A New Path Forward

Making the Longitudinal Family Medicine payment model work for you

Doctors Nova Scotia | March 2024

Contents

Doctors Nova Scotia

A letter
from the authors

We hope this letter finds you well as we navigate the evolving landscape of family medicine in Nova Scotia. Many changes have been introduced by the Longitudinal Family Medicine (LFM) payment model and the recent introduction of numerous new fee codes. We understand the challenges these transformations may bring to community family physicians. We understand because, as community family physicians ourselves, we're jumping these same hurdles right alongside you!

The LFM payment model was designed to strengthen family medicine in our province. It aims to provide stable, equitable funding for physicians dedicated to offering longitudinal family medicine, with a specific focus on improving access and fostering attachment.

LFM by the numbers

- 493 family physicians are under LFM, 96 of whom converted from fee for service
- 6 new fee codes
- 3 major fee code revisions

Key to the LFM is its commitment to providing competitive compensation and increased accountability. Physicians will be remunerated based on the hours they work, the services they deliver and their panel size, resulting in a multi-pronged remuneration structure. This approach not only serves our patients by supporting improved access and attachment, but also contributes to recruiting and retaining community family practice physicians, which will further stabilize primary care in our province.

Doctors Nova Scotia (DNS) asked us to leverage our experience across various payment models and our knowledge of billing procedures, practice optimization and electronic medical records (EMRs), to support your journey with the LFM. We hope this publication will be a starting point for sharing our collective knowledge as a physician community.

We hope you use this resource to help you evaluate the suitability of the LFM model for your practice, to guide you through the application process, and to ensure smooth integration. Look for more information on how to optimize your billing processes with a focus on the newer fee codes in the future.

Like any significant change, adopting the LFM has not been without its challenges. Let's come together to learn from each other by asking questions, holding space and creating dialogue.

We invite you to engage with us and your peers on this journey. Share your knowledge and let us work together in the pursuit of delivering exceptional patient care.

Wishing you continued success and resilience in the face of change.

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Where to Start

Is this new payment model right for you?

Family medicine is the foundation of our health-care system. The Longitudinal Family Medicine (LFM) payment model was designed to strengthen family medicine in our province.

What is the Longitudinal Family Medicine payment model?

The Longitudinal Family Medicine (LFM) payment model offers competitive compensation and enhanced accountability, through a blended payment that is calculated based on hours worked, panel size and services delivered.

How do I know if it's right for me?

The LFM is right for you if you:

- ☐ Bill ME=CARE (comprehensive, continuous, cradle-to-grave care) for patients you would consider attached to you, with the patients considering you their family doctor
- ☐ Work 46 weeks per year in office-based clinical practice (exceptions include weeks doing other clinical work approved by Nova Scotia Health (NSH), such as hospitalist work)
- ☐ Provide most direct clinical services in face-to-face patient encounters
- ☐ Provide an average of 2.8 or more service encounters per hour
- ☐ Use an EMR
- ☐ Take a maximum of six weeks away from your practice each year for educational leave, sick time, holidays and vacation time

How to apply for the LFM payment model

Family physicians interested in converting to or starting a practice under the LFM remuneration model will complete the following steps.

1. **Contact your DNS physician advisor:** Reach out to the DNS physician advisor for your zone; they will address any queries or concerns you may have regarding the LFM.
2. **Determine your ME=CARE panel size:** Email the Department of Health and Wellness (DHW) at lfmfunding@novascotia.ca to request your ME=CARE panel size. This is based on past billings. Physicians may wish to verify their ME=CARE panel size through a panel validation exercise. To initiate this process, email lfmfunding@novascotia.ca and indicate your interest in a panel validation. The DHW will provide further instructions, including your ME=CARE panel size, which you should compare to your EMR panel.
3. **Review your information, then propose a start date:** Once you decide to proceed with the LFM, email lfmfunding@novascotia.ca with a proposed start date that is at least four weeks in the future.
4. **Download and complete the contract:** Upon receiving confirmation of your start date, download and complete the contract and contracted activities template. Physicians have one week from the confirmation of their start date (see Step 3) to return a signed contract.
5. **Email documents:** Email your electronically completed and signed contract and contracted activities template to your DNS physician advisor, with a copy (cc) to the DHW at lfmfunding@novascotia.ca.

