Physicians' Guide to Direct Billing

Includes revisions up to January 2019
(français au verso)

New Brunswick Medical Society
Société Médicale du Nouveau-Brunswick

Introduction

This guide to direct billing is designed to provide guidelines and information to help New Brunswick physicians carry out the direct billing process in an efficient and professional manner.

It was produced by the Economics Committee of the New Brunswick Medical Society (NBMS) in consultation with the Section Liaison Representatives and approved by the Board of Directors.

There are a number of ways by which you can contact the NBMS should you require clarification or further information, or have suggestions or comments regarding this guide.

Contact the New Brunswick Medical Society (NBMS) by mail at 21 Alison Blvd, Fredericton NB E3C 2N5; by telephone at 506-458-8860 or 1-800-661-2001; or by e-mail at info@nbms.nb.ca.

The Guide is also available in the "Members Only" section of the New Brunswick Medical Society website. The address is: **www.nbms.nb.ca**

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What Services Can be Billed Directly to the Patient?

A service may be billed directly to the patient if it is not covered by Medicare or some other insuring body. Using Medicare as the frame of reference, there are three scenarios under which the physician may bill the patient directly: an uninsured service; an uninsured patient; or the physician opts out of Medicare. These scenarios are described below:

- An uninsured service is one requested by an insured patient that is not included in the range of entitled services under New Brunswick Medicare. A complete list of uninsured services is located in the *Medicare Physicians' Manual*. The *Medicare Physicians' Manual* also includes a list of itemized supplies and materials that are not insured.

It is important to note that any "third party" request is not insured by Medicare.

- An uninsured patient is anyone who is not included as a beneficiary of the Medicare System under the *Medical Services Payment Act*. Examples include: regular members of the Canadian Armed Forces; persons serving a term of imprisonment in a penitentiary maintained by the Government of Canada; or international patients.

In addition to Medicare, the New Brunswick Medical Society has Agreements on fees with WorkSafeNB. Therefore, this Guide does not apply to WorkSafeNB. Rates that should be charged to WorkSafeNB are outlined in Appendix A.

- A physician may choose to opt out of Medicare. This can be done for individual services, or completely. When a physician opts out, he/she must advise the patient in advance of providing the service. Medicare also states that the patient must be advised that the "patient is entitled to seek the services from another practitioner on an opted-in basis." Regarding the fee charged to the patient, two possibilities exist:

  a) A patient is charged an amount equal to Medicare. In this instance the physician is required to complete a Medicare Claim Form and indicate the amount charged to the patient. The patient must certify this data on the claim form in order to be reimbursed by Medicare.

  b) A patient is charged an amount in excess of Medicare's fee. In this instance the physician is required to inform the patient that a fee above Medicare's rate is being charged. As a result, the patient waives all right to reimbursement by Medicare. Therefore, a patient must complete the *"Patients Medicare Coverage Waiver"* and the completed form must be submitted to Medicare. By charging the patient an amount in excess of Medicare's fee, this service becomes an uninsured service; the patient is thus not entitled to any reimbursement from Medicare.

Ethical Considerations

When billing a patient directly, physicians must keep in mind ethical considerations. Members should consider the following excerpts from the CMA Code of Ethics:

1. Consider first the well-being of the patient.
2. Practise the profession of medicine in a manner that treats the patient with dignity and as a person worthy of respect.

13. Do not exploit patients for personal advantage.

16. In determining professional fees to patients for non-insured services, consider both the nature of the service provided and the ability of the patient to pay, and be prepared to discuss the fee with the patient.

17. In providing medical services, do not discriminate against any patient on such grounds as age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation or socio economic status. This does not abrogate the physician's right to refuse to accept a patient for legitimate reasons. . . . . .

In addition, the College of Physicians and Surgeons notes that there are several matters which may potentially lead to a claim of professional misconduct. They include:

- stipulating, charging, or accepting any fee that is not fully disclosed, fair and reasonable;
- charging a fee for an undertaking to be available to provide services to a specific patient;
- charging a fee that is excessive in relation to the services performed;
- failure to issue a statement or receipt when requested by a patient or their authorized representative;
- selling or assigning any debt owed to the member for professional services: (but a member may accept a credit card to pay for professional services and may make a general assignment of debts as collateral for a loan to finance his or her medical practice);
- refusing to render a medically necessary service unless payment of the whole or part of the fee is received in advance of the service being rendered;
- refusing to provide professional services for a reason which, having regard to all the circumstances, would reasonably be regarded as discriminatory;
- charging a fee for services not performed. This does not include charging for the cancellation of an appointment less than 24 hours before the appointment time; and
- knowingly submitting a false or misleading account or false or misleading charges for services rendered to a patient.

Uninsured Services and Suggested Fees

The NBMS has historically (since Medicare) published a Guide to Unit Values. The Guide has been incorporated into this document. In addition, the Economics Committee has developed other specific recommended values to serve as a guide to billing for uninsured services.

The following suggested unit values, sessional rates, and itemized fees are not to be construed as either maximum or minimum values. They are only a general guide for services of average complexity. With the assistance of this guide, the individual physician, dealing directly with his or her patient, can set a fair and reasonable value on services provided. The fees charged should reflect time involved, your expertise, and the patient's ability to pay. No physician is obliged ethically or otherwise to follow the Guide; it is not binding on any physician and he or she has the right to deviate from it.

You should review your fees annually to keep pace with inflation, changing conditions within your practice, and your growing expertise. Remember that it is important to discuss your fees with your patient prior to providing services. If your patient's agreement to the fee is not obtained before the service is provided, he or she is not obliged to pay.

Unit Values:

These Unit Values must be multiplied by the units assigned to individual fees in the Medicare Physicians' Manual to produce a dollar figure that may be charged to the patient. The unit values are routinely updated on the basis of inflation and Medicare increases.

General Unit Value $2.60

Radiology Unit Value $2.96

Anaesthesia Unit Value $26.76

(Effective January 2019)

Sessional Rate:

You may decide to either bill patients based on specific fees for services, or the time required to provide a particular service.

Recommended Sessional Rate:

Specialist and Non-Specialist . . . . . .$290-$555/hr or part thereof.

