Family Medicine New Brunswick

Compensation Guide

FEBRUARY 1, 2021

NEW BRUNSWICK MEDICAL SOCIETY AND THE NEW BRUNSWICK DEPARTMENT OF HEALTH

Contents

Chapter One – Introduction

The Family Medicine New Brunswick (FMNB) Program is a provincially funded program delivered by the New Brunswick Medical Society (NBMS) with the goal of increasing patient access to family physicians by encouraging physicians to work in groups and provide extended hours of care. The FMNB Program is included in the Physician Services Master Agreement, Schedule V, and is governed by a Program Management Committee (PMC) consisting of representatives from the NBMS and the Department of Health (DH).

To give background, in 2016 the NBMS proposed a new model of family medicine to be implemented and fully developed in collaboration with the DH. The program encourages enhancements such as extended-hours, improved patient access, health care providers working in teams, and ease of physician recruitment. Sustainability and financial prudency are necessary elements of the program. The FMNB Program creates a structure that supports family physicians in their work.

1.0 Overview

The FMNB Program is based on the best practices of family medicine systems observed in other provinces and jurisdictions worldwide with the goal of improving family medicine effectiveness while ensuring sustainability.

The principles underpinning this program include:

- A patient-centred approach to care;
- Financial responsibility and sustainability;
- Timely, longitudinal access to professionals;
- A team-based and interprofessional approach from providers;
- Full use of an Electronic Medical Record (EMR);
- The integration of care across sectors;
- A focus on prevention, self-care, and chronic disease management; and
- Productive and quality-focused professionals.

Key elements of the program include:

- FMNB Physician Group
- Extended hours
- EMR
- Blended Payment Model
    - Captitation (based on patient roster)
    - Reduced Fee-For-Service
- Altered Billing Rules
    - Nursing Services
    - New Codes for non-face-to-face encounters
- Overhead Provision
- Business Improvement Specialist

1.1 Model

Governing Bodies

The day-to-day operations of the FMNB Program, including recruitment, is run by FMNB Operations which is part of the NBMS. Decisions regarding FMNB are made through negotiations between the NBMS and the DH, through the Program Management Committee (PMC), regarding the management of clinical aspects of the program and pertaining to conflict resolution among the physicians. The PMC is responsible for final decisions regarding any changes to the program.

The Physician Stewardship Group (PSG) is a sub-committee of the PMC that is made up of physicians, including one physician from each FMNB Group, who provide recommendations to the PMC regarding the program on behalf of physicians.

Physician Compensation

The FMNB compensation model for physicians consists of four components: components one and two make up the Blended Payment Model (BPM); and components three and four are incentives.

1. Capitation payment pro-rated by patient demographic
2. Fee-for-service (FFS) at reduced rate
3. Altered billing rules to accommodate services provided by office nursing staff, as well as the creation of new service codes for electronic visits and telephone visits
4. Overhead Support including payment of fees associated with an Electronic Medical Record and annual Overhead Provision.

Office Location – Location 19

Throughout this document any reference to Location 1 – Office will include the temporary Location 19 – Virtual Care while the location is effective. All rules associated to location 1 will apply to location 19 which will fall under the FMNB Program.

Extended Hours

Extended hours are a mandatory part of the FMNB Program. Requirement varies depending on rural or urban settings. Physicians are not required to work longer hours but may choose to start their work day earlier or later and adjust their hours appropriately. While a physician is on leave and a locum is in place, the responsibilities of the Group must be upheld. For example, the Group may decide to take on the extended hours responsibilities of the physician on leave, or the locum may perform those duties exactly as the physician on leave would have.

Urban – 2.5 hour period **four days a week** (Monday to Friday) outside the hours of 8am-5pm and one three hour period over the weekend.

Rural – 2.5 hour period **two days a week** (Monday to Friday) outside the hours of 8am-5pm and one three hour period over the weekend.

FMNB Groups

Physicians are required to work in groups under the FMNB Model. The number of physicians in the group must be two (2) or more but is up to the physicians to determine the size. This allows the physicians to cover each other's patient during absences and share extended hours to ensure timely access to all patients affiliated with the FMNB Group. Whenever possible, physicians are expected to provide same day or next day services to patients. Through an FMNB-approved EMR the physicians are able to share patient charts in order to maintain a comprehensive patient health record.

Electronic Medical Record (EMR)

Every physician who participates in the FMNB Program will be required to submit electronic claims to Medicare using an FMNB-approved Electronic Medical Record (EMR), which has been specifically tailored to the elements of the program. The EMR will allow physicians to formally roster patients to their practice and access charts of patients rostered to other physicians in their FMNB Group to ensure comprehensive patient care. See *Section 6.0 –Electronic Medical Record (EMR)* for further information.

Joining the Program

Physicians can apply to join the FMNB Program as a group by submitting the FMNB Application Form to the PSG. Each physician will also have to sign the *FMNB Group Physicians Agreement* once their application has been approved. Physicians begin receiving regularly scheduled capitation payments as of the "effective date", or their first date of practice in the FMNB Program for their rostered/temporarily rostered patients. Physicians can also join an established FMNB group looking to expand, by submitting the FMNB Application Form. After approval, they will be required to sign the *Accession Agreement* to the *FMNB Group Physicians Agreement*.

