FREQUENTLY ASKED QUESTIONS
PRIMARY CARE INVESTMENTS

Effective dates

Q. When do the fee enhancements and incentives take effect?

A. Following are the effective dates for each element of the March 19 announcement:

- Office and geriatric visit increase: April 1, 2018
- APP family physician rate increase opportunity: April 1, 2018
- Enrolment incentive: April 1, 2018
    - *Note: It will take time to get the process confirmed and activated*.
- Unattached patient bonus (orphan patient incentive): April 1, 2018
    - Telephone fee improvements: April 1, 2018
- Technology stipend – virtual care: As soon as possible; working group to meet as soon as possible to finalize details.
- Technology stipend – Electronic Medical Records: To be determined.

Enhanced Office and Geriatric Visit Fees

Q. When do the enhanced office and geriatric fees become available?

A. The enhanced office and geriatric visit fees are effective as of April 1. Here are some important billing instructions:

- The enhanced rates take effect April 1, but the MSI system was not updated until May 17.
    - Claims submitted between April 1 and May 17 that were paid at the lower rate will be used to calculate an additional payment. This payment will be made in August or September (after the 90-day billing window has closed) to ensure that you have received the full value of the enhanced fees billed from April 1 onward.
- Remember that the enhanced fees are only available to family physicians who are responsible for the comprehensive and continuous care of their patients (see definition in the next Q&A). In early May, physicians were asked to sign a confirmation letter <link to letter> confirming that they will bill the enhanced fees only for visits with patients for whom you are in fact providing comprehensive and continuous care.

Q. What do we mean by "comprehensive and continuous care" of patients?

A. The enhanced office and geriatric visit fees are available only to family physicians responsible for the comprehensive and continuous care of the patient. This means you have an ongoing relationship as a primary care provider to the patient and you ensure the continuity of their medical care. It does not include episodic care provided to walk-in patients.

Q. Is the enhanced geriatric visit fee available for walk-in clinics?

A. No (unless you are seeing one of your own patients for whom you are their Primary Comprehensive Care provider (or a patient of your practice) in the walk-in clinic - see question below for more detail). The enhanced fees are only available to family physicians who are responsible for the comprehensive and continuous care of their patients. This means you have an ongoing relationship as a primary care provider to the patient and you ensure the continuity of their medical care. It does not include episodic care provided to walk-in patients.

Original Publication Date May 17th, 2018

Q. What about comprehensive practices that offer evening hours or a walk-in clinic in the evenings. Are those physicians able to bill the enhanced visit fees?
A: If your practice offers evening hours or a walk-in service, you should bill the enhanced fee whenever you are seeing one of your own patients, or a patient of your practice (that is, you may bill the enhanced fee for any patient for whom you, or a colleague in your practice – provide comprehensive and continuous care). If you also see orphan/unattached patients that the practice is not able to assume full care for, as noted aboce, you would not be eligible to bill the enhanced fee for those patients. You may only bill enhanced fees for the patients for whom you, or your practice provide comprehensive and continuous care.

Q: Are family physicians who practice sports medicine (or a similar targeted area, such as pain management) and see patients regularly, sometimes for months after the initial visit, eligible to bill the enhanced 03.03?
A: It depends on the extent of care you are providing to each patient. The enhanced fees are only available to family physicians who are responsible for the comprehensive and continuous care of their patients. This means you must have an ongoing relationship as a primary care provider to the patient and you ensure the continuity of their medical care.

Q: If the clinic has both walk-in and a patient roster, how are those billings going to be separated? For example: one clinic, one physician, one facility number, and one business arrangement number. The physician would see patient roster patients in the morning and do a walk-in clinic in the afternoon.
A: The physician or a colleague working in the same practice must have an ongoing relationship with the patient as well as providing on-going comprehensive primary care. Physicians should bill the enhanced fees (ME=CARE) only for patients with whom they have an ongoing relationship.

Q: If a physician sees patients that they normally see in their own practice in the walk-in clinic setting, can they claim the geriatric office visit with the modifier for evenings and weekends? What if it is a walk-in clinic within their practice?
A: The use of the enhanced fee depends on the patient's relationship to the provider. As long as they are this patient's primary comprehensive care provider and maintain their medical record, then they are eligible to bill the enhanced fees.

Q: What constitutes comprehensive and continuous care vs episodic care for walk-in clinic patients? Walk-in is a mix of regular patients and non-practice patients.
A: It depends on the extent of care you are providing to each patient. The enhanced fees are only available to family physicians who are responsible for the comprehensive and continuous care of their patients. This means you (or your practice) must have an ongoing relationship as a primary care provider to the patient and you ensure the continuity of their medical care. It does not include episodic care provided to walk-in patients.

