PHYSICIAN'S BULLETIN
March 28, 2025: Vol. LXX, ISSUE 3

NOVA SCOTIA MEDICAL SERVICES INSURANCE

CONTENTS

MSI News

MSI UNIT VALUE CHANGES

MEDICAL SERVICE UNIT
Effective April 1, 2025, the Medical Service Unit (MSU) value will increase from $2.84 to $2.90

ANAESTHESIA UNIT
Effective April 1, 2025, the Anesthesia Unit (AU) will increase from $26.84 to $27.38

Sessional hourly rates, Intensive Care Unit (ICU) minimum income daily guarantees, General Internal Medicine (GIM) minimum income daily guarantees, Emergency Department (ED) hourly rates, Psychiatry hourly rates, Collaborative Emergency Centre (CEC) rates, Community Hospital Inpatient Program (CHIP) rates, Regional Hospitalist daily stipend rates, Primary Maternity Care Program hourly rates, Pathology List B payments, and Alternative Payment Plan (APP) annual rates will increase by 2% effective April 1, 2025.

INTERIM FEE UPDATES

Effective April 1, 2025, interim health service codes 03.03R and 03.03Q are terminated. Physicians are reminded telephone and virtual video encounters may be submitted by using the appropriate AP=PHON and AP=VIRC modifiers. Physicians are reminded to select the appropriate health service codes when claiming for phone and virtual services. As a reminder, phone and virtual visits are not eligible for prolonged/multiples.

- AP=PHON – Encounter occurred via telephone
- AP=VIRC – Encounter occurred via virtual care video platform

LFM BILLING UPDATES

LFM MILEAGE

Physicians remunerated under the LFM funding model may submit the below mileage health service codes under their Fee for Service business arrangement for payment at full value when rendering a health service that allows for mileage. The health service itself must still be billed under the LFM business arrangement for payment at the LFM value.

This applies to:

- HOVM1 – Blended mileage and travel detention for home visits
- HHCMI – Blended mileage/detention time for home care

LFM TEACHING STIPEND

Physicians remunerated under the LFM funding model may submit teaching stipend health service codes under their Fee for Service business arrangement for payment at full value.

This applies to:

- TESP1 – Teaching Stipend for Medical Student
- TESP2 – Teaching Stipend for Resident Elective

Physicians are not required to go back and delete and resubmit any previously submitted mileage or teaching stipends, as MSI will issue a one-time retroactive top-up payment to LFM physicians for any mileage and/or TESP claims submitted under the LFM business arrangement from October 1, 2023 – March 27, 2025. This will be reconciled once 90 days has elapsed.

BACK TO CONTENTS

LFM

Effective April 1, 2025, the following health service codes for the purpose of tracking non-primary care health service LFM hours included within an LFM contract will be available for billing: This change primarily applies to LFM Rural contracts who are able to bill ED/UTC/Inpatient hours when within their LFM Rural contract. LFM Core physicians who are doing inpatient services within their LFM contract can bill these inpatient hours to have inpatient services isolated from their LFM SER calculations.

Category	Code	Description	Base Units
		Longitudinal Family Medicine (LFM) model hourly fee codes for clinical daytime and/or evening work in specific settings.	
PRVR	HUTC1	Urgent Treatment Centre (UTC) All Times	0 MSU
PRVR	HEDD1	Emergency Department Level 4 (ED4) Daytime	0 MSU
PRVR	HEDE1	Emergency Department Level 4 (ED4) Evening/Weekend	0 MSU
PRVR	HIPD1	Inpatient Daytime	0 MSU
PRVR	HIPE1	Inpatient Evening/Weekend	0 MSU

Description
Billable clinical hours for patient specific clinical services both direct and indirect in each setting.

Daytime hours mean the hours between 0800-1700 Monday through Friday Evening, Weekend and Holiday hours follow the eligible time period for the GP Enhanced Hours Premium (1700 – 0800) as outlined in the Physician's Manual.