During the transition to the FMNB Program, the DH offers a transitional payment plan to implement a minimum and maximum guaranteed remuneration. This will provide physicians joining FMNB with a level of income security.

Chapter Two – Roster

2.0 Rostering of patients

Patient rostering is the process by which family physicians formally enroll patients to their practice by signing a *Patient Enrolment Form* that outlines the expectations of both parties. Rostering is a key component of modern primary care models and has been adopted in other provinces. Patient rostering is a core element for FMNB physicians to formalize an affiliation between the physician and the patient.

Patient rostering represents a dual commitment from the patient and the physician:

- ✓ Patients seek treatment from their rostered physician or associated providers in their FMNB Group for all primary care medical concerns, except for imminent emergency care needs; and
- ✓ Physicians agree to provide comprehensive care to their patients in a timely manner – same day/next day whenever possible.

This dual commitment establishes the patient/provider relationship through a formal agreement that benefits both patients and providers and will enable improved continuity of patient care.

Each patient in the FMNB Program will be rostered to the practice of their personal family physician and can only be on the roster of one physician. Please refer to the "FMNB Guide to Patient Rostering" for more details. Patients are strongly encouraged to contact their physician or the physician's group before seeking care from an after-hours clinic.

2.1 Rostering Status

Below are the various roster status that can be applied to a patient:

Roster Status	**Description**	**Expiration timeline**	**Capitation?**	**Fee-for-service?**
Temporarily Rostered	Frontloaded patients and patients added through Medicare System can be this status. This status is not available in the EMR	2 years from Effective Date	Yes	Reduced
Rostered	Patient Enrollment Form is required	None	Yes	Reduced
Roster Exception	Patient has one of the identified conditions (see *Section 2.2*)	None	No	100%
Undecided	Patient is not ready to sign Patient Enrollment Form and needs more time to consider	60 days from Effective Date	Yes	Reduced
Refuse to Roster	Patient refuses to sign Patient Enrollment Form. Patient can be seen by the FMNB physician for 1 year then must find a new family physician.	1 year from Effective Date	No	100%
De-Rostered	Physician has decided to remove patient from practice. Patient can be seen by the FMNB physician for 1 year then must find a new family physician.	1 year from Effective Date	No	100%

2.2 Rostering Exceptions

There are patients of every age group who suffer from disorders and conditions that require significant medical care. The concept of "roster exception" applies to these patients. Patients with these conditions are considered part of the FMNB physicians' practice but are exempt from the FMNB method of payment. The physician will bill traditional fee-for-service rates at 100% for their care and they will not generate access adjustments for seeking care at walk-in clinics, or generate capitation payments. A list of these disorders and conditions have been proposed by the PSG and approved by the PMC.

Below is the current list of disorders and conditions that would cause a patient to be identified as a roster exception are:

- ✓ Psychotic disorders such as schizophrenia, borderline personality and bipolar disorders;
- ✓ Cancer associated with a present systemic chemotherapy or radiation treatment, or in the palliative stage;
- ✓ Motor neuron diseases, such as Amyotrophic Lateral Sclerosis (ALS)
- ✓ Multiple sclerosis;

In treatment for substance addiction, withdrawal or detoxification (excluding tobacco addiction).
This list may be updated periodically by the PMC.

- ✓ To indicate a patient as a roster exception , the FMNB physician will enter a roster exception status for that patient in the Provincial EMR or during the initial roster process, as outlined in *The Physician's Guide to Rostering Patients*.
- ✓ If the physician believes there is a condition that is not included on the list of conditions for roster exceptions and should be, they can make such a request to the PSG, which can consider recommending adding a condition to the list.
- ✓ The PMC must approve any removals or additions to the list of roster exception conditions.
- ✓ There is no cap on the number of roster exceptions per physician or FMNB Group.

2.3 Front loaded Roster

For physicians who have been in an established practice, Medicare will generate a frontloaded roster for the physicians to review. This is a list of patients who have seen that physician more than any other physician over the last three (3) years for in-office services. Physicians already using an EMR can also use a clean patient list derived from their EMR. The patients will be assigned a Temporary Roster status for a period of 750 days, after the 750 days they will lose the Temprory Roster status. Patients are formally rostered once the *Patient Enrollment Form* has been signed, scanned and roster status updated in the EMR. Physicians taking over existing practices or patients from an established physicians may contact FMNB for discussions on generating patient lists.

2.4 Services to non-rostered patients

In-office services rendered to non-rostered patients (except for the in-office procedures payable at 100%) are payable at 0 unless a valid reason is provided (refer to ***FMNB*/*EMR Billing Procedures*** for further instructions). Reasons must be approved by the PSG and PMC.

Chapter three – Compensation

3.0 Blended Payment Method (BPM)

The FMNB Program offers a different type of remuneration for physicians. The BPM is made up of two (2) key elements: capitation and reduced fee-for-service (FFS).