MSI has lots of resources available online, including the LFM Contract Filling Instructions, LFM Contract template and others.

Short and sweet

Here's the short version of how to apply to the LFM model:

1. Contact your physician advisor
2. Email the DHW for your ME=CARE panel size

Note: If you are concerned about your ME=CARE panel size, request a panel validation from the DHW before you proceed to Step 3.

3. Review, then email the DHW with your start date
4. Complete the contract and contracted activities template
5. Email your signed documents to your physician advisor and copy the DHW

CONTACT DHW
To learn more and sign up, or as an LFM physician, lfmfunding@novascotia.ca

Setting up your contract

The following tips will support you in completing your contract and schedule. Read everything before beginning.

MSI provides instructions on how to complete the LFM Contract and Schedule A online. Open the MSI document LFM Contract Filling Instructions and consider these notes as you go.

Populating and signing the contract

1. Your start date must be approved by the DHW before you fill out the contract. Do not start filling out the contract until you have received this approval.

Populating the Schedule A: Contracted Activities template

1. Under "Practice Profile," enter your office/clinic manager or administrator as the primary contact.
2. Before you fill in your projected hours in the "Clinical Working Time" section, calculate the number of clinical hours you'll contract to work each week (see "Be smart about projected hours of work," below, for tips). Multiply this number by 46 weeks to input into Schedule A for your clinical working time per annum.
3. The sample practice schedule is intended to reflect a typical work week when you are seeing patients either face-to-face or virtually, particularly if/when you are offering access to patients outside of daytime hours. If you do paperwork in the evenings or on weekends with no patient contact at all, you can enter those hours in the appropriate time block, but you would claim these at the daytime (non-premium) hourly rate.

Be smart about projected hours of work

The number of annual hours you submit in the "Clinical Working Time" section will determine the hourly portion of your biweekly payments. You will be asked to project how many clinical hours you will work annually. Once you sign this document, that number becomes your contracted hours. Every two weeks, the DHW will pay you for those hours, plus another 10% for your clinical support service time and any complexity modifier for your place of practice.

You will submit your actual hours worked on a regular basis (see page 8) and your submitted (actual) hours will be reconciled with your contracted hours annually, after the end of the fiscal year (March 31). If your submitted hours exceed your contracted hours, you will be paid the difference, but if your submitted hours are less than your contracted hours, you will have to pay back the difference.

To avoid facing a claw back at the end of the year, consider submitting a slightly lower number of projected hours than you intend to work when filling out Schedule A. Here are some additional ideas to consider.

Projected hours considerations
- Statutory holidays
- Time of day
- Practice management
- Hospitalist work

NEED HELP?
Contact your Physician Advisor.

Accounting for statutory holidays

TYPICAL WORK WEEK				
40 hours	x	46 weeks	=	1,840
				minus
RECOGNIZED HOLIDAYS				
40 hours	x	14 (stat holidays)	=	112
				1,728 **total contracted annual hours**

If you work on a statutory holiday, submit premium hours for that time.

If a statutory holiday falls on a day you wouldn't typically work, you will submit more hours worked than you will be paid for that week.

In both cases **the hours will be reconciled at the end of the year** so you will not need to consider them part of your six weeks vacation time or need to make up the hours.

Statutory holidays
If you do not typically work statutory holidays, consider deducting those hours from your annual contracted hours up front. You won'tbe paid for them; therefore, they won't have to be part of your six weeks of uncontracted time and you will not have to make up the hours elsewhere.

