Medicare Billing Information Sessions 2025

SESSION 1 - Medicare Basics & Billing Fundamentals
Tuesday April 1, 2025, 12pm to 12:55pm
SESSION 2 - Family Practice Billing: Review
Tuesday, May 20, 2025, 12pm to 12:45pm
SESSION 3 - Reconciling: Navigating Your Claims Statement
Wednesday, June 11, 2025, 12pm to 12:45pm
SESSION 4 - Family Practice Billing Essentials
Tuesday, September 23, 2025, 12pm to 12:55pm
SESSION 5 - Medicare Claims Entry (MCE) Review: Tips, Templates, and More
Tuesday, Nov 4, 2025, 12pm to 12:45pm

We Want to Hear from you!

Please chat-in any topics you'd like to see included in our session schedule or share them by email at Practicesupport@nbms.nb.ca

New Nouveau Brunswick

Family Practice Billing Essentials

Department of Health

September 23, 2025

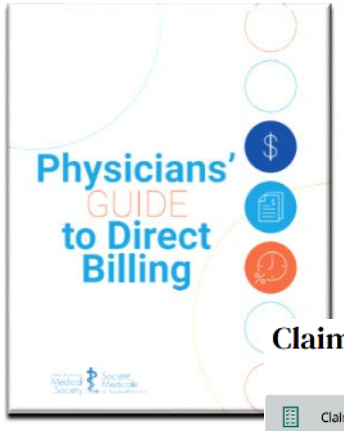
Please note:

This document is intended to be a quick reference guide for codes commonly used by physicians; however, must not be considered the primary source for billing information or codes. The Physician's Manual is still the primary source of billing codes, rules, service definitions/details, policies, and procedures.

***A Practitioner Liaison officer is available to provide a more in-depth training, if needed.**

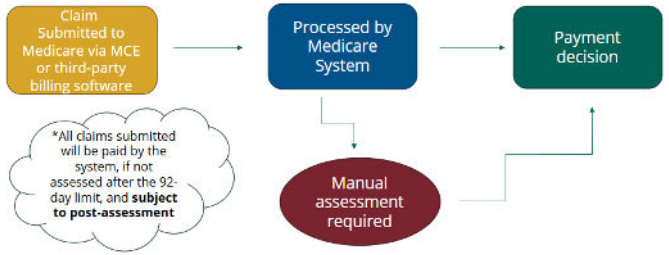
***Enquiries regarding billing issues and specific service codes should be directed to the Practitioner Enquiries unit.**

New Brunswick Physicians' Manual



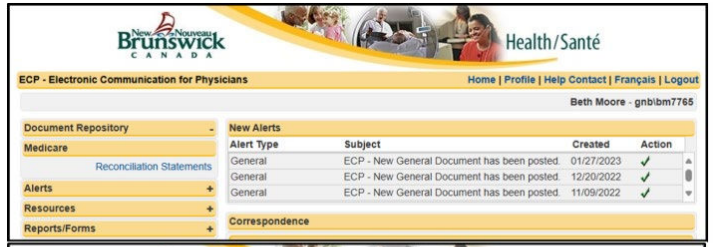
December 2024

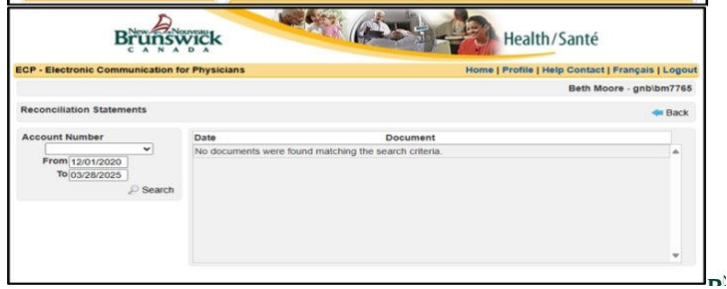
Process of a claim – from submission to payment



Claims submission process

- Claim preparation: gather all required information
- Coding requirements: Select accurate service code and ICD10 diagnosis
- Submit claims electronically: May vary depending on whether you use a billing component of your EMR or Medicare Claims Entry (MCE)
- **Deadline for** claims submission: 92-days from date of service





Nursing codes
effective September 16, 2024

Table 3 – Additional Codes

- Codes that can be billed by primary care physicians for nurses' services, whether the primary care physician is **on-site** or **off-site**.
- These codes will be billed at **100%** of the listed unit value in the Physicians' Manual effective September 16, 2024, using **Role 8**.

		Physician On-site Role / Rôle du médecin sur place - 100%	Physician Off-site Role / Rôle du médecin hors site - 100%
15	Prenatal complete examination / Examen prénatal complet	Role / Rôle 8	Role / Rôle 8
16	Pre or post natal visit / Visite pré ou post natale	Role / Rôle 8	Role / Rôle 8
19	Well baby care / Soins du bébé normal	Role / Rôle 8	Role / Rôle 8
8985	Complex patient care visit - add on Visite pour soins aux patients complexes - en supp.	Role / Rôle 8	Role / Rôle 8
1894	Hyposensitization Subsecuent Hyposensibilisation - injections	Role / Rôle 8	Role / Rôle 8
2089	Wart removal cryotherapy / Verrues exérèse par cryothérapie	Role / Rôle 8	Role / Rôle 8

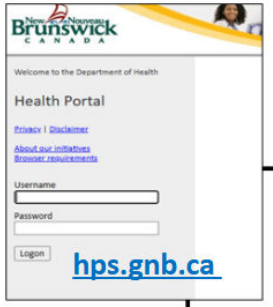
Monitoring and Compliance Guidelines

- Any practitioner may be chosen for an audit of Medicare billing within a **7-year period**.
- Audits are conducted randomly and not intended as criticism.
- Must maintain records to support billings for a period of 7 years.

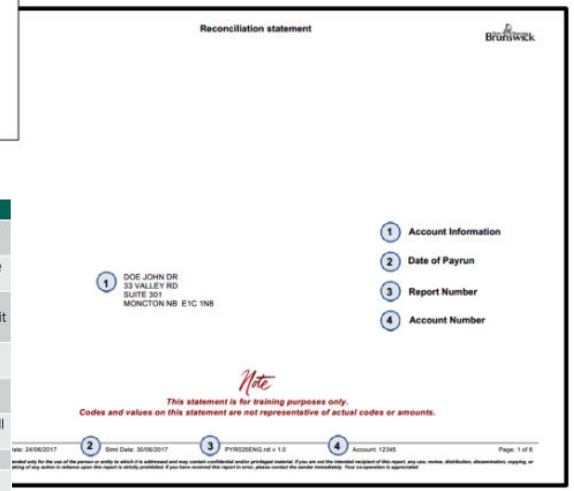
To support your billing, Medical notes/charts should include:

- Diagnosis/Presenting complaint of the patient
- Evidence of Assessment
- Treatment or treatment plan

What's new?



