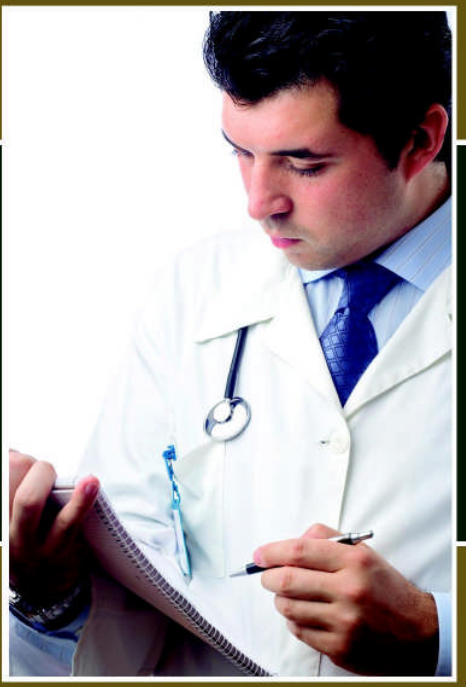
Physicians' Guide to Billing for Non-insured Services



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Doctors Nova Scotia

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Introduction

As a physician, it is perfectly acceptable to charge fees for providing a non-insured service.

This guide to direct billing for non-insured services is designed to help Nova Scotia physicians carry out the direct billing process in an efficient and professional manner.

The document was produced by Doctors Nova Scotia in consultation with representatives from both the Fee and Tariff and Economic committees and approved by Doctors Nova Scotia's Board of Directors.

There are a number of ways that members can contact Doctors Nova Scotia should they require clarification or further information:

- by e-mail at inquiries@doctorsns.com
- by telephone at (902) 468-1866 or 1-800-563-3427
- by mail at 5 Spectacle Lake Drive, Dartmouth NS, B3B 1X7

The guide is also available in the members' only section of Doctors Nova Scotia's web site: www.doctorsNS.com

Doctors Nova Scotia would like to thank the New Brunswick Medical Society for sharing their 'Physicians' Guide to Direct Billing.'

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What services can be billed directly to the patient

A service may be billed directly to the patient if it is not covered by the Medical Service Insurance (MSI) plan or some other insuring body, e.g. Workers' Compensation Board. Typically, there are three scenarios under which a physician may bill the patient directly: a non-insured service; an uninsured patient; or the physician opts out of MSI. These scenarios are described below:

Non-insured services

A non-insured service is one requested by a patient that is not included in the range of services covered by MSI. Examples include cosmetic procedures, acupuncture and reversal of sterilization. A list of non-insured services is located on pages 6 to 8 of the Nova Scotia Physician's Manual Preamble. This document is provided to all physicians by MSI. To obtain a new copy contact MSI directly at (902) 468-9700.

It is important to note that third-party requests are not insured by MSI. Some examples of common third-party requests are insurance forms, driver's license exams, or a school physical.

Uninsured patients

An uninsured patient is anyone who is not included as a beneficiary of either the insured hospital services and/or insured professional services under the *Medical Services and Insurance Act*. Examples include regular members of the Canadian Armed Forces; citizens of other countries; or members of the Royal Canadian Mounted Police (RCMP).

> Note: In addition to MSI, Doctors Nova Scotia has an agreement on fees with the Workers' Compensation Board of Nova Scotia (WCB) and the Department of Community Services. Therefore, this guide does not apply to WCB or Community Services patients. WCB should be billed according to the negotiated agreement, and Community Services should be billed as outlined in section 6.3 of the MSI Billing Instructions Manual.

To learn more about the current WCB agreement please visit the Doctors Nova Scotia website at doctorsNS.com

Opted out of the Nova Scotia MSI plan

A physician may choose to opt out of MSI. When a physician opts out, he/she must give reasonable notice to the patient prior to rendering the service. The provider may, if requested by the patient, complete the claim form or alternatively, provide the necessary information to enable the patient to claim directly from MSI.

A physician who has chosen to opt out of MSI cannot charge a fee for professional services that exceeds the insured fee, or compensation, for the same or similar professional service paid through MSI.

Ethical considerations

When billing a patient directly, physicians must keep some ethical considerations in mind. Physicians should consider the following excerpts from the Canadian Medical Association (CMA) Code of Ethics:

1. *Consider first the well-being of the patient.*

2. *Treat all patients with respect; do not exploit them for personal advantage.*

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

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

The Code of Ethics of the CMA was adopted by the College of Physicians and Surgeons of Nova Scotia in 2005.

The MSI Physician's Manual also provides information on ethical billing practices. These principles of ethical billing cover both insured and non-insured services and situations where both insured and non-insured services are provided at the same visit. The principles of ethical billing can be found on pages 8-9 in the Physician's Manual Preamble.

The benefits of direct billing

Enhanced personal and professional satisfaction

Being remunerated for doing a job is an important factor in job satisfaction. Physicians are no exception to this and should ensure they are appropriately remunerated for their quality work.