Please see 'Schedule C' of the 2023-27 Physician's Agreement for full details on the LFM Model.

Billing Guidelines

- Physicians must submit the number of hours in the claimed units of the claim (i.e., 8.5 daytime hours = 8.5 units).
- Only one instance of each fee code (HUTC1, HEDD1, HEDE1, HIPD1, HIPE1) can be claimed per day per provider.
- Maximum of 24 hours per day across all hourly tracking HSC. (Includes these 5 new codes and the existing HDAY1 and HEVW1 hourly tracking codes).
- The HSC's must be billed under the LFM Hourly Health Card Number 0015800568, DOB April 1, 1969, Dx Code V689.

When it comes to Inpatient, if completing indirect services in the evening hours, these should be claimed as daytime hours if there are no direct services in addition. There must be direct services completed in evening hours to claim the evening health service code HIPE1.

Documentation Requirements
Physicians are responsible to ensure they are entering the correct number of claimed units to match the time worked.

Specialty Restriction:
SP=GENP

LFM SERVICE ENCOUNTER VALUE ADJUSTMENTS FOR HOSPITAL ADMISSIONS AND DISCHARGES

Effective immediately, the LFM Service Encounter values for some services utilized in the LFM payment model will change. The changes will apply effective April 1, 2025 onwards, and will be reflected in LFM physicians' historical SER on their quarterly reports. Changes include:

Admissions and Discharges:

Service	Code + Modifiers	Current Value	New Value
DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS COMPREHENSIVE	3.04 RP=INTL FN=INPT;LO=HOSP;SP=GENP	2	**3**
INITIAL GERIATRIC INPATIENT MEDICAL ASSESSMENT	03.04E FN=INPT;LO=HOSP;SP=GENP	2	**3**
HOSPITAL DISCHARGE FEE	03.02A FN=INPT;LO=HOSP;SP=GENP	0	**1**
COMPLEX COMPREHENSIVE ACUTE CARE HOSPITAL DISCHARGE	3.04F FN=INPT;LO=HOSP;SP=GENP	2	**4**

Minor Procedures:

Health Service	Code + Modifiers	Current Value	New Value
INCISION ABSCESS, SUBCUTANEOUS - BOIL, CARBUNCLE, INFECTED CYST, SUPERFICIAL LYMPHADENITIS, PARONYCHIA, FELON, ETC.	98.03A AN=GENL	1	**2**
CARCINOMA OF SKIN - LOCAL EXCISION, PRIMARY CLOSURE	98.12B	1	**3**
EXCISION OF PLANTAR WARTS OR JUNCTIONAL NEVI OR MOLLUSCUM CONTAGIOSUM	98.12N	1	**2**
REMOVAL OF FIBROMA	98.12A	1	**2**
EXCISION OF TOENAIL - SIMPLE, COMPLETE, PARTIAL OR WEDGE	98.96D	1	**2**
EXCISION OF FINGERNAIL - RADICAL, TO INCLUDE DESTRUCTION OF NAIL BED AND SHORTENING OF PHALANX, IF NECESSARY	98.96A	1	**3**
SIMPLE EXCISION OF WARTS, INCLUDING PAPILLOMATA, KERATOSES, NEVI, MOLES, PYOGENIC GRANULOMATA, ETC., FOR MALIGNANT OR PRE-MALIGNANT CONDITION - INCLUDES CLINICAL SUSPICION OF MALIGNANCY	98.12W	1	**2**
SUTURE MINOR LACERATION OR FOREIGN BODY WOUND	98.22D	1	**2**
SUTURE EXTENSIVE LACERATION OR FOREIGN BODY WOUND	98.22F	1	**3**
BIOPSY OF SKIN/MUCOSA-MALIGNANT OR RECOGNIZED PRE MALIGNANT CONDITION OR BIOPSY NECESSARY FOR HISTOLOGICAL DIAGNOSIS FOR PATIENT MANAGEMENT	98.81C	1	**2**
INCISION WITH REMOVAL OF FOREIGN BODY OF SKIN AND SUBCUTANEOUS TISSUE	98.04	1	**2**
INCISION OF PILONIDAL SINUS OR CYST	98.02	1	**2**
LOCAL EXCISION FOR MALIGNANCY	61.2C	1	**2**

