



Module 8: Physician Remuneration Options



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Tom Faloon, MD, CCFP, FCFP
Assistant Professor, Family Medicine, University of Ottawa
Physician Presenter, MD Physician Services
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Please send your permission request to:
Program Manager, Practice Education
MD Physician Services
1870 Alta Vista Dr.
Ottawa ON K1G 6R7
1 800 361-9151

Key Learning Points

- ▶ Remuneration models
- ▶ Alternative payment plans
- ▶ “Shadow billing”
- ▶ Differentiating between the salaried employee and the self-employed professional
- ▶ The scope of remunerative services physicians provide
- ▶ Fee-for-service (FFS) billing: The anatomy of an FFS bill and the billing process
- ▶ Billing the Workers’ Compensation Board
- ▶ Third-party billing and uninsured services
- ▶ The golden rules of billing
- ▶ Billing examples: Self-learning workshop

Author’s Note:

For specific case examples of billing, the author, who practises in Ontario, has used Ontario-specific codes and fees. Resources for provincial-specific payment models and fee schedules are provided at the end of this module, along with a generic billing examples workshop.

INTRODUCTION

As medical residents, you are remunerated as salaried employees of your hospital or medical faculty. The biweekly income you receive is your net take-home pay after deductions for income tax, Employment Insurance, Canada Pension Plan, group benefits and any other dues that you are obliged to pay. Once in practice, your sources of income will be varied and, potentially, quite complicated, depending on where and how you practice medicine.

Traditionally, most physicians have been paid primarily on a fee-for-service (FFS) basis, unless they worked in an institution and received a salary. Now, there are many new and more complex ways to reimburse physicians for their services. Today, we hear more about alternative payment plans, individually negotiated salaries and other, blended remuneration models. Understanding how you may be remunerated for the many services you provide is important as you evaluate short- and long-term practice options. There are many similarities, as well as significant provincially specific differences, in payment models.

Fee-for-service billing is the foundation from which all alternative payment models evolve. An in-depth and up-to-date knowledge of your provincial specialty-specific fee-for-service billing schedule of benefits is essential, regardless of the payment model you choose. This module will therefore include a more detailed discussion of the principles, definitions and mechanics of FFS billing, after an overview of remuneration options is discussed.

REMUNERATION MODELS

Physicians are paid for their professional services in a variety of ways:

- ▶ Traditional fee-for-service (FFS)
- ▶ Enhanced fee-for-service
- ▶ Alternative payment plans (APP)
- ▶ Salary

Fee-For-Service

In the traditional fee-for-service system, the physician is a self-employed professional who bills for each service provided. The parties responsible for payment for insured services include the provincial ministries of health, the Workers’ Compensation Board and federal government departments, such as Veterans Affairs, National Defence, Indian and Northern Affairs and the Solicitor General.

Each province will establish a schedule of benefits that outlines the fees paid for the many services and procedures that family doctors and specialists provide. The physician’s provincial medical association negotiates with the provincial ministry of health to set appropriate fees. When the Canada Health Act was enacted in 1969, the provincial ministries of health agreed to pay physicians approximately 90% of the fees established by the physicians’ medical associations. The provincial medical associations’ fees have increased in line with cost-of-living increases. Unfortunately, there has been a significant erosion of this agreement since the mid-1980s, and most provincial ministries of health have established fee schedules that are approximately 60% of what the medical associations have deemed as fair tariffs for services rendered. Each province has its own schedule of benefits, which can vary significantly. The principles of fee-for-service billing are the same across the country, but the logistics and coding are provincially specific.

Payment for uninsured fee-for-services is the responsibility of the patient or a third-party payer, such as an insurance company. In these circumstances, physicians are encouraged to use their provincial medical association fee schedules.

Enhanced Fee-For-Service

Most provinces and territories have decided to offer family physicians and some specialties enhancements and bonuses to the existing fee-for-service fee schedule, rather than embark on the more complex and varied alternative payment models that Ontario has adopted. Such enhancements include bonuses for complex and chronic disease management. Several provinces offer guaranteed block funding to complement the FFS payments in more rural areas, or for physicians who are providing care to special-needs populations. Enhancements can also include dedicated funding to assist physician groups to work in a collaborative multidisciplinary model along with nurse practitioners, social workers, etc. Enhanced models are often customized to the demographic and service needs of the particular region. Other enhancements, such as seen in Quebec, include a percentage increase in all FFS billings when the physician works in qualifying rural or remote areas. To learn more, contact your provincial medical association and ministry of health.

Many of the enhancements to FFS models are also incorporated in alternative payment plans (APPs), which will be discussed below.

Alternative Payment Models

Some ministries of health are now promoting other ways of remunerating physicians, via various alternative payment plan (APP) formats. Sometimes referred to as “alternative funding plans”, “alternative relation plans” and “new payment models”, APPs offer an alternative to the traditional fee-for-service remuneration.

At our Practice Management seminars, we often ask how many residents understand the latest alternative payment models proposed by their provincial health ministry. Rarely does anyone say “yes”. Like many practising physicians, residents find the complexity and the variety of terms very confusing. (An overview of APPs will be discussed in more detail below.) Because APPs are constantly evolving, readers are encouraged to visit the websites of their provincial medical association and specialty-specific organization to learn about APP developments in their province.

Alternative Payment Plans (APPs)

One type of APP addresses remuneration for clinical work only, and therefore targets community-based physicians. These APPs have emerged in recent years, as some provincial governments have initiated primary care reform to address a variety of issues.

Among other issues, governments were concerned about the trend for general and family doctors to offer more episodic care and less comprehensive and after-hours care for a designated group of patients. Situations have also emerged wherein some physicians felt compelled to see as many patients or provide as many services as possible in order to sustain what they believe is an appropriate income. At the same time, physicians’ lifestyle expectations have changed. Today’s medical professionals are likely to claim more time for themselves, leisure activities, continuing education and community work.

Governments and medical organizations also have had to address the declining number of family physicians that are available to serve rural, remote, and now, even many urban centres. In addition, successive governments have expressed the need for cost control, predictable demand for healthcare funding and best-quality care for money spent on primary healthcare delivery. Accordingly, these APPs are targeted primarily at family physicians, although they have also been offered to some specialists.

The Complexity Of APPs

The contractual aspects of APPs are much more complex than traditional FFS or salary contracts. Current research indicates that most APPs consist of a blend of some (or all) of:

- ▶ Fees for clinical services
- ▶ Population or capitation funding
- ▶ Time-based payments, whether hourly, daily or other
- ▶ Rewards for participation in specific clinical initiatives
- ▶ Bonuses for achieving specific targets in preventative or quality care
- ▶ Remuneration for administrative duties and costs
- ▶ Financial contributions for medical information technology

In the case of APPs for academic physicians, there may also be some (or all) of:

- ▶ Compensation for teaching
- ▶ Research funding
- ▶ Stipends for administrative duties
- ▶ Partial compensation or subsidies for staff, other healthcare workers, facilities and/or equipment

Because remuneration can be paid either directly to an individual or to a group of physicians participating in the APP, how the income is shared becomes another factor in the formula. Accordingly, the contractual aspects of such new payment models can be quite complex.