Itemized Fees:

1. Third Party Examinations

1.1 Complete Physical Examination . . . . . .$85-$135
(including Camp or School Physical)

1.2 Complete Disability Examination
(a variable fee may be charged in addition depending on the complexity of any required report) $135

1.3 Insurance physical $135
(an additional fee may be charged depending on the complexity of any required report)

1.4 Driver's Examination . . . . . .$85-$135
(fee may vary depending on complexity, ie. NB vs. American, government vs. insurance company)

1.5 Periodic Industrial Health Physical (ie. pre-employment physical) $170
(an additional fee may be charged depending on the complexity of any required report)

2. Requested forms/reports

2.1 Disability Form . . . . . .$58-$85

2.2 Certificates of short term illness or disability . . . . . .$16-$26

2.3 Third party requested letters/ questionnaires on patient attended, including insurance company assessment . . . . . .$170 +$1.00/pg photocopy
(an additional fee may be charged depending on the complexity of any required report)

2.4 SEP (Single Entry Point) Assessment . . . . . .$58-$115

Forms required for prescription drug insurance:

2.5 Drug Coverage Special Authorization Forms and Quantity Ceiling Override . . . . . .$16-$42

2.6 Complete disability report, including Revenue Canada Disability Forms (follow-up requests may also be billed) $135

2.7 Canada Pension Disability Form $135
($85 paid by Government, $45 paid by applicant)

2.8 Proof of Child Immunization . . . . . .$16-$26

2.9 Red Cross or Other Third Party Equipment Form . . . . . .$16-$26

2.10 Blue Cross or Other Third Party Form (i.e. authorization for foot care) . . . . . .$16-$26

3. Medical Legal Services

Physicians should always discuss and confirm arrangements with the lawyer in advance. Note that these fees are ultimately and directly passed on to the patient as an add-on to the lawyer's fees. Rates may vary based on the complexity of the report.

A lawyer's request for a medical report should always include the patient's consent to the transfer of information. For further information, members can consult the "Lawyer/Physician Interaction Guidelines". Copies of the Guidelines are available from the Society.

3.1 Medical legal report, with opinion . . . . . .$290-$555
extended or complicated . . . . . .I/C (independent consideration)

3.2 Medical legal office briefing by arrangement between physician and lawyer (not involving court appearance) . . . . . .$290-$555/hr or part thereof

3.3 Court appearance
(including waiting time). . . . . $290-$555/hr or part thereof (minimum 3 hours)

3.4 Cancellation of Court Appearance
(without 1-2 working days notice) . . . . . .$290-$555/hr (minimum 3 hours)

3.5 Copying of file on request of lawyer . . . . . .$58 + $1.00/pg

3.6 Travel and Preparation Time . . . . . .$290-$555/hr or part thereof

Note: The above fees may also apply to services performed on behalf of the Crown.

4. Administrative-Technical Services

4.1 Medical advice by letter . . . . . .$290-$555/hour or part thereof

4.2 Medical advice by telephone, fax or electronic media . . . . . .$37-$58

4.3 Prescription renewal . . . . . .$16-$37
(Charges for prescription renewal apply to phone requests, requests for non-present family member, etc. This fee should not be charged in conjunction with a Medicare office visit)

4.4 Missed appointment . . . . . .30%-100% of fee

4.5 Rebooking tests at hospital . . . . . .$16-$26

4.6 Travel . . . . . .$0.55/km plus hourly rate per quarter hour

4.7 Hospital/Regional Health Authority
Committee Work . . . . . .$290-$555/hour or part thereof

4.8 Medical Supplies/Equipment not
included as part of insured service . . . .cost (including carrying cost and storage)

4.9 Fax transmission/receive (+ telephone charges) . . . . . .$1-$2/pg

4.10 Return NSF cheque $25

4.11 Annual Administration Fee . . . . . .Please see Appendix C

4.12 Medical records transfer
or chart summary . . . . . .$42-$58 plus $1.00/pg photocopy

NOTE: In June 1992, the Supreme Court of Canada rendered a judgement dealing with a patient's right of access to his/her medical records compiled in the office of a physician. It is important to note that this decision clearly states that although a physician may charge for transferring a patient's records, a physician cannot impede a patients' right to access their records based solely on their inability to pay.

In addition, physicians should keep in mind that the health needs of the patient can often be addressed without transferring or copying the entire medical record. This should be discussed with the patient, and the patient should be advised of the fee that will be charged, before the physician proceeds with any copying.

5. Clinical Services (Selected)

5.1 Newborn Circumcision . . . . . .$115-$165

5.2 Injectables (includes flu shots, cortisone, etc.) + medication costs . . .$16-$26

5.3 Vasectomy Reversal $815

5.4 Subsequent Injections for Impotence $58

5.5 Nursing Services provided in a Physician's Office (Doctor not in attendance)

- Blood Pressure $16
- Urinalysis $16
- Blood Sugar $16
- Hemoglobin $16
- Injection $16
- ECG $32
- Spirometry $21
- Peak Flow $16

5.6 Travel Consultation (single) . . . . . .$115-$135

Follow-up Consultation/Injection . . . . . .$42-$74 + $11/injection

6. Court Ordered Psychiatric Assessments

An agreement in September 2010 between the NBMS and the Department of Justice and Consumer Affairs, provides for the remuneration of psychiatrists who perform forensic psychiatric court ordered assessments. The agreement is in effect from April 1, 2010 until March 31, 2014. Rates remain in effect until such time that a new contract is negotiated.

Remuneration

In-patient Assessment $2,601
(Restigouche Hospital Center or other)

Out-patient Assessment $1,378.53
(Community Mental Health Clinic or other)

Travel time to/from Court $200/hr

Court Attendance Time $200/hr

Travel Expenses: Travel expenses are paid at Government of New Brunswick rates. The present rates are:

Hotel . . . . . .(provide receipt)

Kilometrage $0.41/km

Meals:

Breakfast $7.50

Lunch $10.50

Supper $19.50

Access Request and PHIPAA

The Personal Health Information Privacy and Access Act (PHIPAA) came into effect on June 2009 and provides a set of rules that protect patient privacy and the confidentiality of your personal health information. The Act also ensures that information is available, as needed, to provide health services to those in need and to monitor, evaluate and improve the health system in NB.

Physicians are custodians of patient's personal health information and as such may be subject to access requests for patients. The Act states that an individual has a right, on request, to examine or review a copy of his or her personal health information maintained by a custodian. The custodian must respond to the request no later than 30 days after receiving the request.

Patient requests health information from the custodian

The custodian responds to the request within 30 days.