3.0.1 Capitation

Patients are formally rostered to individual FMNB physicians that are practising in the program. Based on the patients rostered to them, physicians receive an annual capitation amount per patient that is prorated into bi-weekly payments regardless of whether patients receive care in a given year.

Age Category	Male	Female
00-04	1.03	0.98
05-09	0.55	0.54
10-14	0.44	0.46
15-19	0.47	0.81
20-24	0.46	1.01
25-29	0.50	1.05
30-34	0.58	1.05
35-39	0.71	1.14
40-44	0.80	1.18
45-49	0.87	1.29
50-54	1.01	1.44
55-59	1.15	1.46
60-64	1.27	1.49
65-69	1.43	1.58
70-74	1.67	1.71
75-79	2.04	2.08
80-84	2.21	2.28
85-89	2.65	2.81
90+	3.34	3.57

- ✓ The payments for individuals vary depending on the ratios applicable to the various age and gender cohorts. Age and gender modifiers are applied to the base rate.
- ✓ Upon receiving the initial, approved list of patients to be rostered (temporarily rostered, front-loaded residents) Medicare will begin paying the physician the correct capitated amount for each patient. Capitation payments will be adjusted for each additional patient rostered into the practice.
- ✓ The annual capitation value is prorated into daily amounts to be paid to physicians on a bi-weekly basis over the course of the year.
- ✓ Medicare will recover capitated payments if errors are made.

The capitation base rate is set at **$96.09**. This rate is set by the PMC. The capitation rate calculated is for each rostered patient by applying their age and gender ratio to the base rate. This ratio is designed to reflect the average level of care by demographic category. The capitation payment per patient will be calculated daily to consider changes in roster composition, and appropriately compensate physicians bi-weekly.

3.0.2 Fee-for-service (FFS)

A physician that is practising in the FMNB Program must continue to bill in accordance with the *New Brunswick Fee Schedule* outlined in the *Physicians' Manual* for all insured services provided to patients.

- ✓ The physician shall bill for all insured services provided to rostered patients in the office at the reduced FMNB FFS rate, using the existing billing codes. Examples of some in-office codes are listed in **Appendix A;** however, this is not an exhaustive list of in-office codes open to GPs and the *Physicians' Manual* **MUST** be reviewed**.**
- ✓ A number of in-office services have been identified to be billable at 100% FFS for all patients as they may be offered to rostered and non-rostered patients. (**Appendix B**). For additional procedural codes please refer to the *Physicians' Manual*.
- ✓ Out-of-office services, such as work in hospitals (in-patient, outpatient, ER shifts), nursing homes, home visits, etc., are billable at 100% of the current rate as they are rendered in a location other than location 1 – Office.

- ✓ FMNB physicians **<u>are not</u>** entitled to bill Service Code 3 – Walk-in Clinic – Visit as they are not permitted to work in designated After-hours walk-in clinics. They are expected to offer extended-office hours for patients affiliated with their FMNB Group.

3.1 Access Adjustments

Every patient rostered with an FMNB physician must sign the FMNB *Patient Enrolment Form* acknowledging that they understand and agree to abide by the terms outlined on the form. A patient's participation in the program will depend on their willingness to access their own FMNB physician or their physician's larger FMNB group for care, taking advantage of the FMNB Group's extended weekday and weekend hours whenever possible. If a patient does not comply with the terms of the program the physician can choose to de-roster them from their practice, as outlined in the *Physician's Guide to De-Rostering.*

When a Code 3 – Walk-in Clinic – Visit is billed for a rostered patient in a designated after-hours walk-in clinic the patient's rostering physician will be deducted that amount from the capitation amount on the next pay and the visit will appear their *Practitioner Reconciliation Statement*.

The purpose of the Access Adjustment is to encourage FMNB physicians to provide timely access to their patients as well as extended hours so patients affiliated to their FMNB Group are not required to seek care at after-hours walk-in clinics. FMNB physicians are not permitted to work in these settings or bill Code 3.

- ✓ If another member of the FMNB group other than the rostering physician sees the patient, no access adjustment is applied.
- ✓ The access adjustment applies only to Code 3 billed in designated after-hours walk-in clinics.
- ✓ The Access Adjustment section of the *Practitioner Reconciliation Statement* will indicate the patient, date of the service, and the amount recovered from the rostering physician.
- ✓ No access adjustment will be applied to the rostering physician for the first three months of their participation in the FMNB Program. After three months, the access adjustment is applied regardless of whether the patient has a signed *Patient Enrolment Form* so long as the patient remains on the physician's roster.
- ✓ No adjustment will apply to use of alternate providers for patients identified as roster exemptions. *Code 8107 – Chart Initiation Fee* may appear in the Access Adjustment section of the statement to notify the physician that a chart has been opened on one of their patients by another physician. If this occurs, the physician should contact the patient or de-roster. (see Chapter two – Roster)
- ✓ Access adjustments for the physician will continue until they have reached a deduction limit which is currently set at 25% of their total capitated payments.
- ✓ If the physician believes an adjustment has been incorrectly applied, they can appeal the decision to the PSG, who will determine if a reversal is necessary. The PSG will also consider if a rule change is necessary but the Program Management Committee (PMC) must approve any changes to the remuneration model.
- ✓ Access adjustments may also occur if the physician goes on-leave, whether or not the physician has a locum replacement. See *Policy 10 – Locum coverage for physicians paid in accordance with Family Medicine New Brunswick.*