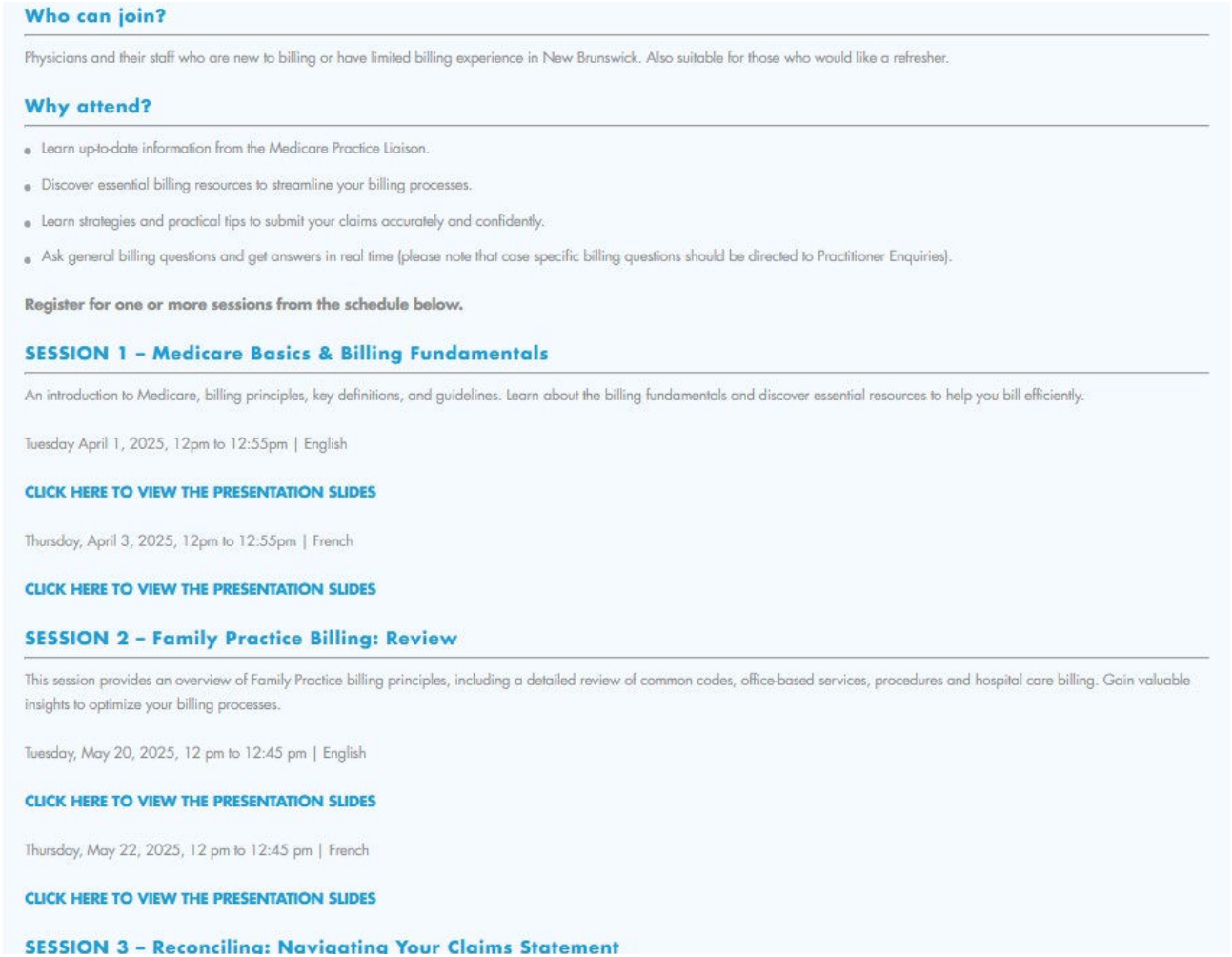
ICD10 codes



Payment Messages on Statement	Possible reason(s) for message
Too Many Visits same day	More than one visit billed for the same patient on the same day
Apparent Duplicate billing	Duplicate claim submitted (same patient, same codes, same dates)
Resident not eligible, Patient to contact Medicare	Patient's Medicare coverage is expired, and they need to contact Medicare or SNB to have it renewed
Hospital care billed by different physician	Another physician has billed for daily care of patient causing overlap in billing
Add on visit, no related claim	Add on code billed without primary code (ex Code 8101 but no Code 1)
Please send Operative Reports	Operative Reports required to assess claim, will not be considered for payment until received
Paid on claim #	Service was paid on claim # listed
Circumstances of emergency visit not identified	Diagnosis given does not indicate an emergency visit was required
Included in post operative period	Service billed in post-op period (14 days after surgery), Assessment Rule 27

Recap of previous sessions

Presentation slides from earlier sessions are posted online at: https://www.nbms.nb.ca/nbms-practice-support/



Who can join?

Physicians and their staff who are new to billing or have limited billing experience in New Brunswick. Also suitable for those who would like a refresher.

Why attend?

- Learn up-to-date information from the Medicare Practice Liaison.
- Discover essential billing resources to streamline your billing processes.
- Learn strategies and practical tips to submit your claims accurately and confidently.
- Ask general billing questions and get answers in real time (please note that case specific billing questions should be directed to Practitioner Enquiries).

Register for one or more sessions from the schedule below.

SESSION 1 – Medicare Basics & Billing Fundamentals

An introduction to Medicare, billing principles, key definitions, and guidelines. Learn about the billing fundamentals and discover essential resources to help you bill efficiently.

Tuesday April 1, 2025, 12pm to 12:55pm | English

CLICK HERE TO VIEW THE PRESENTATION SLIDES

Thursday, April 3, 2025, 12pm to 12:55pm | French

CLICK HERE TO VIEW THE PRESENTATION SLIDES

SESSION 2 – Family Practice Billing: Review

This session provides an overview of Family Practice billing principles, including a detailed review of common codes, office-based services, procedures and hospital care billing. Gain valuable insights to optimize your billing processes.

Tuesday, May 20, 2025, 12 pm to 12:45 pm | English

CLICK HERE TO VIEW THE PRESENTATION SLIDES

Thursday, May 22, 2025, 12 pm to 12:45 pm | French

CLICK HERE TO VIEW THE PRESENTATION SLIDES

SESSION 3 – Reconciling: Navigating Your Claims Statement

Outline of today's session

Review Billing basics

– getting started, physician payment, principles of billing

Review Commonly Billed Family Medicine codes

Review Items Common to all Practitioners

Examples and Practice Questions

Introduction to Physician Payment

In New Brunswick, physicians get paid in a variety of different ways. Depending on your payment arrangement, you may get paid through multiple payment models.

Fee-for-Service (FFS): Income is generated from claims submitted for each insured service per the fee schedule.

Salaried: Practitioners shadow bill and may receive FFS, AFP, or sessional pay for services provided outside their salaried arrangement. See – Guidelines for Mandated On-call and Fee-For Service Income Guidelines.

Sessional: Income is based on an hourly rate in approved settings like ERs. Shadow billing is required unless advised otherwise.

Family Medicine New Brunswick (FMNB): A Blended Payment Model. Income is generated from FFS (reduced) and capitation. Applicable only to Family Medicine physicians who participate in the program.

Locum: Replaces an established practitioner on leave. Can be short or long-term depending on duration of leave. typically receives the same remuneration method as the position they are covering.

Accounts

Personal Account - An account automatically generated for all practitioners and linked to the Practitioner Number.

Professional Corporation Account - Fee-for-service account that may be requested if a practitioner has an **Incorporated** bank account. This would be used instead of the physician's Personal Account.

On-call Account - Fee-for-service account that is mandatory for salaried physicians who will be rendering on-call, **emergent** services outside their salaried hours.

Shadow Billing Account (History Only) - Shadow billing account in which claims are paid at zero. This is mandatory for physicians remunerated under the Salaried, Sessional, or Alternate Funding Plan models.

To access necessary forms to add or remove an account and/or add or remove a delegate, please visit* **Medicare Payments, Account and Delegate Authorization Forms *on the GNB website.*

Payment Information & Run Schedule

- Medicare operates on a bi-weekly billing cycle
- Physicians are paid every two weeks
- Practitioner Run schedule can be found on ECP - Electronic Communication for Physicians
- Cut-off for each billing period is every second Thursday at 8am
- Reconciliation statements are made available electronically in ECP bi-weekly on the statement date.