Under the Act, a custodian shall permit an individual to examine a record free of charge, and may, in accordance with the regulations, require an individual to pay to the custodian a fair and reasonable fee for search, preparation, copying and delivery of courier services. If a patient formally authorizes another individual, in writing, to act as their agent in making a PHIPAA request (ie: a lawyer acting on behalf of a patient), a physician must comply with that request. In responding to a PHIPAA request from a patient, or from an individual formally authorized to act as the agent of the patient, physicians are required to limit their fees to those set out in the Regulation.

The fees are set out in Regulation as follows:

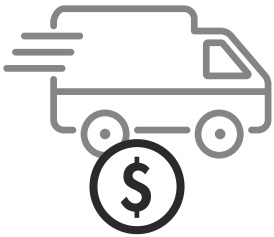
Search and Preparation Fees	$15 per half hour beyond the first 2 hours
Copying Fees	$0.25 for each page copied
Computer Programming and Data Processing Fees	$10 for each 15 minutes of internal programming or data processing or the actual cost of programming and data processing
Mail and Courier Delivery	No fee is payable for mailing a request. If courier delivery costs are necessary, the Custodian may charge the actual cost of the courier delivery.

The Custodian may waive all or part of these fees.

The Personal Health Information Privacy and Access Act (PHIPAA) and its Regulations are available on the Government of NB website under the Department of Health/Legislation/Personal Health Information Privacy and Access.

Fee for search

Fee for preparation and copying



Fee for delivery of courier services

Harmonized Sales Tax and Uninsured Services

According to the Canada Revenue Agency (CRA), "where the physician is directly involved in the examination/treatment of the patient (ie. examination and reports to WorkSafeNB, a life insurance company, a lawyer, provides a sick certificate etc.) this service will be classified as a medical service and will be HST exempt - whether it is paid for by the patient or the third party."

"However, if the physician is only involved in referring documents, providing an expert opinion in writing or personally, ie. functions as the expert witness only, the physician will be required to bill for, collect and transmit the 15% HST." Most physicians, though, will be affected by the "small supplier" clause; if services subject to HST total less than a designated amount, you need not collect or pass on the HST.

From the time the GST and later HST were introduced in New Brunswick, it was understood that Independent Medical Examinations (IME's) were a taxable supply. Billings to insurance companies, lawyers, and others for IME's were to include collection of GST/HST, unless the small supplier rules applied.

However, in late 2006, a GST/HST Policy Statement was released by CRA which contained their current view that most IME's may be exempt from GST/HST.

The 2013 Federal Budget introduced amendments to the Excise Tax Act, which when implemented, will apply a new approach to the application of GST/HST to uninsured services provided by physicians, retroactive to March 22, 2013. CRA will be applying a new "purpose test" for the determination of GST/HST exemption for Health Services.

The policy intent of these changes is still be finalized by CRA and Finance Canada (FC).

Physicians are encouraged to discuss HST related issues with their own accountant.

The Direct Billing Process

Keys to Efficiency

The following procedural guidelines are provided to enable you to carry out the direct billing process in a professional, efficient and timely manner:

- Establish and maintain a simple and clear office policy and procedure for direct billing. To achieve this you should first determine:
  - Those services for which patients will be directly billed
  - The fees attached to those services
  - Any exemptions, such as seniors or low-income patients
  - Bookkeeping and collection procedures

Your office policy on direct billing must be specific and detailed so that your staff and your patients fully and clearly understand it. At the same time, it should allow sufficient flexibility to adapt to any unique or unexpected circumstances you may encounter.

- Inform your staff of this policy and procedure, and keep them apprised of any changes.
- Maintain up-to-date accounts.
- Collect payments from patients at the point of service as often as possible.
- Follow-up in an orderly and consistent manner.
- Always discuss fees with your patients before providing the service.

Written Guidelines

Put your office policy in writing and distribute it to the staff.

In addition, you should schedule regular meetings to update and remind staff about the direct billing process, answer any of their questions or queries, and to gain feedback on their experiences with patients. This will help you to evaluate the success of your policy and procedures. It will also aid you in identifying any emerging problems before they become serious enough to negatively affect your staff or patients.

Keeping Patients Well-Informed

Most difficulties between a physician and a patient arise from a lack of clear communication. Many patients simply do not realize that there are some services the Government does not pay for and they may become upset when presented with a bill.

To prevent this from happening, you must ensure that your patients are well-informed about uninsured services and your direct billing policy well in advance of receiving treatments.

While posters displayed in your office may introduce your patients to the concept of direct billing, they are not a substitute for more direct methods of informing patients of your fees. It is recommended that patients be provided with an information sheet or booklet which states current fees.

Developing your Patient Information Booklet

A patient information booklet is an important guide to your practice which will benefit your patients, your staff and you. Its purpose is to provide a written general description of the scope of your practice as well as setting out guidelines on the direct billing policy. Ultimately it will save you and your staff the time and trouble of repeating answers to commonly asked questions. Your patient information booklet should include:

General information

- Office hours
- Telephone hours
- Test or x-ray procedures and availability
- Prescription refill instructions
- After-hours procedures
- Other office policies

Direct billing information

- A brief description of the direct billing concept.
- Services that are billed directly by you.
- Procedures for third party claim forms.

It is not advisable to list your fees in the booklet. These fees will require periodic updating while the rest of the information in the booklet remains current. Fees should be listed on a separate typewritten sheet which can be easily and inexpensively revised. Your patient information booklet may be produced through desktop publishing and good quality photocopying. The information contained in the booklet is the important factor, not its appearance.

Receiving Payment

One of the most important aspects of receiving payment for services you provide is to maintain an up-to-date reporting and billing system. The importance of this system is amplified when you deal with third party agencies that often make partial initial payments.

You may want to consider offering a payment plan to your patients whom you bill directly. Remember, the easier you make it for the patient to pay, the higher your collection success rate will be. You may also want to consider accepting credit cards. Start-up and operating information is available from your bank.

The longer an account remains unpaid, the more difficult it becomes to receive payment, and the account actually decreases in value. According to MD Physician Services the real value of a dollar owed becomes:

$0.90 .... after two months

$0.67 .... after six months

$0.45 .... after one year

$0.23 .... after two years

$0.14 .... after three years

$0.01 .... after five years

Accounts Receivable

Keeping Track of Your Accounts

To begin with, you will need appropriate receipts which state "professional services rendered," the type of service, and fee, and invoices for those who cannot immediately pay.

