For LFM Core Physicians

Making the Longitudinal Family Medicine payment model work for you

Doctors Nova Scotia | May 2026

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Doctors Nova Scotia

Where to Start

Is this 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 (virtual services cannot exceed 50%)
- ☐ 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

Whether you're new to practice or converting from fee-for-service to LFM, it's easy to apply. Follow these steps.

Before you begin, it's important to note that four weeks' notice is required to process your application and get you set up on the LFM payment model, so choose a start date no sooner than four weeks in the future.

1. **Contact your DNS physician advisor:** They will assist you in completing your documentation and answer any questions you may have.
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 based on past billings. Physicians can verify their ME=CARE panel size through a panel validation exercise. To do so, email lfmfunding@novascotia.ca and ask for a panel validation. The DHW will provide further instructions, including your ME=CARE panel size, which you should compare to your EMR panel.
   - New-to-practice physicians have a protected panel for their first year, based on the FTE in their offer letter (1317 for a 1.0 FTE). The panel portion of your LFM remuneration will be based on this number.
   - Fee-for-service physicians' panel payment will be determined by your current panel size. Your EMR panel and the panel calculated by DHW may vary. If you'd like to get a sense of what your panel payment will be for you LFM remuneration before your conversion, you can request a panel validation exercise through DHW to verify. Email LFMfunding@novascotia.ca to initiate the process. This is not a requirement, but available to you if you wish to participate.
3. **Complete the contracted activities document:** It is a good idea to complete this document along with the help of your physician advisor. Once complete, send the contracted activities document, along with your start date, to lfmfunding@novascotia.ca. The DHW will complete the process by sending you a contract to sign and notifying MSI to issue the Business Arrangement (BA) numbers you will need.

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

Setting up your contract

The following tips will help you set up your LFM contracted activities. Read everything before beginning. You can also contact your DNS physician advisor for assistance.

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. Enter your provider profile information
2. Under "Practice Profile," enter your office/clinic manager or administrator as the primary contact. Also list the other providers in your clinic and support staff. Your clinic manager or Primary Health Services Lead can help you obtain this information.
3. Fill in your projected hours in the "Clinical Working Time" section. Please see the section "Be smart about projected hours of work," below, for tips before completing this section.
4. 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 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 (weekly hours x 46 weeks). Clinical hours include direct patient care as well as indirect patient care (i.e., paperwork). Once you sign this document, that number becomes your contracted hours. Every two weeks, the DHW will pay you for those hours.

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 are in excess of 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 – Do you want to subtract these hours from your annual total?
- Time of day – Do you plan to work regular day time hours and/or incorporate evening and/or weekend clinics?
- Hospitalist /PMC/ER work – If you plan to do work in these other areas, the equivalent in hours/weeks need to be excluded from your LFM. Contact your physician advisor a discuss.

Note: You may consider not including your indirect patient care time outside of regular office hours in your contracted activities, as the amount of time you spend outside of regular office hours doing this work can be unpredictable. That way you will not be paid in advance for that time but you can bill it as you go and be paid the difference at the end of the year. The choice is yours.

NEED HELP?
Contact your Physician Advisor.

Accounting for statutory holidays

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

If you deducted a statutory holiday but end up working that day, submit premium hours for that time. You will be paid for the holiday at reconciliation time. For clarity, if you had patient interactions (visits or calls) on a statutory holiday, you can claim premium hours; if you did administrative work, claim regular daytime hours.

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 uncontracted time or need to make up the hours.

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

Statutory holidays
If you do not typically work statutory holidays, consider deducting those hours from your annual contracted hours up front. You won't be 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 (see MSI *Physician's Bulletin*). 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%.*

Other service area work outside of LFM
If you do hospitalist or weekly rotational Primary Maternity Care (PMC) or Community Hospital Inpatient Care (CHIP) 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

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
- Honoraria/external committee work
- EMR grant A (new adopters) is payable on top of the LFM
- NSH Committee work and/or meeting time
- Collaborative Practice Incentive Program (CPIP) is paid at 100% fee-for-service and the new CFP fee code will be billed to your 100% FFS Business Arrangement number.

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.
- Medical Assistance in Dying (MAID)
- Obstetrical deliveries for both attached and unattached patients

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

All LFM physicians are required to work 46 weeks per annum across the health care system. However, the number of hours they work each week can be flexible and unique to each physician.

The LFM payment model is flexible and allows family physicians to work part- or full time hours weekly. 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.

IMPORTANT: You can only bill hours worked for time you actually spent providing direct or indirect patient care. You cannot wait to see how many encounters you saw in each day or week, and then calculate how many hours you feel you "should" bill. Your daily hours should be billed at the same time as your daily encounters. If you're concerned you will overbill indirect time and not meet the 2.8 SER requirement, you might choose to hold back on submitting your hours. If you do that, you should keep track all hours worked for reference when going back to bill your hours. Best practice, however, is to bill your hours with your service encounters to mitigate risk of audit.