3.2 Medicare Practitioner Reconciliation Statement

Like all physician, FMNB physicians receive bi-weekly *Medicare Practitioner Reconciliation Statements* through the Electronic Communications to Physicians (ECP). These statements reflect the payment status of claims that have been billed, as well as the Access Adjustments, Roster breakdown, and the the amount the physician was paid for the two (2) week payment cycle. While some EMRs have a reconciliation component it is crucial that physicians review their *Medicare Practitioner Reconciliation Statements* regularly as it is the final word in how the claims have been processed. In some instances claims may need to be resubmitted or additional information provided before a claim can be properly processed.

3.3 Minimum Guaranteed Remuneration (MGR)

The MGR is a fixed, bi-weekly payment that physicians may opt into receiving when transitioning into the program. The MGR was designed to mitigate risk and facilitate the transition into the FMNB Program.

For the first year a physician is with the program, they will be given the option to be paid the MGR amount for their first year, which will be prorated into bi-weekly payments **OR** be paid directly under the Blended Payment Model (BPM). They will be paid under the BPM in year 2.

The MGR is based on:

1. The best of their last two years of **in-office** fee-for-service billing (calculation is based on pay dates) divided over 26 pays; or
2. $175,000 (divided by 26 pays) – for new physicians or established physicians with insufficient in-office billing history in New Brunswick. Regional Health Authorities (RHAs)/Zones will be required to provide Medicare and the NBMS with a copy of the Letter of Offer/Employment, describing the practice expectations of physicians who are being offered the MGR of $175,000 under the FMNB Program.

All new physicians that do not have a prior fee-for-service billing history, or established physician with insuficient history of billing in New Brunswick, and opt to be paid a fixed MGR, shall sign a Return of Service Agreement with the Department of Health substantially in the form attached as **Appendix E**.

Once a physician moves to the BPM, they cannot switch back to MGR.

3.4 Maximum Remuneration

The maximum remuneration a physician is entitled to earn a year for in-office services, while receiving an MGR, known as the Maximum Remuneration, will be the greater of the following:

- ✓ The best of their last two years of FFS in-office billings (12 month periods); or
- ✓ The equivalent to the value of the Converted FFS Equivalent amount including nursing; or
- ✓ The Blended Payment Model value (reduced FFS and capitation);

To a maximum remuneration of 100% Converted FFS Equivalent plus 5%.

3.5 FMNB Reconciliation

While the FMNB physician is being paid under the MGR, the Department will reconcile billings and payments 12-month mark based on the physician's start date in the program. Reconciliations may be done more frequently if required by FMNB Operations. This is the process whereby FFS claims are reviewed compared under the BPM vs. 100% FFS vs. MGR to see how the different remunerations would have paid the physicians.

Physician-provided services billed to the FMNB Medicare Billing Account at the reduced FFS rate per the BPM will be converted to the value of what would have been earned for the same services under the traditional FFS model of 100% value. Claims billed to the non-FMNB Account will not be considered.

- For BPM Reconciliation: all services (physician and nurse, telephone email or traditional) are valued at the rate they were originally submitted (per the BPM guidelines).
- For Converted FFS Equivalent:
    - Services rendered by the physicians will be converted to 100% tof the FFS code
    - All telephone visits and email visits (Role 0 and/or Role 7) will be reconciled to 100% of the Code 1 – Office Visit value;
    - Other services provided by nurses will be reconciled to 75% of the normal value of the service provided, except for the excluded codes; and
    - Claims paid at 0 or cancelled will not be considered in the reconciliation.

Based on the reconciliation, the physician may be topped-up to the higher value as prescribed in section 3.4 - Maximum Remuneration. .

Chapter four – Altered Medicare Billing Rules

4.0 Billing Rules

While FMNB physicians are required to bill in accordance with the *New Brunswick Fee Schedule* (per the *Physicians' Manual*) for insured services the FMNB compensation model has altered Medicare billing rules to allow billings to be submitted for services provided by Registered Practical Nurses (RNs) or Licensed Practical Nurses (LPNs). New codes have also been created as well for email and telephone visits for use by FMNB physicians only.

4.1 Code 210 – Extramural Communication and Code 1898 – Warfarin Supervision

It has been determined through discussions between the Department of Health and the New Brunswick Medical Society that when billing Service Code 210 – Extramural Communications or Code 1898 – Warfarin Supervision for patients rostered to the FMNB provider or a member of his/her FMNB Group that Location 1 – Office must be used and services must be billed to the physician's FMNB Medicare Billing Account during the MGR period.

