PHYSICIAN'S BULLETIN

September 20, 2023: Vol. LXVIII, ISSUE: 11

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MSI News

PHYSICIAN AGREEMENT 2023-2027

Any additional MSI items including new or modified fees, policies, and procedures with regard to the new Physician Agreement 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 Anesthesia Unit (AU) increased from $25.30 to $26.06.

Note: These increases are 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.

WORKERS COMPENSATION BOARD UNIT VALUE CHANGES

WCB MEDICAL SERVICE UNIT
Effective April 1, 2023, the Workers Compensation Board Medical Service Unit (WCB MSU) value will increase from $2.98 to $3.07.

WORKERS COMPENSATION BOARD ANAESTHESIA UNIT
Effective April 1, 2023, the Workers Compensation Board Anesthesia Unit (WCB AU) value will increase from $28.11 to $28.96.

Note: These increases are 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.

LONGITUDINAL FAMILY MEDICINE (LFM)

The Longitudinal Family Medicine payment model (LFM) is focused on improving access, patient attachment, and positioning Nova Scotia to both retain and recruit to office-based, longitudinal family medicine. The LFM will be available to all family physicians providing office-based, longitudinal family medicine in Nova Scotia. Physicians can work full-time or part-time within the LFM.

Blended payment

Physicians in the LFM model will be paid a blended payment that is calculated based on hours worked, services delivered and panel attachment. The LFM model includes a community complexity modifier to account for age, sex and socio-economic status factors in different communities.

Details related to this payment model are included in Schedule C of the 2023 Physician Agreement.

Additional information will be published in a future bulletin.

★ Fees New Fees and Fee Revisions

NEW INTERIM FEES

Per the 2023-2027 Physician Agreement, the following new interim health service codes are now available for billing with service dates effective July 24, 2023.

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. It includes review of clinical documents prior to the visit and establishment of a medical record on the same day. (Includes face to face and non-face to face time). **Billing Guidelines** • Such an encounter shall include documentation of the new patient's current health status, past medical history, relevant social and family history, and a list of current medications and allergies, as well as any physical examination as clinically appropriate. All components of this service must be completed on the same day. • If a medically necessary service is indicated during the initial visit, the time taken to address this can contribute to the multiples claimed. This fee is considered to compensate for a medically necessary service, if required at the initial visit. • Physician must submit ME=CARE declaration letter before billing any NPIV services. • The fee can only be billed once per physician per patient when the physician is first accepting the patient into their attached roster, it cannot be billed for patients already on your roster. For physicians in a collaborative practice, you may bill the NPIV1 when you are accepting a patient from a retiring/relocating physician within your collaborative practice for whom you may have billed ME=CARE in the past, as long as the patient is new to your panel. • For New Patient Intake Visits that are less than 30 minutes (including both the face to face and non-face to face time), the physician should bill fee code	34 MSU +MU

		NPIV1 with one multiple. For New Patient Intake Visits that are greater than 30 minutes the physician can bill a maximum of 5 multiples, i.e., 90 minutes. Prolonged office visits are paid in 15-minute time blocks or portion thereof. When billing multiples, start and stop times of the encounter 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. • It may not be billed with any other visit code or procedure code at the same encounter. • It is 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	

NOTE: ADON health service codes 03.03S and 03.03P can be billed when services are provided in conjunction with NPIV1 as an added incentive to bring a patient onto your physician panel.

Amendment to NPIV1: This HSC may be billed if a physician accepts a patient from a physician in the same collaborative practice due to physician retirement, relocation etc. If you have billed ME=CARE for this patient in the past, please submit your NPIV1 claim as health service code 'EC' with text indicating 'NPIV1 for collaborative practice' until the system is updated in October.

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. • It may not be billed more than 4 times per year per patient per provider. **Specialty Restriction:** SP=GENP	4 MSU

NOTE: In order to bill for the TPR1 Telephone Prescription Renewal, the prescription refill must be assessed, ordered and completed by the physician, not another allied health care provider such as a Nurse Practitioner or Pharmacist. The EMR 'Meds List' is adequate documentation.

NEW INTERIM FEES CONTINUED

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 a 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. • 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 • It is only billable once per patient per day per physician. • It may not be billed more than 15 times per physician per week. • It cannot 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	7.5 MSU

Per the 2023-2027 Physician Agreement, the following health service codes have been updated to include multiples for prolonged services. Physicians may now claim multiples for prolonged visits with service dates effective date July 24, 2023 onward. Claims submitted with a date of service between July 24 – September 14 will not automatically pay at the new rate, a retroactive payment will be issued once the 90-day submission window has elapsed.

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 with whom they have an ongoing relationship. Prolonged office visits are paid in 15-minute time blocks or portion thereof, and 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 (68 MSU) 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 in 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	17 MSU +MU
VIST	03.03A	**Prolonged Geriatric Office Visit for ME=CARE** ME=CARE **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, and 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.	20.99 MSU +MU

		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 (83.96 MSU) 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	

NOTE: The regular 03.03 and 03.03A visits may be billed as virtual, however prolonged visits with multiples cannot be billed as virtual.

