Nurse Practitioner

Shadow Billing Manual

July 2023

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INTRODUCTION

This document is intended as a tool to help guide Nurse Practitioners (NPs) in the shadow billing process. All practitioners who provide insured services to eligible residents are required by the New Brunswick Department of Health to submit information to Medicare. NP's must bill in accordance with the billing requirements laid out in the Medicare Shadow-billing Manual for Nurse Practitioners. The NP manual has been created using the New Brunswick Physician Manual as a **guide** as similar rules will be applied.

WHAT IS SHADOW BILLING?

Shadow Billing refers to the process where non-fee-for-service health practitioners submit claims to New Brunswick Medicare for insured services provided to eligible residents. Claims are paid at zero. This information is used, in conjunction with data collected from fee-for-service practitioners, to maintain a consistent patient history. This consistent history is required to ensure accountability, as well as to monitor and to assist with planning for the future of health care in New Brunswick. It has been mandatory for all NPs, regardless of employment setting, to shadow bill since June 2010; however, NPs began shadow billing on a voluntary basis in 2006. The service codes used at this time were uploaded into a database that was separate from the primary Medicare database. In October 2012, NPs began using the same codes as General Practitioners which allowed the information to reach the Medicare database, thereby ensuring greater consistency in continuity of the patient history. In addition, changes to New Brunswick's Public Health Act require the capture of all immunizations in the Medicare system.

ELECTRONIC BILLING SYSTEMS

Medicare offers an electronic billing system, Medicare Claims Entry (MCE), free of charge to all practitioners. The system is web-based and can be access through any computer with an up-to-date web browser (Edge, Internet Explorer 11+, Google Chrome 40+, Mozilla Firefox 33+, Apple Safari 8+), and an internet connection. Username and password associated with Regional Health Authority account or Government of New Brunswick (GNB) account is required to access MCE. Please contact the Provincial Health Application Services User Support at 453-8274 opt. 4 with any questions or to arrange access.

While Medicare does offer the MCE option for billing, the nurse practitioner is able to choose from any third-party billing systems available for New Brunswick Medicare billing. Be sure to verify with office staff what system is being used in that setting.

SHADOW BILLING TRAINING

Medicare Practitioner Liaison officers offer training on shadow billing and the Medicare Claims Entry (MCE) billing system to all NPs and their billing staff, free of charge. This training is strongly encouraged and can be scheduled by emailing Medicare.Training.Formation@gnb.ca

"Refresher" training sessions on shadow billing or on the MCE system is also offered as needed.

GENERAL PREAMBLE

Service codes specified are for professional services which are medically required for the diagnosis and/or treatment of a patient and are not excluded by legislation or regulations but do not include claims for drugs, injectable materials, or appliances.

If it is not medically necessary for a patient to be personally reassessed prior to prescription renewal, specialty referral, release of laboratory results, etc., claims for these services must not be made to the plan regardless of whether or not a practitioner chooses to see their patients personally or speak with them via the telephone.

MEDICARE INFORMATION

General Points

- Only service codes listed in this manual may be used by NPs. Claims submitted with codes that are not listed in the NP Manual will automatically be cancelled by the Medicare System.
- Select the most responsible service code. In some circumstances, more than one service code may be used (refer to Code definitions, Assessment Rules, and Legend in this manual).
- Claims must be submitted within 92 days from the date of service.
- All documentation that supports billing must be retained for 7 years.
- "GP" may appear in the service description of service codes being used by NPs in billing systems as the codes were negotiated for General Practitioners. Some service codes in the billing systems may appear differently than below but they are still the appropriate codes to use.
- Service codes apply to face-to-face visits unless otherwise specified; appropriate physical examination when pertinent to the service; and ongoing monitoring of the patient's condition during the encounter.
- Electronic Reconciliation Statements are available through the ECP on a bi-weekly basis and must be reviewed. Some Third-Party billing systems offer reconciliation options, but the Reconciliation Statements from Medicare must still be reviewed. (See Reconciliation Section).

Patients

a) In-province Patient - If a practitioner renders a service to a patient who presents themselves with a valid New Brunswick Medicare Card an electronic "In-Province" shadow billing claim can be submitted.

b) Out-of-Province Patient - If a practitioner renders a service to a patient who is a resident of a Canadian province/territory, outside of New Brunswick who presents themselves with a valid Provincial Healthcare Card, an electronic "Out-of-Province" shadow billing claim can be submitted.

c) Excluded services and third-party request – If a practitioner renders a service to a patient, at the request of a third party (WorkSafeNB, insurance, work/school requirement, etc.), or for an excluded

service such as military, federal inmates, shadow billing claims **cannot** be submitted for the service as these patients/services are not insured by New Brunswick Medicare.

d) Expired Medicare Card - If a practitioner renders a service to a patient with an expired Medicare card, they can still shadow bill the service with the Medicare number but will note the following message on the Reconciliation Statement: "Resident not eligible. Patient to contact Medicare." The claim will still appear on the nurse practitioner's statistical information. The patient should be advised to go to Service New Brunswick to have coverage reinstated or to contact Medicare directly. **Please note:** Medicare personnel cannot give any patient Medicare information to practitioner's offices.

e) Patient not registered with Medicare - If a practitioner renders service to a New Brunswick resident who is not registered with Medicare, they can proceed as follows:The practitioner can assist the patient by advising them to go to Service New Brunswick to obtain a registration form. Having been issued an identification number, the patient should then give this information to the practitioner who can submit an electronic shadow billing claim.