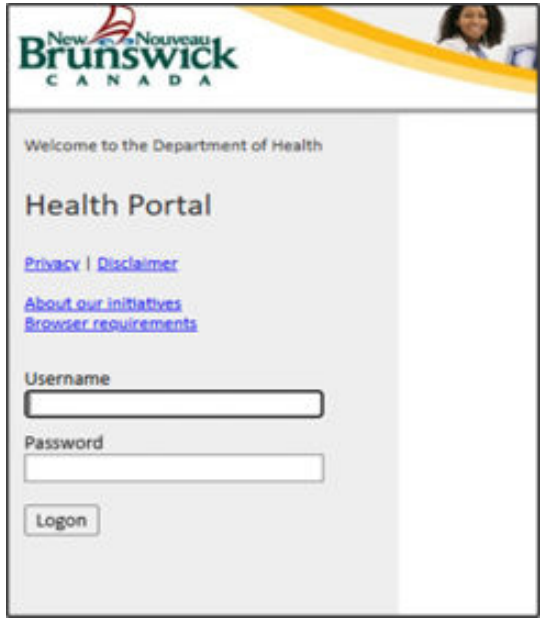
Practitioner Run Schedule - 2025

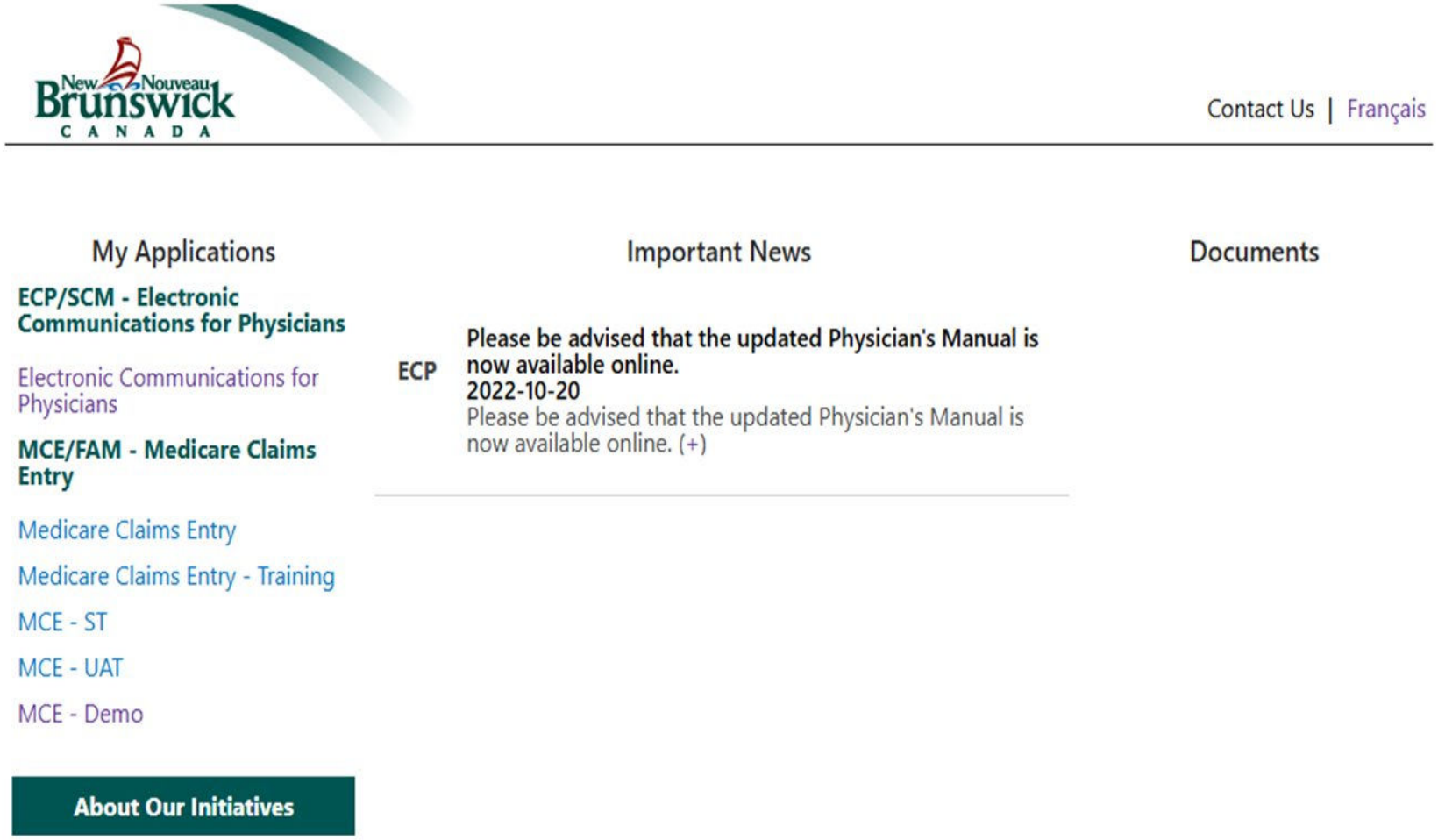
Cédule de Paiement des Praticiens - 2025

	MP#	Cut-Off Date 8:00AM Thursday for Claims Date d'arrêt 08:00AM	Run Date FRIDAY Date d'exécution	Process Pay Run MONDAY	Statement and Deposit Date FRIDAY Date du Relevé de compte et du dépôt	NOTES ON HOLIDAYS
1	2226	9/Jan/25	10/Jan/25	13/Jan/25	17/Jan/25	
2	2228	23/Jan/25	24/Jan/25	27/Jan/25	31/Jan/25	
3	2230	6/Feb/25	7/Feb/25	10/Feb/25	14/Feb/25	
4	2232	20/Feb/25	21/Feb/25	24/Feb/25	28/Feb/25	
5	2234	6/Mar/25	7/Mar/25	10/Mar/25	14/Mar/25	
6	2236	20/Mar/25	21/Mar/25	24/Mar/25	28/Mar/25	
7	2238	3/Apr/25	4/Apr/25	7/Apr/25	11/Apr/25	
8	2240	17/Apr/25	18/Apr/25	21/Apr/25	25/Apr/25	APRIL 18 - GOOD FRIDAY/APRIL 21 EASTER MONDAY

Electronic Communications for Physicians (ECP)

ECP contains Reconciliation Statements, as well as useful documents and forms such as: Practitioner Run Schedule and Practitioner Enquiry form





What you need to get started

- ☑ Provider number
- ☑ Accounts
- ☑ Complete delegate authorization form
- ☑ Billing software (MCE or third-party)
- ☑ Health Portal access (hps.gnb.ca)

Key Billing Resources:

- List of common service codes
- NB Physician's Manual – fee schedule, reference, provides more details e.g., descriptions, rules
- Billing training – Medicare Practitioner Liaison
- PELs – Practitioner Enquiries
- Stay informed: Electronic Communication for physicians (ECP) – Medicare memos, Medicare Policies, Reconciliation Statements
- NBMS Economic News available at www.nbms.nb.ca

Medicare Coverage Summary

Covered	Not Covered
Professional services as outlined in the Physician's Manual	Minor skin lesion removal (unless precancerous or suspected)
Face-to-face Encounters (unless otherwise specified)	Medicines, drugs, materials, surgical supplies, prosthetic devices
Eligible nursing services	Testimony in a court or tribunal
NB residents with valid Medicare cards	Travel /employment /Immigration related exams, immunization or certificates
Out of province patients (except Quebec)	Periodic medical examinations / check-up not medically necessary.
	Quebec residents (manual submission to RAMQ)
	Military personnel
	Third party requests (ex: insurance forms, driver's license)
	Federal inmates
	WorkSafeNB claims

Medicare Fee Schedule

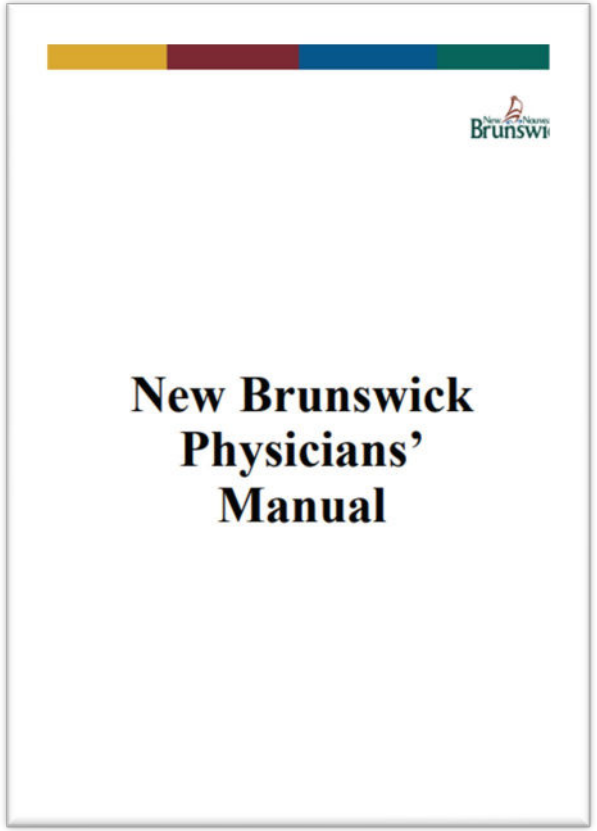
In the NB Physician's Manual, you'll find a code that correlates for every service you provide, each with its own unit value.

Fees for service codes are unit based instead of per dollar. See Chapter 3, Section 1.5 in Physicians' Manual for Unit Values per Specialty.

Fee-for-service practitioners can calculate dollar amount for codes by multiplying the Units (indicated in the Manual beside the service code) by the dollar amount for their specialty based on the table.

Lists	Code	Units Gen	Units An
..B	368	46	7

Chapter 5: Section 1 Family medicine



Physicians' Manual

CHAPTER 5: SPECIALTIES

Section 1: Family Medicine

See legend – *Chapter 3, Section 1.7* for description of lists A, B, C and D.

The fees cannot be correctly interpreted without reference to the General Preamble.

1.1 Consultations

(See definitions in General Preamble, ***Chapter 3, Section 1.2.4***)

Major or regional consultation	10	57
Repeat, within 30 days	12	42

1.2 Office Visits

To include where applicable hemoglobin, urinalysis, injections, pelvic examination and services to which they apply as outlined in ***Chapter 3, Section 1.2.2***.