Patient FMNB? Y/N	Roster Status	Location to be billed	Account (During MGR)	%
Y	rostered, temp rostered, undecided	1	FMNB	50%
Y	roster exception, excluded (includes orphans), refuse to roster	1	FMNB	100%
N (orphan)	N/A	Applicable location (outside location 1)	Non-FMNB	100%

4.2 Office Nurse

Physicians are encouraged to hire RNs or LPNs who are duly licensed by their professional regulatory organization to provide care to maximize patient access. FMNB physicians are entitled to bill for applicable services rendered by the RNs and LPNs.

- ✓ The physician must hire RNs and LPNs privately. There is no financial relationship between the Department of Health and nurses in the FMNB Program.
- ✓ FMNB physicians will bill for applicable office work accomplished by both nursing staff, whether the patient physically sees a physician or not.
- ✓ As services rendered by the RN or LPN are billed under the physicians Practitioner Number, billing rules for a single provider apply.
- ✓ Claims must be submitted with **Role 7 - Nurse**
- ✓ Physician are not required to be on-site.
- ✓ Physicians are responsible for ensuring that work performed and billed is done according to the standards prescribed in the *Physician's Manual*.
- ✓ Certain codes are payable at 100% if they are part of the list of codes in the **Appendix B** of this document.
- ✓ Services provided and the reduced FFS rates associated with services provided by RNs and LPNs are outlined in the **Appendix C** of this document.

Please note: If the nurse and physician provide the same service during the same appointment, only one can be billed.

4.3 Service Code 849 - E-visits

The FMNB Program offers a way to compensate physicians rendering clinical services electronically to patients as opposed to seeing them face-to-face in the office for diagnosis and/or treatment of a medical concern. FMNB physicians will be able to communicate with patients through a secure email if their EMR is equipped with the necessary functionality. Record of this communication will be logged in the patient's electronic medical record.

- ✓ **Service Code 849 - e-Visit** has been created
- ✓ Patients must initiate the conversation
- ✓ When using e-Visits, physicians or nursing staff must use the EMR to communicate securely with patients.
- ✓ The e-Visit communication shall relate to a clinical inquiry and health issue – i.e. not a communication about administrative needs, such as booking or cancelling an appointment, and is not to cover typical follow-up care, such as relaying test results or refilling a prescription.
- ✓ Only billable if the communication is conducted by a physician or nursing staff. Not applicable to administrative staff.
- ✓ Physicians may ensure the proper level of care by having the patient come in for an office visit, if necessary.
- ✓ Only one e-Visit per patient can be billed on the same day. Back and forth dialogue is included in one service and only one communication can be billed.

The fee for Code 849 - e-Visit is set at **$18.72** for physicians, and **$17.68** for nursing staff **(See Appendix C).** Office visits can be billed on the same day for the same patient when an e-Visit (code 849) code is billed, but a telephone visit (Code 850) cannot be billed on the same day.

4.4 Service Code 850 - Telephone Visits

The FMNB Program offers a way to compensate physicians rendering clinical services by telephone to patients as opposed to seeing them face-to-face in the office for diagnosis and/or treatment of a medical concern. Telephone encounters must be charted in the patient's medical record.

- ✓ **Service Code 850 - Telephone Visit** has been created.
- ✓ Service Code 8101 - Seniors Office Visit, add-on may be billed in addition at reduced FFS value provided the necessary criteria associated to the code is met.

- ✓ Patient initiated **OR** initiated by the physician/nursing staff as medical follow-up of an abnormal result investigation, or consultation requiring clinical reasoning and action. (See examples below)
- ✓ The conversation will need to be charted in the EMR.
- ✓ Communication pertaining to administrative needs, such as booking or cancelling an appointment, typical follow-up care, such as calling a patient about test results, or requesting a prescription renewal cannot be billed.
- ✓ Only billable if the communication is conducted by a physician or nursing staff. Not applicable to administrative staff.
- ✓ Physicians may ensure the proper level of care by having the patient come in for an office visit, if necessary.
- ✓ In-office services can be billed on same day for the same patient when an electronic (Code 849) or telephone code (code 850) is billed when appropriate.
- ✓ Only one phone conversation per patient can be billed on the same day. (Back and forth dialogue is included in one service and only one conversation can be billed.)

Example:

- ✓ Follow-up on an **abnormal** Pap test or x-ray result where further investigation is required, medical discussion on next steps after a specialist consult, etc. would be appropriate and eligible for Code 850.
- ☒ Follow-up on a normal test result or routine medication refill would not be appropriate for Code 850.

Note: While location 19 – Virtual Care is available the applicable in-office codes may be billed if provided by telephone as opposed to Code 850.

The fee for Code 850 – Telephone Visit is set at **$18.72** for physicians, and **$17.68** for nurses **(See Appendix C).** Office visits can be billed on the same day for the same patient when a phone call code (Code 850) is billed but an e-visit (Code 849) cannot be billed on the same day.