Physicians may also experience increased personal satisfaction because, in paying for their services, patients are demonstrating their confidence in the physicians' abilities.

Greater patient engagement

When patients pay directly for services, they may become more active and discerning consumers. They often make it their business to be better informed about the medical treatment they receive. In this way, patients gain a clearer understanding and appreciation of both the costs and responsibilities associated with health care.

Economic practicality

Physicians practicing in Nova Scotia are most likely self-employed professionals. In order to meet the demands of their practice and provide a high quality service to their patients, adequate revenue is required.

Even when providing a non-insured service, physicians continue to bear medical and legal responsibility for their decisions. Overhead costs - including staff salaries, rent, utilities, insurance, equipment costs, memberships, accounting and legal fees, etc. - are not waived simply because a service provided is non-insured.

From an economic standpoint, it makes sense that physicians should have the option to recover these expenses and be compensated for the services provided through direct billing.

Setting fees for non-insured services

When setting fees for non-insured services, a number of factors should be considered. The fee should appropriately reflect:

- the service provided;
- the level of expertise;
- the amount of time required to provide the service;
- the materials and equipment required;
- the practice's needs (overhead); and
- the patient's ability to pay.

When physicians decide on an appropriate fee, assessing the value of their time is an important step. One way to do this is by determining the opportunity cost of providing a non-insured service.

Opportunity cost

The concept of opportunity cost can be used to help determine appropriate rates for non-insured services.

Simply stated, if a physician is asked to provide a service not normally considered part of their regular job, they should be remunerated at a rate at least reflective of the amount of revenue given up because of not providing their usual services. For example, if a physician is asked to participate on a hospital committee that requires him/her to be out of their office for two hours, then the physician has lost the opportunity to bill for two hours of regular work, hence the opportunity cost is two hours. (Note: In some cases physicians may work under an alternative payment plan where committee involvement is an outlined deliverable. In these cases, a physician may not bill this service as a non-insured service.)

A good starting point for determining the value of an hour's worth of regular work is a physician's annual gross insured billings. For example, if a physician bills $200,000 a year and works 1,610 hours per year (35 hours a week for 46 weeks a year) then this physician's hourly rate is approximately $124/hour.

The rate calculated above is based upon insured services provided as part of a physician's regular job; however, work done outside of usual office hours has no less value. If anything, the leisure or family time given up by physicians to provide non-insured services has a higher opportunity cost.

Inflation

Fees should be reviewed annually to keep pace with inflation, changing conditions within the practice, and the physicians growing expertise.

Examples of non-insured services

When creating the list of non-insured services which will be billed to patients, it is extremely important that each service be clearly defined and described. In this section, examples of concisely worded fees for commonly requested non-insured services are provided.

If there is any doubt as to whether a service is non-insured, contact MSI for clarification.

Also in this section, a list of fees to accompany the described services is offered. These fees are not to be construed as either the minimum or the maximum value for the service being described. They provide only a general guide for the payment of services of average complexity. With the assistance of this guide, physicians can set a fair and reasonable value for the services provided.

No physician is obligated ethically or otherwise to follow this guide; it is not binding on any physician and he or she has the right to deviate from it.

Sessional rates for non-insured services

In certain circumstances, it may be preferable to charge by the hour for services provided. In those cases, a sessional rate may be charged.

Sessional rates may change depending upon the services being provided but again, it is important to consider the overhead costs, as well as the service being provided, when setting a sessional rate.

It is strongly recommended that physicians discuss fees with their patient prior to providing services.

Common non-insured services and associated fees

The following fees represent the professional component of the procedure only. Any equipment or supplies required, above those considered as normal overhead, should be included in the fee, in addition to the professional component.

General services

- Non-insured injectables
  (e.g. vaccinations for travel) .....$20-30 + medication costs

  Note: Physicians may claim for the administration of immunizations covered by the Provincial Immunization Program.

- Examinations or physicals unrelated to treatment
  of an illness or medical symptom $60-70

  Note: Age specific preventative services (for well-baby care, vaccinations, inoculations, yearly exams and Paps, etc.) are insured services. This also includes examinations offered to individuals who have a family history, symptoms or signs or other diseases that would put them at risk for preventable target conditions.

- Medical advice by letter/telephone/e-mail/etc. $20-50

  Note: Medical advice over the telephone is insured when providing certain types of services, for example supervision of long-term anticoagulant therapy or a palliative care telephone call initiated by a health-care professional. Please contact MSI for a complete list of telephone fees.

- Acupuncture $35-50

  Note: MSI will pay for a visit or consultation to determine if a treatment method is insured, even though the proposed procedure is non-insured.

- Removal of wax from ear $20-30

  Note: Visit for diagnosis of ear symptoms is insured. Necessary removal of wax from the febrile child (up to age 12) to assist in diagnosis is insured.