Sample Invoice

Invoice Number XXX	Date XXX	Charge XXX	Payment XXX	Current Balance XXX	Previous Balance XXX

Invoiced to: _____

_____

Amount: _____

For professional services rendered *(Description of Service)* _____

_____

_____

Your name, address, telephone number _____

- The (charge, payment, previous balance, current balance) section appears on a one-write or similar invoice. It gives you and your patient, an instant picture of the patient's account.
- On a receipt, the invoice number is replaced with receipt number, and "invoiced to" is replaced with "received from".
- You will also require a ledger to provide you with an accurate daily picture of the status of your accounts.

There are a variety of computer programs and apps which will print a receipt and make all the appropriate bookkeeping entries. The staff member who does the billing must ensure each statement is complete and accurate. An incomplete or inaccurate bill not only creates more work for you and your staff, but also gives delinquent patients one more excuse not to pay.

Collecting Accounts

While a payment plan encourages payment from your patients, you must have an organized system to successfully collect.

Accounts should normally be billed on a 30/60/90 day schedule. Payment should be due at time of service - interest charges of 1.5% per month can be applied to outstanding accounts after 30 days. If payments are not being made, letters and telephone calls by staff should be used to prompt patients into paying.

The staff person making the telephone call should ask if the payment was made. If not, a verbal commitment to pay should be obtained. The staff member should restate the commitment by telling the patient you will be expecting payment by the date promised.

Interest charges
1.5% per month
can be applied to
outstanding accounts
after 30 days

Because it can be easy to forget what was said during a busy day, written records of the calls should be kept.

Sample Collection Timetable – 120 day schedule

Procedure	Time	Period	Step
Send patient statement.	Month service is rendered	January	Billing
Send patient statement with first letter reminding patient this is a second statement.	Month after	February	Billing "Reminder"
Problem-solving call to patient. Goal to secure commitment of payment; arrange payment plan; determine if patient has a hardship or is dissatisfied with service.	Prior to mailing of March bill	mid-March	Phone Call "Education"
If you did not reach patient by phone or have not received promised payment, send the second letter.	Second month after service	March	Billing "Letter #2"
Phone patient and ask for a definite dollar amount and date. Render problem-solving assistance if necessary OR you may have to deal with a "broken promise to pay".	Prior to mailing of April bill	mid-April	Phone Call "Persuasion/ Information"
Send patient statement and last letter. You may wish to phone a patient several days after mailing this letter … some offices do.	Third month after service	April	Billing "Final Letter
If payment hasn't been received and you are certain the patient is not dissatisfied with the service, send the account to a collection agency.	Fourth month after service	May	Turn account over

Sample Collection Letters

To follow are a few sample collection letters which may help you develop your own format:

First Reminder:

Dear Patient name,

Your payment of $XX hasn't been received by our office. If there is an error in your statement, please call me so that we can correct it. If not, please send your cheque today so we can keep your account up to date.

Sincerely,

Signature & title of staff member responsible for billing

Second Reminder:

Dear Patient name,

Payment for your bill of $XX is now _____weeks past due. If there is some problem, call me today so we can discuss it. If not, please send your cheque so we can keep your account current and avoid collection action.

Sincerely,
Signature & title of staff member responsible for billing

FINAL Reminder:

Dear Patient name,

This is our third try to help you settle your past-due account of $XX. You are obliged to pay your accounts once you have said you will.

Please call this office **within 10 days** so that we can agree on a plan to settle your account. If not, we will have to turn it over to a collection agency.

Sincerely,
Physician's Signature

A copy of the patient's account statement should be included with each letter. While specifying dates of past correspondence in the final letter is optional, you should keep file copies of all letters and telephone logs. This provides you with an accurate record of past efforts and will be helpful to a collection agency should you need to use one.

You may wish to send your final reminder via registered mail to ensure the patient receives it.

Accounts Gone Bad

Collecting Overdue Payments

No matter how generous a payment plan you provide, some patients will deliberately try to avoid paying and you will need to take collection action. This is a fact of business life.

Before taking collection action, have your staff member telephone the patient to find out why he or she is not paying. If the patient is genuinely dissatisfied with the service or undergoing unexpected hardship, it may be better for you in terms of goodwill to write off the bill.

If dissatisfaction with the service or hardship is not the case, a collection agency may be your preferred route. It is not acceptable for a physician to sell a debt to a collection agency. The agency must work for a percentage of the fee that is being collected. The ultimate control of the debt must remain with the physician.

While you can realistically expect an agency to collect only a portion of your outstanding accounts, the fact that an agency has been called indicates to a patient that, like any other business, yours will not tolerate delinquent accounts.

You should wait no longer than **120 days** before turning the account over to a collection agency. Waiting too long makes the agency's job more difficult and allows the outstanding amounts to decrease in value *(see **Receiving Payment**, page 15).*

Always check references when selecting an agency. You need one that is firm in dealing with delinquent accounts, but your professional reputation is too valuable to retain an agency that employs "borderline" collection tactics. Physicians are considered to remain ethically responsible for the conduct of the agency during the course of debt collection.

Once you turn an account over to an agency it becomes the agency's job to collect the account, and you should no longer contact the patient about it.

As a final step, you may wish to take a delinquent patient to small claims court. To initiate a small claims action, you, or one of your staff, must first file a summons form at a provincial court house. In order to file, you will have to provide the defendant's name, address, amount of claim and location of service. Once the form is completed, a court clerk sets a court date. It is not essential that you attend the court hearing. A member of your staff can do so on your behalf.

The defendant must be informed of your action prior to the court date. You must ensure the defendant is personally served the summons. You can do this by personal delivery or by double-registered mail. Another option is to have a sheriff serve the summons, but you must pay the sheriff's fee. If the court, however, rules in your favour, you are entitled to the amount owing plus your costs of the action.

Physician or staff files a summons form

A court clerk sets a court date

The defendant is personally served the summons

Appendix A

Agreement between the New Brunswick Medical Society and WorkSafeNB Regarding Payment Arrangements for Medical Services

The unit values listed below are to be applied to the Medicare Physicians Manual as follows:

Unit Values

	October 1, 2018
Anaesthesia	$24.52
General Practice	$2.40
Specialist	$2.48

Note: These rates do not include the Early Reporting Bonus

These rates will be automatically adjusted annually by the percentage change in the "All Items" Consumer Price Index (CPI) for Canada.

All other non-Medicare Fee Schedule items in the WorkSafeNB contract (ie. early reporting fee payments for denied claims, acupuncture, etc.) remain part of the new agreement and will be adjusted annually.

Early Reporting Bonus (ERB)

There shall be an early reporting bonus of 20% for all services for which a report is received by WorkSafeNB within 5 working days of the service.