4.5 Services payable at 100%

Specific in-office procedures have been negotiated to be payable at 100% for rostered and non-rostered patients **(see Appendix B)**.

4.6 Non-FMNB billings (during the MGR period)

During the MGR period, any services rendered in a location other than location 1 – Office, will be billed to a Non-FMNB Medicare Billing Account regardless of the patient's roster status, and are eligible to be billed at 100% FFS. This includes home visits, nursing homes, hospital care, on-call, services under an AFP, sessional, or other payment arrangements. Services rendered by nurses outside of the office location are not eligible for payment. Once the physician transitions to the BPM any service rendered outside location 1 – Office will continue to be billed at 100%; however, they will be billed to the same account as FMNB services.

Locations

Location 2 – Nursing Home	Location 3 – Emergency Room	Location 4 – Patient Residence
Location 5 – In-patient	Location 6 – Intensive Care Unit	Location 7 – Outpatient Department
Location 8 – Telemedicine	Location 9 – Special Care Home	Location 11 – Sexual Health Centre

Chapter five – Locums

One of the fundamental tenets of the FMNB Program is to promote teamwork, enabling collaboration between physicians providing primary care to a group of patients. Before requesting a locum, established FMNB physicians are expected to coordinate vacation(s) and other leaves within their group.

During a short-term leave of absence, it is expected that the other members of the FMNB group will provide access to patients as well as covering the group's extended-hours schedule of the on-leave physician. If the group determines coverage is not possible or the absence will be long term (ex: parental leave) a locum may be hired provided the requirements in Policy 10 are met. Please see Medicare *Policy 10 - Locum coverage for physicians paid in accordance with Family Medicine New Brunswick* for information regarding hiring requirements and payment of locums.

Chapter six – Overhead Support

Recognizing there are inherent costs with a team approach and using an EMR, and that both are requirements of the FMNB Program, the DH will support physicians' overhead in two ways: EMR Support and the Overhead Provision Payment.

6.0 Electronic Medical Records (EMR)

A one-time installation fee and on-going operational costs for an EMR are covered for FMNB physicians as follows.

- ✓ Physicians will be required to purchase a FMNB-approved EMR in order to bill under the FMNB Program. However, the Department will reimbursed up to $8,000 one-time start-up fee to the FMNB physician.

- ✓ Monthly EMR fees will be reimbursed to the FMNB physician each month by the Department.
- ✓ If a physician leaves the FMNB Program, that physician must pay their own monthly fees from date of their exit from the program.
- ✓ If a physician previously without an FMNB-approved EMR withdraws from the FMNB Program prior to completing six months in the program, the Department will recover from the physician the reimbursement of the one-time EMR cost.
- ✓ The funding levels for the FMNB-approved EMRs are subject to change by the Department, though advance notice must be provided to the physician.
- ✓ Any additional training or other services will be at the expense of FMNB physicians.

Effective March 1, 2021, **Service Code 860 - FMNB - EMR Monthly Fee** will be available to bill electronically through the EMR for reimbursement of monthly fees, once per calendar month. The following information must be included on the claim:

Account: NON-FMNB (under MGR)

Primary/sole Account (under BPM)

Medicare #: 521111112

First Name: FMNB

Last Name: Patient

DOB: 24/11/2020

Gender: M

Date of Service: date in month for which fees cover

Service Code: 860

Diagnosis: EMR monthly fees – applicable month

ICD10: Not required

Location: 0 - Other

Role: 0 - General

Units: 454

Service Count: 1 (each month must be billed separately by each provider)

6.1 Overhead Provision Payment

There is an annual $5,000 Overhead Provision Payment for each FMNB physician to encourage hiring of family practice RNs or LPNs; to renovate their offices; to purchase additional information technology; or to otherwise equip their offices. The payment will be made to each FMNB physician upon submission of a funding request, via an invoice, with a brief description of expenses, for a maximum of $5,000 per physician per government fiscal year which runs from April 1 to March 31.

Expenses must be incurred during the year in which the payment is being requested. Receipts must be maintained at the physician's office for audit purposes. The Department has the right to audit a physician up to seven (7) years after a payment is made.

Examples of eligible expenses include:

- ✓ Clinical staff salary, such as RNs or LPNs;
- ✓ Physical space improvements or renovations to add capacity to the practice; and
- ✓ Additional information technology to improve communication with members of the group.
- ✓ Medical equipment to improve services and/or efficiencies

Please refer to **Appendix D** for the *Overhead Provision Expense Form or the FMNB portal at www.fmnb.ca*.

FMNB physician working out of a facility owned by Horizon Health Network or Vitalité Health Network are not eligible for the overhead incentive.

Chapter seven – Medicare Information

7.0 Accounts

During the MGR Period:

While physicians are being paid under the MGR they will be required to bill to at least **two** separate Medicare Billing Account.

1. An FMNB Billing Account for all FMNB in-office billings and capitation payments – FFS **will not** be paid under this account; and
2. A non-FMNB Billing Account for all services rendered outside the office – FFS **will** be paid under this account.