*Please also see the LFM Cheat Sheet with minor updates: LFM Service Encounter Cheat Sheet

BACK TO CONTENTS

PREAMBLE UPDATES

Please be advised of the following Preamble update:

New Definition

5.1.118
Supervision of a patient on long term ~~anticoagulant~~ **warfarin** therapy (13.99C) may be claimed once monthly if the patient's treatment is managed by telephone/fax or e-mail advice and the patient is not participating in the Community Pharmacy-led Anticoagulant Management Services. If the date of the service falls within a complete month of hospitalization, this service may not be claimed.

OTHER MISCELLANEOUS ANTICOAGULANT SUPERVISION NEC

VADT	13.99C	Supervision of long-term ~~anticoagulant~~ **warfarin** therapy (per month telephone/fax/e-mail communications) 10

Note: Other anticoagulants do not have the same monitoring requirements as warfarin, code 13.99C is specific for warfarin management.

Please be advised of the following Preamble addition:

New Definition

Incentive for use of Official Interpreter services when caring for a patient of Limited English Proficiency (LEP) - OFI1

This incentive is available to health care professionals who utilize the services of an official interpreter, as designated by the NSHA or IWK, when providing care to a patient of Limited English Proficiency (LEP). LEP refers to individuals who do not speak English as their primary language and have a limited ability to read, speak, write, or understand English. This definition includes individuals who are deaf or hearing impaired and communicate using American Sign Language. Contact with the interpreter may be in person or via real time PHIA compliant technology. The interpreter's official identification must be documented in the patient's health record.

Note: Health Service Code ADON: OFI1 was announced and effective Feburary 8, 2019. There are no changes to the code or guidelines, however the description is being added to the Physicians Manual Preamble.

WORKERS COMPENSATION BOARD UNIT VALUE CHANGES/INCREASES

WCB MEDICAL SERVICE UNIT

Effective April 1, 2025, the Workers Compensation Board Medical Service Unit (WCB MSU) value will increase to $3.23.

WORKERS COMPENSATION BOARD ANAESTHESIA UNIT

Effective April 1, 2025, the Workers Compensation Board Anesthesia Unit (WCB AU) value will increase to $30.43.

BACK TO CONTENTS

Workers' Compensation Board Fee Code Updates

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 2025-26.

The WCB specific services listed below will have their values increased effective April 1, 2025:

CODE	DESCRIPTION	APRIL 2025 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:** $225.65 + $66.05 per 15 minutes to a maximum 4x (RO=EPS1 and RP=INTL) **Subsequent visit:** $225.65 (RO=EPS1 and RP=SUBS)
WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable	GPs……$55.27 per 15 min EPS (RO=EPS1)..$66.05 per 15 min Specialists…….$74.32 per 15 min
WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable	GPs……$55.27 per 15 min EPS (RO=EPS1)..$66.05 per 15 min Specialists…….$74.32 per 15 min
WCB17	Photocopies of Chart Notes	10 pgs or less (ME=UP10)……..$33.11 11-25 pgs (ME=UP25)……..$66.05 26-50 pgs (ME=UP50)……..$131.91 Over 50 pgs (ME=OV50)…….$197.68
WCB20	Carpal Tunnel Syndrome (CTS) Assessment Report	$84.66
WCB21	Follow-up visit report	$49.58
WCB22	Completed Mandatory Generic Exemption Request Form	$16.63 per form
WCB23	Completed Non-Opioid Special Authorization Request Form	$16.63 per form
WCB24	Completed Opioid Special Authorization Request Form	$55.56 per form
WCB25	Completed WCB Substance Abuse Assessment Form	$37.08
WCB26	Return to Work Report – Physician's Report Form 8/10	$84.66
WCB27	Eye Report	$74.32
WCB28	Comprehensive Visit for Work Related Injury or Illness	$85.21
WCB29	Initial Request Form For Medical Cannabis	$91.93
WCB30	Extension Request Form For Medical Cannabis	$55.27
WCB31	WCB Interim Fee – Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed	$85.21
WCB32	WCB Safe Work Connectedness Report	Specialists…… $74.32