Office visit, to be billed by Family Medicine Practitioners when providing service within the context of a community-based family practice, which is defined as one in which the practitioner maintains a comprehensive patient chart to record the service code 1 and all other encounters, provides all necessary follow-up care for that encounter and takes responsibility for initiation and follow-up on all related referrals	1	32

Service code 1 applies also to office consultations and complete examinations that cannot be claimed at a higher fee under other codes, for example due to limitations in frequency or service intervals.

Seniors Office Visit, add
For complex case assessment for seniors **65** years of age or over, presenting with multiple systems pathology including medication review, as required 8101 9

Medicare Note: Once multiple system pathology has been diagnosed, the senior's office code may be billed for subsequent visits regardless of presenting complaint(s).

See legend – *Chapter 3, Section 1.7* for description of lists A, B, C and D.

Injections
See *Chapter 4, Section 2.15.10*

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Quick Reference / Cheat Sheet

Example cheat sheets provided during a Medicare billing training session.

Cheat sheets are a great time saver for commonly used service codes!

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FAMILY MEDICINE TRAINING SESSION

Consultations

Code 10	**Major Consult** Requiring the consulting practitioners opinion and treatment recommendation Required to provide a consult report back to the referring physicians with findings and recommendations. Claim must include: a) Referring Practitioner Number b) Date of referral *(verbal request must include time)* c) Referred to or Referred From field Code 10 cannot be billed more than once in a 30-day period
Code 12	**Repeat Consultation** (new referral and seen within 30 days of major consultations)

Office Visits *(Location 1 and 19) *Anything billed in Locations 1 or 19 MUST include start time*

Code 1	**Office Visits** a) Providing a patient with diagnosis and/or treatment b) Non-clinical follow-up by phone c) Ordering additional blood work, maintaining or updating files Code 1 cannot be billed in addition to another visit or consultation. Can be billed in-office (location 1) or virtually (location 19).
Code 8101	**Seniors Office Visit (65+, multiple system pathology) –Add on** a) When 8101 is used for the 1st time in addition to the ICD 10 diagnosis, multiple systems pathology must be indicated in the diagnosis or comments.
Code 8985	**Complex Patient Care Visit -add on** a) Once multiple system pathology has been diagnosed, code 8985 may be billed for subsequent visits regardless of presenting complaint(s). b) In order to bill service code 8985, each patient must have 2 of the identified complex disease diagnosis. • Diabetes • Congestive Heart Failure • Asthma • COPD • Dementia • Palliative • Obesity BMI > 40 • High Blood Pressure • Chronic Pain Syndrome c) Code 8985 is not payable in addition to code 8101
Code 8986	**Complex Medical Care – visit with a group of patients (2 or more) (per 15 minutes)** *Please refer to Practitioner Enquires with any questions on how to bill*
Code 9348	**New Patient Complete Exam & Chart Initiation Fee (replaces code 8107)** **See Distribution Memo dated March 28, 2025 for full description* a) Billable once per new patient b) Open to Location 1 (office) only c) Time of day is required on claim d) Detention is billable after first 30 minutes, when applicable

Review: Family Medicine – Commonly Billed Codes

Visit codes for family medicine

- Code 1 – Office Visit
- Code 3 – Walk-in Clinic Visit
- Code 4 – Home Visit
- Code 15 – Prenatal complete examination
- Code 16 – Pre and/or postnatal visits
- Code 19 – Well baby care

Visit: Refers to services rendered by a practitioner to a patient for diagnosis and/or treatment at home, office, or hospital. Unless otherwise specified, a practitioner can only bill one patient encounter per patient per day.

Consultation

When a practitioner specifically requests the opinion of another practitioner able to give advice in this field, because of the complexity, obscurity or seriousness of the case.

- Code 10 – Major or Regional Consultation
- Code 12 – Repeat Consultation (performed by the same practitioner within thirty days of a prior consultation, for the same or related condition)

Add-on codes and Chronic Disease Management codes

Ensure primary code is submitted. Add-on codes will not be paid unless a corresponding primary visit or procedure code is billed.

- Code 8101 – Seniors' office visit, add-on (65+ with multiple systems pathology)
- Code 8985 – Complex Patient Care Visit, add-on
- Code 1999 – Tray Fee for Pap test
- Chronic Disease Management (billable once per 365 days)
    - 8109 – Diabetes
    - 8113 – COPD

Time based codes

Per 15 minutes or part thereof

Start and end time required on claim

Each 15-minute block = 1 count

Code 200 – Detention

Example: In-office consultation from 9:00am to 10:45am (1hr and 45 min)

- Code 10 (for first 60 min)
- Code 200 (for extra 45 min)

- **Start and end times, count of 3 on claim for extra 45 minutes**

Code 216 – Family counselling

Example: Discussion with patient's spouse regarding treatment plan +\- DNR from 2:15 pm to 2:45pm (30 minutes)

- Code 216
- Start and end times, count of 2 (30 min)

- **Required info: Patient's diagnosis, who you spoke with (e.g., spouse, parent) and topic discussed (e.g., treatment, DNR, placement)**

Time based codes

Per 15 minutes or part thereof

Start and end time required on claim

Each 15-minute block = 1 count

Code 20 – Psychotherapy

Example: Psychotherapy with patient from 10:45am-11:45am (1 hr)

- Code 20
- (count of 4)
- Start and end time

* Code 20 cannot be billed same day as a visit fee.

Immunizations

Immunization service codes payable with visit (15 units)

- Maximum 4 payable per service date (3 @ 100% + 1 @ 50%)
- Codes listed in **Column A** from table in Manual

Immunization service codes not payable with procedure or visit (20 units)

- Maximum of one (1) payable per service date
- Codes listed in **Column B** from table in Manual

Chapter 4, Section 2.15.11 Immunizations

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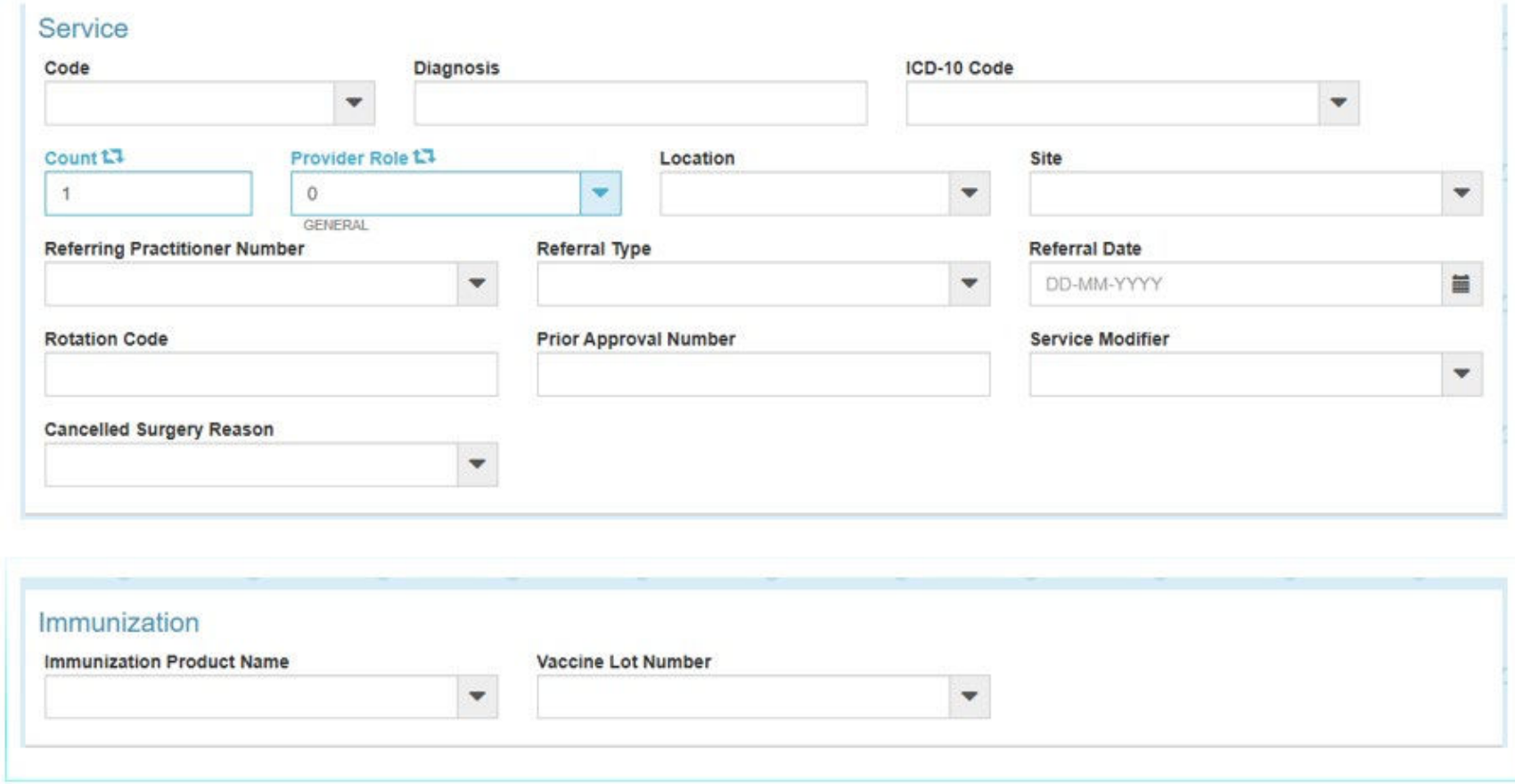
Physician's Manual- Chapter 4, section 2.15.11 Immunizations

