARE CONSIDERED TO BE INCLUSIVE OF THE CURRENT CLAIM.

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Code	Description
VA102	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED ONE OF THE FOLLOWING COMPREHENSIVE HEALTH SERVICE CODES: 48.0A, 48.0C, or 48.0F.
VA103	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED ONE OF THE FOLLOWING COMPREHENSIVE HEALTH SERVICE CODES: 48.0A, 48.0C, or 48.0F.
VA104	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE PREVIOUSLY CLAIMED HSC 48.0A PERCUTANEOUS CORONARY ANGIOPLASTY DURING THIS ENCOUNTER. THE CLAIM FOR CORONARY ANGIOPLASTY INCLUDES SELECTIVE CORONARY ANGIOGRAPHY.
VA105	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS YOU HAVE PREVIOUSLY CLAIMED A PORTION OF THIS FEE (HSC 48.98B SELECTIVE CORONARY ANGIOGRAPHY) DURING THIS ENCOUNTER. PLEASE SUBMIT A REVERSAL FOR THE PRIOR 48.98B BEFORE SUBMITTING A REASSESSMENT REQUEST FOR THIS COMPREHENSIVE CLAIM.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday March 19th, 2021. The files to download are:
Health Service (SERVICES.DAT),
Health Service Description (SERV_DSC.DAT),
Modifiers (MODVALS.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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Master Agreement - Program Payment Schedule (2021/22)

Program	Payment
EMR (Envelope "A" Payments) EMR Envelope "A" payments continue monthly to eligible physicians	Monthly
CME (GP & Specialist) Payment for 2020/21 fiscal year (eligible billings based on 2020 calendar year)	Issued by May 31, 2021
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from April 1, 2021 – June 30, 2021	Issued by July 31, 2021
CMPA Premium Reimbursement Covering April - June 2021	Issued by August 31, 2021
Electronic Medical Records (EMR – B&C) Payments for 2020/21 Fiscal Year	Issued by August 31, 2021
Family Physician Alternative Payment Plan 5.6% Incentive	Issued by September 30, 2021
Surgical Assist Payments Payment based on eligible billings from April 1, 2020 – March 31, 2021	Issued by September 30, 2021
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from July 1, 2021 – September 30, 2021	Issued by October 31, 2021
Collaborative Practice Incentive Program Payments for 2020/21 Fiscal Year	Issued by October 31, 2021
CMPA Premium Reimbursement Covering July -September 2021	Issued by December 31, 2021
Rural Specialist Incentive Program Measurement period April 1st, 2020 – March 31st, 2021 / Payment for 2020/21 fiscal year	Issued by December 31, 2021
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from October 2021 – December, 2021	Issued by January 31, 2022
CMPA Premium Reimbursement Covering October -December 2021	Issued by March 31, 2022
CDM, CGA (Eligible APP Physicians) Payment based on eligible shadow billings from January 2022 – March, 2022	Issued by April 30, 2022
CMPA Premium Reimbursement Covering January - March 2022	Issued by May 31, 2022

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

Payments for fiscal 2020/21	Continuing payments