For example: If you typically work 40 hours per week over 46 weeks, you would be contracted to work 1,840 hours annually. MSI recognizes 14 statutory holidays in 2024. If you typically work an eight-hour day, subtract 112 hours from 1,840 to get 1,728 hours for your contracted annual hours. This is the equivalent of "banking" another 14 days of uncontracted time. You will still work your 40-hour work week on the weeks there are no statutory holidays. If you were to work a statutory holiday, you would submit premium hours for that time and be paid for those hours at the end of the year following the annual hours reconciliation. Similarly, if the stat holiday falls on a weekend or a day you wouldn't typically work, you will have submitted more hours worked than you were paid for that week and it will be reconciled at the end of the year. This ensures you are not paid upfront for the statutory holidays so you will not need to consider them part of your six weeks uncontracted time or need to make up the hours.

Time of day
Daytime (regular, non GPEW premium eligible) hours are Monday to Friday between 8 a.m. and 5 p.m. To calculate your yearly daytime non GPEW premium eligible hours, multiply the number of daytime hours you work per week by 46 (if your weekly hours vary, use the average).

Premium (GPEW premium eligible) hours are Monday to Friday, from 6 to 8 a.m. and 5 to 10 p.m., plus Saturdays, Sundays and statutory holidays (as recognized by MSI). These hours are paid at a higher rate than daytime hours. You can only claim GPEW hours if you are seeing patients (in person or virtually) during that time. You cannot claim GPEW hours if you are doing indirect patient care only (such as charting, writing referrals, reviewing lab/DI reports). To capture indirect hours worked during premium time, add them to your daytime (non GPEW premium) hours calculation of annual contracted hours. To determine your annual contracted GPEW hours, use the same methodology used to calculate your daytime (non-GPEW) hours above.

Practice management doesn't count
When projecting your contracted hours, only count the time you will be doing direct and indirect clinical work. Do not include the time you spend managing your practice or providing clinical support services. Your 10% clinical support service payment is intended to cover some of this work. Do not track or bill hours for this kind of work. These hours are automatically added to your biweekly payments and to your annual adjustment should you work more hours than you were contracted to work. *Note: Physicians may choose how they direct their time within this 10%.*

PROJECTING CONTRACTED HOURS?
Only count time spent on direct and indirect clinical work.

Hospitalist work
If you do hospitalist work and you know how many weeks per year you'll be working, you can deduct that number from the 46-week requirement – just be sure to include your hospitalist work in the notes section below the practice schedule. When projecting your annual contracted hours of work you multiply your weekly average by 46 weeks minus the number of weeks you'll be doing hospitalist work; for example, if you're going to do six weeks of hospitalist work per year, you'd use 40 weeks as your multiplier to determine annual contracted (projected) hours of work.

Making it work

What's in, what's out, how to optimize and how to get paid

The work involved in longitudinal family medicine can vary widely, considering that your patients may range in age from newborn to 100 years old (or more!). Be aware of what work is covered so that you can bill appropriately.

What services are included in and excluded from the LFM payment model?

It's important to know what is included in the Longitudinal Family Medicine (LFM) payment model as well as what is excluded and what's optional. Services that are not included in the LFM can be billed separately, outside of your LFM hours.

Included

- Most insured services for patients in your panel
- Services for out-of-province patients (DHW pays the physician and recovers the fee code amount from the relevant province)
- Chronic Disease Management (CDM), paid at 30%
- EMR envelopes B and C are included in the LFM, so there is no longer a need to apply for these incentives
- *Note: It is anticipated that the Collaborative Practice Incentive Program (CPIP) will be paid at 30% once it's converted to fees, but details are being finalized with Fee Committee*

Excluded

- Non-insured services (including third-party, medico-legal, insurance, out-of-country services), including work for Workers Compensation Board of Nova Scotia, Community Services, Province of Quebec
- Hospital-based work with an established payment model (including hospitalist, surgical assists, primary maternity care and emergency department shifts)
- Hospice
- Medical Assistance in Dying (MAID)
- Obstetrical deliveries for both attached and unattached patients
- Honoraria/external committee work
- EMR grant A (new adopters) is payable on top of the LFM
- NSH Committee work and/or meeting time