The ERB also applies to anaesthesia and surgical assist services, when the surgeon submits an operative report. There is no need for the physician to include the ERB on the physician billing form; the bonus will be automatically incorporated by the WorkSafeNB processing system. When fees are adjusted by the ERB, the amount payable will be subject to "rounding".

To facilitate early reporting, physicians can fax reports toll-free to **1-888-629-4722** (when faxing, no need to mail reports). The toll-free line for physician inquiries is **1-877-647-0777**.

Payment for Services Where a Claim is Denied or Not Created

WorkSafeNB shall pay a fee of 33% of the General Practice office visit fee for the initial office visit/service provided for claims which are subsequently denied by WorkSafeNB, where the employer is not required to be registered with WorkSafeNB, or which does not result in an established claim, provided that the physician submits a Form 8 – Initial Report of Accident – and a "Worker's Report of Injury" which is completed and signed by the worker.

WorkSafeNB shall provide notification, to the physician, of the acceptance or rejection of such a claim.

Opioid Reporting Fee

i) The rate will be two (2) times the appropriate office visit fee

ii) eligible for early reporting bonus

iii) no additional visit fee payable, unless there is a new report with new/additional findings

Fees for Other Services

Where an item, treatment or procedure is not listed under the Unit Values or **Individual Fee Items Sections** above, WorkSafeNB shall pay for those services generally covered by WorkSafeNB, based on the units as set out in the Medicare Physician's Manual, as updated from time to time upon receipt of notice from Medicare and the unit value contained in this agreement.

Where WorkSafeNB requests an independent consultation and assessment from a physician and where WorkSafeNB and the physician agree the case is complicated, and a timely report is necessary, WorkSafeNB may pay a rate two times the rate of the negotiated rate at the time of the request.

Fee Premium for After-Hours Service

The WorkSafeNB after-hours emergency premium for consultations, anaesthesia and procedures apply as follows:

The 100% premium applies:

- Between the hours of midnight and 06h00 every day.
- All day on weekends (Saturday & Sunday) and holidays.

The 50 % premium applies:

- Between 18h00 and midnight weekdays
- Between 06h00 and 08h00 weekdays

The After-hours premium does not apply to regularly scheduled hours of operation, such as regular weekend or evening office/clinic hours.

Reporting

- Reporting shall be on a form as provided by WorkSafeNB or other form acceptable to WorkSafeNB. WorkSafeNB may withhold payment for any report submitted under this agreement that is illegible and/or incomplete. Such reports will need to be corrected and re-submitted for payment.
- For consultation and surgery reports and emergency room contacts, WorkSafeNB will provide access to a phone-in transcription service if there is sufficient demand for this service.
- For office visit services (not consults) which involve more than one claim for a claimant, the physician will provide separate reports for each claim and WorkSafeNB will pay separately for each service and report provided.

Frequency of Office Visits

- In the acute injury phase, WorkSafeNB encourages the physician to follow the claimant frequently to ensure the earliest possible return to work date even at lighter job demands.
- When a claimant has stabilized medically, by virtue of the physician and WorkSafeNB agreeing the claimant has stabilized, the parties agree that WorkSafeNB will pay for not more than one routine office visit every second month.
- Should the claimant's medical status subsequently change, the physician would submit a Form 10 noting how the medical status has changed. WorkSafeNB will pay for office visits as required until such time as the claimant stabilizes again.
- WorkSafeNB will pay for all patient-initiated visits related to the claim.

Other Services Compensated by WorkSafeNB

Conversion of non-Medicare Items

1.Items not covered in the Medicare Physician's Manual are paid at a percentage or multiple of the office visit fee.

1.1. Acupuncture

1.1.1. Fee code: W1010 – initial 10 minutes; W1011 – count of additional 10 minutes

1.1.2. Paid at: 100% of the office visit fee for the 1st 10 minutes and at 48% of the office visit fee for each additional 10 minutes to a maximum of 40 minutes

1.2. Telephone consultation between physician and employer to discuss return to work and accommodation

1.2.1. Fee code: W1020 – initial 10 minutes; W1028 – count of additional 10 minutes

1.2.2. Paid at: 100% of the office visit fee for the 1st 10 minutes and at 48% of the office visit fee for each additional 10 minutes

1.2.3. Requirement for payment: completion of the Telephone Consultation Form. The physician must provide the name of the employer and the name of the person with whom they were speaking

1.3. Telephone consultation between physician and WorkSafeNB

1.3.1. Fee code: Initial 10 minutes – Case Manager: W1030, WorkSafeNB Physician: W1031, Cadre Physician W1032; W1038 – count of additional 10 minute blocks

1.3.2. Paid at: 100% of the office visit fee for the 1st 10 minutes and at 48% of the office visit fee for each additional 10 minutes

1.3.3. Requirement for payment: completion of the Telephone Consultation Form. The form is generally completed by WorkSafeNB and forwarded to the physician for validation and signing

1.4. Case management or WRC case conference requested by WorkSafeNB

1.4.1. Fee code: Initial 10 minutes – Case Management: W1040, WRC: W1041; W1048 – count of additional 10 minute blocks; W1049 – round-trip in kilometres to attend case conference

1.4.2. Paid at: 100% of the office visit fee for the 1st 10 minutes and at 48% of the office visit fee for each additional 10 minutes. Travel to attend a case conference at a WorkSafeNB location is paid at the rate paid to WorkSafeNB non-bargaining staff

1.4.3. Requirement for payment: completion of the Telephone Consultation Form. The form is generally completed by WorkSafeNB and forwarded to the physician for validation and signing

1.5. Telephone consultation between physician and physiotherapist to discuss functional capacity assessment and match with job demands, physiotherapist's assessment and rehab plan and progress

1.5.1. Fee code: W1050

1.5.2. Paid at: 100% of the office visit fee

1.5.3. Requirement for payment: completion of the Telephone Consultation Form. The physician must provide the name of the physiotherapist with whom they were speaking

1.6. Telephone consultation between family physician and specialist

1.6.1. Fee code: W1060

1.6.2. Paid at: 100% of the office visit fee

1.6.3. Requirement for payment: completion of the Telephone Consultation Form. The physician must provide the name of the physician with whom they were speaking

1.6.4. The family physician and the specialist would each submit a Telephone Consultation form. Both would be paid.

1.7. Telephone consultation between specialist and specialist

1.7.1. Fee code: W1062

1.7.2. Paid at: 100% of the office visit fee

1.7.3. Requirement for payment: completion of the Telephone Consultation Form. The physician must provide the name of the physician with whom they were speaking