Added November 30th, 2018
Q: When can the enhanced fees be billed for family physicians that are providing prenatal care to patients?
A: The fees can be billed in the following scenarios:

1. When you are providing prenatal care to your own long-term patients;
2. When you are providing prenatal care to patients of colleagues within your practice;
3. When you are providing prenatal care to patients referred from the community from another family physician (i.e a temporary transfer of care has occurred); and

4. When you are providing prenatal care to patients referred to you from a walk-in clinic without a family physician

For #3 and #4 we recommend that you document in the patient's chart that you are prepared to assume the comprehensive care of the patient for the duration of her pregnancy.

APP Contract Increase Opportunity

Q: For CEC physicians, is the 80% shadow billing target calculated on the basis of individual physician shadow billings, or the total/collective billings of the CEC?
A: The 80% target will be calculated on the basis of individual shadow billings. Any CEC physician who shadow bills above 80% of their contract rate will receive the 5.6% increase pro-rated according to their FTE. CEC physicians will receive further instructions from DHW and DNS on reporting processes once these processes have been finalized.

Q: What does this mean for APP physicians who shadow billed in excess of 80% in fiscal year 2017/18?
A: The opportunity for the 5.6% increase does not take effect until April 1, 2018. This means there will be no payment of 5.6% for shadow billings in excess of 80% in fiscal year 2017/18. The first payments will be made based on shadow billings in fiscal year 2018/19 (April 1, 2018 to March 31, 2019).

Q: What about physicians who convert from fee-for-service (FFS) to an APP contract mid-year – are they eligible for the 5.6% increase if they reach 80% of their pro-rated shadow billing target?
A: Yes. Those physicians will be eligible for a pro-rated payment equal to 5.6% of the value of their APP contract in the year in question (starting with fiscal year 2018/19).

Enrolment Fee

Q: When will the enrolment fee of $7.50 per patient be available?
A: The enrolment incentive is effective April 1, 2018. But it will take some time to define the enrolment process and for the initial/preliminary patient panel lists to be developed and distributed to family physicians for verification. We will keep you apprised on the timing of this work, however it is expected that this process will begin in mid to late June.

Q: Will I be able to make changes to the initial patient panel list?
A: Yes. An initial/preliminary list will be sent to you for verification. You will have the opportunity to add and/or remove names from the list based on your own charts. You will be paid $7.50 per patient on the final approved and validated roster.

Q: What if a patient ends up on the roster of more than one physician? Does each physician still receive the $7.50 for that patient?
A: This is one of the details that Doctors Nova Scotia (DNS) and the Department of Health and Wellness (DHW) are still finalizing. Further communication will follow regarding this issue and how it will be handled as soon as possible.

Q: If two or more physicians are sharing a practice how would they sort out the patient roster?
A: There will be one $7.50 payment per patient per practice. If there are two physicians in a practice who share a patient panel of 1000 patients, that practice will receive$7.50 x 1000 and work out the distribution amongst themselves.

Original Publication Date May 17th, 2018

Q: Which family physicians are eligible to receive the enrolment fee?
A: All family physicians regardless of payment model (FFS, APP and AFP) are eligible to receive the enrolment fee of $7.50 per patient should they choose to participate in the enrolment process.

Unattached Patient Bonus (Orphan Patient Attachment Fee)

Q: When do the new rules for the unattached patient bonus take effect?
A: The expanded rules for the unattached patient bonus take effect April 1. This means the fee is available to all APP, AFP and FFS family physicians who take on orphan/unattached patients, regardless of whether the patient has come from the 811 list, has been referred from the emergency department, does not have a family physician, or is about to be without a family physician due to physician retirement or relocation.

Q: Do patients have to be on the 811 list before I can bill the unattached patient bonus?
A: No. Starting April 1, you will be able to bill the unattached patient bonus for any orphan/unattached patient that you take on. This includes patients who are on the 811 list, as well as those who are not (specifically, it includes patients referred from an emergency department, patients who do not have a physician, and patients whose family physician is about to retire or relocate and does not have a new family physician to assume their practice). Note that you cannot claim the unattached patient bonus if you are a new physician still building your practice (see next question for more details).

Q: I am a new physician. Can I bill the unattached patient bonus for every orphan/unattached patient I take into my practice?
A: If you are a new physician (that is, new to your community within the last two years), you are not eligible to bill the unattached patient bonus until you have 1,350 patients on your patient panel. Once you have reached that threshold, or once have been practising in the community for more than two years (whichever comes first), from that point onward you can bill the unattached patient bonus for any additional orphan/unattached patients that you take into your practice.