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 met the 2.8 SER and 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. IMPORTANT: It is crucial all LFM physicians review their LFM Quarterly Reports from the DHW so they are not surprised. If you read your report, you will be aware of how you're tracking and likely have time to adjust so you do not end up owing money back to the government at the end of the year.

Expected 46 weeks per year

Physicians are expected to work 46 weeks per year, but payments will be smoothed over 52 weeks (or 26 pay periods). Under the LFM contract, a "week worked" is defined as any week (Sunday to Sunday) where a physician provides 40% of their "targeted service encounters." An individual physician's target service encounter rate is defined as the number of contracted hours per week multiplied by 2.8 (minimum service encounter rate per hour). For example, if a physician is contracted for 40 hours per week, their target service encounter rate is 112. That means that to meet the 2.8 minimum SER, they would need to provide at least 112 service encounters each week. The DHW knows not all weeks wind up looking the same so they call it a "week worked" if a physician has seen 40% of their target service encounters. In this example, 40% of 112 is 44.8 service encounters. This adjusts for unexpected things that pop up during the week that may interfere with a physician's typical schedule. Physicians will still need to make up the hours for which they were paid during that week that they didn't work, but they will have satisfied the expectation of working 46 weeks per annum.

If you're an LFM physician that meets the 46 weeks of work per annum doing work across the system (for example, hospitalist, CHIP, PMC, ED) not just in your LFM office, a "week worked" is defined by hours. In these cases, a week worked is defined as whether or not the hours you provided and were paid for in the "other" service area is equal to 40% of your weekly contracted LFM hours. In the same example outlined above, if you're a physician who is contracted for 40 hours per week in your LFM practice across five days for eight hours per day, then as long as you provide two days or 16 hours (40% of five, eight-hour days) of service in the other service area, you've satisfied a week of work. The DHW tracks LFM physician weeks worked (both inside and outside the model) and will reconcile it at the end of year.

Uncontracted time

Physicians are entitled to six weeks per year of uncontracted time. This time includes unpaid days for sick time, bereavement leave, educational leave, statutory holidays and vacation days. Although away from practice, physicians will still receive their biweekly base pay (hours and panel amount) during this time off. If the DHW finds during the annual reconciliation process that after applying the 40% calculation outlined above, a physician took more than six weeks of uncontracted time, they will recover the physician's panel payment allocation for the number of weeks of uncontracted time over and above the allowable six weeks and there may be contractual consequences.

Billing LFM hours

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.

When billing your LFM hours, you must first remember to only use your Hourly Business Arrangement (BA) Number. This number has been issued to you specifically to bill your LFM hours. If your hours are billed to the wrong BA they will not get counted toward your hours worked. You must also use the appropriate health service codes (HSCs).

- 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.

DON'T FORGET
Physicians are paid biweekly according to the 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 (HEVW1) instead of the daytime rate (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.

Clinical working time – eligible activities

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 immediately rosters a patient to your panel.
- The ME=CARE service modifier billed over time also rosters a patient to your panel.

If you are taking a patient over from a retiring or downsizing physician, bill NPIV1 when you complete your intake visit with the new patient to move them from the other provider's patient roster to yours. For further information on roster size calculations, taking over patients from another provider or the 811 Need a Family Practice registry, please contact your physician advisor.

Panel size is calculated dynamically and smoothed for payment every quarter to account for additions to your practice as well as inactive patients who have died or moved out of province. Refer to the LFM FAQ or contact your physician advisor.

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

Your panel payment

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.

How are patients removed from my panel?

A patient will be removed from your panel if they die or if they are formally taken on by another physician (if that physician bills NPIV1 or has seen the patient consistently and more often than you over time). The NPIV1 is weighted very heavily at the onset but decreases over time, allowing a patient to be removed from your panel if they are seen more often by another physician.

What is ME=CARE?

ME=CARE is a fee code modifier that pays physicians 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 LFMfunding@novascotia.ca to request a panel validation. Consider hiring a third-party biller or billing expert to help you bill appropriately. Contact your physician advisor for options.

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. Please refer to the MSI LFM Service Encounter Cheat Sheet if you have questions regarding SE rates for certain services or procedures.

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
- See a full list of service encounters by referring to the LFM Service Encounter Cheat Sheet

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 daily precepting stipends (TESP 1 and TESP 2) – see note on the precepting stipends waiver on page 12
- Workers Compensation Board services (paid outside LFM contract)

The definition of LFM service encounters continues 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.
  - o **Know your fees** – especially the codes for prolonged office visits (03.03, 03.03A, NPIV1)
  - o **Check out the billing education** information available on the MSI website
  - o **Bill for all face-to-face and non-face-to-face visits**.