1.7.4. The family physician and the specialist would each submit a Telephone Consultation form. Both would be paid.

1.8. Opioid review report

1.8.1. Fee code: W1070

1.8.2. Paid at: twice the office visit fee

1.8.3. No additional visit fee is payable unless there is a separate report submitted with new or additional findings

1.8.4. This service involves an office visit by the claimant to complete the review and is therefore eligible for the early reporting bonus

1.8.5. WorkSafeNB pays the Opioid Review Report fee when the review is triggered by the pharmacy or by WorkSafeNB. WorkSafeNB will generally not pay the fee when the review is initiated by the prescribing physician

1.9. Follow-up letter by specialist to family physician and/or patient

1.9.1. Fee code: W1080

1.9.2. Paid at: the office visit fee

1.9.3. Requirement for payment: WorkSafeNB is copied on the follow-up letter

1.9.4. WorkSafeNB pays for the primary letter. WorkSafeNB does not pay to generate copies to others.

1.10. Physician letter responding to a basic question from WorkSafeNB

1.10.1. Fee code: W1090

1.10.2. Paid at: the office visit fee

Copying Medical Records: WorkSafeNB will pay a base rate of 70% of the fee in the NBMS Guide to 3rd Party Billing plus 100% of the per page fee. When changes are made to the fees in the NBMS Guide to 3rd Party Billing, the Medical Society will notify WorkSafeNB. Changes would come into effect 15 working days after the Medical Society has verified that WorkSafeNB has received the notice of change.

Appendix B

Billing for patients from the Canadian Armed Forces and Royal Canadian Mounted Police (RCMP)

Canadian Armed Forces

Billing physician services for members of the Canadian Armed Forces is done through Medavie Blue Cross. Physicians must register on the Medavie Blue Cross' website to bill for their services to Canadian Armed Forces personnel.

The process takes approximately three weeks from the time of registration to the time that physicians can bill. Once registered, physicians will receive a username and password by email, and can use that to bill for patients online, by using the appropriate Medicare codes multiplied by the General Unit Value found on page 4 of this guide.

Information that physicians will need to bill Medavie Blue Cross for services rendered include the Canadian Armed Forces member's personnel number and referral information, if applicable.

Payments will either be mailed in the form of a cheque or transferred electronically at the choice of the physician. Physicians can alternately bill Medavie Blue Cross manually on paper, although paper claims will not be paid as quickly as online claims.

If you need to register for direct billing to Medavie Blue Cross, please visit the Medavie Blue Cross website at: https://www.medaviebc.ca, then click on the "For Health Professionals" Link at the top of the page.

*Medavie Blue Cross website and link information is subject to change.

RCMP

The Federal Government passed Bill C-38 in June of 2012 which contained a provision that amends the Canada Health Act so that members of the RCMP are included in the definition of the 'insured persons'. Members of the RCMP living in NB will now be covered under New Brunswick Medicare and physicians will bill NB Medicare rates for members of the RCMP. This provision became effective **April 1, 2013**.

Appendix C

Annual Administration Plan

An Annual Administration Plan offers patients the option of paying an Annual Administration fee to cover the cost of services not insured by Medicare, rather than paying for services as needed.

It should be noted that the NBMS does not suggest any fees for services associated with an Annual Administration Plan, since the breadth of services that could be covered under this plan could be quite large and varied based on individual practice. In developing fees for an annual administration plan, physicians should be mindful of the College policy, and take into account the factors in their practice that will determine the value of fees for non-insured services.

The following is an excerpt from the College of Physicians and Surgeons of New Brunswick Guidelines

It is acceptable for a physician to bill a patient on an annual basis for uninsured services, subject to the following conditions:

- The contract between physician and patient must cover a period of not less than three months nor more than one full year.
- The contract must accurately and clearly show in writing the services that are covered by the annual composite fee and those that are not included. Patients have the right to ask their doctor about any charge they do not understand.
- The contract must also show the fees for each uninsured service if paid for on an individual basis.
- The contract and fees may vary from physician to physician and within group practices according to the services provided. Physicians may be guided by the Physician's Guide to Direct Billing from the New Brunswick Medical Society.
- A copy of these rules must be given to the patient, and the patient must indicate acceptance of this form of paying for uninsured services before being billed the annual fee.
- Patients must retain their choice of paying the annual fee or being billed on an individual item by item basis.
- Acceptance or continuation of care by a physician of an individual patient cannot be conditional on the patient agreeing to the annual administrative fee.
- Under College regulations, it is improper to charge a patient simply for being available for telephone advice or any other service.

Appendix D

Medical Chart Transfer

Date

Dr. _____

Address

RE: MEDICAL CHART TRANSFER

Patient: (Name Here)

Dear Doctor,

Thank you for taking over the medical care of this patient. The signed request for the transfer of medical records was recently received in our office. As you know, the CMPA discourages the transfer of original records, but a copy of the chart will be forwarded to your office.

The fee charged for this service varies depending on the complexity of the chart. To cover costs of chart preparation and mailing, your new patient is responsible for forwarding $_____ to this office at the above address.

Sincerely,

Dr. (Name here)

Sample Out-of-Country Consent Form

GOVERNING LAW

a) I hereby agree that the relationship between me and _____ *(Physician in private practice) OR (health care organization)* _____ (as well as her/his agents, delegates, employees, and any physicians and other independent health care practitioners providing medical care or other health care and treatment to me, or in association with _____ *(Physician in private practice) OR (health care organization)* _____), including without limitation any medical or other health care and treatment provided to me, and

b) the resolution of any and all disputes arising from or in connection with that relationship, including any disputes arising under or in connection with this Agreement,

shall be governed by and construed in accordance with the laws of the Province of New Brunswick and the laws of Canada applicable therein.

JURISDICTION

I hereby acknowledge that the medical or other health care and treatment I receive from _____ *(Physician in private practice) OR (health care organization)* _____ will be provided in the Province of New Brunswick, and that the courts of the Province of New Brunswick shall have exclusive jurisdiction to hear any complaint, demand, claim, proceeding or cause of action, whatsoever arising from or in connection with that medical or other health care and treatment, or from any other aspect of my relationship to _____ *(Physician in private practice) OR (health care organization)* _____.

Date _____

_____ _____

Name of Patient (please print) Signature of Patient / Substitute decision- maker on behalf of patient

Request to Appear in Court

Date

To

Re: Request to appear in court

Client

Court date

The summons to appear in court regarding your client named above was received today. This letter is written to confirm that I will make appropriate arrangements to be available for court appearance on that date.