Q: I am an established physician with fewer than 1,350 patients in my practice. If I am able to take some orphan/unattached patients into my practice, am I eligible for the unattached patient bonus (even though I am below the threshold)?
A: Yes. The 1,350-patient threshold only applies to new physicians (that is, new to the community within the last two years). If you are an established physician with a smaller patient panel and you are now able to take on additional patients, you can bill the unattached patient bonus for all orphan/unattached patients you add to your practice.

Q: Do I bill the unattached patient bonus at the time of the initial visit, or after I have had the patient in my practice for a year?
A: You should bill the unattached patient bonus at the time of your initial visit (as is presently the case). You are required to keep the patient in your practice and to maintain an open chart for at least a year, but you should still bill the incentive at the time of the initial visit. (Note that this is a change from the instructions first communicated, which suggested that you should hold your billing until the orphan/unattached patient has been in your practice for a year. This is no longer the case. You should bill at the time of the initial visit.)

Original Publication Date May 17th, 2018

Q: What if the patient dies within the first year? Will I lose the incentive payment for that patient because I am no longer able to maintain an open chart for a full year?
A: No. If the patient dies, you will still receive the unattached patient bonus; it will not be clawed back as a result of the patient's death.

Q: Do newborns qualify as orphan/unattached patients?
A: Yes. Newborns qualify as orphan/unattached patients, regardless of whether one or both parents is already part of your practice.

Q: What about part-time APP family physicians? I am an APP physician at 0.5 FTE. Is the 1,350 threshold pro-rated as a result?
A: Yes. If you are a part-time APP family physician building your practice, the patient panel size threshold that you must achieve before you are eligible to bill the unattached patient bonus is pro- rated from 1,350 patients. So, for example, a 0.5 FTE would have a threshold of 675 patients.

Q: I've taken on orphan/unattached patients from the 811 list in the past six to 12 months. Will there be any retroactive payment for those patients now that the rules for the unattached patient bonus have been expanded?
A: No, unfortunately there will not be retroactive payments. The previous rules apply until April 1; after that date, the expanded rules apply.

Q: If a physician is doing rounds in a nursing home they are now the primary care physician, however the patient still has a general practitioner. Can the nursing home physician claim the UPB1? Can they add this patient to their roster?
A: If the physician is just doing rounds and has not assumed full care of the patient, then no, they cannot claim the UPB1 for the nursing home patient as they already have a primary care physician. Doing rounds does not make them the patients primary comprehensive care provider.

Q: Some physicians believe that they can claim the UPB1 for patients that just receive a MSI card. These would be international students that they have seen before and technically have them as a patient, but now that they are registered with MSI they want to claim the unattached bonus. Is this allowable?
A: No If the patient has been in the practice, regardless of whether they have had an MSI card, they cannot bill the UPB1 once the patient receives their MSI card. But a physician CAN bill the UPB1 when they first take on the patient, regardless of whether they have an MSI card or not.

Added November 30th, 2018
Q: Can a physician claim UPB1 for university students?
A: Based on the fact physicians often take on care of university students for 9-10 months of the year and maintain charts on them over the course of their years in university, it was agreed that so long as the physician was becoming the student's comprehensive primary care provider while the student/patient was at university they could bill the ME=CARE modifier.

Added November 30th, 2018
Q: Will UPB1 claims count towards a physician's shadow billing calculations?
A: No. The UPB1 will be paid out bi-annually to eligible physicians. It will not be included in their shadow billing calculations if they have already received remunerations for their services.

Original Publication Date May 17th, 2018

Telephone Fee Improvements

Q: When will the telephone billing rules be changed?
A: The Master Agreement Management Group has agreed to remove the requirement that phone calls must be "pre-scheduled" with either the patient or the consulting physician in order for a physician to be able to bill the telephone fees. This change will benefit both specialists and family physicians who opt not to enrol in MyHealthNS and take advantage of the technology stipend (see below). This comes after very consistent feedback from physicians indicating that the scheduling requirement was one of the biggest barriers to using the new codes.

Billing instructions:

- This change is effective April 1.
- Revised detailed billing rules are included in the May 18 MSI *Physician's Bulletin*.

Technology Stipend – Virtual Care

Q: When will the up to $12,000 technology stipend be available?
A: The DHW and DNS are establishing a working group to finalize the details on the technology stipend for family physicians who are prepared to enrol in MyHealthNS. The working group is committed to getting the program up and running as quickly as possible.

Q: Will the $12,000 stipend count toward shadow billings for APP physicians?
A: No. The stipend is available to APP physicians and will be payable in addition to the base contract rate. As a result, it does not count toward shadow billings.

Original Publication Date May 17th, 2018