Optional

Physicians can determine whether they want to bill the following services as part of their LFM agreement or outside it:

- **Long-term care/nursing home work**
  - **Under LFM:** Can bill hours worked plus 30% FFS and nursing home patients will be included in your panel calculation.
  - **Not under LFM:** Bill 100% FFS; no LFM hours to be submitted for this work. Patients not included in panel.
- **Unattached patient work (non ME=CARE)**
  - **Under LFM:** Bill hours worked plus 30% FFS. No panel payment.
  - **Not under LFM:** Bill 100% FFS; no LFM hours to be submitted for this work. Reminder: ME=CARE cannot be billed for unattached patients, with the exception of prenatal codes.

Physicians may dedicate some of their 10% clinical support service time to NSH committee and quality improvement work should they have capacity to do so.

Reporting requirements – hours, fees and time away from practice

The LFM payment model is flexible and allows family physicians to work part- or full time. It's important to think carefully about how many patients you see each day, how many hours you want to work each week and how much time you'd like to take away from your practice each year before you commit to the LFM payment model.

Contracted hours worked

Physicians project the number of hours they will work each year, spread over 46 weeks, as part of their LFM contract. This projection is called "clinical working time" and these are your "contracted hours." The hourly component of your biweekly paycheque for the next year is based on this projection.

Contracted hours include all work with panel patients, except the following: uninsured services, MAID, third-party services including WCB, and when providing services that are paid under other provincial funding models, such as hospitalist work, CHIP, Primary Maternity Care and emergency department coverage.

Do not claim hours for clinical support services that are not patient-specific but provide benefit to the patient population and the health system, such as meeting with your admin team to rearrange your schedule or spending time ordering new equipment. These hours are paid as a 10% top-up to your weekly contracted hours.

When calculating your contracted hours, remember to exclude a daily lunch break if you typically take a non-working lunch. If you don't take a lunch, or if you do paperwork or provide indirect patient care while you eat your lunch, you can include that time in your contracted hours.

Actual hours worked

Submitted (actual) hours worked are claimed daily and include clinical work that is both direct and indirect patient care.

- **Direct**: Any visit with a patient (face-to-face or virtual) that is insured by MSI.
- **Indirect:** Specific patient care where the patient isn't engaged in an encounter with you, for example, any necessary discussion with or advice to a patient's family/caregivers; charting; prescribing medication or therapy; arranging diagnostic services; writing or arranging referrals; reviewing labs, diagnostic images, consult or OR reports; and updating the patient's chart, as appropriate. This time also includes consulting with other physicians or allied health-care providers regarding the management of your patient.

Physicians should claim actual clinical working hours daily, 365 days per year – while always being mindful of the need to bill an average of at least 2.8 service encounters per hour. Depending on your practice efficiency (service encounter ratio), you may or may not be able to bill all working hours.

Annual reconciliation of hours

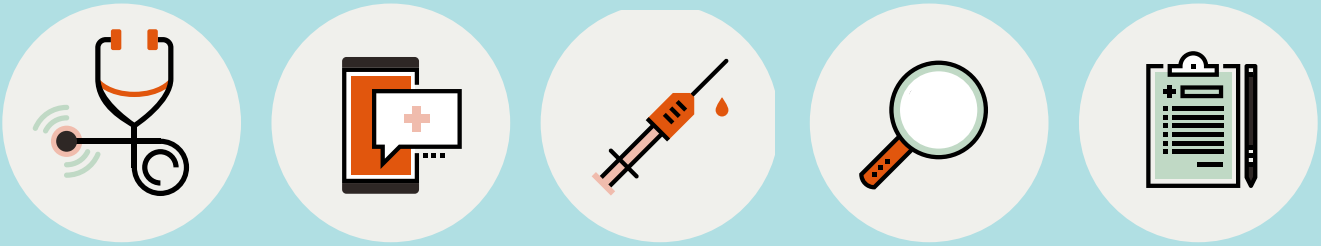
Once a year, around July 1 (90 days after March 31, the end of the DHW's fiscal year) the DHW will reconcile LFM physicians' submitted (actual) hours worked with their contracted hours as per the Schedule A – Contracted Activities form they submitted with their contract.