- Circumcision of newborn $150-300

  Note: Newborn circumcision is non-insured from birth to age one. If considered medically necessary in this age group, the service may be submitted under exceptional circumstances (EC) with text supporting the claim.

- Skin scraping for fungi..... $20-30

  Note: This service is insured when direct microscopic examination is carried out, using KOH, immediately following the scraping of the lesion.

- Audiometric test not carried out by
  ear, nose and throat specialist.....$25-35

  Note: Claims submitted under these codes will only be paid to physicians certified as specialists in otolaryngology.

- Tongue tie, simple or Z-plasty..... $20-30

  Note: This service is insured if considered medically necessary, and should be submitted under exceptional circumstances (EC) with text supporting claim.

- Gender reversal (trans-sexual surgery)

  Fee will depend upon the surgeon and the facility where the procedure is being performed.

Cosmetic services

When there is doubt as to whether the proposed procedure is medically required or cosmetic, the operating physician should obtain prior approval from MSI. MSI will pay for a visit or consultation to determine if a treatment method is insured, even though the proposed procedure is non-insured.

- Cosmetic piercing $35-60
- Cosmetic diagnosis/treatment of vein(s)

  Fee depends upon the complexity of the procedure and extent of the condition.

  Note: These services are insured for diagnosis of varicose vein, varicose vein with inflammation, or any claim stating compression sclerotherapy or feganization. Diagnosis of spider veins or nevi, telangiectasia, superficial varicosities, or any procedure for cosmetic purposes only are non-insured.

- Excision of benign superficial cysts, lipomata, subcutaneous neuromas, skin tags and other superficial skin blemishes $50-75

  Note: These services are insured for malignant or recognized premalignant conditions. Port wine stains of the face and visible areas of the neck are covered. Physicians may submit claims under EC for consideration of coverage in cases of uncertainty. For example, the drainage of an infected sebaceous cyst, or the removal of a large lipoma causing interference with function, would be covered as an insured service and should be submitted under EC with supporting text.

- Removal of xanthelasma $75-100

- Removal of warts, including papillomata, keratoses, nevi, moles and pyogenic granulomata $50-75

  Notes:

  1. Excision of lesion for clinical suspicion of skin cancer is an insured service. This includes premalignant or atypical pigmented lesions including, but not limited to: Dysplastic nevi, Junctional nevi, Spitz nevi, Halo nevi, Regressing nevi, Lentigo, Melano acanthoma and Melanocytic neoplasia.

  2. Treatment of Condylomata, molluscum contagiosum, and plantar warts are insured services. This includes both excision and destruction by cautery or cryotherapy. Other conditions where medical necessity is deemed to exist by the physician may be submitted under EC with text to justify. Pathological examination of excised specimens remains an insured service.

Cosmetic surgical procedures

- Gastroplasty or gastric bypass for morbid obesity

  Fee will depend upon the surgeon and the facility where the procedure is being performed.

  Note: This service is insured for patients who meet defined criteria for morbid obesity. Prior approval is required.

- Breast reduction/augmentation surgery

  Fee will depend upon the surgeon and the facility where the procedure is being performed.

  Note: Breast reduction/augmentation surgery is insured only if medically necessary, and with prior approval.

- Lipectomy and apronectomy (surgical fat removal from abdomen, peritoneum and omentum)

  Fee will depend upon the surgeon and the facility where the procedure is being performed.

Ophthalmologic services

Eye Exams

These services are insured where there is a presenting symptom of visual reduction or other complaint suggestive of a disease of the visual system. A comprehensive consultation (03.08), initial visit with complete examination (03.04), and comprehensive eye examinations (09.02) include refraction testing in the fee code, therefore, a patient cannot be billed for a refraction in addition to claiming any of these codes.

A detailed refraction for the provision of a prescription for eyeglasses is non-insured in the 10 - 65 year age group. However, children who suffer from serious myopia and who require frequent refractions in adolescence, show medical necessity and will be covered (with text to justify). These rules refer equally to ophthalmologists and optometrists.

- Partial eye examination with refraction for dispensing visual correction.....$25-55
- Refraction for dispensing visual correction $25-45
- Routine vision care from 10th to 65th birthday $25-45
- Contact lens fitting $400-750
- Replacement lens only $50-100

  Note: The fitting of contact lenses is an insured service when medically indicated. See article 9.9.2b of the MSI Physician's Manual Preamble for the list of conditions for which this service is insured. Contact lens fitting is not an insured service for the following conditions: macular degeneration, open angle glaucoma, diabetic retinopathy, strabismus, borderline glaucoma and amblyopia.

Reproductive services

- Vasectomy reversal

  Fee will depend upon the surgeon and the facility where the procedure is being performed.

- Tubal ligation reversal

  Fee will depend upon the surgeon and the facility where the procedure is being performed.