Physicians participating in APPs that target community-based primary care physicians can choose from several payment formats, but they all require the physician to formally enrol patients in his/her practice and register this enrolment with the provincial government. The terms for the payment formats may differ from province to province, but, essentially, include the following:

- ▶ Fee-for-service payments
- ▶ Capitation payments
- ▶ Sessional fees
- ▶ Block funding
- ▶ Blended formats

APPs that target primary care physicians will include some or all of the following components.

Patient-enrolled models (PEMs). Any APP in which a physician or a group of physicians agrees to formally enrol patients in the practice and register this enrolment with the ministry of health (MoH) is known as a PEM. The health ministry will require the patient's signature on the enrolment form before paying any PEM bonuses.

Rostering. This is the process of enrolling patients in a physician's practice and registering that enrolment with the MoH for tracking purposes. Many APPs will pay the physician either a set fee per patient (\$5 in Ontario for the first year), or a lump-sum payment for the administrative work of rostering their patients.

Fee-for-service billing. In an APP that incorporates the FFS format with a percentage bonus top-up for each service, a physician is paid only if the patient is seen and a medical service is provided. Income relates directly to the number of patients seen and the services provided for each patient. Payment, as defined in the provincial FFS schedule of benefits, is made directly to the physician who provides specific services. For enrolled patients, the fee paid is topped up; for example, by 10% during regular office hours and, potentially, an additional 30% for evenings and weekends. Additional bonuses of approximately 15% are added for the common services offered to seniors.

Another model used for an APP with an FFS blended payment format incorporates traditional FFS billing for a portion of the physician's income, which is then topped up with a guaranteed amount of money annually. This model is often employed in the more rural and remote areas.

Capitation payments. An APP that incorporates capitation provides the physician with a guaranteed fixed payment for the comprehensive annual care of a rostered patient, regardless of the number of times the patient visits the doctor or the number of services provided. The capitation payment is in lieu of FFS payment for a designated number of outpatient primary care services. The designated services are often referred to as a "basket" of services. The payment varies demographically by age and gender. The annual capitation payment for a 25-year-old male may be approximately \$50, while the annual capitation payment for a 90-year-old female may be \$300. If the service provided is not in the "basket" of services, then full FFS payment will be received. For example, many office procedures and biopsies are often outside of the defined "basket".

The physician bills FFS for the patients who choose not to roster, and the physician can choose to not roster patients who historically require a high volume of services. There are often limits on how much FFS income a physician participating in a capitation model can receive. The total of capitation fees, fee-for-service billings and bonuses for all patients, minus expenses, is your net income.

Shadow fee-for-service billing. The physician who is participating in an APP with capitation payments must also submit FFS invoices for all services provided to rostered patients. Although the physician will not receive full FFS payment for these services, physicians who participate in a capitation PEM may receive a percentage bonus (e.g., 15% per service) for all shadow FFS billings they submit. This is an incentive to keep accurate records of all services provided. The MoH requires this information for evaluating patient access and utilization under the various APP models.

Preventative care bonus. Most enhanced fee-for-service models and APPs offer annual bonuses when the physicians can document that they have met or exceeded certain percentage targets for preventative health care. For example, physicians who can document that they have given or can ensure that a flu shot was received by a predetermined percentage of the target population may receive a lump-sum bonus payment.

Other preventative care bonuses proposed in some provinces include biennial Pap tests for women aged 35-70; biennial mammograms for women aged 50-70;

colorectal screening every 30 months for patients aged 50–74; and primary childhood immunization, as per the latest guidelines, for children up to two years old.

Comprehensive care management fee. This is a payment for the ongoing administrative work, medical record review and upkeep that comprehensive family doctors do in addition to seeing their patients. A monthly capitation rate is paid per rostered patient. Rates vary, based on age and gender, and average approximately \$2 per month per patient.

Chronic disease management bonuses. Several provinces will pay GPs an annual bonus for managing chronic diseases, such as diabetes and congestive heart failure. Clinical practice guidelines and documentation criteria must be adhered to. In certain provinces, specialists may also qualify for such bonuses.

New patient incentives. This refers to a fixed bonus to physicians who accept “orphaned” patients (i.e., those who do not have a family doctor) as new patients into their practices. There are generally a limited number of new patient enrolment bonus payments per year. For example, in Ontario, there may be a \$110–\$180 bonus, based on age, for the first 60 new patients accepted per year into an existing practice. As an additional incentive, new-entrant physicians may be offered these bonuses for a greater number of new patients in their first year of practice.

Administrative fees. These per-patient fees are paid annually to the physician or the group practice to help defray some of the administrative costs of meeting all of the accountability criteria required by APPs that have a capitation payment format. Not all APP formats offer administrative fees.

Sessional fees. These fees, typically based on an hourly rate, are paid for the delivery of specific services. For example, many emergency departments now offer physicians a guaranteed sessional fee for working as the doctor on duty, regardless of the number of patients seen. These physicians are obliged to ‘shadow bill’ so that the actual services rendered can be monitored. Failure to capture and submit all shadow bills will result in a reassessment and possible reduction of the guaranteed sessional fee in some jurisdictions.

Block funding. Some physicians receive a guaranteed payment to provide medical services for patients in a specific location or region for a defined interval of time. Block funding is often offered to physicians who work in rural and remote areas, where they would not receive adequate remuneration if they had to rely solely on FFS billings. Shadow FFS billing may or may not be required. In an APP that incorporates block funding, these physicians often also qualify for additional FFS billing and other bonuses. The block funding guarantees a monthly minimum gross income, from which physicians can pay themselves as well as their overhead expenses.

Alternative Payment Plans For Academic Physicians

APPs for physicians who work in academic centres not only address remuneration for clinical work, but also provide remuneration for academic teaching, administration, research and the provision of all facilities, staffing and resources. Community physicians who participate in an APP will negotiate and deal directly as a group with the MoH. Each of the several hundred academic physicians of a medical faculty, however, will be obliged to evaluate and understand their own individual contractual obligations and benefits when they participate in the APP contract that is negotiated between the medical faculty, the participating teaching

hospitals, their specialty-specific division and department heads, the medical research facilities and the MoH.

**Case Example: An AFP (Alternate Funding Plan)
For Emergency Services In Academic Centres**

An emergency department has six full-time emergency physicians, presently remunerated by a combination of fee-for-service, salary and other earnings. They also perform clinical, teaching and administrative functions at an academic institution. The local healthcare authority offers the group an AFP, whereby the 'global funding' is valued at \$1.5 million to provide all agreed-upon emergency room services for a fiscal year. The amount negotiated would be based on previous audits of the FFS billings and numbers of services offered annually, averaged, for example, over the past five years. Additional funding is added to cover administrative and academic work by the group. Once agreed upon, there is, essentially, a fixed limit to the 'funding pie'.

If the participants accept the AFP offer, the physicians will provide the agreed-upon services to the public, and then must agree among themselves how to share the funds. Although it may be simple to divide the income equally (e.g., \$250,000 each), some of the physicians may feel they deserve higher income because of their seniority, they work more hours, or because they perform other valuable duties. Therefore, each member must negotiate a sub-contract within the overall AFP contract.