The hourly component of each biweekly LFM payment is based on the contracted working hours in each physician's contract. The reconciliation will use billing data to assess whether the submitted (actual) working hours claimed align with the hours paid based on the contracted hours. If the physician has worked more than their contracted hours, they will be paid for the extra hours after the reconciliation. If they've worked less, the money must be repaid; repayment terms will be arranged with the DHW on an individual basis.

Expected hours per year

Physicians are expected to work 46 weeks per year, but payments will be smoothed over 52 weeks (or 26 pay periods). The DHW expects physicians who are planning to be away from clinical work for more than two weeks to make every reasonable effort to ensure necessary medical coverage for their patients.

Clinical working time – eligible activities



Office visit | **Virtual visit** | **Flu shot** | **PAP smear** | **Paperwork for panel patients**

Uncontracted time

Six weeks per year are deemed uncontracted time. This time includes unpaid days for sick time, bereavement leave, educational leave, statutory holidays and vacation days.

Billing LFM hours

To enable billing of submitted (actual) LFM hours, two health service codes (HSCs) have been created:

- HDAY1 – This is the hourly fee code for clinical daytime hours worked, billed at the daytime rate, that is, not eligible for the GPEW premium. This is also the appropriate code to bill for paperwork done during evenings or weekends when there are no concurrent visits.
- HEVW1 – This is the hourly fee code for clinical evening/weekend/holiday hours worked, billed at the premium rate, that is, eligible for the GPEW premium.

To facilitate billing submitted (actual) hours as a fee code, MSI has created a "mock patient."

The mock patient demographics and diagnosis are:

- Health Card Number 0015800568
- DOB April 1, 1969
- Diagnostic code V689

To bill your submitted (actual) hours worked, enter the number in the "units" box of the claim (for example, 8.5 daytime hours = 8.5 units). Each provider can only bill one HDAY1 and one HEVW1 claim per day. Round submitted (actual) hours to the nearest 15-minute increment.

Physicians must bill their submitted (actual) hours under their LFM Hourly Business Arrangement (BA) Number.

Because these claims are strictly for tracking purposes, the LFM hourly HSC pays $0. Reporting the hours you worked under this HSC enables reconciliation at the end of the year. For more complete billing guidelines, refer to the MSI *Physician's Bulletin* from Oct. 27, 2023.

TIP

Many physicians find it useful to book this mock patient at the end of their daily schedule as a reminder to bill their submitted (actual) LFM hours when the work day is complete.

DON'T FORGET

Physicians are paid biweekly according to the contracted hours they entered in their contract. Submitted (actual) hours are not reflected in the biweekly pay. Contracted vs. submitted hours will be reconciled at the end of the fiscal year.

Billing premium rates

Physicians will bill HSCs GPEW and HEVW1 for premium rates for early morning, evening, weekend and holiday visits (direct clinical services) with patients. These visits can be face-to-face or virtual. The premium available under the LFM for this after-hours work is two-fold:

1. You can bill the GP Enhanced Hours Premium (TI=GPEW) for all eligible services you provide, which adds a 25% premium to the MSU value for the visit billed, and
2. You can claim your submitted (actual) LFM hours at the premium rate of $139.05 (HEVW1) instead of the daytime rate of $92.70 per hour (HDAY1).

The premium rates (GPEW and HEVW1) can be billed for work conducted Monday to Friday between 6 and 8 a.m. and 5 and 10 p.m., and on Saturdays, Sundays and holidays. Remember that after-hours paperwork (that is, indirect patient care) cannot be claimed at the premium rate (HEVW1) unless direct patient services (visits) are provided during that hour. If no direct patient care is provided, the hour should be billed at the daytime rate (HDAY1).