Please be advised that my medicolegal fees for case preparation is $_____ per hour, regardless of whether this matter proceeds to court. Also, court attendance will be billed at $_____ per hour, with a $_____ minimum charge per day. If this case is settled prior to court action, or it is otherwise decided that my appearance in court that day is no longer needed, I will require notification of this a full 24 hours prior to the proposed court date and time. Otherwise, the minimum charge of $_____ will apply. Early notification of cancellation is encouraged to minimize medicolegal charges.

If you have any questions regarding this matter, I may be contacted at the address and phone number above.

Sincerely,

Dr. (Name here)

Third Party Requested Report

Dear (Third Party),

Re: Request for (type of report) on (name of person)

This is to acknowledge your (date) request for this report. The cost of providing this information is not covered by Medicare as an insured service. My fee for this service is $_____.

Please acknowledge your acceptance of this fee by signing a copy of this request and returning it by mail or fax. The report will then be prepared and sent to you. Thank you kindly.

Dr. (Sending Physician)

Request for Medical Information

TO WHOM IT MAY CONCERN

Date

Your request for medical information regarding one of my patients was recently received in this office. Unfortunately, the payment limitation mentioned in your request has delayed the preparation of this information.

Please be advised that my standard charge for this type of medical form is $_____, plus $_____ per page of photocopied material.

If you would like us to proceed, please resubmit your request with revised payment authorization.

Sincerely,

Dr. (Name here)

Specific Arrangements with a Lawyer

Date

Address

RE: Request for (Type of report) on (Name of Patient)

Dear (Name of Lawyer)

As discussed on (Date), your request for a (type of report) for (Name of Patient) has been received in our office on (Date). My fee for this will be $ _____. Other associated costs, which may be incurred, are listed below.

Court time per hour	$_____
Waiting and/or travel time per hour	$_____
Photocopying	$_____
Typing	$_____
Preparation Time	$_____

Payment for the above services will be expected within two weeks of my claim being submitted.

In the event that payment is not received on time, an additional ___% will be added each month for overdue accounts.

Unless you advise me to the contrary in writing within two weeks of the date of the writing of this letter, I will assume that these payment arrangements are satisfactory. Thank you kindly.

Dr. (Sending Physician)

Appendix E

Preparing Medico-Legal Reports: Guidelines for Physicians By CMPA General Counsel

The following is a reproduction of an Information Sheet produced by the Canadian Medical Protective Association (CMPA) in May 2001 and revised in July 2008. It has been reprinted with permission from CMPA.

You may be requested by a lawyer to provide a medical report for legal purposes. Such requests generally fall into three categories:

1. Report of treating physician

The most common request is for a report on the condition of a patient you are treating (or have treated). The patient's lawyer will use this report to substantiate the client's medical disability, treatment and prognosis. It may be presented to an insurance company in the course of settlement negotiations or to a Court in the event that the claim is not settled.

2. Independent defence medical examination

A lawyer may ask you to conduct an independent medical examination in a personal injury lawsuit. You will be asked to examine a plaintiff who is claiming compensation for personal injuries and to report on the plaintiff's current status, physical limitations and prognosis. This report will be used by the parties involved in the litigation and by the Court as a basis for assessing compensation. You may also be asked to perform an independent medical examination to help an insurer evaluate the extent of an injury or to help a Worker's Compensation Board determine the extent of a disability.

3. Expert opinion

In medical malpractice actions, you may be asked by either side to provide a report addressing the question of whether a treating physician's medical care of the plaintiff was in compliance with professional standards.

Are you obligated to prepare a report?

1. Report of treating physician

You are under a professional obligation to provide a report on your own patient's medical condition. You should insist that the request be in writing and specify the purpose for which the report is requested. You should also insist on a written authorization, signed by the patient, for the release of this information to the person requesting it.

You are entitled to a reasonable fee for the preparation of this report.

The Supreme Court of Canada clarified in 1992 that, where there is a doctor/patient relationship, the patient is entitled, for a reasonable fee, to obtain a copy of any records concerning his/her medical treatment in the physician's chart, including any consultants' reports. Privacy legislation now provides patients with specific rights of access to their personal health information, the scope of which may differ from jurisdiction to jurisdiction. The legislation also prescribes fee structures relevant to access requests.

On occasion, you may be asked to supply copies of records to your patient, or to his or her authorized representative, with or without an accompanying request for a medico-legal report. Upon receipt of such a request and an appropriate written authorization from the patient, you should forward copies of the relevant records unless there is a valid concern that information in the records may cause harm to the patient or a third party, or if another exception provided by privacy legislation applies. You must be prepared to prove that there is a legitimate basis upon which to justify the refusal. Members should seek advice from the CMPA if they are unsure whether certain information in the record should be disclosed and what provisions of applicable privacy legislation in their province or territory govern the request.

Without a request or authorization from your patient, you should not release any information from or copies of patient records unless you are required or permitted to do so by law. For example, you may receive a Court Order requiring you to produce information or you may have to do so pursuant to a statutory requirement such as reporting of child abuse or compliance with a College investigation. You should seek advice before disclosing any information if you are unsure whether there is legal authorization for the disclosure.

2. Independent defence medical examination

It is your personal judgment as to whether you wish to be retained to examine a claimant as an independent medical expert. If you do so, you should carry out a thorough examination including history, physical exam, appropriate tests, etc. and report fairly and objectively on your findings and conclusions.

3. Expert opinion

Again, this is a matter of choice and there is no obligation to act as an expert. However, many physicians feel a professional obligation to do so (for either side). The CMPA endorses this view.

Before acting as an expert, you should be satisfied that you have the specific expertise the matter requires and that you have no actual or potential conflict of interest. For example, it would not be advisable to be an expert witness for the defence when either you or your colleagues at the same institution are or have been one of the plaintiff's treating physicians. As an expert, you should ensure that you have received and carefully reviewed all the required documents so that you are aware of all relevant facts on which to base your opinion. These documents should include the pleadings, all relevant medical records of the plaintiff's treatment and transcripts of the evidence from Examinations for Discovery.

You should understand that the purpose of your report and your opinion is to assist the Court in determining the standard of care that the defendant physician was expected to meet at the time the care was provided.