Column A *Service Codes payable with visit (8 units)*	Column B *Service Codes not payable with procedure or visit (13 units)*	Column C *Description*	Column D *Product Name*
8630	8660	DIPHTHERIA, TETANUS, ACELLULAR PERTUSSIS, INACTIVATED POLIO,	• QUADRACEL
8631	8661	DIPHTHERIA, TETANUS, ACELLULAR PERTUSSIS, INACTIVATED POLIO, *HAEMOPHILUS INFLUENZAE* TYPE B	• PEDIACEL
8632	8662	HEPATITIS A	• HAVRIX 720 JUNIOR • HAVRIX 1440 • VAQTA PEDIATRIC/ADOLESCENT • VAQTA ADULT
8633	8663	HEPATITIS A & B	• TWINRIX JUNIOR • TWINRIX
8634	8664	HEPATITIS B	• RECOMBIVAX HB PEDIATRIC • RECOMBIVAX HB ADULT • RECOMBIVAX HB DIALYSIS • ENGERIX-B PEDIATRIC • ENGERIX-B ADULT
8635	8665	HAEMOPHILUS INFLUENZAE TYPE B	• ACT-HIB • HIBERIX
8636	8666	HUMAN PAPILLOMAVIRUS	• GARDASIL • GARDASIL 9
8637	8667	INFLUENZA	• AGRIFLU • FLUVIRAL • VAXIGRIP • FLUZONE QUADRIVALENT • FLULAVAL TETRA
8638	8668	INACTIVATED POLIO	• IMOVAX POLIO
8639	8669	MEASLES, MUMPS RUBELLA	• M-M-R II • PRIORIX
8640	8670	MEASLES, MUMPS, RUBELLA, VARICELLA	• PRIORIX-TETRA • PROQUAD
8641	8671	MENINGOCOCCAL CONJUGATE MONOVALENT	• NEIS VAC-C • MENJUGATE
8642	8672	MENINGOCOCCAL CONJUGATE QUADRIVALENT	• MENVEO • NIMENRIX
8643	8673	MENINGOCOCCAL POLYSACCHARIDE	• MENOMUNE
8644	8674	PNEUMOCOCCAL CONJUGATE 13-VALENT	• PREVNAR 13
8654	8684	PNEUMOCOCCAL CONJUGATE 15-VALENT	• PREVNAR 15
8655	8685	PNEUMOCOCCAL CONJUGATE 20-VALENT	• PREVNAR 20
8645	8675	PNEUMOCOCCAL POLYSACCHARIDE 23-VALENT	• PNEUMOVAX 23
8646	8676	RABIES	• IMOVAX RABIES
8647	8677	TETANUS, DIPHTHERIA (REDUCED)	• TD ADSORBED
8648	8678	TETANUS, DIPHTHERIA (REDUCED), ACELLULAR PERTUSSIS (REDUCED)	• ADACEL • BOOSTRIX
8649	8679	TETANUS, DIPHTHERIA (REDUCED) ACELLULAR PERTUSSIS (REDUCED), INACTIVATED POLIO	• ADACEL-POLIO • BOOSTRIX-POLIO
8650	8680	VARICELLA	• VARILRIX • VARIVAX III
8651	8681	MULTICOMPONENT MENINGOCOCCAL B VACCINE	• BEXSERO
8652	8682	LIVE ATTENUATED ROTAVIRUS VACCINE (ORAL SUSPENSION 1.5ML)	• ROTARIX (effective June 1, 2017) • ROTA TEQ

Immunization MCE template



Flu and COVID

Influenza

8637: with visit

8667: without visit

COVID-19

8653: with visit

8683: without visit

Updates and Changes

Effective April 4, 2025, the following service codes move from List C to List B procedures:

- 9148 -Contraceptive Implants, Implantation
- 9149 -Contraceptive Implants, Removal
- 9150 -Opioid Implants, Implantation
- 9151 -Opioid Implants, Removal

What this means:

List B procedures are **payable in addition to same-day visit** or consultation fees.

(Reference: The Legend - Chapter 3, Section 1.7 – NB Physician's Manual)

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Code 9348 New Patient Complete Examination & Chart Initiation Fee

Effective April 4, 2025, Code 8107 – Chart Initiation Fee **is replaced by Code 9348** - New Patient Complete Examination & Chart Initiation Fee

Key Billing Details:

- Fee: 100 units
- Can be billed once per new patient
- Provider must initiate a permanent patient chart
- Must be in community-based family practice (established ≥ 1 year)
- Time of day is required
- Open to locations: 1 (office), 4 (patient residence) & 9 (special care home)
- Detention (code 200) is billable after the first 30 minutes (if applicable)

Chapter 4: Items common to all practitioners

Emergency Visit codes

- Emergency visits may include any visit codes for services rendered on an emergency basis at the office, home, nursing home, Extra Mural or hospital
- Bona fide emergency (the need for immediate response)
- All claims for emergency-based visits must show the time of day the services were rendered
- Does not apply to pre-arranged after-hours attendance, nor when patients are seen as emergencies in the office during office hours or in hospital during regular rounds

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Emergency visit codes cont.

"Daytime" applies to attendance between 07:00 and 17:59 hours on weekdays.

"Nighttime" applies to attendance between 18:00 and 06:59 hours, weekdays.

"Weekends" applies to attendance on Saturdays, Sundays and legal holidays.

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In hospital (for in-patient, NOT ER)

Code 2855 – Daytime emergency visit

Code 2856 – Nighttime and weekend emergency visit

Nursing home, patient's residence or Extra-Mural patients

Code 1752 - Nursing Homes Emergency Visit, nighttime and weekend

Code 206 – EMP Emergency Home visit

Code 848 – EMP Palliative Care Emergency Home visit

Code 8 – Emergency Home visit

Mandated On-Call Stipend

- “On-call” means, any period outside regular working hours (Monday through Friday and on weekends and statutory holidays), whereby a Practitioner will be available to respond to urgent or emergent requests from a facility (hospital, nursing home, or an NB Provincial Jail) for the purpose of examining, treating, providing diagnostic services or advice regarding a patient.

- In the case of a hospital facility this includes discharged or unaffiliated patients who: present from the community via the emergency room, are referred by Practitioners from other facilities or are in-patients admitted under the care of a Practitioner in another specialty.

- In the case of nursing homes, this includes all existing or newly admitted residents.