- Artificial/intrauterine insemination

  Fee will depend upon the surgeon and the facility where the procedure is being performed.

- Second and subsequent ultrasound examinations in uncomplicated pregnancy $50-100

  Note: Medical literature supports only one examination at 18-20 weeks, per normal pregnancy. Additional examinations are non-insured unless evidence of medical necessity is provided.

  Note: The College of Physicians and Surgeons of Nova Scotia have developed guidelines regarding ultrasound for non-medical reasons.

Anaesthesia services

Anaesthesia services performed in conjunction with non-insured services are considered to be non-insured as well.

These services should be determined on a case-by-case basis.

Anaesthesia services performed in conjunction with dental services are insured in some cases and not in others. Please contact MSI for more information.

Administrative and technical services

When billing for administrative or technical services the fees should appropriately cover all the costs incurred providing these services including, but not limited to, staff time, cost of the supplies used, etc.

- Prescription renewal $10-30

  Note: Charges for prescription renewal apply to phone requests, requests for non-present family member, etc.

- Missed appointment ..... Listed fee for scheduled service

- Medical records transfer or chart summary -
  for transfer of care ..... $30-75 + photocopying

- Hospital/district health authority committee work ..... hourly rate

  Note: In some cases physicians may work under an alternative payment plan where committee involvement is an outlined deliverable. In these cases, a physician may not bill this service as a non-insured service.

- Medical supplies/equipment not normally considered
  as part of office overhead ..... $ cost

  Note: Charges typically include carrying costs and cost of storage.

- Long distance telephone and fax charges ..... $ cost

- Return NSF cheque .....$ 30-50

- Photocopying .....$0.25 +/page

  Note: Photocopying charges for third-party requests are at the discretion of the physician.

Third-party requests

When performing services at the request of a third party, the fees may vary depending upon the complexity of the examination required and/or the complexity of any required reports.

- Third-party examinations .....$75 and up

  Note: Including camp or school physical, insurance physical, driver's examination, periodic industrial health physical, etc.

Requested forms/reports

- Disability form $25-75
- Certificate of illness or disability - requiring office visit ..... $10-20 + office visit fee
- Certificate of illness or disability - not requiring office visit $10-20
- Third-party requested letters/questionnaires on patient attended, including insurance company assessment $100-250
- Third-party requested letters/questionnaires not requiring patient attendance $50-150

  Note: An additional fee may be charged depending on the complexity of any required report.
- Complete disability report, including Revenue Canada disability forms (follow-up requests may also be billed) $50-200
- Canada Pension disability form - $65 paid by government.....$65-150 total
- Proof of child immunization..... $10-20
- Special authorization form for medication/equipment/or services $10-35

Medical-legal services

Physicians should always discuss and confirm arrangements with the lawyer in advance. Note that these fees are ultimately, and directly, passed on to the patient as an add-on to the lawyer's fees.

Some examples of medical-legal services that a physician may choose to bill for are:

- Medical-legal report with opinion;
- Medical-legal office briefing by arrangement between physician and lawyer (not involving court appearance);
- Court appearance (including waiting time);
- Cancellation of court appearance (without one to two business days notice);
- Copying of file - on request of lawyer; and
- Travel and preparation time.

Rates may vary based on the complexity of the report; however the physician must be able to, upon request, disclose both the basis for the fee(s) charged for medical-legal services and the method of calculation of their cancellation fee.

A lawyer's request for a medical report should always include the patient's consent to the transfer of information.

> Note: Fees may also be applied to services performed on behalf of the Crown.

For further information, please see Appendix A: *Guidelines for Medical-Legal Reports*. These guidelines were agreed to jointly by Doctors Nova Scotia and the Nova Scotia Barristers Society, and are available on the members' side of doctorsNS.com

Annual block fees for non-insured services

Physicians may bill patients for non-insured services one-by-one, or charge an annual or block fee to cover all services not paid for by MSI.

The College of Physicians and Surgeons of Nova Scotia has established the following rules, which physicians must adhere to if they wish to charge annual fees:

1. Physicians cannot charge a patient an annual fee for a period of less than a year.

2. The bill for the annual fee must list in writing each of the services that are covered by the fee. The patient has the right to ask the doctor about any charge he/she does not understand.

3. The patient must be told how much each service would cost if paid for by itself.

4. The patient does not have to pay an annual fee. Patients are allowed to pay for each service which is not covered by MSI one-by-one.

5. The patient can decide whether or not to pay for services not covered by MSI as an annual fee. The physician cannot refuse to see the patient if he/she does not wish to pay this way.

6. Before a patient is charged an annual fee, the physician must:
   a. give the patient a copy of these rules, and
   b. ask the patient if he/she agrees to pay an annual fee.

7. The physician cannot charge the patient a fee for "being available" in advance (for example, being available to take calls from patients).

In developing a fee for a block of services, physicians should be mindful of the College of Physicians and Surgeons of Nova Scotia policy. For more information on the above-mentioned policy, please contact the college at (902) 422-5823.

