PHYSICIAN'S BULLETIN
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NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MSI News

PHYSICIAN AGREEMENT 2023-2027

This bulletin is being issued to introduce new interim health service codes and rate changes as ratified in the 2023-27 Physician Agreement effective July 24, 2023.

The MSI system is anticipated to be updated September 15, 2023 with the information contained in this bulletin. For services that are required to be held, an additional bulletin will be published when these claims can be billed.

Any additional MSI items including new or modified fees, policies, and procedures with regards to the new Physician Agreement that are not outlined in this bulletin, will be published as information becomes available.

MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT
Effective April 1, 2023, the Medical Service Unit (MSU) value increased from $2.68 to $2.76.

ANAESTHESIA UNIT
Effective April 1, 2023, the Anaesthesia Unit (AU) increased from $25.30 to $26.06.

Note: These increases will be automatically applied on any claims submitted with a date of service on or after September 15, 2023. Claims submitted with service dates from April 1 – September 14, 2023 will be identified and a retroactive payment will be sent to physicians once the 90-day submission window has elapsed.

MSI RATE CHANGES

Please note rate changes not addressed in this bulletin will be published in a future bulletin as information becomes available.

PSYCHIATRY FEES

Effective April 1, 2023, the hourly psychiatry rate for General Practitioners increased to $165.62 while the hourly rate for Specialists increased to $220.24 per the tariff agreement.

Note: These rates will automatically take effect on any claims submitted as of September 15, 2023. Claims submitted and paid with service dates from April 1– September 14, 2023 will be identified and a retroactive payment will be sent to physicians once the 90-day submission window has elapsed.

SESSIONAL FEES

Effective April 1, 2023, the hourly sessional payment rate for General Practitioners increased to $165.62 while the hourly rate for Specialists increased to $193.23 per the tariff agreement.

Note: These rates will automatically take effect on any claims submitted and paid as of August 18, 2023. Claims submitted and paid from April 1 – August 17, 2023 will be identified and a retroactive payment will be sent to physicians once the 90-day submission window has elapsed.

LEVEL 3/4 ED REMUNERATION

Rate increases per the 2023-2027 Physician Agreement will automatically take effect on any claims submitted and paid as of August 18, 2023. Claims submitted and paid from April 1 – August 17, 2023 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window has elapsed.

CHIP & PMC

Rate increases per the 2023-2027 Physician Agreement will automatically take effect on any claims submitted and paid as of August 1, 2023. Claims submitted and paid from April 1 – July 31, 2023 will be identified and a retroactive payment will be sent to physicians once the 90 day submission window has elapsed.

Payment Claim Forms:

New claim forms will be distributed along with timelines of implementing new rates for payment to those physicians and groups affected by the rate increases.

Please note rate changes not addressed in this bulletin will be published in a future bulletin as information becomes available.

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NEW INTERIM FEES

Per the 2023-2027 Physician Agreement, the following new interim health service codes will be available for billing with service dates effective July 24, 2023. Physicians are asked to hold their claims until the system is updated. Notification will be published when claims for these services can be submitted.

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

Category	Code	Description	Base Units
DEFT	AHCP1	**Allied Health Care Provider to Physician** **Description** This service is billable when a physician has a conversation with an allied health care practitioner, either face to face, by phone, email or fax to provide advice on a patient with whom the physician has an established relationship to determine management decision. This service is intended to compensate the physician for unexpected interruptions to the physician's normal practice routine. This would also include the physician's time to update the patient's chart. **Billing Guidelines** • The allied health care providers must work outside of the physician's practice • Telephone calls initiated by the patient, or patient's family member may not be billed under this code	7.5 MSU

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- 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
- Physicians may use a copy of the documentation from the allied health care worker to support this HSC claim, but it must be reviewed and 'signed off' by the physician. The physician should add any needed clarifications or corrections to this documentation as an addendum
- Claims, outside the pharmacy pilot, can only be made for physician interaction and not for staff (clerks, nurses etc.) of the physician
- With regards to pharmacists, this code is for discussion of patient care and is not for prescription renewal, clarifying illegible prescriptions or switching to a generic form of drug
- This fee code may not be billed with the Telephone Prescription Renewal
- Only billable once per patient per day per physician
- May not be billed more than 15 times per physician per week
- Not to be billed on the same day as a visit unless the status of the patient has changed in the intervening time. If there has been a visit on the same day, text is required regarding the intervention

Specialty Restriction:
SP=GENP

Location:
LO=OFFC

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 cannot be billed for existing patients where ME=CARE has been billed by that family physician or collaborative practice.	34 MSU +MU

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- 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, total 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.

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

INTERIM FEE UPDATES

Per the 2023-2027 Physician Agreement, the following health service codes have been updated to include multiples for prolonged services. Prolonged visits have an effective date of July 24, 2023, however physicians are asked to hold their claims until the system is updated to allow for multiples. Notification will be published when claims for these services can be submitted.