Mandated On-Call Stipend

On-Call Service codes

Code 8989 - General Practice (FFS and Salaried) rotations

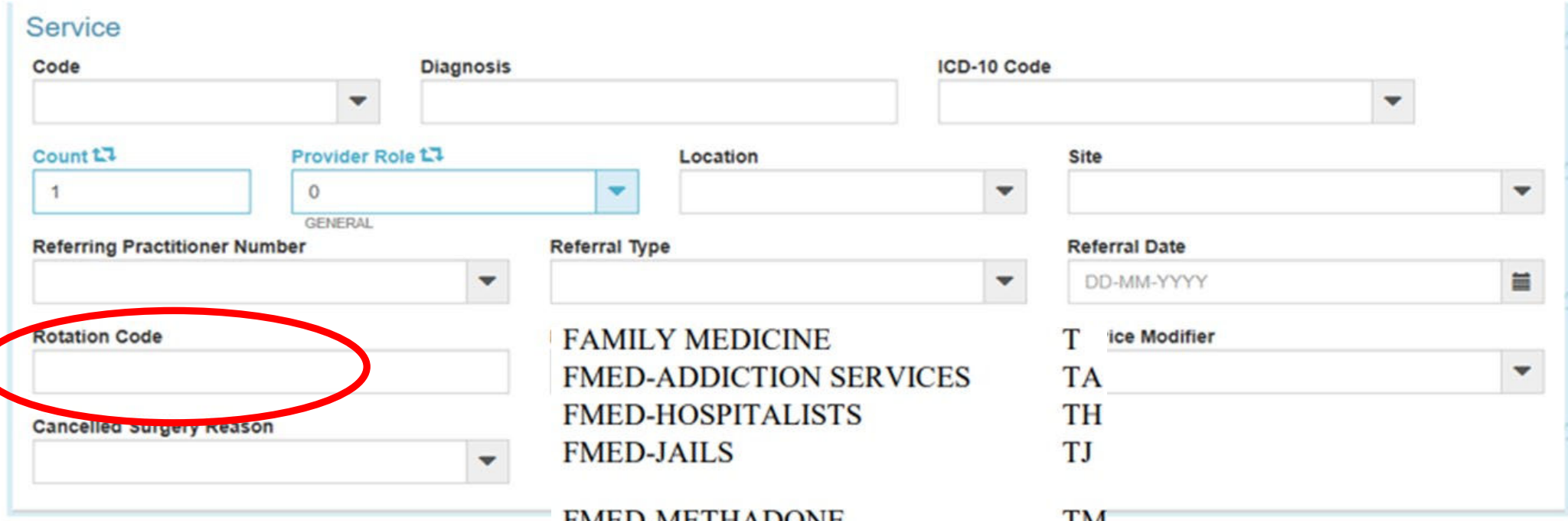
Code 8991 - Nursing Home rotations

Code 8992 - Provincial Jail Rotations

Code 8987 – In-Hospital Overnight stipend

New Nouveau Brunswick

Where to enter Rotation code in MCE



FAMILY MEDICINE	T
FMED-ADDICTION SERVICES	TA
FMED-HOSPITALISTS	TH
FMED-JAILS	TJ
FMED-METHADONE	TM
FMED-NEWBORNS	TN
FMED-O/R ASSISTS	TO
FMED-OBSTETRICS	TC
FMED-PALLIATIVE CARE	TP
FMED-SEXUAL ASSAULT	TS

Extra Mural Codes

The following service codes apply exclusively to services related to patients admitted to the Extra-Mural Program (EMP).

**(See Chapter 4, Section 2.15.1 in Physicians' Manual for codes and descriptions)*

New Nouveau Brunswick

Commonly used EMP codes

- **Code 209** – A visit, other than a home visit, with a patient that requires an admission/referral to EMP services. Not applicable to Location 19 (Virtual).
- **Code 210** – Communication initiated by EMP staff member and requires a response from a practitioner. Can be by fax, email, phone call, hardcopy or video conference.

Extra Mural Codes

The following service codes apply exclusively to services related to patients admitted to the Extra-Mural Program (EMP).

**(See Chapter 4, Section 2.15.1 in Physicians' Manual for codes and descriptions)*

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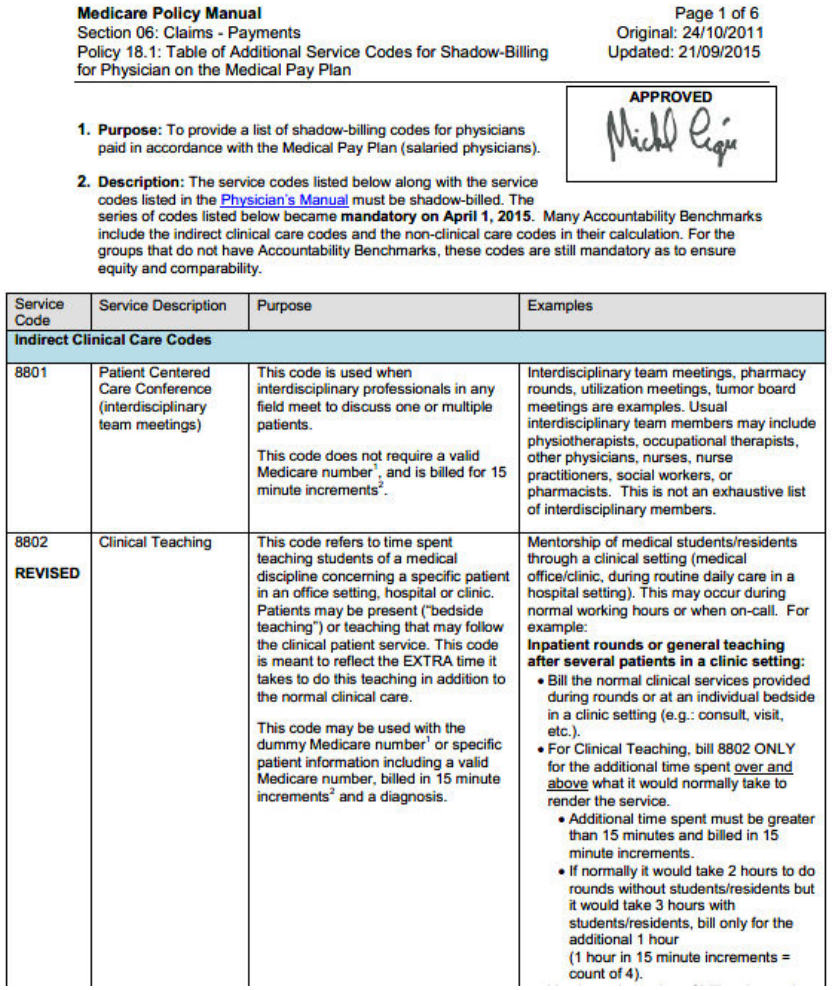
Home visit & Palliative Care Home visit

- **Code 204** – Home visit with admission to EMP
- **Code 205** – Home visit to a previously admitted patient
- **Code 206** – Emergency Home visit
- **Code 208** – Additional patient, admitted or not, seen during a home visit
- **Code 847** – Palliative Care Home visit, to previously admitted patient
- **Code 848** – Palliative Care Emergency Home visit

Additional Service Codes for Shadow Billing

- The additional service codes, also referred to as Admin Services codes, are for **Salaried Physicians only**.
- These codes are mandatory to bill, and many Accountability Benchmarks include the codes in their calculation.
- Codes are for indirect clinical care and non-clinical care (ex. Interdisciplinary team meetings, Clinical teaching, reviewing charts, lab results or patient history, filling out forms)
- Many of the codes do not require a valid Medicare number and can be billed under the dummy Medicare number 111 111 126.
- Codes are billed in 15-minute increments and require the number of services (ex. 1 hour = count of 4 number of services)



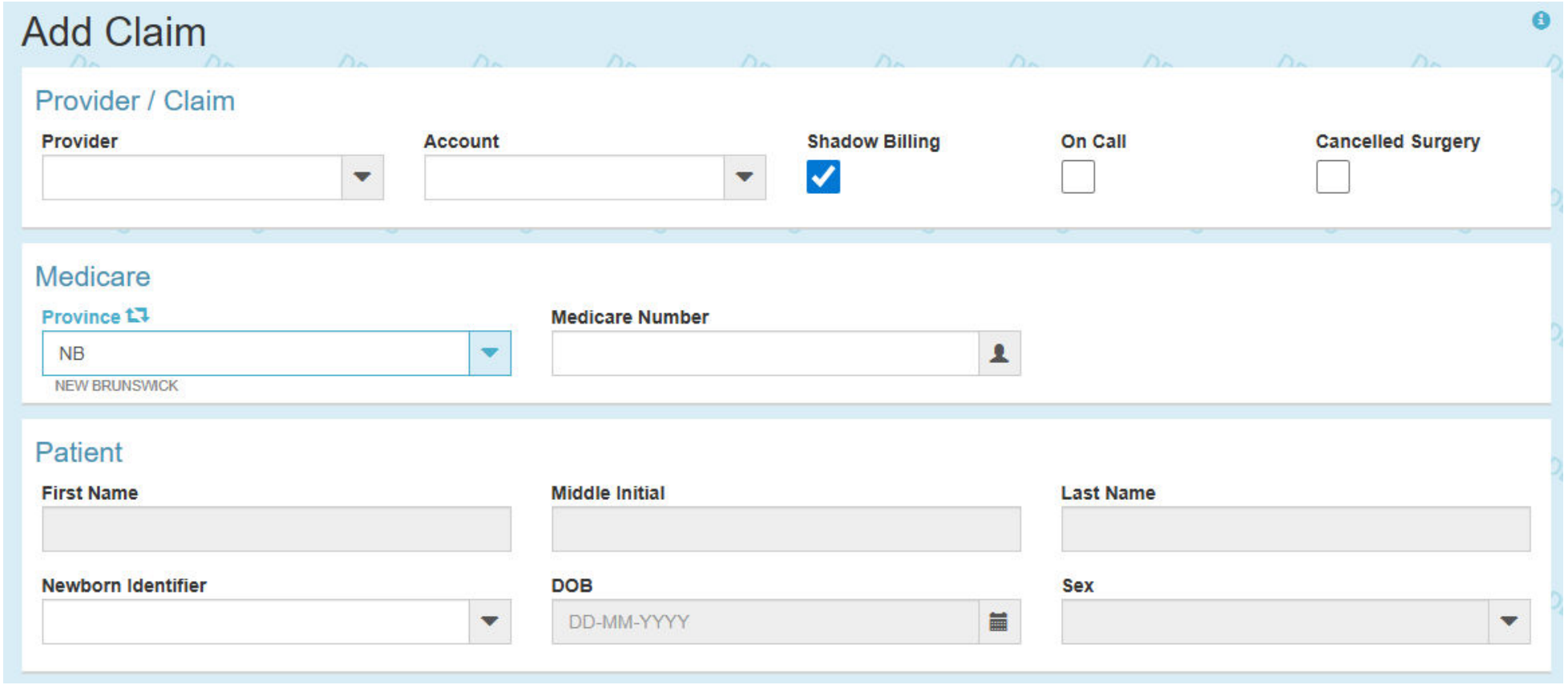
Medicare Policy Manual Page 1 of 6
Section 06: Claims - Payments Original: 24/10/2011
Policy 18.1: Table of Additional Service Codes for Shadow-Billing for Physician on the Medical Pay Plan Updated: 21/09/2015