Caveat venditor - seller beware

Acting as a passport guarantor

Every passport application must be signed by a guarantor who is a professional such as a physician, lawyer or minister and who has known the applicant for at least two years. One of the caveats is that the guarantor cannot receive any form of compensation. If they do accept payment, the application becomes invalid and the applicant can be ordered to submit a new form signed by a different guarantor. This type of misunderstanding can result in a potentially embarrassing and time-consuming problem for applicants who will often request that their payment be returned. **Physicians can avoid this problem by not charging for this service.**

Harmonized Sales Tax and non-insured services

According to the Canada Revenue Agency (CRA) most health, medical, and dental services performed by licensed physicians or dentists for medical reasons are HST exempt. There are, however, some services provided by physicians that are not exempt, for example, medical-legal reports.

According to the CRA's GST Policy Statement: P-080 Medico-Legal Reports, *"…a service of supplying medico-legal reports are supplies of documents required for legal purposes relative to the condition of an individual (as opposed to rendering a health-care service to an individual pursuant to Section 5 of Part II of Schedule V of the Act) and is subject to the HST."*

Most physicians, though, will be affected by the "small supplier" clause; if services subject to HST total less than a designated amount, you need not collect or pass on the HST.

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

Access to patient records

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

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

Keeping staff well-informed

Keys to efficiency

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

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

Office policies on direct billing must be specific and detailed so staff and patients fully and clearly understand it. At the same time, sufficient flexibility should be in place to adapt to any unique or unexpected circumstances that may be encountered. For instance:

- inform staff of this policy and procedure, and keep them apprised of any changes;

- maintain up-to-date accounts;

- collect payments from patients at the point of service as often as possible;
- follow-up in an orderly and consistent manner; and
- always discuss fees with patients before providing the service.

Written guidelines

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

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

Keeping patients well-informed

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

To prevent this from happening, ensure patients are well-informed about non-insured services and the direct billing policy well in advance of receiving treatments.

While posters displayed in the physician's office may introduce patients to the concept of direct billing, they are not a substitute for more direct methods of informing patients of the fees. It is recommended that patients be provided with an information sheet or booklet that states the current fees. Doctors Nova Scotia provides an information sheet to physicians which is available on the members' side of doctorsNS.com under 'physician payment,' 'other funding sources.'

Developing your patient information booklet

A patient information booklet is an important guide that will not only be beneficial for the physicians but also benefit the patients and staff. Its purpose is to provide a written general description of the scope of the practice as well as setting out guidelines on the direct billing policy. Ultimately it will save the physician and staff the time and trouble of repeating answers to commonly asked questions. The patient information booklet should include:

General information

- Office hours;
- telephone hours;
- test or X-ray procedures and availability;
- methods of payment;
- prescription refill instructions;
- after-hours procedures;
- other office policies; and
- office phone number.

Direct billing information

- A brief description of the direct billing concept;
- services that are billed directly; and
- procedures for third-party claim forms.

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

Accounts receivable

Keeping track of your accounts

When billing patients directly for non-insured services it is very important that your records are accurate and up to date.

Whether using a computerized, handwritten, or a custom-made system, the staff member who does the billing must ensure each statement given to or sent out to the patient is complete and accurate.

An incomplete or inaccurate bill not only creates more work for the office staff, but also gives patients with outstanding bills an excuse not to pay.

Electronic medical records and direct billing

One option available to physicians to track patient accounts is an electronic medical record (EMR) system. More physicians are taking advantage of the features and functionality of an EMR system for the purposes of direct billing. Most systems can generate invoices to directly bill both patients and third-party organizations. This helps ensure that non-insured services, when delivered, are easily captured and invoiced at time of service.

EMR systems provide an opportunity for physicians to gain significant efficiencies in the administration of their direct billing process and their practices as a whole.

Physicians interested in learning more about establishing an EMR system in their office should contact Doctors Nova Scotia's information technology department at (902) 468-1866, or 1-800-563-3427.

Receiving payment

The easier it is for the patient to pay, the higher the success in the collection rate. Accepting a range of payment methods should help make it easier for patients to pay. Accepting credit cards, or setting up a debit card machine are two options of payment to consider. Start-up and operating information is available from most banks.

Physicians may also want to consider offering a payment plan to patients whom they bill directly.

It is also important to know that the longer an account remains unpaid, the more difficult it becomes to receive payment and the account actually decreases in value. According to MD Management Ltd., the real value of a dollar owed becomes:

- $0.90 - after two months;
- $0.67 - after six months;
- $0.45 - after one year;
- $0.23 - after two years;
- $0.14 - after three years; and
- $0.01 - after five years.

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

Collecting accounts

Payment at the time of service should be encouraged; however patients will not always be able to pay immediately.