Workload increases that require the recruitment of additional emergency physicians will complicate the negotiations further. Prospective group members should not assume that they will automatically have an equal share of the remuneration offer because there is a fixed size to the existing funding pie of \$1.5 million. Income for additional docs would need to come from the shares of the existing docs until the group can negotiate for an increase in the global funding. Such a request would need to be backed by shadow billing records, proving that the number of services delivered has increased. Additional documentation proving that non-clinical work has also increased would also be required in order to negotiate for an increase in the global funding.

These APP contracts are extremely complex. Each physician who participates in negotiating for individual salary and benefits, clinical, teaching, research and administrative responsibilities and obligations is actually negotiating for how his or her individual contract will fit into the very large contract that comprises the global funding of the entire institution. Each medical faculty will negotiate the specifics of their own APP—so experience with one APP does not assure in-depth knowledge of another.

Each individual contract will require the approval and signature not only of the chair of the specialty-specific department, but also of hospital officials and medical faculty administrative heads.

Ensuring that all of the "what ifs" are addressed is very important. *Module 9: Principles Of Negotiation* addresses the specifics of this in more detail.

Physicians are advised to seek independent, expert advice from their professional advisors. Accountants and lawyers who are experienced in contract law should review all aspects of the contracts offered.

Key Message

There are a growing number of new payment models available to physicians. Comprehensive knowledge of traditional fee-for-service billing is essential when evaluating APPs. Conduct a detailed analysis with the expert advice of your professional advisors to help you choose the format that best suits your practice environment.

Accountability

APPs strive to make the physician, the patient and the payer (Ministry of Health) more accountable so that healthcare dollars can be spent more effectively and efficiently. Meeting the accountability standards requires an excellent office management infrastructure, clear administrative policies and, above all, documentation of all clinical and non-clinical service-related activities. Even the best paper-based medical record systems will not provide physicians and staff with an efficient way to capture and document all of the direct and indirect services that qualify for bonuses offered by an APP. The potential loss in income can be significant. A comprehensive electronic medical records (EMR) system that is accessible to all participants, physicians and staff is the best solution for meeting all of the obligations required by the APP contract and, more important, for assisting the physician in capturing and receiving all of the potential benefits.

Salary

The physician who works on salary receives regular payment from an employer, which is specified in an employment contract, in consideration for services provided. Remuneration is often based on 'time-based payments'. Time-based payments provide a fixed dollar amount per specific time period. Time-based payments are made for active clinical work, but there may also be time-based fees for standby availability, administration, professional development, research and teaching. The specific time period can vary as well—annual salaries, sessional payments, shift stipends and hourly rates are all time-based payments. The contract will also often stipulate minimum expectations and maximum limits for payment. Therefore, working overtime or provided 'extra' time or services may not necessarily be remunerated.

In reality, only a small percentage of community-based GPs or specialists will work within a salaried format. Examples include physicians who work in community health centres, as clinical associates in cancer clinics, or as hospitalists. Most academic institutions will offer a variety of salaried positions.

As discussed later in this module, it is essential to dissect every APP and salaried contract in great detail to verify what obligations and benefits are included and excluded.

THE DIFFERENCE BETWEEN BEING SALARIED AND SELF-EMPLOYED

At the root of the question of compensation is whether a physician is engaged in a contract of service or a contract for services, and what are the subsequent tax consequences. Under the former, a contract of service physician is considered an employee, while the contract for services arrangement suggests that a physician is an independent contractor.

The consequences of whether a physician is an employee or is self-employed are considerable—particularly with respect to obligations for both federal and provincial income taxes. The many benefits of incorporation are available only to self-employed physicians.

For example, a pathologist who works solely for a single hospital that provides for all of his overhead and whose remuneration is fixed, regardless of the volume of work done, is generally considered an employee for tax purposes. A family physician who has sole control over his or her practice, is responsible for all costs related to that practice, and whose remuneration will vary with the number of patients seen or procedures performed will generally be considered as self-employed by the tax department.

When the situation is not so straightforward (e.g., a family physician who, in addition to generating FFS income in her office practice, receives predetermined payments for working one day per week at a downtown community clinic, working one shift per week at the local hospital emergency room, and teaching), Canada Revenue Agency considers several factors in the context of the entire working relationship to determine whether a physician is an employee or an independent contractor. These factors are: control; ownership of tools; chance of profit or risk of loss; and integration of work into the business of the owner/employer. The CRA offers more detailed discussion in its document titled “Employee or Self-employed” (see the Resources section). It is essential to seek the advice of an accountant in complex situations. (Also consult *Module 4. Personal And Professional Accounting And Taxation.*)

Salaried Employee

As a resident, you receive a salary that was negotiated by your provincial residents’ association and is paid by the Ministry of Health. Income tax and employee contributions for Canada Pension Plan (CPP), employment insurance (EI) and other benefits are deducted at source by the medical institution that employs you. A biweekly cheque represents your take-home income, which is guaranteed by contract. You receive standard employee benefits, such as medical/dental coverage, disability coverage, potentially CMPA coverage, paid vacation and sick leave. Your contract stipulates your basic work hours, service obligations and expectations, as well as on-call duties and practice restrictions.

Regardless of the number of patients you see, the services you provide or the intensity of after-hours on-call work you perform, your income is fixed and non-negotiable. As discussed in detail in *Module 4. Personal And Professional Accounting And Taxation*, your professional deductions for tax purposes during residency are very limited. As well, you have minimal control over your work environment, the patients you serve, who you work with, the clinic’s policies, holidays and your call schedule.

If you consider a long-term practice position for which you are offered a salary, you will, potentially, be subject to benefits and limitations that are similar to those you receive as a resident—unless you specifically negotiate for more favourable benefits, income and obligations. With the advent of alternative payment plans for academic centres, many new physicians will be obliged to do just that. There can be many variations in what is included or excluded in your contract. Your contract should address everything you give, everything you get and all of the “what ifs”. If it isn’t in writing, it doesn’t exist! Therefore, it is essential that you seek professional advice before signing any contract.

Also remember that the term salary, when used to describe physician remuneration, may be a misnomer. Sometimes it is used to describe a guaranteed gross amount of payment for services rendered to a self-employed physician who is contracting services to an institution. In such cases, there are no benefits, and the physician is responsible for all professional expenses and income tax payments. Because the taxation implications can be profound, expert advice is essential.

Other PMC modules offer detailed advice about what to look for and negotiate when evaluating long-term practice options. Please consult *Module 10. Evaluating Practice Opportunities: Family Medicine*; *Module 13. Evaluating Practice Opportunities: Specialists*; and *Module 9. Principles Of Negotiation*.

The Self-Employed Physician Is Considered An Independent Contractor.

Medicine is the profession of all physicians. From an income tax perspective, however, there are limited allowable professional deductions for physicians who do not have either partial or complete self-employed status within the profession. Most physicians who qualify for professional deductions as independent contractors are self-employed, and will bill either entirely on a fee-for-service basis or participate in a blended program of FFS and alternative payment.