Required information – Electronically Submitted Claims

- Patient's name;
- Patient's Medicare number;
- Patient's date of birth;
- Province of healthcare coverage, if applicable;
- Patient's sex;
- Date of service;
- Start time, if applicable (time based codes and emergency department visits);
- End time, if applicable (time based codes);
- Valid ICD10 diagnosis;
- Service code;
- Referring/collaborating practitioner number when applicable;
- Number of services when applicable (otherwise remains at 1);
- Location;
- Vaccine lot number – required if immunization is being administered.
- Site code - must be provided for services rendered in hospital emergency department, walk-in clinic, nursing home (if not primary location), community health centers (CHC).

Valid Diagnosis

A valid ICD 10 medical diagnosis is required on all shadow billing claims submitted. The Service Code lets Medicare know the type **of service provided** while the diagnosis must indicate **why** the service was provided.

Referral Date

The Referral Date is required when billing a new Consultation for a patient. The Referral Date is the date the patient was seen by the referring practitioner, which should be indicated on the written referral request, not the date it was received, faxed, or the patient was seen in consultation. The referring practitioner must be active on the date indicated as the Referral Date.

Also, if an NP decides to refer a patient to a practitioner or another NP for consultation following a visit it is important that the Referring Practitioner, Referral Date, and Type (1 – Referred To) be indicated on the visit claim. There is no separate code for referrals.

EXCLUDED SERVICES

Certain services are excluded from the range of insured services under Medicare, namely:

(a.04) removal of minor skin lesions, except where the lesions are or are suspected to be precancerous;

(b) medicines, drugs, materials, surgical supplies or prosthetic devices;

(d) advice or prescription renewal by telephone which is not specifically provided for in the Schedule of Fees;

(e) examinations of medical records or certificates at the request of a third party, or other services required by hospital regulations or medical by-laws;

(f.1) services that are generally accepted within New Brunswick as experimental or that are provided as applied research;

(f.2) services that are provided in conjunction with or in relation to the services referred to in paragraph (f.1);

(h) testimony in a court or before any other tribunal;

(i) immunization, examinations or certificates for purpose of travel, employment, emigration, insurance, or at the request of any third party;

(r) complete medical examinations when performed for the purpose of a periodic check-up and not for medically necessary purposes.

ASSESSMENT RULES

Assessment Rules dictate how shadow billing claims will be processed by the Medicare System. Nurse Practitioner claims are subject to the same assessment rules as other practitioners.

Rule 1 Services rendered for or at the request of a third party are not entitled services under Medicare.

Rule 2 Consultations, examinations or written reports for medico-legal purposes are not entitled services under Medicare.

Rule 3 Certification for a driver's license is not an entitled service under Medicare.

Rule 4 Mileage is not an entitled service under Medicare, except as specifically provided for in the Schedule of Fees.

Rule 5 Telephone advice is not an entitled service under Medicare unless noted in the service codes.

Rule 6 Services listed in Schedule 2 of the Regulations under the *Medical Services Payment Act* are not entitled services under Medicare.

Rule 10 Visit codes cannot be submitted for days on which a nurse practitioner provides psychotherapy services to a patient (or vice versa) except when the visit is for a consultation.

Rule 11 Shadow billing claims for a consultation under Medicare will be adjusted to a non- referred office visit if the recorded medical history for the patient does not indicate a prior service rendered by the practitioner shown on the consultant's claim form as the referring practitioner.

Rule 12 If a sickness-related complete physical examination has been performed on the patient by the same nurse practitioner in the preceding 42 days a second complete medical examination may not be shadow billed.

Rule 13 When the performance of a List A or List B procedure is the sole purpose of attendance in an emergency department, the procedure alone should be shadow billed. Also, if any visit or consultation has been submitted during the preceding 30 days, no further visit may be claimed on the day of the List A or B procedure.

Rule 17 Detention: The total time (visit + detention) spent with the patient must be provided using the start time of the visit to the end time of the detention. Number of services will represent extra time above and beyond initial service.

Rule 28 For surgical procedures (List D) the normal postoperative period will be taken as 14 days.