In cases where payment is not received at the time of service, it will be necessary to bill the patient for the service provided. Accounts should normally be billed on a 30/60/90 day schedule and interest charges can be applied to outstanding accounts if the physician is appropriately registered (see note). If payments are not being made, letters and telephone calls by staff should be used to prompt patients into paying.

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

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

NOTE: Physicians who wish to charge interest on overdue accounts for non-insured services must register under the *Consumer Protection Act of Nova Scotia* to be able to legally collect interest on overdue accounts.

SAMPLE COLLECTION TIMETABLE - 120 day schedule

PROCEDURE	TIME	PERIOD	STEP
Send patient statement.	Month service is rendered	January	Billing (see page 37)
Send patient statement with first letter reminding patient this is a second statement.	Month after	February	Billing "Reminder"
Problem-solving call to patient. Goal to secure commitment of payment, arrange payment plan; determine if patient has a hardship or is dissatisfied with service.	Prior to mailing of March bill	mid-March	Phone Call "Education"
If you did not reach patient by phone or have not received promised payment, send the second letter.	Second month after service	March	Billing "Letter #2" (see page 38)
Phone patient and ask for a definite dollar amount and date. Render problem-solving assistance if necessary OR you may have to deal with a "broken promise to pay".	Prior to mailing of April bill	mid-April	Phone Call "Persuasion/ Information"
Send patient statement and last letter. You may wish to phone a patient several days after mailing this letter... some offices do.	Third month after service	April	Billing "Final Letter" (see page 39)
If payment hasn't been received and you are certain the patient is not dissatisfied with the service, send the account to a collection agency.	Fourth month after service	May	Turn account over

Collecting overdue accounts

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

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

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

While realistically an agency will only collect a portion of the outstanding accounts, the fact that an agency has been called indicates to a patient, that like any other business, delinquent accounts will not be tolerated.

An account should be turned over to a collection agency within 120 days of the invoice's due date. Waiting too long makes the agency's job more difficult and allows the outstanding amounts to decrease in value (see the receiving payment section on page 24).

Physicians should always check references when selecting an agency. The agency should be firm in dealing with delinquent accounts, but maintain the physician's professional reputation. Avoid agencies that employ "borderline" collection tactics. Physicians are considered to remain ethically responsible for the conduct of the agency during the course of debt collection.

Once an account has been turned over to an agency it becomes the agency's job to collect the account, and the physician should no longer contact the patient about it.

Small claims court

As a final step, patients who have not paid outstanding bills can be taken to small claims court. To initiate a small claims action, a summons form must first be filed at a provincial court house. In order to file, the defendant's name, address, the amount of claim and the location of service must be provided. Once the form is complete, a court clerk sets a court date. It is not essential for the physician to attend the court hearing. A member of staff can do so on the physician's behalf.

The defendant must be informed of this action prior to the court date. The physician must ensure the defendant is personally served the summons. This can be done by personal delivery or by double-registered mail. Another option is to have a sheriff serve the summons, but there is a sheriff's fee for this service. If the court, however, rules in the physician's favor, the physician is entitled to the amount owing plus the costs of the action.

Appendix A

Guidelines for Medical-Legal Reports

A Joint Statement by Doctors Nova Scotia

and

The Nova Scotia Barristers' Society, published February 1994

Approved by Doctors Nova Scotia's Board of Directors, June 1993

Direction and disclosure

1. The lawyer should provide the physician with clear and simple instructions, in writing, as to the matters to be addressed by the physician in the report. The letter of request should follow the guidelines of Schedule "A".

2. The physician must be fully informed by the lawyer of all available medical information concerning the injuries.

3. The physician should ensure the medical-legal report answers all the questions posed by the lawyer and is written to be easily understood by non-physicians.

4. If possible the medical-legal report should be typewritten.

5. The form of the medical-legal report can follow the guidelines in Schedule "B".

Confidentiality

1. The lawyer should provide the physician with adequate written consent from the patient, spouse, parent, guardian, or next of kin.

Obligation to provide a prompt report

1. A report requested by a patient or authorized agent in respect of any examination or treatment performed by the physician should be provided by the physician within 45 days of the receipt of the request. If it is not possible to provide the report within 45 days, you should, within that time period, advise the requesting party of the fact and the reason(s) therefore.

Prompt payment of fees

1. The lawyer should pay the physician's fee within 45 days of the receipt of the report unless the lawyer indicates, in writing, at the time the request is made, that he or she is not prepared to meet this obligation personally in which case a physician is not obligated to prepare the report.

2. It is not appropriate for a lawyer, as a matter of course, to disclaim responsibility for payment of the physician's fee or to make payment contingent on the litigation. It is for the lawyer to make necessary arrangements with the client/patient.

3. It is not appropriate for a physician to demand his or her fee in advance.

4. It is not appropriate for a physician to charge a fee for a copy of file material other than a reasonable charge for the photocopying of the materials.