BACK TO CONTENTS

FACILITY ON-CALL

Physicians are reminded that Facility On-Call payments transitioned to electronic billing effective July 1, 2021. Claims for Facility On-Call are to be submitted as Fee-For-Service (FFS) using the appropriate health service code. Please see section 5.2.191 in the Physician's Manual for more information on submitting for Facility On-Call and the associated health service codes.

90-DAY SUBMISSION TIMELINE POLICY REMINDER

Physicians are reminded all original claims must be submitted to MSI within 90 days from the date of service. Service encounters submitted over the 90-day limitation will be adjudicated to pay "zero" with the following exceptions:

- Reciprocal billing claims (out of province) must be submitted within 12 months of the date(s) of service.
- Resubmission of refused claims or incorrect billings. These claims must be resubmitted to MSI within 185 days of the date of service. Each resubmission must contain an annotation in the text field of the service encounter submission referencing the previous service encounter number.

Service encounters submitted beyond 90 days from date of service shall not be payable and will be adjudicated to pay zero unless MSI is of the opinion the delay is justified.

Exception to this policy for claims that are outside of the specified time limitations will be made only be through special consideration if extenuating circumstances can be demonstrated for a late submission and are within a reasonable time frame past the 90-day limit. Request for an extension must be made to MSI in writing and will be approved on a case-by-case basis.

The time frame for submitting the request to MSI for late submission should be within one month following the 90-day limit. Examples of extenuating circumstances may include physical damage to office such as fire or flood and/or a serious technical issue.
Circumstances relating to staffing issues/shortages and mislaid, misfiled, or lost claims cannot be accepted by MSI as valid explanations for a late submission. Explanations relating to late discharge summaries, or facilities not consolidating the required information for the physician, cannot be accepted as a valid explanation for a late submission.
Failure to use a preauthorization code given by MSI and annotate the text field with the previous service encounter number will result in an adjudication paid at "zero".

Notes:

- WCB and facility-based service encounters follow the same ruling.
- Claims for registered hospital in-patients must also be submitted within the 90-day time limitation regardless if the patient has been discharged or continues on an in-patient basis. It is incumbent on the physician to obtain the required billing information for these patients and submit claims within the prescribed time limitations.
- **All health service codes, including codes without a patient (Facility On-Call, LFM hours, etc.) and shadow billings are all subject to the same requirements.**

BACK TO CONTENTS

PHYSICIAN'S MANUAL

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

INTERIM FEE REFERENCE GUIDE

Physicians are reminded of the Interim Fee Reference Guide (PDF) available on the MSI website, which provides a comprehensive list of all current interim fees.

NEW AND UPDATED EXPLANATORY CODES

Code	Description
LF004	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 24 HOURS MAY BE BILLED PER DAY FOR ALL LONGITUDINAL FAMILY MEDICINE (LFM) MODEL HOURLY FEE CODES COMBINED
LF006	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 24 HOURS MAY BE BILLED PER DAY FOR HSC HUTC1
LF007	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 24 HOURS MAY BE BILLED PER DAY FOR HSC HEDD1
LF008	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 24 HOURS MAY BE BILLED PER DAY FOR HSC HEDE1
LF009	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 24 HOURS MAY BE BILLED PER DAY FOR HSC HIPD1
LF010	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 24 HOURS MAY BE BILLED PER DAY FOR HSC HIPE1

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

UPDATED FILES

Updated files reflecting changes are available for download on March 28, 2025. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), and Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

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

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)
http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS
www.novascotia.ca/dhw/

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BACK TO CONTENTS