If you become solely self-employed, you will be responsible for generating all of your income, paying your personal as well as professional expenses, and calculating and paying your income taxes. You will have no guaranteed benefits unless you pay for them yourself, nor will you be paid when you take holidays or sick days—in fact, you may need to cover your share of operating expenses, even when you are away, unless you have a professional services agreement wherein you pay a fixed percentage of your gross income to the clinic in return for providing staff, office and equipment. This percentage would be deductible, akin to overhead costs.

As an independent contractor, you can still do some part-time work as a salaried employee, with some potential benefits. Your accountant will advise you about taxation and professional deductions. As with all scenarios, it is essential to clarify your professional status for taxation purposes with your accountant and your lawyer before you sign any contract. This is especially important for APPs in academic settings because, in many cases, the tax department will classify you as an employee, not an independent contractor.

THE SCOPE OF REMUNERATIVE SERVICES THAT PHYSICIANS PROVIDE

Physicians, like other professionals, are members of the professional services industry, where payment is offered for services rendered. It is essential that you understand the variety of services that you will be paid for and how they are measured, regardless of which remuneration model you choose. Essentially, physician services fall into two categories: clinical and non-clinical.

Clinical Services

Regular clinical evaluation, provision of procedures and management of patients.

There are several categories of clinical services that physicians provide for their patients, and a specialty-specific fee may be paid for each of these services. However, not all of the time spent evaluating and managing our patients is captured for payment by specific fee codes. Alternatively, an hourly honorarium or salary may be offered, as is common in many emergency departments and institutional settings.

After-hours clinical care and medical supervision of patients. In the traditional FFS model, the physician on call would earn no income unless a medical service was provided. A salaried physician would be remunerated for after-hours work as part of the negotiated salary. In an alternative funding model, a guaranteed hourly payment could be negotiated either with the hospital directly, or with the Ministry of Health or regional health authority. Sometimes, FFS billing is possible in addition to the guaranteed hourly payment if a guaranteed “on-call stipend” is offered.

Because of the increasing shortage of physicians, many institutions offer guaranteed financial incentives for after-hours and weekend care, in addition to the FFS income generated while on call.

Non-Clinical Services

Administration and teaching. There are various ways for physicians to negotiate remuneration for administrative and teaching responsibilities. Examples include a mutually agreed upon hourly or daily honorarium, or a fixed annual payment for administrative and/or teaching responsibilities. Don't assume, however, that you will be paid for administration and teaching. Many physicians have taught and continue to teach part-time and provide hospital committee work on a voluntary basis.

Research. Alternative funding is required to cover the loss of clinical income when a physician conducts research. The institution may pay a salary or guaranteed honorarium for the physician's dedicated research time, or the physician may be responsible for acquiring grants to fund research.

Professional consulting. Physicians are often called upon to offer expert opinions. Payment for these services is typically based on an hourly fee, as negotiated with the requesting party (e.g., insurance company, pharmaceutical company, lawyer or regulatory college). Provincial medical associations offer billing guidelines for these and other uninsured services; members can access this information via their provincial association's website.

Medical record maintenance and management. While strict guidelines apply for the maintenance of physicians' medical records, for the most part, physicians are not remunerated directly for this requirement. (See *Module 6. Medical Records Management* and *Module 7. Electronic Medical Records*.)

FEE-FOR-SERVICE BILLING: PRINCIPLES AND MECHANICS

During our practice management seminars, we often hear questions such as:

"Why should I learn about fee-for-service billing if I plan to work in an academic centre where I will be paid a salary as part of their alternative payment plan, or if I am a family doctor in an APP?"

Our response is that an understanding of FFS billing is essential for all physicians, regardless of their payment model. There are several reasons.

- ▶ 95% of family physicians' and the majority of specialists' remuneration will still directly or indirectly depend upon the provincial specialty-specific FFS billing schedule of benefits.
- ▶ Alternative payment plans most often require shadow FFS billing for all services provided, so that the Ministry of Health can continue to track whether there is a change, improvement or drop in services offered under the new payment formula. This applies in Ontario, for example, where some family doctors work in capitated models, such as family health networks (FHNs), family health organizations (FHOs) and family health teams (FHTs). Shadow billing is also required of many specialists who work under APPs.
- ▶ Shadow billing requires the physician to submit an invoice for all services provided, as if still paid by FFS—even though there will be no remuneration for the individual service. To encourage compliance, bonuses for effective shadow billing are often being offered these days.
- ▶ Alternative payment plans require most academic institutions to capture and submit shadow FFS billing for all of the services provided by the faculty and residents.
- ▶ Institutions that have hired a hospitalist or government-sponsored clinical associate on salary will collect data regarding the equivalent services provided under an FFS model.

Failure to capture all shadow billings will result in an under-representation of services provided by both the individual physician and the overall group. This may have a significant negative impact when the group next negotiates for an increase in global funding. If all of the individual clinical work is not tracked, it will also adversely affect each physician's ability to negotiate his or her next contract renewal.

All physicians have a vested interest in ensuring that every service provided is documented. This can be difficult for individuals in a large institution, unless effective, efficient procedures and policies are in place. Unless one is financially dependent upon and responsible for tracking and submitting personal shadow billings, it is likely that a significant number of services will not be documented. When this happens, both the individual physician and the group may be compromised.

Case Example: Diligence Pays Off

Thanks to diligent double-checking of all clinical records, a manager who was responsible for an academic institution and her team were able to capture more than \$1 million in shadow FFS billings that the physicians failed to submit in a one-year period. Imagine how four to five years' worth of missed shadow FFS billings would negatively influence the renegotiation of the APP contract renewal for that institution.

Obtaining A Billing Number

The process of applying for your MoH billing number is essentially the same in each province. Before you can apply, you need an independent practitioner licence or certificate that is granted by the provincial licensing body (e.g., the College of Physicians and Surgeons of your province) after presentation of certain required documentation, which may include:

- ▶ Photo
- ▶ Certificate of graduation from an accredited medical school
- ▶ Proof of successful completion of the RCPSC or CCFP exams
- ▶ Proof from the Medical Council of Canada of successful completion of the LMCC Parts 1 & 2
- ▶ Proof of Canadian citizenship or permanent residency status
- ▶ Evidence of standing in the College (i.e., no unethical activity or misconduct)
- ▶ Curriculum vitae
- ▶ Payment of an application fee, as well as first-year membership dues

Once you receive your independent licence to practise, you can apply for your billing number. Contact your local provincial MoH to request the application package while you are applying for your licence to practise. You also could consider applying for a billing number prior to graduation, noting that certain documentation (such as RCPSC results) is pending and will be forwarded upon receipt.

It is important to know that there is often a six- to 10-week delay before you receive payment for your first billings; therefore, seek advice from your financial advisor so that you can proactively plan for bridge financing during this period.

Once you receive your billing number, you need a way to submit your bills. In most jurisdictions, computerized billing and electronic data transfer is mandatory, so you will need to have a billing software program. This will be in place for new entrants who are joining existing practice groups. Verify that the group uses software from a reputable company that has been in business and serving many

of the local doctors for a long time, and has provided excellent on-site support and staff training.