Appropriateness of fees

1. The factors to be taken into account in establishing a fee for a medical-legal report are:
   a. The amount of time spent;
   b. The expertise and experience of the particular physician;
   c. The complexity of the case;
   d. Whether an examination was done;
   e. Whether the report is a repetition of previous work already done or a follow-up on an earlier report;
   f. Whether the report discloses relatively routine attendances and observations; and
   g. The number of documents reviewed.

2. The physician must, on request, disclose the basis for the fee charged.

3. A physician should not charge for a follow-up request to a medical-legal report where the information was requested in the first instance.

Attendances at discoveries and trial

1. A physician who attends, on request by a lawyer or by Court Order, an interview, discovery or trial, is entitled to expect the lawyer to pay the physician's fee within 45 days of the attendance.

2. The factors to be taken into account in establishing a fee or an attendance are:
   a. The amount of time spent;
   b. The expertise and experience of the particular physician;
   c. The complexity of the case;
   d. The amount of preparation involved; and
   e. The amount of money that would otherwise be earned by the physician during the time spent.

3. It is not appropriate for a physician to demand his/her fee in advance.

4. The lawyer must inform the physician as soon as possible concerning attendances, adjournments, and cancellations and should inquire as to any cancellation fees.

5. The physician is entitled to charge a reasonable cancellation fee, based on income lost.

6. The physician must, on request, disclose the method of calculation of a cancellation fee to be charged if one is to be charged.

7. The lawyer should meet with a physician to prepare his/her evidence for discovery or trial on behalf of the patient.

Schedule "A"

Request

1. Identification of who lawyer represents and nature of matter, e.g. car accident, work injury;

2. Enclose authorization;

3. Brief relevant history of events surrounding treatment;

4. Nature of request; If not treating, attach all relevant prior medical reports;

5. Request that physician respond to attached outline and/or answer the following specific questions;

6. Request copy of C.V.; and

7. Undertake to pay fees for report within 45 days of receipt or advise of alternate payment proposal (failure to agree otherwise will obligate lawyer to pay within 45 days).

Schedule “B”

Detailed skeleton outline for long-term medical reports

1. Your qualifications or copy of C.V. (if you have not already submitted them in an earlier report dealing with this patient).

2. The patient’s name (preferably as stated in the pleadings).

3. Date, place and reason for the examination.

4. Other reports and material reviewed.

5. History as related by the patient.
   a. The patient’s version of what he believes caused his condition (i.e. the mechanics of the injury – how it was caused, not who was at fault)
   b. A complete list of the injuries or conditions complained of by the patient (whether these seem significant and relevant or not and whether the patient has recovered or not). If consulted as a specialist, confine yourself, if you think it appropriate, to matters relevant to the topic to be reported on.

6. Your findings which do (or do not) corroborate each of these items of complaint, or which indicate the results of an injury which have not been noticed.
   a. Physical corroboration (spasm, limitation of movement, etc.) of complaint A, of complaint B, etc.
   b. Diagnostic corroboration (X-rays, EEG, etc.) of complaint A, of complaint B, etc.

7. Diagnosis
   a. A description of diagnostic procedures undertaken by you or by others with respect to each symptom or condition.
   b. Your conclusions.

8. Causal connection with the accident – consider and give your professional opinion on the precipitating factor or “cause” of the patient’s condition. The court must know if the injury or condition for which damages are claimed was probably caused, aggravated or accelerated by the accidents or event complained of.

9. Treatment
    a. The treatment you recommended for symptom A, for symptom B, etc
    b. Whether or not your recommended treatment has been followed. If not, why not, and the probable result.

10. Degree of Disability
    a. The extent of impairment of function at the time of your examination which (i) should be treated and (ii) cannot be treated (this is most important if it exists), (iii) is unlikely to improve spontaneously, and (iv) will probably improve spontaneously.
    b. The pain, suffering, inconvenience and discomfort which you would expect (i) the patient has suffered and (ii) will probably suffer (or not) in the future.

11. Prognosis
    a. Your opinion as to the probability of future recovery.
    b. Your opinion as to the probable nature of permanent impairment.
    c. The probable time within which maximum recovery can be expected.
    d. Having regard to the individual and his personal activities, the extent to which his activities should or will be curtailed.

    Note: Avoid throughout your report vague expressions such as “it is possible that”. Express the matter in terms of percentages if you can (e.g. “there is a 10 per cent chance of recurrence within five years”). Throughout, use technical medical terms for the sake of precision and then follow these by a description couched in ordinary lay language.

Appendix B

Proposed templates for use

Doctors Nova Scotia has created some templates for common situations that arise when developing, billing for, and collecting payment for non-insured services.

These templates are provided for convenience, and can be modified as needed to fit with the guidelines and policies in place in members' practices.

Sample change in billing policy letter

Date

Address

Dear ⟨Patient Name⟩:

I am/We are writing today to update you on the recent changes to my/our billing procedures for non-insured services.