These accounts are for billing purposes only. Multiple bank accounts are not required as physicians can link both billing accounts to the same bank account. Payment will be issued to the bank account identified at the time Medicare Billing Accounts are created. The MGR payments will be issued to the bank account associated with the FMNB account in the instance a different bank account will be linked to the two billing accounts.

Account Creation Forms are available on the Government of New Brunswick website or by contacting the Medicare Services Support Unit within the Department.

Other accounts may also be required if the physician is participating in other payment arrangements such as Alternate Funding Plans.

Under the BPM:

Once the physicians transition to the BPM they will bill to **one** of the existing Medicare billing accounts. The physicians may select which account the will continue to use and request the secondary account be terminated in the EMR and Medicare System.

*Please refer to the **Medicare Policies** on the intranet at Medicare Account Policies for a complete listing of all account types and account descriptions.*

7.1 Auditing

FMNB physicians will be subject to the same requirements as all other physicians and will have the same opportunity to be chosen for an audit as all other physicians. All documentation that supports billing must be retained for seven (7) years. Please refer to the *Physicians' Manual* for further information.

7.2 Enquiries

Claim related questions will be directed to the Practitioner Enquiries within the Department. They will answer any inquiries related to claims, codes, procedures etc.

Questions related to accounts, reconciliation statements and monetary payments will be directed to the Medical Services Support Unit in the Department.

Program specific questions may be directed to the FMNB Operation within the NBMS.

Chapter eight – FMNB Training

Being part of the FMNB Program allows for each participating physician, office nurse, and Medical Office Assistants (MOA) to receive training on process improvements, such as more effective scheduling of patients, how to make use of the new e-Visit and telephone codes to provide more patient-centered care, and more.

8.0 Training from the Department of Health – Medicare

Training for Medicare billing rules, service codes, policies, and procedures as per the *Physicians' Manual* will be offered free of charge by the Medicare Practitioner Liaison Officers and is mandatory for all physicians and billing staff joining the FMNB Program. Refresher training sessions are also available.

8.1 Training from New Brunswick Medical Society – FMNB Operations

Physicians and staff receive in depth on-site training from NBMS/FMNB Operations team regarding the Program and rostering. Staff from FMNB Operations remain on-site during the first few days the clinic is practising under the model to ensure a smooth transition for physicians, staff and patients.

NBMS/FMNB will reimburse every physician participating in the FMNB Program for up to two days of mandatory training at standard NBMS rates, as well as two days of Income Replacement reimbursed at the equivalent rate as prescribed by the Program of Supplementary Funding for CME – Fee-For-Service. FMNB training is not yet eligible for CME credits and the amounts reimbursed will not count towards the physician's annual CME allocation.

NBMS/FMNB will provide FMNB groups with continuous practice management support through business improvement initiatives, though this training is optional and not reimbursed.

8.2 Training from EMR providers

Physician and staff receive training from their EMR provider.

8.3 Business Improvement Specialist

Once physicians are established with FMNB a Bunsiness Improvement Specialist will do a review of various elements of the practices in order to provide feedback to physicians that will allow them to work more efficiently and effectively

Chapter nine – Conclusion

FMNB provides an alternate method of remuneration to family physicians by introducing a blended payment model. The model combines a weighted capitation component and a reduced fee-for-service remuneration as well as introduces new billing rules for nurses, e-Visits and telephone services, and overhead support. The FMNB model is not to replace existing models, but it provides physicians with a progressive choice as to how to practice medicine in New Brunswick.

Appendix A: FMNB-Specific Services (location 1 and 19 only)

Refer to Physicians' Manual for additional service codes.

Consultations			
GP	**Nurse**	**Code**	**Service Code Description**
100%	N/A	10	Major consult (must have written request)
100%	N/A	12	Repeat consultation (new referral within 30 days of major consultation)
Office visits (location 1)			
GP	**Nurse**	**Code**	**Service Code Description**
50%	45%	1	Office visits
50%	45%	8101	Seniors office visit, add-on to Code 1 or Code 850
100%	100%	19	Well-Baby Care (up to 365 days)
100%	N/A	8116	Opiate Addiction – Office visit (physician must have appropriate license to dispense Methadone)
50%	N/A	7	Complete Physical Exam
Chronic Disease Management (billable once in a 365 days) ***Patient must be seen at least 2x per year in relation to their chronic disease. Must complete appropriate flow sheet.***			
GP	**Nurse**	**Code**	**Service Code Description**
50%	45%	8109	Diabetes
50%	45%	8113	COPD
Obstetrical Care			
GP	**Nurse**	**Code**	**Service Code Description**
100%	100%	15	Prenatal Complete Check (not payable within 42 days of code 7 or 2173)
100%	100%	16	Pre and/or postnatal visits other than complete examinations
Nursing Homes			
GP	**Nurse**	**Code**	**Service Code Description**
50%	N/A	2000	Pre-admission complete examination (billed in office prior to admission)
Extramural Program			
GP	**Nurse**	**Code**	**Service Code Description**
50%	N/A	209	Visit with admission to program
50%	45%	210	Communication requiring response (initiated by EMP staff member)
50%	N/A	195	Visit to physician's office by Extramural Program staff to discuss <u>one</u> patient
50%	N/A	196	Visit to physician's office by Extramural Program staff to discuss <u>multiple</u> patients
Miscellaneous Services			
GP	**Nurse**	**Code**	**Service Code Description**
50%	45%	200	Detention – (per 15 minutes) – *Indicate start and end time on both the visit and the detention*
50%	45%	2	Injection (intradermal, subcutaneous, intramuscular, terapeutic) (List C)
50%	45%	1948	Injection of medication – bursa, ganglion, joint or tendon, including preliminary aspiration if necessary or intramuscular (List B)
50%	45%	1898	Warfarin supervision – telephone service (List C)
50%	45%	1999	Tray fee for pap test
Codes for FMNB physicians only (payable @ $1.04 per unit)			
GP	**Nurse**	**Code**	**Service Code Description**
18 units	17 units	849	E-Visit
18 units	17 units	850	Telephone Visit
Immunizations			
GP	**Nurse**	**Code**	**Service Code Description**
50%	45%		All immunizations over 12 months of age
Counseling (per 15 minutes – start time, end time and number of services are required)			