If you are starting a practice on your own, ask the doctors in your area which software suppliers they use, and test their systems. Provincial medical associations often provide lists of available suppliers. (See *Module 7. Electronic Medical Records.*)

While most doctors delegate the responsibility for submitting their billing to a staff member, you can also use the services of a billing agent. Be aware, however, that, ultimately, you are still responsible for the accuracy and timeliness of your billings. It is essential that your office has a daily back-up procedure for all submissions made to the MoH.

Contact the provincial health insurance program to receive instructions and a manual of information about how to work with them. Your medical billing software company should assist you, however, with registering with the provincial health insurance program and ensuring that your computer submissions are readable. A test is generally submitted in advance of your start day in practice.

Once your application for a billing number and software submission are accepted, you will sign a letter of understanding with the provincial insurer, stating that you understand and accept the rules you must follow when billing. (Note: Physicians doing locums have three options for billing, which are discussed in detail in *Module 11. Locums: Negotiating A Mutually Beneficial Locum Contract.*)

The provincial health insurance program should provide all of the information required for you to carry on your daily interaction with the Ministry of Health. Read the material in detail; if ever you are in doubt, contact the office nearest you and ask to speak to an advisor.

Your physician information package will include:

- ▶ An overview of physician responsibilities
- ▶ Specialty-specific definitions, requirements and criteria for billing for services
- ▶ A schedule of benefits (general and specialty-specific)
- ▶ A claim submission and remittance manual
- ▶ A diagnostic and procedural code manual
- ▶ Remittance advice explanatory codes
- ▶ Remittance advice inquiry procedures
- ▶ An application for direct bank deposits
- ▶ Various forms
- ▶ Contact numbers

Read Everything.

It is extremely important to read everything about the schedule of fees. Ignorance of the rules is not a defence if your billing practices come under the scrutiny of your provincial health ministry. Do not rely on the example and explanations for billing you have received from peers and mentors; best practices are not always passed down by word of mouth.

Avoid Lost Income.

Learn your specialty-specific fee schedule, stay up to date, and always read every MoH bulletin that you receive, because fees can change. Don't delegate this task to staff unless you are confident that they will promptly advise you about any and all changes.

Research conducted by the Canadian Medical Association in the mid-1990s indicated that physicians, on average, failed to bill for at least 5% of the insured services they provided.

Example: A GP fails to bill for one \$30 patient visit daily over the course of a year. If this doctor works 220 days (six weeks of holidays), then he or she will be \$6,600 “out of pocket”.

CMA research has also discovered that physicians and their staff fail to identify, correct and resubmit approximately 3% of the bills that were initially submitted but not paid by the ministry. If a physician has a potential gross income of \$300,000 of insured services, the combined loss would be \$24,000 per year. That means you will have provided \$24,000 of insured services for which you were not paid. In many cases, the amount can be much greater. This lost income exceeds the maximum RRSP contribution one can make yearly—and the potential losses over 20 to 30 years is staggering.

All physicians have a vested interest in ensuring that their billing policies are effective and efficient. This is just as important for shadow billing, if you are participating in an APP.

Determining Specialty-Specific Fees

All MoH insured services outlined in the schedule of benefits are negotiated by the provincial medical association on behalf of their physician members. Each specialty has a specific section within the association that lobbies on the specialists' behalf for fees, removal of outdated services and addition of new services that the specialists believe should be insured by the MoH. Each specialty-specific section also determines its corresponding fee schedule for uninsured clinical services.

The Components Of A Bill

All of the following components of a bill must be correctly submitted by you or your billing staff before the MoH can review and remit payment. Therefore, every time patients register to be seen—whether at the office, outpatient clinic, ER, hospital or other location—it is important for them to present their health cards so that your staff can verify that the cards are valid. Each patient's demographic and personal contact information should also be verified and updated. In some provinces, the health cards have electronic strips that can be swiped for easy confirmation of some data, but up-to-date patient contact information is not included.

The following information may be required on your billing, depending on the service rendered:

- ▶ Patient identification (health card number with correct version code if indicated, name, date of birth and the expiry date of the health card)
- ▶ Doctor identification, including name and billing number
- ▶ Date of service(s) to the patient (multiple visits for hospital care can be submitted with one bill)
- ▶ Diagnostic (numerical) code, designating the diagnosis
- ▶ Alpha-numeric service codes, designating the professional service rendered. The number of services, if repeated, must be designated.
- ▶ Alpha-numeric procedural code, designating the procedures rendered
- ▶ Place of service, whether office, hospital, emergency, home, outpatient clinic, nursing home or other location (location identifying codes are provided by the provincial MoH)

- ▶ Premiums, extra payments, modifiers or bonus codes, if any
- ▶ Identification of the party responsible for payment (e.g., health plan insurer, Workers' Compensation Board, reciprocal provincial plan, third-party, patient or other payer)

The most common reason for rejected claims is the failure to submit the required information accurately.

Who Does The Billing?

Generally, it is your staff's responsibility to verify that the patient has up-to-date coverage and a valid health card, and to enter the demographic and personal information when you submit a bill for your services. However, you must indicate what services you performed. It is also extremely important to capture billings for services that your MoH allows you to delegate to your staff. In essence, you do the billing and your staff members submit the claims.

The Anatomy Of FFS Billing

Every clinical encounter can be broken down into essential billing components, and all appropriate components must be completed when a claim is submitted for payment. This module will reference Ontario billing codes for example purposes, but be aware that each province has its own distinct codes.

Diagnostic code. This code indicates the reason for the medical assessment or procedure. Most provinces utilize a modified three-digit version of the International Classification of Diseases (ICD) to designate how to numerically code the diagnosis. The list of numerical diagnostic codes is provided to each physician once his/her independent billing number is assigned. Note that the codes are not always specific.

Service code. These codes indicate the type and detail of service you provided during the patient encounter. This service fee covers your history-taking, examination, assessment, investigation plan and counselling of the patient, as well as the documentation of the encounter. Service codes are specialty-specific and are typically alpha-numeric combinations.

Examples for specialists would include the service code for a consultation, repeat consultation, specific reassessment or regular office follow-up visit. The coding may be different, depending on where the service was provided (e.g., the office, outpatient clinic, inpatient or emergency room). All physicians must learn the province-specific coding format.

Common service codes for family doctors include regular office visits, complete assessments, counselling, interviews, prenatal visits, well baby exams, house-call visits and limited consults. The place of service may require a specific code.

2010 Ontario fee schedule rates have been used for the examples that follow.

Example 1: An Ontario family doctor assesses a patient in her office for bronchitis. The diagnostic code for bronchitis is 466, and the service code is an intermediate examination A007A. The fee would be \$32.35.

Example 2: An Ontario plastic surgeon is consulted to see a patient with a complicated fractured finger. The diagnostic code is 816, the consultation service code is A085A and the fee would be \$77.55.

Procedure code: Professional, technical and tray fees. Procedures are billed in addition to the professional service fee. Minor and major procedures covered by

the MoH can be billed when performed by the physician or, when allowed, an assignee. Procedures may include a specific professional component, technical component or tray fee. The technical component and tray fee can be billed by the physician if he or she provides the equipment and staff to do the procedure; however, if the procedure is done in a hospital where all technical support and equipment is provided, then the physician can bill only for the professional component. Staff who perform procedures on your behalf must take care to include these technical and tray procedural fees in your daily billing submissions; otherwise, a lot of income can be lost. Which procedures are covered varies from province to province. Procedure codes are generally alpha-numeric.