TIP

Consider adding early morning, evening and weekend appointments to your clinic hours – scheduling more patients during GPEW and LFM premium hours boosts compensation and creates better access for patients. For example, choose one day per week to book six patients for 10-minute appointments from 7 to 8 a.m. or 5:30 to 6:30 p.m.

Part-time work and unexpected leaves

Under the LFM payment model, physicians are contracted to work 46 weeks per year. Physicians may work part time or extended hours each week, however, they must be accessible to their practice and patients (virtually and in-person) for 46 weeks of the year. The LFM is not an appropriate model for physicians who intend to take extended time away from their office-based family practice.

Exceptions will be made for physicians who are unable to be in their office practices for 46 weeks due to other approved clinical work, such as hospitalist work, Primary Maternity Care (PMC) or emergency department coverage. These specific arrangements will be determined on a case-by-case basis as part of your contract discussion.

If a physician will be absent for more than six weeks in a year, 30 days' notice must be given to the DHW and NSH by emailing lfmfunding@novascotia.ca. Parental leaves and extended absences due to unforeseen circumstances (that is, medical leave) will be approved. Your LFM model will be paused or terminated depending on your unique circumstances.

Everything you need to know about panels or rosters

Your panel or roster is made up of patients who would consider you their family doctor. The size of your panel affects the amount of your panel payment. Learn about how panel sizes are calculated and other considerations.

How is the panel/roster size calculated?

When calculating physician panels, the DHW considers the New Patient Intake Visit (NPIV1) code and the ME=CARE modifier.

- Use of the NPIV1 code will immediately roster a patient to your panel.
- In the absence of a NPIV1 code, use of the ME=CARE service modifier will be used to determine rostering. The DHW considers:
  - the number of ME=CARE encounters with each provider
  - the most recent ME=CARE encounter date with each provider, with more recent visits weighted more heavily

In the absence of a billed NIPV1 code, the patient is counted in the panel of the physician with whom they have had the most ME=CARE encounters. If tied, the patient is counted in the panel of the physician with whom they have had the most recent ME=CARE encounter.

Panel size is calculated dynamically and smoothed for payment every quarter.

TIP
Don't forget to use the NPIV1 code for newborn babies.

Your panel payment

You will receive $103 per year for each patient rostered to your panel. (The panel payment will increase by 3% on April 1, 2024.) Panel payments are smoothed into your biweekly paycheque. Bill the NPIV1 code when accepting a new patient into your practice, including for newborn babies.

How are my "healthy unseen" patients counted?

The DHW understands that physicians have a number of "healthy and unseen" patients in their practice. To account for this, an additional 10% is added to your calculated panel size. Currently, if a patient has been added to your panel by billing NPIV1, they will only be removed from your panel when another physician bills NPIV1 for that patient. If a patient has been added to your panel based on the ME=CARE algorithm, they will be removed from your panel if another physician bills ME=CARE for that patient more often than you or if a physician claims the NPIV1 code for that patient. Nurse practitioners do not shadow bill ME=CARE, so seeing a nurse practitioner will not result in a patient being removed from your panel. ME=CARE is also not billable by walk-in clinics, local emergency departments or primary care access clinics (PCCs). Accessing services in these locations will also not result in a patient being removed from your panel. *Note: The LFM attachment methodology is evolving and being refined on an ongoing basis. Changes will be made with approval of all stakeholders and members will be notified accordingly. The above information is true as of the date of publication.*

What is ME=CARE?

ME=CARE is a fee code modifier established in 2019. Physicians receive a premium on most office-based billing codes when seeing a rostered/attached patient. Physicians must commit to providing ongoing comprehensive primary health care to that attached patient to claim ME=CARE. ME=CARE can be billed for a patient of another provider within your collaborative practice group.