Suggested format for a medico-legal report

Organize your report, using headings where possible. For example:

- **Address the report to the lawyer or individual who requested it**, never "To Whom It May Concern".
- **Refer to the purpose for which the report is prepared**, e.g., "You have asked me to assess Mr. Jackson and to answer your questions about his current medical situation and prognosis…"; or, in a medical negligence case, "You have asked me to review and comment on the standard of medical care in the spinal surgery carried out by Dr X."
- **State your credentials and experience in one or two paragraphs**. A résumé will likely have to be supplied before testifying at trial, but a brief summary is helpful in a report. For example, "I have practised as an orthopaedic surgeon in the City of Sawbones for the last 30 years and was, until recently, Chief of Surgery at the Sawbones General Hospital and former Chairman of the Department of Surgery at the Faculty of Medicine, University of Sawbones."
- **Enumerate specifically what documentation you have reviewed to prepare the report.** Ideally, this should be a complete list of the medically relevant materials available at the time your report was prepared. Again, ensure you have all relevant documentation, and if not, communicate with the requesting party.
- **State any assumptions used in preparing your report** and include any photographs, diagrams, calculations or other research data on which you have relied.

- **Outline the relevant patient history.**
- **Describe your examination of the patient and functional enquiry** if you have in fact examined the patient.
- **Summarize and conclude.** This will normally involve your opinion as to the patient's current condition, degree of disability and the cause of same, and prognosis.

In a medical negligence claim you will need to identify and comment on the deficiencies, if any, in the medical care rendered by the physician(s) in question and, of equal importance, state your opinion as to whether any deficiencies in the care have caused any direct harm or detriment to the patient. A medical negligence claim cannot be sustained unless a plaintiff is able to establish that one or more of the defendant physicians have failed to meet a recognized professional standard of care and that the breach of professional standards has actually caused harm to the patient.

Similarly, in a personal injury action, the report should address whether and to what extent the patient's complaints are caused by the accident.

While medical terminology is normally necessary, an effort to write comprehensibly for educated laypersons (lawyers and judges/juries) is very helpful. Unduly technical discussions, understandable only to experts, are of limited use in legal proceedings. Except in the case of "progress reports" provided by treating physicians, the medical report must address all the material issues that may be expected to be addressed by the expert in Court. For this reason, it is often helpful for the expert to discuss this content in advance with the lawyer who has requested the report. The report should be printed on the physician's personal stationery or that of the university or facility in which the physician practises.

Common problems with medico-legal reports

Experience has shown that avoiding certain practices in conducting a medico-legal examination and in report writing can optimize your contribution to the legal process and avoid difficulties with the litigant or the Court. Here are some problem areas you may wish to avoid:

- **Avoid making critical comments to or debating issues with a patient when performing an independent medical examination.** Patients in this situation are often defensive and inclined to take critical comments in a negative light and to retaliate by writing letters of complaint.

- **Avoid words or actions that may appear to be insensitive.** Take the utmost care in discussing matters relating to a patient's ethnic background, religious affiliation, sexual preferences, language abilities or family history. Where these are appropriate subjects for discussion, indicate to the patient your purpose in making such enquiries. This will help to avoid misunderstandings.
- **Avoid using the phrase "dictated but not read" on your letter, and allowing anyone else to sign it.** Sign the report yourself after a careful proofreading.
- **Avoid mentioning your fee in the report. Medico-legal reports are usually filed with the Court.** You therefore do not want to have something to this effect as the last line of your report: "My fee for this report is $750 and I will expect payment before its release." Also, your fee and the time it reflects provide ammunition for cross-examination. Your fee and payment terms can best be discussed before you agree to act as an expert or independent medical assessor.
- **Avoid making overtly pejorative references to the patient in a medical report.** For example, a psychiatric report stating, "This patient exhibits a rigid Teutonic personality" calls your objectivity into question and can undermine the credibility of your report.
- **Avoid comments about the patient's socio-economic status.** One sometimes sees broad-brush references to a patient's attitude being typical of the views of certain groups, e.g., "This man and his siblings have subsisted on welfare and he may see this injury as an opportunity for secondary gain." This may lead others to question your objectivity and doubt the credibility of your report.
- **Avoid stating legal conclusions (i.e., who's at fault) in your report.** A medico-legal report may not be admissible if it unduly goes into the cause of the accident and states whose fault the accident was. Do not state or quote the patient as stating anything like, "The patient's vehicle was sideswiped by a drunk driver who was speeding in the opposite direction."
- **Avoid making overt statements or offering specific conclusions on issues of credibility.** It is the function of the trier of fact (the judge or jury) to decide who to believe. It is seldom helpful to label someone a "malingerer" or to assert that someone is acting fraudulently or is lying. It will normally suffice to set out the facts that may lead to that conclusion.
- **Avoid "borrowing" the words of others.** If your report involves your reliance on other physicians' reports, say so, and properly attribute any quotes from them. At trial, it can be very embarrassing to find that portions of the text of a medico-legal report are in fact unattributed quotations from another physicians' examination or analysis.

- **Avoid reference to insurance in personal injury actions (other than discussing no-fault or rehabilitation benefits).** When in doubt, talk to the party requesting the report. Juries are not supposed to be told that the defendant is insured. They should not learn this indirectly through your report.
- **Avoid criticism of other physicians or health care providers except when providing an objective opinion about standards** when asked to do so in the context of a medical malpractice case, or other matter involving professional standards. Such gratuitous remarks can lead to mutual recriminations and may cast doubt on the quality of your report.
- **Avoid lengthy and/or repetitious reports.** The length of a report will of course vary with the complexity of the matter. However, overly lengthy reports (10 to 15 pages) are seldom helpful and should be avoided.
- **Avoid making corrections to reports at a patient's request unless you are satisfied the correction is warranted.** Patients sometimes improperly request that reports be changed when they realize the implications of what they may have told you. However, it can be embarrassing if your office chart records certain information given by a patient and your medico-legal report contains conflicting information.
- **Don't be reluctant to be as helpful as possible with respect to a patient's prognosis.** To compensate a personal injury victim, a Court must make certain assumptions about the patient's future. They do this by deciding what will occur on the balance of probabilities (i.e., what is the most likely scenario). An expert's views on this subject are crucial, even though it may seem to the physician to be "educated guessing". Medical standards of proof and of causation do differ from legal standards. Our system depends on guidance from experts concerning future events.

Most misunderstandings concerning medico-legal reports can be solved in discussion with the party who requested the report. Be aware that your report will become available to many people. You will want to ensure that your comments are professional, accurate, unbiased and objective.

Members who doubt the propriety of rendering a report or their right to decline to provide a report can contact the CMPA for advice.