As you know, the medically necessary care that you receive is paid for through Nova Scotia's Medical Services Insurance (MSI). As your physician, I automatically make claims on your behalf to MSI and receive payment for all of the insured services provided to you.

There are, however, some commonly requested services that are not covered by MSI. Historically, I/we have provided these non-insured services at no cost to my/our patients, however, after much consideration I/ we have decided that I/we can no longer provide these services free-of-charge.

To help prepare you for any future costs I/we have developed and attached for your information, a menu of commonly requested non-insured services and the fees associated with each service. As well an information booklet, which outlines the policies and procedures around payment, has been prepared and is available at my office.

I would like to reassure you that my/our new non-insured billing policy applies only to non-insured services and that I/we will discuss each fee with you before the service is provided.

If you have any questions regarding non-insured services or our new billing processes, please feel free to discuss the issue with me during our next visit.

Sincerely,

Dr. X

Sample invoice and billing letter #1

Date

Address

Dear ‹····Patient's Name····›,

Below, please find an invoice for the non-insured service(s) provided at your request.

As discussed prior to receiving this service, this service is not covered by the provincial health insurance plan and it is therefore your responsibility for pay for the service.

Date service was provided:

Description of Service	Fee
Total Due	$XXX

For convenience, we accept the following forms of payment:
‹····List forms of payments accepted····›

We ask that payment be made within 30 days of the date on this invoice. If you have already paid this bill, please disregard this notice.

If you have any questions regarding this invoice, please call ‹····name of billing contact····› at ‹····number····›.

Thank you,

Dr. X

Sample invoice and letter #2

Date

Address

Dear ⟨Patient Name⟩,

This is a reminder that your payment for the non-insured services provided on ⟨Date of Service⟩ has not yet been received by our office, and is now overdue.

Again, we remind you that the service(s) provided were not covered by the provincial health insurance plan, and you are responsible for the costs listed below:

Date service was provided:

Description of Service	Fee
Total Due	$XXX

Please note, we accept the following forms of payment:
⟨List forms of payments accepted⟩

We again ask that payment be made as soon as possible.
If you have already paid this bill, please disregard this notice.

If you have any questions regarding this bill, please call ⟨name of billing contact⟩ at ⟨number⟩ as soon as possible.

Thank you,

Dr. X

Sample invoice and letter #3

Date

Address

Dear ⟨Patient Name⟩,

This is a reminder that your payment for the services performed on ⟨Date of Service⟩ has not yet been received by our office, and is now XXX weeks overdue.

Again, we remind you that the services provided were not covered by the provincial health insurance plan, and you are responsible for the cost of these services listed below:

Date service was provided:

Description of Service	Fee
Total Due	$XXX

Please call ⟨name of billing contact⟩ at ⟨number⟩ within 14 days so we can agree on a plan to settle your account. If we do not hear from you within that time, we will have to place your overdue account with a collections agency.

Thank you in advance,

Dr. X

Providing an estimate for services

Date

Address

Dear _____,

Thank you for your request for ⟨Insert non-insured service here⟩ on ⟨Insert date of request⟩.

As you may or may not know, the service you have requested is not covered by the provincial health insurance plan. As such, you will be responsible for providing payment for this service.

Below is an estimate of the cost of this service.

Item Description	Fee Estimate

Please acknowledge your acceptance of the above estimate by signing below and retuning this form to our office.

Sincerely,

Dr. X

Approval Signature:_____ Date:_____

Medical record transfer request template

Date

Address

Dear:_____

RE: Requested Transfer of Medical Records

I have received your request to transfer a copy of your medical records to your new physician, Dr. _____. In keeping with the guidelines of the College of Physician and Surgeon of Nova Scotia, I am required to keep your original records on file for at least 10 years from the date of your last professional visit, and therefore, I am only able to forward a copy of your record to your new physician.

Please note that this service is not covered by MSI, and as such, you are responsible for the cost of copying and transferring the chart.

Please select the best option for you:

- **Option 1 - Summary of files**
  A summary of the pertinent medical information contained in your chart, including significant medical history, lab reports, and/or consultations.

  Based on your file, the charge for this service will be $_____

- **Option 2 - Complete copy of your chart**
  Your entire file will be photocopied and transferred to your new physician.

  Based on your file, the charge for this service will be $_____

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continued from previous page...

Please select the payment option that works best for you:

- Cheque is included with this consent form. Your chart/chart summary will be sent directly to your new physician.
- Please notify me when the chart is ready for transfer so I may arrange to make payment at that time.
- Cancel the request.

Please sign and return this form to our office.

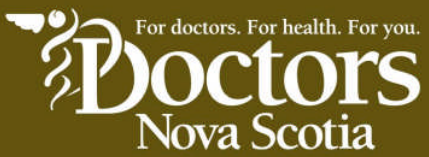
Sincerely,

Dr. X

Patient Signature: _____ Date: _____

Notes

Notes



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