APPROVED

1. **Purpose:** To provide a list of shadow-billing codes for physicians paid in accordance with the Medical Pay Plan (salaried physicians).
2. **Description:** The service codes listed below along with the service codes listed in the Physician's Manual must be shadow-billed. The series of codes listed below became **mandatory on April 1, 2015**. Many Accountability Benchmarks include the indirect clinical care codes and the non-clinical care codes in their calculation. For the groups that do not have Accountability Benchmarks, these codes are still mandatory as to ensure equity and comparability.

Service Code	Service Description	Purpose	Examples
Indirect Clinical Care Codes			
8801	Patient Centered Care Conference (interdisciplinary team meetings)	This code is used when interdisciplinary professionals in any field meet to discuss one or multiple patients. This code does not require a valid Medicare number[1], and is billed for 15 minute increments[2].	Interdisciplinary team meetings, pharmacy rounds, utilization meetings, tumor board meetings are examples. Usual interdisciplinary team members may include physiotherapists, occupational therapists, other physicians, nurses, nurse practitioners, social workers, or pharmacists. This is not an exhaustive list of interdisciplinary members.
8802 **REVISED**	Clinical Teaching	This code refers to time spent teaching students of a medical discipline concerning a specific patient in an office setting, hospital or clinic. Patients may be present ("bedside teaching") or teaching that may follow the clinical patient service. This code is meant to reflect the EXTRA time it takes to do this teaching in addition to the normal clinical care. This code may be used with the dummy Medicare number[1] or specific patient information including a valid Medicare number, billed in 15 minute increments[2] and a diagnosis.	Mentorship of medical students/residents through a clinical setting (medical office/clinic, during routine daily care in a hospital setting). This may occur during normal working hours or when on-call. For example: **Inpatient rounds or general teaching after several patients in a clinic setting:** • Bill the normal clinical services provided during rounds or at an individual bedside in a clinic setting (e.g.: consult, visit, etc.). • For Clinical Teaching, bill 8802 ONLY for the additional time spent over and above what it would normally take to render the service. • Additional time spent must be greater than 15 minutes and billed in 15 minute increments. • If normally it would take 2 hours to do rounds without students/residents but it would take 3 hours with students/residents, bill only for the additional 1 hour (1 hour in 15 minute increments = count of 4).

Shadow Billing in MCE



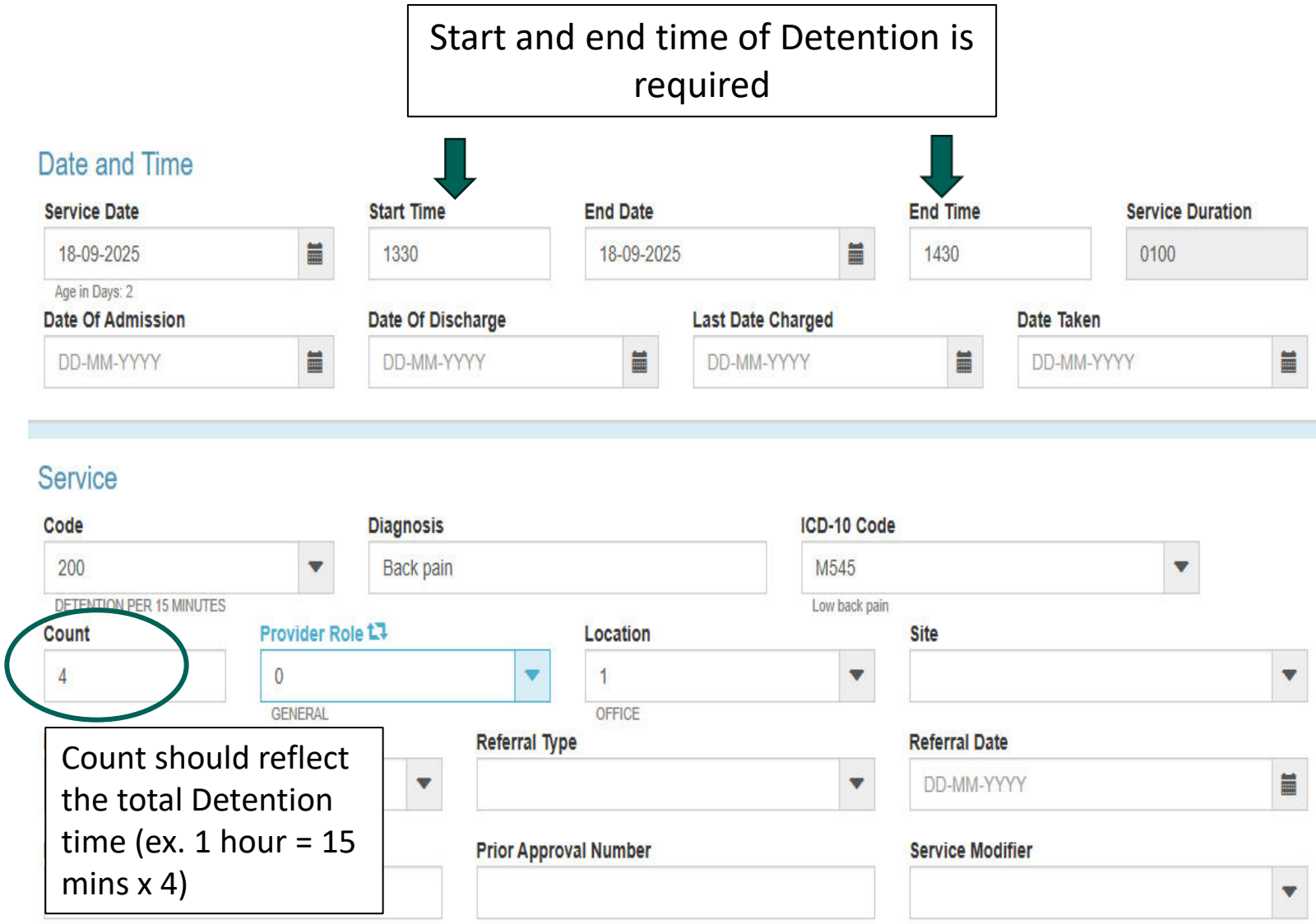
Example #1 Visit with detention

Patient seen in office for a follow-up visit. Physician is with the patient from 13:00 to 14:30.

Claim #1 – Visit claim (Code 1)
Start time = 13:00

Claim #2 – Detention claim (Code 200)
Start time = 13:30
End time = 14:30
Number of services = 4

Example #1 Visit with detention



Practice Questions

Emergency visit to patient's residence.

You drop everything to do an emergency house call for an elderly patient. You are detained at the patient's home providing care. The total visit duration is 51 minutes

1. What services codes +/- add-on can be billed?

a) Code 4
b) Code 8
c) Code 8 plus code 200 (count of 1)
d) Code 8 plus code 200 (count of 2)

2. Same scenario as above, however the patient has been admitted to Extramural program receiving Palliative care

a) Code 206 plus code 200 (count of 2)
b) Code 848 plus code 200 (count of 2)

Practice Questions

Emergency visit to patient's residence.