Procedural fees are the bread and butter for such specialists as obstetricians, surgeons and ophthalmologists, and are especially important for anesthesiologists, radiologists and pathologists, whose billing is mostly procedure-based. Forgetting to bill for minor procedures, however, such as urinalysis, injections, phone supervision of anticoagulation and chemical treatment of skin lesions is very common among family physicians—and results in the significant loss of thousands of dollars of income each year.

Example 3: An Ontario family doctor who assesses a patient with rectal bleeding does a rigid sigmoidoscopy and makes a provisional diagnosis of ulcerative colitis.

Description	Code Number	Fee
Diagnostic code	556	
Service code for an intermediate examination	A007A	\$32.35
Procedure code for sigmoidoscopy	Z535A	\$36.80
Tray fee code for providing the instruments in the office	E746A	\$5.85
Total fee		\$75.00

Example 4: A respirologist has an office consultation with an asthmatic patient and does a flow-volume loop (volume-versus-flow study) and then repeats the test after a bronchodilator.

Description	Code Number	Professional Component Fee	Technical Component Fee	Total Fee
Diagnostic code for asthma	493			
Service code for the consultation	A475			\$143.40
Procedure code for the initial flow-volume loop test	J304	\$10.25	\$19.05	\$29.30
Procedure code for post-bronchodilator test	J327	\$6.05	\$2.88	\$8.93
Total fee				\$181.63

Example 5: A general surgeon sees a patient in consultation for an inguinal hernia, and performs elective surgery 12 weeks later.

Description	Code Number	Fee
Diagnostic code for inguinal hernia	550	
Surgical consultation code	A035	\$89.30
Surgical procedure code (The procedural fee typically includes postoperative care.)	S323A	\$331.80
Total fee		\$421.10

Example 6: A radiologist reviews and reports on an MRI of a patient’s knee. Only the professional component of the procedure is billable (unless the radiologist provides the MRI and staff—which is not allowed, for example, in Ontario). The professional procedure code is X471 and the fee is \$66.10.

Special premium or modifier code. Additional fees are paid when the physician provides the service at a location other than the regular office or clinic and needs to travel to provide the service, and/or when the service is provided after regular work hours or on weekends or holidays. The terms “premium” or “modifier” may be used to describe this additional fee. In some provinces, these special visit premiums are now billed as two components: a travel premium (which is usually a set fee) and a special visit premium, which is coded and paid based on where and when the special visit is offered, as well as if one or more patients was/were seen during that visit. These codes are now very complicated. Provincial medical associations will offer additional resources to assist physicians to learn and capture these codes.

Example 7: A family doctor who is on call for his group is called on a Saturday afternoon by an emergency room nurse to come in to evaluate a colleague’s patient. An ECG and chest X-ray is ordered, and is negative. The patient is ultimately diagnosed with non-cardiac chest pain.

Description	Code Number	Fee
Diagnostic code for chest pain NYD	785	
Service code for complete assessment	A003A	\$68.75
Special visit premium for going to the ER on a weekend afternoon	K998 K963	\$54.55 \$36.40
Travel premium to ER		
Total fee		\$159.70

In Example 7, the physician could not bill for the professional component of reading the ECG and the X-ray because all ECGs and X-rays are reviewed by specialists the next day. If this was not the hospital policy, then the physician could bill for the professional components but not the technical components, because the hospital provides the staff and the equipment.

Bonuses. As a result of primary care reform, bonuses are becoming increasingly important as a component of alternative payment plans for physicians who participate in patient-enrolled programs, as well as in provinces with enhanced

fee-for-service models, such as Alberta and British Columbia. Financial incentives are not the same in all provinces, so verify the situation in your jurisdiction.

These bonuses can apply in different formats. When a patient is officially rostered in your practice, a percentage bonus may be paid in addition to regular service fees for every encounter with a rostered patient. To join your roster, an individual will sign a patient enrolment form, indicating that he or she has enrolled with you as the family doctor. You sign and submit the form to the MoH. Once the enrolment is confirmed, the MoH will automatically pay an additional bonus fee for all services that qualify for bonuses.

Example 8: Q200 is the Ontario code for enrolling a patient in your practice when you are part of a family health group (FHG). The fee is \$5.00. The bonus for seeing a rostered patient when you are participating in an Ontario FHG is 10% for routine daytime office visits. Therefore, for an intermediate exam, you would bill A007A for a fee of \$32.35, and the MoH would automatically pay you a bonus of \$3.23. The total fee would be \$35.58.

You might also qualify for a bonus for meeting preventative care targets. Such bonuses may be offered retroactively when, for example, a physician who is participating in an alternative payment plan can confirm that he/she has given flu shots to 80% of patients in the target population over the past year.

Contact your provincial medical association to obtain the latest information about primary care reform and incentives that may be part of the offered alternative payment plans. A comprehensive electronic medical records system that will capture all of the required data will serve you well, and help to ensure that you receive all of the bonuses for which you qualify.

To learn more about FFS billing, please review the detailed self-directed learning tools provided in Appendix 1 for family physicians and Appendix 2 for specialists.

The Billing Process

Now let's discuss some helpful explanations of billing mechanics.

Billing documentation. This is the process by which the physician and staff capture and document all possible billable services for submission to the MoH. Ways to capture this information include:

- ▶ Use a billing day sheet that has a list of patients seen and a column for all billing codes. This is prepared daily by staff for the physician or assigned staff member to complete. It is essential at the end of each day to cross-reference this with the appointment schedule and names of any additional patients given last-minute appointments.
- ▶ Combine billing with medical record documentation. With electronic medical record systems, the physician and staff can document bills at the same time that medical records of the patient visit are being completed. Reconciling these billings with your billing day sheet can really help to capture all billable services, especially those delegated to staff. Use a program for your personal digital assistant (PDA), designed to capture all services delivered when you are on call or providing services out of the office.

Forgetting to bill for one patient visit each regular office day will result in a loss of upwards of \$6,000 per year or more.

Key Message

For every clinical encounter and medical procedure undertaken by you or your staff members, verify that you have included the diagnostic code and all appropriate service codes, procedural codes and tray fees, premiums and bonuses.

Medical records and billing. Your medical records must stand alone, without your interpretation, to justify the bills you submit to the health plan insurer. At any time, the MoH can request copies of the clinical records that correspond to the bills you submit. Be honest and accountable. For more information, see *Module 6. Medical Records Management*.

Billing submission. Most physicians should submit billings daily, or at least three times per week. Some specialists, such as surgeons, tend to submit billings weekly. Once you and your staff have accounted for all of the appropriate billing codes for every patient, submit the bills to the MoH.