Rule 30 When more than one List A or List B procedure is done, the fee for the principal procedure will be paid in full and the additional procedure, when payable, will be paid at 75% of the appropriate fee.

RECONCILIATION STATEMENTS

Nurse Practitioners have a responsibility to ensure the accuracy of information entered into the Medicare database. This is done by accessing the electronic Practitioner Reconciliation Statement and through shadow billing reports sent to NPs that summarize services provided to patients by NPs.

Reconciliation Statements

Reconciliation statements can provide valuable billing feedback and indicate cancelled claims that need to be resubmitted.

Reconciliation Statements can be accessed through the Electronic Communications to Physicians (ECP) website (https://hps.gnb.ca). The website also contains the Practitioner Run Schedule, Service Provider Reference List, and general communication from Medicare to Practitioners. The Department of Health does not distribute these documents via non-electronic methods. While some Third-Party billing systems offer reconciling options within the billing system, practitioners must still review their Medicare Reconciliation Statement through ECP to ensure accuracy.

In order to access the ECP website, NPs are required to have a username and password that is associated with their Government of New Brunswick (GNB) account or with a Regional Health Authority account. Please contact the IT Helpdesk in your region for questions regarding this (see ECP User Guide).

If a nurse practitioner chooses to have a delegate submit shadow billing claims and access Reconciliation Statements on their behalf, they must complete a "**Medicare Account Delegate Authorization Form"** which will provide the delegate with their own access to the ECP website. This form can also be obtained through the GNB website or through Medicare Payments. Please refer to your contact information sheet at the end of the manual.

The Practitioner Run Schedule indicates the cut-off dates for claim submissions (every second Thursday at 8:00 am). Claims submitted prior to this cut-off date will appear on statements the following week (available Tuesdays).

The *Claims* section of the Reconciliation Statement identifies claims that have been processed appropriately by the Medicare System with the message "History Claim, Paid at zero". If changes need to be made to claims listed in this section (i.e., change to service date or code) please **do not** resubmit a new claim electronically. Adjustments can be made in writing to Practitioner Enquiries (see contact information).

The *Claims to Correct* section of the Reconciliation Statement identifies the cancelled claims with an accompanying message to indicate what information is incorrect or incomplete. If these cancelled claims are not resubmitted as new electronic claim with corrected information within 92 days from the statement date the services will not be accounted for in the NP's statistical information (Shadow Billing Report).

The *Outstanding Claims* section of the Reconciliation Statement identifies claims that have not been processed yet. These claims will appear on a future statement either under the *Claims* section or *Claims to Correct* section once they have been processed.

Additional questions regarding the Reconciliation Statements can be directed to Practitioner Enquiries.

NURSE PRACTITIONER MONITORING AND COMPLIANCE

General information

The services submitted by nurse practitioners to Medicare are subject to verification. This in no way implies criticism of persons providing or receiving services but assists in maintaining an efficient public program and as a check to confirm that information is recorded correctly.Reviews, audits, and monitoring are conducted in a strict confidential environment.

Documentation is an integral component of a medical service. Good medical records enhance quality and continuity of care and provide protection for both patient and practitioner.

All claims submitted to NB Medicare must be verifiable by patient records with respect to the service performed and claimed. If such records cannot be produced and a suitable explanation cannot be provided, then the specific service involved will be deemed invalid. A nurse practitioner shall make every effort to provide or make available, upon request by Medicare, patient records to clarify or verify services submitted.

For Medicare monitoring purposes, a practitioner must maintain records to support their claims to NB Medicare for a period of seven (7) years.

1. Records standards

A clinical record of a service must include (at a minimum) the following legible information:

- Patient name, Medicare #, Date of Birth, Sex.
- Date of Service.
- Diagnosis/Reason for the service, i.e., Presenting complaint.
- Name of referring practitioner, where applicable.
- Name of Consultant, if referred.
- Findings/evidence of physical examination (part or region) or emotional disorder– if applicable.
- Plan of investigation or treatment (including medications, if applicable).
- For procedures, in addition to the above, a brief description of the service performed should be included.
- For time-based codes, e.g., Counseling, the start and end time is required.
- For time-of-day codes, i.e., all visits provided in an office setting including virtual care, emergency visits, the time of day (24-hour clock) is required.

- For procedures, in addition to the above; a Clinical Record/ Procedural Report or another type of supporting document providing the details of the procedure performed must include
  - pathology reports (when applicable)
  - the name of the primary surgeon, assistant, and collaborator (when applicable)
  - the name of the anesthesiologist (if applicable) and type of anesthetic used (general, local sedation?)
  - pre-operative and post-operative diagnosis

1.1 **Electronic Signature/Password requirements**

The critical function of a signature (electronic or otherwise) is to associate the signatory / login user with the service rendered. Practitioners or other service providers must enter their own electronic signature/login to clearly identify who provided the service. Users should manage and protect their identification including passwords.