1. Answer is D

Code 8 plus code 200 (count of 2)

* Code 8 billed for the Emergency Home Visit (first 30 minutes)

* Code 200 (count of 2) for the additional time spent with the patient (51 mins = 15 x 2)

2. Answer is B

Code 848 plus code 200 (count of 2)

*Code 848 for Emergency EMP Palliative Care Home Visit (first 30 minutes)

* Code 200 (count of 2) for the additional time spent with the patient (51 mins = 15 x 2)

Example #2
Visit with add-on

A 50-year-old patient with arthritis seen in office for cortisone injection in both knees. Patient also has been previously diagnosed with hypertension and asthma.

1. What services codes +/- add-on can be billed?

    a. Code 1
    b. Code 1 + Code 1948 (count of 2, both at 100%)
    c. Code 1 + Code 8985 + Code 1948 (count of 2, 1st at 100%, second at 75%)
    d. Code 1 + Code 8101 + Code 1948 x 2 (two separate claims)

Example #2 – Visit with add-on

Answer with explanation

Answer is C

Code 1 + Code 8985 + Code 1948 (count of 2, 1st at 100%, second at 75%)

- *Code 1 can be billed for the office visit.
- *Code 8985 as the patient has been diagnosed with 2 of the complex diseases listed in the description for this code.
- *Code 1948 for a count of 2 for both knees and 1st at 100% and 2nd at 75% as this code is a List B. Can also be billed on 2 separate claims.

Tip: Be sure to indicate "bilateral" if billing one claim or "Right" and "Left" if billing two claims.

Code 8985 – cont.

Medicare Note: Service code 8985 is an add on to service code 1 only. In order to bill service code 8985, each patient must have two of the following complex disease diagnosis listed below. Service code 8985 is not payable in addition to service code 8101.

- Diabetes
- Congestive heart Failure
- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Dementia
- Palliative
- Obesity BMI > 40
- High Blood Pressure
- Chronic Pain Syndrome

Additional Services

- Role 3 Surgical - assistance fee
- Code 1898 Warfarin - supervision of long-term therapy, per month (telephone service)
- Code 8 - Home Visit
- Code 8715 - Attendance at labour leading to delivery
- Office Procedures
    - Code 2089 - Cryotherapy of wart (total fee) **List C**
    - Code 837 – Diagnostic punch skin biopsy **List A**

New Nouveau Brunswick

WorksafeNB

WSNB claims that are not accepted by WSNB can be submitted to Medicare for payment consideration with the refusal letter from WSNB (within 92 days from date on letter)

Payment messages that may appear on your Reconciliation Statement for claims that are WorksafeNB related:

- Reversal, please submit to WSNB
- Do not rebill – WSNB refusal requires enquiry, refusal letter & claim #
- Paid by WSNB
- Payable by WSNB
- WSNB refusal letter >92 days old from claim submission date

Tips to streamline your billing processes

Submit claims regularly – 92 days from date of service

Include information in your notes to make billing easier

Start and end times

Diagnosis, ICD10 dx codes,

Billing code(s)

Patient's Medicare number

Review reconciliation statements regularly

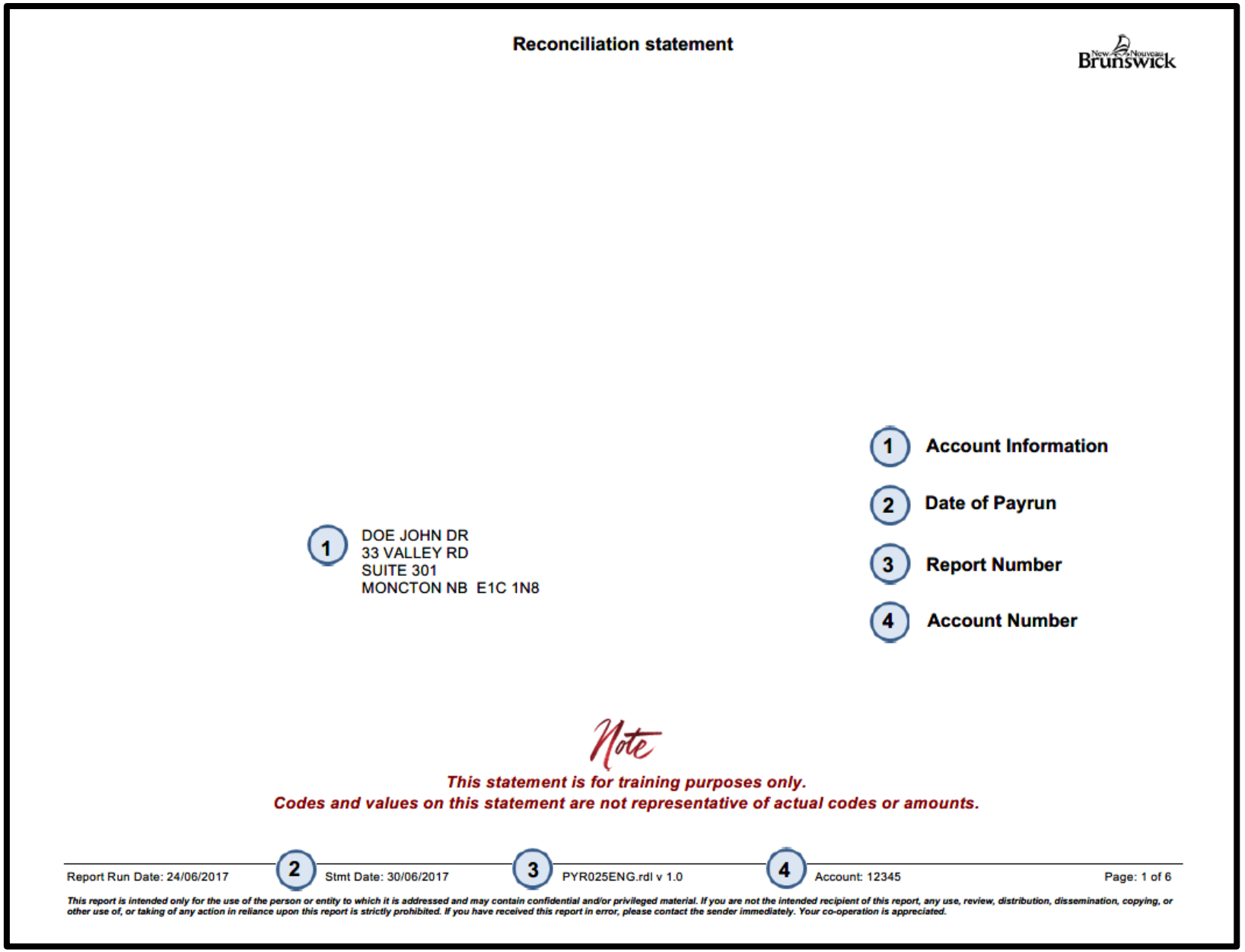
Know your commonly billed codes – create cheat sheets

Know where to look and who to ask if unsure

New Nouveau Brunswick

Reconciliation Statement

Practitioner reconciliation statements are available every 2 weeks on ECP and should be reviewed on a regular basis, as it is the most accurate for what has been processed by Medicare and indicates claims that may require action.



Reconciliation statement

1 DOE JOHN DR
33 VALLEY RD
SUITE 301
MONCTON NB E1C 1N8

1 Account Information
2 Date of Payrun
3 Report Number
4 Account Number

Note

This statement is for training purposes only.
Codes and values on this statement are not representative of actual codes or amounts.

Report Run Date: 24/06/2017 | 2 Stmt Date: 30/06/2017 | 3 PYR025ENG.rdl v 1.0 | 4 Account: 12345 | Page: 1 of 6

Reconciliation Process: Ensuring Accurate Payment

- Review Reconciliation Statements regularly.
- Keep track of submitted claims and compare against your paid claims.
- Identify discrepancies – look for unpaid claims, cancelled claims, or reduced claims.
- Investigate and take action to resolve issues - correct and resubmit as needed, and/or contact PELs to request adjustments.
- Monitor future statements to ensure resolution and all services have been paid.

New Nouveau Brunswick

Medicare Contacts

Who	When	How
Practitioner Enquiries	Questions regarding submitted claims (adjustments, corrections, cancel claims) Questions regarding Reconciliation Statements	pels.drpl@gnb.ca (506) 444-5860 (English only) (506) 457-7572 (Bilingual) (506) 444-5876 (Bilingual) (506) 453-5332 (Fax)
Medicare Payments	Anything pertaining to accounts and/or banking information	DHMedPay@gnb.ca
MCE Admin	Technical issues with MCE, account issues or to reset password	MCEAdmin@gnb.ca
Practitioner Liaison	To request billing/MCE training or refresher	Medicare.Training.Formation@gnb.ca

New Nouveau Brunswick

Questions?

Let us know how we can improve!

Evaluation Survey:

https://forms.office.com/r/TkmZKcBdbT