In most provinces and territories, this is done by electronic data transfer (EDT). Electronic submission enables the MoH to review all submissions and to quickly verify which, if any, are not accepted. The next time your staff go online, they can check which bills from the last submission are not accepted, pull the charts, correct the errors that the MoH will identify with explanatory codes, and then resubmit the corrected bills—so that you can be paid within the same billing period. This reconciliation, or comparison, is important to ensure that you receive remuneration for all services you provide.

Remittance. This is the process wherein the MoH or other responsible payer remits payment to you. MoH payments are generally made by automatic deposit into your designated bank account. You will receive, electronically, a remittance advice document, which you must reconcile.

Remittance review and reconciliation. Your computerized billing program will automatically reconcile or compare your billing submissions with the corresponding remittance records from the MoH. Pay careful attention to what isn't paid and why. Failure to correct unpaid remittances may result in lost income for work you have performed and procedures for which you are legally responsible.

Billing period. Depending on the province, the MoH pays physicians either once or twice monthly. In general, the billings you submit for services rendered up until approximately the 25th day of each month will be paid for as of the 15th day of the next month. Bills submitted right at the end of a month will not be paid for at least six weeks, which means that your accounts receivable (monies owed to you) can sometimes take six to eight weeks to be settled.

Submission time limits. In most provinces, physicians need to submit the bill for a service rendered within three months of performing the service. Some provinces allow six months. Those who fail to do so will not be paid and cannot bill the patient directly. This commonly happens when a physician fails to record and hand over to the billing staff the record of services performed outside of the office (e.g., when on call.) Many physicians have scribbled patient information from the hospital visit on a card, then have forgotten to empty their purses or wallets until it was too late to submit the bill. Your timely use of handheld technology should make this a scenario of the past.

Reciprocal billing. What if the patient is from another province? In such cases, it is essential to have the patient present a valid provincial health card, and to verify the party responsible for payment. All provinces and territories except Quebec have a reciprocal agreement, so you can use your billing program to submit the bill to your provincial MoH, using the patient's provincial health card number. You will be paid according to the fees of your province, not those of the patient's home province.

If you work outside of Quebec and see a Quebec resident, you have the following options:

- ▶ You can bill these patients directly, using your provincial MoH fee scale. Give the patient a receipt and record of services provided, and he/she can submit for reimbursement from the Quebec Ministry of Health. You can provide these patients with a specific form that you can order from the Quebec MoH. The “Application for Reimbursement – Health care services insured outside Quebec” is available in English and French. The patient can complete this form without the time and assistance of your office staff. This is the billing option most physicians utilize.
- ▶ You can bill these patients directly, using your provincial medical association fee scale. As above, provide an appropriate receipt and reimbursement form.
- ▶ You can bill these patients directly, using Quebec fee codes and fees. Once again, provide an appropriate receipt and reimbursement form.
- ▶ You can register with the Quebec MoH and obtain a billing number so that you can submit accounts directly to the Quebec MoH, which will remit payment to you. This option is most often exercised by physicians who work near the provincial border and see a significant number of patients from Quebec. Note that physicians pay an annual fee to the Quebec MoH to provide this convenience for patients.

If you work in Quebec and see Canadians who are not residents of Quebec, you have two options. In either case, use the Quebec government Form 2688, Out-of-Province Claim for Physician Services/Réclamation hors province pour services médicaux (available at http://www.ramq.gouv.qc.ca/fr/professionnels/form_pro/pdf/2688-f.pdf).

- ▶ You can bill the Ministry of Health in the province where the patient is resident. Some provinces will pay according to the Quebec fee schedule, others according to their own fee schedule.
- ▶ You can bill the patient directly.

BILLING FOR NON-CANADIAN PATIENTS

Sometimes visitors to Canada need medical attention and come to Canadian physicians for assistance. Generally, you would use your provincial medical association fee schedule as a guide for billing foreign patients, such as American tourists. The Canadian Medical Protective Association (CMPA), however, may not provide legal assistance to physicians who offer medical services to non-Canadians.

To ensure that you will not be incurring significant medico-legal liability without knowing it, contact the CMPA to verify what criteria are needed to maintain your coverage, or whether you should obtain other liability coverage. Some information is available on the CMPA website (www.cmpa.org), including such policies as CMPA assistance in legal matters initiated by non-residents of Canada and CMPA assistance in internet and cross-border prescribing to non-patients.

BILLING THE WORKERS' COMPENSATION BOARD

You must register with your provincial Workers' Compensation Board (WCB) before you can submit bills. Once you contact the WCB to establish a billing account number, you will be sent the physicians' guide, which explains how to bill for clinical services and how to complete the required forms.

There are two components to a WCB bill: the bill for the professional services, and the bill for completion of the specific WCB forms. In some provinces, physicians bill the WCB for the professional service and/or procedure in the same way that bills are sent to the MoH. The only difference is that it is important to change the “responsible party” window of the MoH billing template to “WCB”. (Note: You will be paid by the MoH with your next remittance and the MoH will be reimbursed by the WCB.) Some provinces oblige you to bill WCB directly for both the service and the form completion.

When billing for form completion, physicians typically send the paperwork directly to the WCB. The physicians’ first report form and the progress report forms requested by WCB have billing codes and a section where the physician enters his/her WCB billing account number, as well as the patient’s provincial health number. Because the WCB pays physicians directly for completing the required forms, you will need to establish an accounting format for tracking the submission and payment of WCB forms and other uninsured services.

Family doctors are usually the ones involved with the first reports and progress reports, but consultants may also bill WCB for their services.

Example 9: You evaluate a patient who works several hours per day at a computer terminal and presents with a right lateral epicondylitis that, by reasonable history, is secondary to repetitive strain injury. You recommend physiotherapy (covered by WCB) and an ergonomic evaluation of the patient’s workstation.

You complete the physician’s first report (Form 8 in Ontario) and fax it to the WCB. The diagnostic code is 727 (tendonitis), and the service fee is an intermediate exam A007A (\$32.35), billable to WCB via the MoH. The fee for Form 8 is \$65.00, which will be sent to you directly by the WCB. The total is \$97.35. The patient must be advised to complete her own form, and have her employer complete a form for WCB so that she can receive a claim number. You will be paid for your office visit and Form 8, regardless of whether the patient is ultimately accepted for a claim number.

All provincial WCBs are members of the Association of Workers’ Compensation Boards of Canada and can be located through the national website (www.awcbc.org).

ALWAYS DETERMINE THE PARTY RESPONSIBLE FOR PAYMENT

With every patient’s medical consultation, it is important to verify who is the party responsible for payment.

Billing the MoH for a work-related condition contravenes the agreement physicians sign when obtaining the MoH billing number. It also negatively affects MoH global funding limits, because WCB services will be included inappropriately in the statistics of total physician billings. Failure to submit the physician’s first report and progress reports to the WCB compromises patients’ access to insured physiotherapy treatment, and many other resources.

Physicians are obliged to proactively inquire whether the patient is covered by WCB. If in doubt, send in a physician’s first report and bill WCB for the service (and remember that WCB will also pay you for completing the required forms). If the patient is not covered by the WCB, you will be able to submit the bill for medical services (but not form completion) to the MoH.

If it is a WCB case but the patient does not allow you to notify the WCB, document the situation and bill the patient directly for the service—the provincial health insurer will not cover work-related conditions that should be billed to the WCB as the party responsible for payment.