Category	Code	Description	Base Units
VIST	03.03	**Prolonged Office Visit for ME=CARE** ME=CARE, RP=SUBS **Description** This service is paid to family physicians who are delivering face to face 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. **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.	17 MSU +MU

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- 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.

Multiples:
17 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

VIST	03.03A	**Prolonged Geriatric Office Visit for ME=CARE** ME=CARE	20.99 MSU +MU

Description
This service is paid to family physicians who are delivering face to face comprehensive and continuous care to patients aged 65 or older with whom they have an ongoing relationship.
Prolonged geriatric 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 geriatric office visits are not to be confused with active treatment associated with detention.

Billing Guidelines
- Only physicians eligible to bill the ME=CARE modifier may bill for prolonged geriatric office visits.
- Each office visit can be billed up to a maximum of 60 minutes (83.96MSU) 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.

Multiples:
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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Per the 2023-2027 Physician Agreement, nursing home visit codes have been updated to include multiples for prolonged services, as outlined below. In addition to allowing for multiples, the 2023-2027 Physician Agreement has also removed any differential rate for second or subsequent patients visited while in a nursing home facility. Effective July 24, 2023 nursing home visits requirements to use PT=FTPT and PT=EXPT have been removed and the unit value updated to reflect this.

Claims without multiples that are submitted with dates of service between July 24, 2023 and September 14, 2023 will be identified and a retroactive payment will be sent to physicians once the 90 day billing window has elapsed. Physicians are asked to hold their prolonged claims until the system is updated to allow for multiples.

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

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The MSU for HSC 03.09L Specialist Advice – Referring Physician has increased, and the guidelines for the following health service codes have been updated and are effective July 24, 2023. HSC 03.09L claims that are submitted with dates of service between July 24, 2023 and September 14, 2023 will be identified and a retroactive payment will be sent to physicians once the 90 day billing window has elapsed.

Category	Code	Description	Base Units
CONS	03.09K	**Specialist Advice – Consultant Physician – providing advice**	25 MSU
	03.09L	**Specialist Advice – Referring Physician – requesting advice**	13 MSU

Description

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

This health service code may also be reported for asynchronous communication regarding the assessment and management of a patient, but only when utilizing a health authority-approved platform and consistent with all other billing requirements.

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

The referring physician or provider must document:

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

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

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

Billing Guidelines

This service includes a review of the patient's relevant 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 physician or provider.

The consultant physician service is not reportable in addition to any other service for the same patient by the same physician on the same day.

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The referring physician or provider service may be reported when the communication with the consultant occurs on the same day as a patient visit or other service.

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

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

This service is not reportable for telephone calls or face to face conversations of less than 5 minutes of two-way medical discussion.

This is billable once per patient issue regardless of the number of asynchronous interactions.

Documentation Requirements

- The referring physician or provider must document that the referring physician or provider has communicated the reason for the consultation and relevant patient information to the specialist
- Both the specialist consultant and the referring physician or provider must document the patient's name, identifying data, date and encounter time in their respective charts or EMRs.
- The names of the referring physician or provider and the consultant physician must be documented by both the referring physician or provider and the consultant physician.
- The diagnosis, reason for referral, elements of the history and physical as relayed by the referring physician or provider, the opinion of the consultant physician and the plan for future management must be documented by the referring physician or provider and the specialist consultant. The consulting physician may use a copy of the documentation from the referring provider to support this HSC claim, but it must be reviewed and 'signed off' by the consulting physician.
- A written report must be sent to the referring physician or provider by the specialist consultant. The specialist consultant may satisfy this requirement by returning a copy of the documentation from the referring provider as long as it was reviewed and 'signed off' by the consulting physician.
- The referring physician's or provider's billing number must be noted on the claim from the consultant. This is not required for the referring physician's or provider's claim.

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PREAMBLE UPDATE

Effective July 24, 2023, the GP Evening and Weekend Premium (TI=GPEW) will be available for patients seen in walk-in clinics. For GPEW services that are not for ME=CARE (comprehensive and continuous care patients), physicians are asked to hold their claims until the system is updated to remove the ME=CARE requirement. Notification will be published when claims for these services can be submitted.

New Definition

GP ENHANCED HOURS PREMIUM *(5.1.188)*

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**.

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 Physician's Bulletin) the eligible time period is from 9a.m. to 10p.m.
- **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

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.

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 for an appointment during a premium-eligible time period. The appointment time should be record in the patient's record or office appointment books retained.

APP contract physicians may shadow bill the GP Enhanced Hours Premium.

The Enhanced Hours Premium should not be claimed in circumstances where the patient is booked for an appointment time that is not eligible for the premium and then the physician "runs late"

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