GP	Nurse	Code	Service Code Description
50%	45%	20	Psychotherapy
50%	N/A	216	Family counseling (re: placement, DNR, treatment decisions – per 15 minutes)
50%	45%	193	Patient Counseling (“family” unit, ex: marriage counseling, contraceptive advice and sexually transmitted diseases)
Nurse Practitioner (NP) Collaboration			
GP	**Nurse**	**Code**	**Service Code Description**
50%	0	8104	Case conference with NP
50%	0	8105	Patient transfer to/from NP
50%	0	8106	Review for referral to specialist (request by NP)
Office code not billable under FMNB			
Code	**Service Code Description**		
3	Walk-in Clinic Visit		

Appendix B: Excluded In-Office services billable at 100%

Code	***Service Code Description***
10	Consultation
12	Repeat Consultation
15	Prenatal Complete Check (not payable within 42 days of code 7 or 2173)
16	Pre and or postnatal visits other than complete examinations
19	Well-Baby Care (up to 365 days)
99	Suture – other areas - first 5cm.
355	Incision – Abscess – subcutaneous – Local Anesthetic
357	Incision – Abscess – Perianal or pilonidal – Local Anaesthetic
367	Removal of foreign body or fibroma – Local Anaesthetic
369	Biopsy by excision or total excision of small lesion (max three per day)
370	Carcinoma of skin – Excision and repair
376	Resection of portion of nail, nailbed, or matrix
378	Lipoma – Simple
384	Plantar wart – simple, excision, complete care
837	Diagnostic punch skin biopsy
1472	I U C D Insertion
1892	Desensitization acute, e.g. antitetanus serum, penicillin
1894	Hyposensitization injection, including supervision (except initial injection and assessment), per visit
1895	Tests, and antigen, any method – per test (Maximum for any six-month period: 30 tests
2089	Removal of skin lesions by non-surgical methods such as electrocautery, cutterage, or cryotherapy (total fee)
2227	Suture – Face – first 5cm
2487	Suture – Face – more than 5cm
2488	Suture – other areas – more than 5cm but not exceeding 10cm
8116	Opiate Addiction – Office Visit (physician must have appropriate license to dispense Methadone)
Imm.	All immunization for babies up to 12 months of age (365 days and under)

Appendix C: Billing Codes and Rate Table for RN and LPN services provided in the FMNB Program

GENERAL VISITS/EXAMS		
Code	**Service Description**	**Nurse Rate**
1	G.P. OFFICE VISIT	45%
15	G.P. PRENATAL COMPLETE EXAMINATION	100%
16	G.P. PRE OR POST NATAL VISIT	100%
19	G.P. WELL BABY CARE	100%
20	PSYCHOTHERAPY	45%
193	PATIENT COUNSELING	45%
200	DETENTION PER 15 MINUTES	45%
210	EXTRAMURAL COMMUNICATION	45%
849	E-VISIT	$17.68 ($1.04 unit value)
850	TELEPHONE VISIT	$17.68 ($1.04 unit value)
1898	WARFARIN SUPERVISION	45%
8101	SENIOR'S OFFICE VISIT	45%
8109	DIABETES – CDM	45% ($1.01 unit value)
8113	COPD – CDM	45% ($1.01 unit value)
Code	**Service Description**	**Nurse Rate**
2	OFFICE CALLS INJECTION ONLY	45%
1894	HYPOSENSITIZATION SUBSEQUENT	100%
1999	TRAY FEE FOR OFFICE PAP TESTS	45%
2089	CRYOTHERAPY	100%
Imm.	Immunization with Visit	45%
	Immunization without Visit	45%
	All immunization for babies up to 12 months of age	100%

Appendix D: Manual Billing Form, Overhead Support for FMNB Physicians

Appendix E: Family Medicine New Brunswick Physician Return of Service Agreement