THIRD-PARTY BILLING AND UNINSURED SERVICES

Many of the services that physicians provide are not insured by either the MoH or the WCB. The party responsible for paying for the service may be an insurance company, the employer or a lawyer—but very often it will be the patient.

Uninsured services have always existed, and are clearly defined in the preamble of the MoH schedule of benefits. Recommended fees are updated annually by most provincial medical associations. When you compare your medical association fee schedule with the provincial MoH fee schedule, note the often significant difference in fees recommended by your association compared with those paid by the MoH.

Common uninsured services include insurance reports; medico-legal reports; missed appointments; phone call prescription renewals; sick notes and medical certificates; cosmetic procedures; medical examinations for work, travel or insurability; and chart transfer and summary.

Many of today's physicians still hesitate to bill their patients for uninsured services. Prior to 1969, physicians billed patients directly at provincial medical association rates and, on average, collected only about 70% of all billings. When universal health care was introduced in 1969, medical professionals welcomed the MoH as a guaranteed payer for insured services. Physicians subsequently lost touch with both the concept and the practical aspects of billing patients for services rendered. The guaranteed FFS payment by the MoH, which at the time was negotiated to pay 90% of the provincial medical associations' fee schedule, allowed physicians to distance themselves from this very important business responsibility—and they then became less diligent in capturing and billing for uninsured services. For many years, patients also assumed that all medical services, not just "medically necessary" services, were insured.

This has resulted in a generation of physicians who are reluctant to bill patients for uninsured services, even though reduced income is the most common complaint of physicians across the country. The reduction in individual physicians' incomes has been largely due to the provincial health ministries' decision to increasingly distance their fee schedules from the provincial medical associations' recommended fee schedules for insured services.

A significant percentage of residents have had little or no exposure to third-party and uninsured service billing during residency.

Surveys have determined some of the perceived reasons why physicians don't bill for uninsured services:

- ▶ It will create public relations problems.
- ▶ It will create administrative problems.
- ▶ It is not financially worth it.
- ▶ I have never done it.
- ▶ I don't want to be the first in my group to do it.
- ▶ I don't know how.
- ▶ My patients won't like me.

Key Message

Before you offer medical services, always determine who is responsible for payment. Then be sure to bill the appropriate payer for all services rendered.

As a new-entrant physician, you will need to develop your own policy regarding billing for uninsured services. Alternatively, if you think you will be joining an existing group practice, part of your evaluation will include determining the group's policy. It may be necessary for you to educate other physicians regarding the appropriateness and benefits of billing for uninsured services. If you do not attach a value to your time, neither will your patients and society. By establishing that your time and expertise for services outside of Medicare have value, your patients will not assume that your available time is endless.

What will really happen when you bill for uninsured services?

- ▶ Your patients will recognize that several services they have requested of you are not insured by the provincial MoH.
- ▶ You will accept that your time spent providing these services is valuable time.
- ▶ You will get paid for things that were provided free of charge in the past.
- ▶ Your revenues will increase.

Be Proactive From Day One.

Include your policy regarding uninsured services billing in your new patient information package (see *Module 12. Starting Your Practice On The Right Foot*).

Always inform patients of their responsibility for payment prior to providing the uninsured service. Doing otherwise is deemed professionally improper by the regulatory colleges and is a very common reason for patient complaints.

Example 10: You evaluate a patient in your office for an exacerbation of asthma and the patient requests a medical certificate for sick leave for the three days he will miss work. He receives paid sick leave benefits. Your diagnostic code is 493 for asthma, your service code is A007A (\$32.35) and you charge the patient \$15 for a completed and signed medical certificate of illness that notes the date he is to return to work.

Remember: Any time you sign a form, you are in fact offering a medical opinion for which you are medically and legally liable. Never devalue the significance of your professional signature. This is a key reason why a charge should be levied for your effort.

Appendix 1 provides more examples of uninsured services billing for you to work through.

Always Use Discretion.

You should always use your discretion when billing patients, particularly if you suspect that a bill will cause financial hardship. By tactfully inquiring about a patient's ability to pay, you can consider either reducing the bill or delivering the invoice and marking it as "No Charge". In such circumstances, we recommend that physicians inform their patients of the decision to reduce charges or not charge at all. Patients will appreciate this immensely, and will not feel demeaned or patronized.

Always back your staff up when they carry out your office policies. If a patient disputes any policy that your staff members carry out, act immediately and personally to diffuse the issue.

Key Message

Every physician needs to understand fee-for-service billing. Stay current with the fee schedule, and bill for uninsured and third-party services as appropriate.

THE GOLDEN RULES OF BILLING

You should always follow the Golden Rules of Billing.

- ▶ Be honest.
- ▶ Be accountable.
- ▶ Be knowledgeable.
- ▶ Be meticulous.
- ▶ Be effective.
- ▶ Be efficient.
- ▶ Always close the loop to be sure you're paid for all billable services rendered.

Although many of the billing tasks will be delegated to staff, establish a protocol so that you personally review the status of all aged accounts receivable (outstanding unpaid accounts listed chronologically) on a monthly basis.

Billing Checklist

- ▶ Stay up to date with the fee schedule.
- ▶ Complete all components of the bill.
- ▶ Always verify what party is responsible for payment.
- ▶ Capture all billings, no matter how small.
- ▶ Bill the WCB whenever appropriate.
- ▶ When billing the MoH, confirm that the billing is for an insured service that is not work related.
- ▶ If the patient is responsible for payment, inform him/her before you provide any medical service.
- ▶ Be proactive, but use discretion when billing uninsured services.

ACTION PLAN

- ▶ **Understand the different remuneration models for physicians.**
- ▶ **Clarify your independent contractor status before signing any contract.**
- ▶ **Become very competent and knowledgeable about your specialty-specific FFS billing.**
- ▶ **Get expert advice to assist in evaluating any APP.**

RESOURCES

Valuable Websites

Provincial Medical Association websites can be accessed via cma.ca.

Resources available on cma.ca:

▶ *Alternative Payment Models to Fee-for-Service*

An analysis of how physicians are remunerated for clinical and non-clinical activities was prepared by the Physician Consulting Group Inc. on behalf of MD Physician Services. This self-learning module is designed to assist CMA members who are considering new payment models as an alternative to conventional fee-for-service or salary.

▶ *A Physician's Guide to Implementing an Electronic Medical Record (EMR) in Medical Practice*

As increasing numbers of CMA members consider a migration to electronic records, MD Physician Services offers this self-learning module to help doctors prepare for the changeover. The module outlines a process by which to assess readiness, identify vendors, evaluate products, then choose and implement an EMR program. See the MD Physician Services website at cma.ca.

Resources Available From Canada Revenue Agency

▶ *Employee or Self-employed*

Visit the CRA website at <http://www.cra-arc.gc.ca/E/pub/tg/rc4110/>

Resources Available From The Canadian Medical Protective Association (www.cmpa.org)

- ▶ The CMPA offers assistance in legal matters initiated by non-residents of Canada.
- ▶ The CMPA also offers assistance in internet and cross-border prescribing to non-patients.