TIP
Be sure to bill ME=CARE codes for your rostered patients. If you are in a collaborative practice, bill ME=CARE for all patients within your collaborative group.

More tips for billing success

- Bill submitted (actual) hours worked, including paperwork time, but **keep an eye on your service encounter ratio**. Make sure to distinguish between daytime (non-premium) (HDAY1) hours and premium (HEVW1) hours.
- **Billing hours daily (or when you bill your FFS billings) is best practice**. Do not delay billing your submitted (actual) hours worked. Use calendar reminders to make sure you don't forget and consider using an app to help track your submitted (actual) hours worked.
- **Consider using your EMR to help you log times**. In Med Access, use the "Memo" feature at the top of your daily schedule to log your start/end times for every work session.
- Remember that EMR data can be easily accessed to see every click you make and when you made it. This information can help you track your submitted (actual) LFM hours if needed. **Refer to your cell phone call log for phone call durations**.
- **Get in the habit of time-stamping all encounters** – for example, if you realize you had a patient encounter that will be billed to Veteran's Affairs or WCB NS, you'll need to subtract it from your actual hours worked. Find the times by checking the time stamps on the visits straddling that encounter. When the visits on either side of it were time-stamped, the calculation is easy to do.

What about patients who receive prenatal care outside of my practice?

Prenatal care codes are not accounted for in the ME=CARE attachment algorithm, so the patient will remain on your panel.

Community complexity modifier

The LFM payment model includes a community complexity modifier to account for variations in socio-economic status factors in different communities. This calculation is currently based on your community of practice, but work is being done to provide a more accurate calculation that would reflect the actual medical complexity of your specific patient panel. This is still under development. Currently, the complexity modifier is applied automatically to your panel and hourly payments and smoothed into your biweekly payments. The community complexity modifier is paid as a quarterly premium on your 30% FFS claims.

How to request a panel validation

Physicians may participate in a panel validation exercise to receive a report comparing their panel size as calculated by their EMR patient count and the panel size as calculated by the ME=CARE/NPIV1 algorithm. Email psaccountability@novascotia.ca to request a panel validation.

Physicians are responsible for all claims

You are responsible even when claims are entered by someone else, such as billing staff. MSI is the ultimate authority on physician billing. If you have questions about billing under the LFM, email MSI and save the response for audit purposes.

Understanding and optimizing service encounters

The LFM payment model requires physicians to perform a minimum of 2.8 service encounters per hour. Service encounters will be averaged quarterly.

It's important that physicians bill all insured services and accurately track their hours.

What is a service encounter?

In the LFM payment model, service encounters track qualifying medical services. Every patient appointment counts as at least one service encounter. Most MSI-insured, community-based medical services are valued as one or more service encounters.

What qualifies as a service encounter:

- All patient appointments
- Pap smear and vaginal/pelvic exams with speculum each count as an extra service encounter, in addition to the service encounter earned for any associated appointment
- Services with time-based multiples (such as prolonged office visits, counselling, psychotherapy, palliative care support) are valued at 1 SE per multiple
- Procedures count as one or two service encounters (refer to the LFM Service Encounter Cheat Sheet)
- Surgical and fracture services
- Most complex visits are valued as two service encounters, including:
  - NPIV1
  - Palliative care support visits (03.03C)
  - Comprehensive visits (03.04)
  - Gender readiness assessments (03.04K GAC)
  - Initial opioid agonist treatment (OAT) codes (03.03J, 03.03K,03.03L)
  - Comprehensive GP consultations (03.08)

TIP

Check the MSI website for an LFM service encounters cheat sheet that lists common billing codes and combinations of codes, plus their related service encounter value.

What does not qualify as an extra service encounter:

- Insured injections and immunizations do not qualify as an extra service encounter when billed with an office visit
- NSH interpreter (ADON OFI1)
- Yearly CDM incentive fees
- Indirect patient care codes, such as Allied Health Care Provider to Physician Discussion (AHCP1), Prescription Renewal (TPR1) and the Teaching Stipend for Medical Student
- Workers Compensation Board services (paid outside LFM contract)

The definition of LFM service encounters is new and will continue to evolve as data is gathered and physicians provide feedback.