Per the 2023-2027 Physician Agreement, nursing home visit codes have been updated to include multiples for prolonged services, as outlined below. Effective July 24, 2023, the nursing home visits requirement to use PT=FTPT and PT=EXPT have been removed and the unit value has been updated to reflect this.
Claims submitted without multiples for service dates between July 24 - September 14 will be identified and a retroactive payment will be issued once the 90-day submission window has elapsed.

Physicians holding their prolonged nursing home visit claims may now submit them to be paid for the 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 it is the first patient or extra patient. Prolonged nursing home visits are paid in 15-minute time blocks or portion thereof, and 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 in the text field of the claim.	21.3 MSU +MU

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- 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

NOTE: The regular 03.03 nursing home visit may be billed as virtual, however prolonged visits with multiples cannot be billed as virtual.

NEW FEE

The following health service code is now available for billing for service dates effective July 28, 2023
Please note the amendment to the physician requirements:

Category	Code	Description	Base Units
VIST	03.04K	**Gender Transition Readiness Assessment, follow up of patients undergoing medical transition, and follow up of patients undergoing surgical transition where the primary care provider is required to provide postoperative care** **Description** Gender transition readiness assessment, gender transition follow-up of patients who are undergoing medical transition, and postoperative care of patients who have had gender affirming surgery provided to them in or out of province. Physicians providing Gender Affirming Care (GAC) and billing for GAC fee codes must be informed, knowledgeable and experienced in providing culturally competent and safe trans care and are required to complete and return the GAC Competency Declaration. Any necessary counselling or physical examinations are included in this HSC and should not be claimed separately. **Billing Guidelines:** • This code is to be used only for services provided that are directly related to Gender Affirming Care; it does not replace all visit codes for that patient. • It has a base 30 minutes of time spent by the physician in direct patient care with multiples of 15 minutes when the service encounter exceeds 30 minutes to a maximum of 75 minutes. 80% of the time claimed must be in direct patient care.	40 MSU +MU

- When claiming for multiples on a time-based service, the start and stop times must be documented in the health record and submitted in text with the claim.

Multiples:
20 MSU per 15 minutes to a maximum of 4 multiples (75 minutes)

Premium Eligible:
TI=GPEW

Specialty Restriction:
SP=GENP

Location:
LO=OFFC

FACILITY ON CALL UPDATES

Per the 2023-2027 Physician Agreement, the Facility On-Call program rates will continue in their current form and the following new rates will be effective October 1, 2023:

Category	**Current Rate**	**Current Rate**	**New Rate (October 1, 2023)**	**New Rate (October 1, 2023)**
	Weekday	Weekend/ Holidays (DA=RGE1)	Weekday (M-Thurs)	Weekend (Fri, Sat, Sun) / Holidays (DA=RGE1)
Category 1	$300	$400	$350	$500
Category 2	$250	$300	$300	$350
Category 3	$150	$200	$200	$250
Community Hospital Inpatient Program (CHIP)	$300	$400	$350	$500

Category	**Current Rate**	**New Rate (October 1, 2023)**
	Callback (US=CALL)	Callback (US=CALL)
Category 3	$100	$150
Category 4	$300	$350

Effective September 15, 2023, Obstetrics/Gynecology is eligible for level 1 rota at Cumberland Regional Health Care Centre

Health Service Code	**Description**	**Approved Regional and Tertiary Hospitals**
F1004	Facility on Call Category 1 – Obstetrics/Gynecology RO=OBS1 (Yarmouth and IWK only) RO=OBS2 (IWK only) RO=GYN1 (Dartmouth and IWK only)	South Shore Regional, Yarmouth Regional, Valley Regional, Colchester East Hants, Aberdeen, St. Martha's, Cape Breton Regional, Dartmouth General, IWK, Cumberland Regional

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 2023-24.
The WCB specific services listed below will have their values increased effective April 1, 2023:

CODE	DESCRIPTION	APRIL 1, 2023 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:** $211.98 + $62.01 per 15 minutes to a maximum 4x (RO=EPS1 and RP=INTL) **Subsequent visit:** $211.98 (RO=EPS1 and RP=SUBS)
WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable	GPs……………….$51.88 per 15 min EPS (RO=EPS1)..$62.01 per 15 min Specialists……….$69.78 per 15 min
WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable	GPs……………….$51.88 per 15 min EPS (RO=EPS1)..$62.01 per 15 min Specialists……….$69.78 per 15 min
WCB17	Photocopies of Chart Notes	10 pgs or less (ME=UP10)……..$31.07 11-25 pgs (ME=UP25)………….$62.01 26-50 pgs (ME=UP50)………….$123.87 Over 50 pgs (ME=OV50)……….$185.70
WCB20	Carpal Tunnel Syndrome (CTS) Assessment Report	$79.51
WCB21	Follow-up visit report	$46.54
WCB22	Completed Mandatory Generic Exemption Request Form	$15.60 per form
WCB23	Completed Non-Opioid Special Authorization Request Form	$15.60 per form
WCB24	Completed Opioid Special Authorization Request Form	$52.16 per form
WCB25	Completed WCB Substance Abuse Assessment Form	$34.78
WCB26	Return to Work Report – Physician's Report Form 8/10	$79.51
WCB27	Eye Report	$69.78
WCB28	Comprehensive Visit for Work Related Injury or Illness	$80.03
WCB29	Initial Request Form For Medical Cannabis	$86.33
WCB30	Extension Request Form For Medical Cannabis	$51.88
WCB31	WCB Interim Fee – Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed	$80.03

Note: These increases are 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.