Precepting on LFM

All LFM physicians are compensated for serving as a preceptor to medical trainees.

Medical trainees are defined as:

- undergraduate medical students registered with Dalhousie Medical School (DMS)
- residents in an accredited postgraduate specialty or subspecialty training program registered with DMS
- other practice-ready providers who are not part of the Physician Assessment Centre of Excellence (PACE)
- physician assistants (while still in training during their two-year program)

A medical trainee is not a:

- clinical observer
- clinical fellow
- PACE participants
- physician extenders, such as associate physicians, and their learners
- other healthcare providers, and their learners

All LFM physicians may qualify for three streams of funding.

Daily stipend when precepting

Effective Jan. 1, 2026, physicians can submit claims in either half- or full-day increments using the PREC 1, PREC 2 or PREC 3 fee codes and be remunerated according to the number and level of learners they are precepting. These fee codes should be claimed under your 100% FFS BA. Physicians who provide tutoring/lecturing services are still paid for that work by Dalhousie. Learn more here.

5% preceptor premium

Supervising physicians (preceptors and assessors) who hold an academic appointment at Dalhousie's Faculty of Medicine and have been approved by Dalhousie Medical School to supervise a medical trainee will be paid a premium of 5% on all Nova Scotia Medical Services Insurance (MSI) claims for insured services provided by the supervising physician, the medical trainee or both – as long as both are present in person and working in the same clinical location.

When an LFM supervising physician submits an eligible claim under their LFM 30% BA with the 5% preceptor premium, the bi-weekly payment deposit will contain payment for the 30% LFM BA as well as any eligible claims where the 5% preceptor premium field was selected. For clarity, LFM supervising physicians will receive a total payment of 35% of eligible claims, and the 5% preceptor premium will appear as a separate payment on the detailed statement.

Annual $5,000 stipend

All LFM physicians who are approved by Dalhousie Faculty of Medicine and the DHW to precept and who spend more than nine days (or 18 half days) between April 1 and March 31 of the following year working directly with learners are eligible to receive the $5,000 annual stipend.

2.8 SER waived while precepting

There is a temporary waiver of the 2.8 SER for supervising LFM physicians only during periods when they have an eligible medical trainee. To qualify, physicians must bill the 5% premium on all applicable services as well as bill PREC 1, PREC 2 or PREC 3 codes for the appropriate medical trainees to their 100% FFS BA number.

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 and billed 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 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. If hours are billed to any code other than your hourly billing code in error, the hours will not be counted, your SER will be impacted and you could potentially owe money to the government, even if you worked the hours. It's very important to bill hours under this BA number. (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.

Glossary

Here are some of the key terms you'll read throughout the document.

Service encounter: Service encounters are qualifying medical services in the LFM model. Their purpose is to enable the measurement of patient throughput using billing data.

ME=CARE: ME=CARE is a billing modifier family physicians can claim when providing comprehensive and continuous primary care to their patients as outlined in the May 17, 2017, MSI *Physician's Bulletin*. To bill ME=CARE, physicians must submit a confirmation letter to MSI.

Business arrangement numbers: Business arrangement (BA) numbers (supplied by MSI) are unique identifiers for different clinical activities or locations. Payments are tracked through various BA numbers.

Contracted hours: Contracted hours are the annual clinical working time you commit to work over the 46 weeks of your LFM contract.

Uncontracted time: Uncontracted time relates to the six weeks that you will not work annually. This includes sick days, leaves, statutory holidays and vacation days.

NPIV1 billing code: The New Patient Intake Visit (NPIV1) billing code is used to roster a new patient to your practice (including newborn babies). It also pays at a higher rate than a regular office visit. See the Sept. 20, 2023, MSI *Physician's Bulletin* for details.

Direct clinical hours: Clinical hours are the hours you spend providing insured clinical services to patients on your or your clinic's roster. These must be billed regularly to show you are working the hours you have committed in your contract. These are claimed using HDAY1.

Indirect clinical hours: Indirect clinical hours are the hours you spend doing work related to patient care but not in direct contact with the patient. These must be billed regularly to show you are working the hours you have committed in your contract. These are claimed using HEVW1.

A letter

from the original contributors

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 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.

Key to the LFM is its commitment to providing competitive compensation and increased accountability. Physicians are 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. This publication has served as 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.

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.

Alison Wellwood, MD
Family physician, Wolfville, N.S.

Ben Sabine, MD
Family physician, Wolfville, N.S.

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.

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How to reach the DHW
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