Make the most of each service encounter

- Delegate work mindfully so that you can achieve the service encounter ratio. For example, delegate some indirect care tasks and components of more time-consuming tasks (such as first prenatal visit history, CDMs, Rourkes), but retain some straightforward service encounters in your own schedule (such as insured stand-alone injection/immunizations and suture removals).

- Bill all insured services.
  - **Know your fees** – especially the codes for prolonged office visits (03.03, 03.03A, NPIV1)
  - **Check out the billing education** information available on the MSI website
  - **Bill for all face-to-face and non-face-to-face visits**, and indirect services like Allied Health Care Provider to Physician Discussion (AHCP1), Prescription Renewal (TPR1) and Physician to Physician Advice (03.09L)

Understanding business arrangement numbers

Physicians who are remunerated under the LFM payment model receive a paycheque biweekly (every two weeks).

This payment consists of three components: an hourly component, a payment based on panel size and a payment for 30% of their FFS billings. The hourly component is static and reflects the annual hourly commitment the physician made in their contract (that is, their contracted hours) and Schedule A (reconciliations happen annually; see page 7). The panel payment may vary depending on fluctuations in panel size; changes are tracked and adjustments made quarterly. The FFS billing payment will fluctuate with each cheque, depending on what/how many FFS services were provided during the pay period.

Each of these payments is tracked through a different business arrangement (BA) number. These numbers are automatically provided to LFM physicians by MSI.

Business arrangement numbers

Each LFM physician will receive three BA numbers – and a fourth, for 100% FFS work, if applicable.

1. **LFM Annual Hours BA** – For submitting actual hours worked. Nothing should be billed to this BA except for the new hourly health service fee codes HDAY1 and HEVW1. This is necessary for annual reconciliation of your submitted (actual) hours worked with your contracted hours outlined in Schedule A of your LFM contract. (See page 7 for more about the annual reconciliation.)
2. **LFM Attachment BA** – This BA is for the patient attachment (panel) component of the LFM model. Physicians should not bill any codes to this BA – it exists so that the panel payment is easy to see as a separate payment component, rather than getting combined with one of the other BAs.
3. **LFM 30% BA** – For billing FFS health service claims, which are paid at 30% under the LFM payment model. Payments under this BA will fluctuate because they reflect 30% of actual FFS billings. If you are on vacation for a few weeks, you'll notice this payment decrease accordingly.
4. **100% FFS BA** – This BA is for services provided outside the LFM if applicable. This number is for FFS-eligible claims (such as WCB, MAID, Community Services).

You may see payments to additional BA numbers on your account. These numbers include:

- **CMPA BA** – For issuing CMPA rebates and/or incentives – no billing occurs on this BA.
- **Locum BA** – A temporary or long-term BA set up for physician locum payments.

TIP

Consider setting your LFM 30% BA as your default billing number in your LFM but remember to toggle to the hourly BA when submitting hours. It is recommended all hours be billed at the same time as daily encounters.

Understanding payments

Go to www.msielink.ca and log in using the six digits of your provider number as your username. You will then be able to reconcile your payments with your billings by looking at what is listed under your business arrangement numbers.

Need help?

Who to call

Whether you're considering adopting the LFM payment model, in the process of converting or already using the LFM but in need of support, we're here for you. The DNS Physician Advisory Team is ready to answer your questions and guide you through the LFM application process. Call or email the advisor in your zone any time.

DNS Physician Advisory Team

Noelle Moulaison
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Ryan Brown
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Connect with colleagues
Doctors Nova Scotia has created an LFM hub on the Doctors Lounge – check it out to pose your questions, share tips with your colleagues and find reliable information.

How to reach the DHW
To learn more and sign up, or as an LFM physician with questions, email lfmfunding@novascotia.ca