Reminder: Time-based codes

Time-based codes with a requirement of 80% direct patient intervention, such as the new prolonged 03.03 visit codes, means that a physician must spend 80% of the total time in direct patient care. I.e., to claim for a 30-minute visit, 24 minutes must be spent in direct patient care. If 24 minutes was not reached with the patient, the physician would not be eligible to claim for the additional multiple. For the prolonged 03.03 visits:

Multiples	***Total Time***	***Direct physician to patient contact***
MU 2	*30 minutes*	*24 minutes*
MU 3	*45 minutes*	*36 minutes*
MU 4	*60 minutes*	*48 minutes*

Reminder: Guidelines for a limited visit

Physicians are reminded that in order to claim for a visit code (e.g., prolonged 03.03) the guidelines must be met and satisfied per the preamble requirements. A limited visit may be claimed when the physician provides a limited assessment for diagnosis and treatment of a patient's condition. It includes a history of the presenting problem and an evaluation of relevant body systems.

Reminder: TI=GPEW

Per the August 4, 2023, Physician's Bulletin, the GP Evening and Weekend Premium (TI=GPEW) no longer requires the ME=CARE modifier on applicable codes. Effective July 24, 2023, TI=GPEW is available for patients seen in walk-in clinics. If physicians were holding TI=GPEW claims for non-ME=CARE patients, these may now be submitted.

03.09K 03.09L

Per the updated guidelines, effective July 24, 2023, the rule requiring start and stop times on these health service codes has been removed.

Amendment: 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 **to the consultant physician**.*

Please see full details in the Interim Fee Reference Guide.

Expanded eligibility for high-dose influenza vaccine during 2023/24 flu season

For the 2023-24 flu season, the high dose influenza vaccine (HSC 13.59L RO=HDIN) may be claimed for any eligible patient ≥65 years of age, regardless of location.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
DE037	SERVICE ENCOUNTER HAS BEEN REFUSED AS THE MAXIMUM NUMBER OF 4 TELPHONE PRESCRIPTION RENEWALS PER PATIENT PER YEAR HAS BEEN REACHED.
DE038	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY BILLED A VISIT OR PROCEDURE SERVICE FOR THIS PATIENT ON THE SAME DAY.
DE039	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE MAY ONLY BE CLAIMED ONCE PER PATIENT PER DAY.
DE040	SERVICE ENCOUNTER HAS BEEN DISALLOWED AS TEXT INDICATING NECESSITY/INTERVENTION IS REQUIRED WHEN THERE HAS ALREADY BEEN A VISIT CLAIMED FOR THIS PATIENT ON THE SAME DAY. PLEASE RESUBMIT WITH APPROPRIATE TEXT.
DE041	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST SUBMIT YOUR SIGNED CONFIRMATION LETTER IN ORDER TO CLAIM NPIV1.
DE042	SERVICE ENCOUNTER HAS BEEN REFUSED AS COMPREHENSIVE CARE SERVICES HAVE PREVIOUSLY BEEN CLAIMED FOR THIS PATIENT.
DE043	SERVICE ENCOUNTER HAS BEEN REFUSED AS THIS SERVICE MAY ONLY BE CLAIMED ONCE PER PATIENT.
DE045	SERVICE ENCOUNTER HAS BEEN REFUSED AS A VISIT OR PROCEDURE HAS PREVIOUSLY BEEN BILLED FOR THIS PATIENT ON THE SAME DAY.
GN131	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU MUST SUBMIT YOUR PROOF OF CBRC ONLINE TRAINING CERTIFICATION BEFORE CLAIMING THIS CODE.
GN132	SERVICE ENCOUNTER HAS BEEN REFUSED AS YOU HAVE ALREADY BILLED A TELEPHONE PRESCRIPTION RENEWAL FOR THIS PATIENT ON THE SAME DAY.
GN133	SERVICE ENCOUNTER HAS BEEN REFUSED AS NPIV1 HAS PREVIOUSLY BEEN BILLED FOR THIS PATIENT ON THE SAME DAY.
GN134	SERVICE ENCOUNTER HAS BEEN REFUSED. HEALTH CARD NUMBER IS NOT VALID FOR THE HSC BEING CLAIMED.

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

UPDATED FILES

Updated files reflecting changes are available for download on Friday September 15, 2023. The files to download are: Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT) and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

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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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