User identifiers are an important aspect of computer security and are the front line of protection for user accounts.

Users remain accountable for all activity logged against their user identifier and must treat it as sensitive and confidential information by always following the directives listed below:

-Keep their password confidential

-Do not share their user identifier with anyone including a co-worker or administrative assistant

-Do not transmit their user identifier in the clear or plaintext outside the secure location.

-Do not display their user identifier (visible to other)

Additional resources on documentation can be found through the NANB standards of documentation or through CNPS as per the links below:

NANB-Standards-Documentation-May20-E-1.pdf

Info LAW: Quality Documentation: Your Best Defence - Canadian Nurses Protective Society (cnps.ca)

2. Interval

- All practitioners will be audited on a random basis.
- Non-random audit will be conducted as warranted, based on utilization review or other data.

NURSE PRACTITIONER SERVICE CODES		
Service Codes/List	**Service Code Definition**	**Nurse Practitioner Code Description**
10	MAJOR / REGIONAL CONSULTATION	Used when NP sees a patient for the first time based on a referral from a practitioner, nurse practitioner, or another approved professional due to the complexity of the situation and the NP's extensive knowledge in the area. A formal written referral request and consultation report is necessary. – *Not to be used when referring a patient.* A consultation refers to a full history of the presenting complaint and detailed examination of the affected part(s), region(s) or system(s) as needed to make a diagnosis, exclude disease and/or assess function on a patient previously assessed by the referring nurse practitioner or practitioner or; will include a review of pertinent x-ray and laboratory data and such special examinations as are considered to be essential to a complete assessment in this specialty. The consultant's opinion and recommendations must be submitted to the referring practitionerin writing. **Required on claim:** Referring Practitioner #, date of referral (date patient was seen by referring practitioner), and Type 2 – Referred From. Code 10 cannot be billed more than once in a 30-day period and is not used for follow-up visits for referred patients. Code 10 should also not be used in the instance that the patient is referred to the NP for a procedure as the NPs opinion is not required. If a consultation exceeds 1 hour, Code 200 may apply to extra time.
1	OFFICE VISIT	Used for a face-to-face encounter, within the context of a community-based family practice, for diagnosis and treatment of a medical complaint. The NP maintains a comprehensive patient chart to record all encounters, provides all necessary follow-up care for thatencounter, and takes responsibility for initiation and follow-up on all related referrals, including referrals to specialists. Examples of activities/interventions included in the initial visit claims that should not be shadow billed under additional codes or services are follow-up phone calls to patients, ordering additional blood work, maintaining files, updating files, informing another healthcare provider about a patient's health status and advocacy on behalf of a patient with mental illness. These services are considered part of the Office Visit. If time spent with the patient exceeds 30 minutes, Code 200 - Detention can be considered. **Note:** It is recognized that not all visits require 30 minutes. Do not bill Code 1 in addition to another visit or consultation.

8101	SENIOR'S OFFICE VISIT, ADD	Refers to complex case assessment for seniors 65 years of age and over, presenting with multiple systems pathology and may include medication review, as required. Used as an add on to code 1 if patient meets the above requirements; however, if the patient is 65 years of age or older without multiple systems pathology code 1 would be used. When Shadow Billing code 8101 is used for the first time, in addition to the ICD 10 diagnosis, multiple systems pathology must be indicated in the diagnosis or comments field of the electronic claim submission. On subsequent submissions of Code 8101, presenting complaint **only** is required. Not for use by NP working in nursing home as their primary location.
8985	COMPLEX PATIENT CARE VISIT – ADD ON	Refers to patients presenting with complex disease diagnosis The service code 8985 is an add on to service code 1 only. In order to bill service code 8985, each patient must have two of the following complex disease diagnosis listed below. . • Diabetes • Congestive heart Failure • Asthma • Chronic obstructive pulmonary disease (COPD) • Dementia • Palliative • Obesity BMI > 40 • High Blood Pressure • Chronic Pain Syndrome Once multiple system pathology has been diagnosed, service code 8985 may be billed for subsequent visits regardless of presenting complaint(s). <u>Service code 8985 is not payable in addition to service code 8101</u>
3	WALK-IN-CLINIC - VISIT	Refers to a visit that occurs in a location **designated** as an after-hours walk-in that has an established site code that has been issued by the Department of Health (300 series). Does not apply to unscheduled walk-in patients at CHCs or community practices. To determine if a setting has been designated as an after-hours walk- in clinic, contact Practitioner Enquiries and Liaison Services (see contact list provided in NP Training Manual). Use appropriate office visit codes (1; 8101) for **walk-in visits at Community Health Centres or community-based practices** as Code 3 does not apply in this instance.

8116	OPIATE ADDICTION – OFFICE VSIT	For diagnosis and follow-up of opiate addiction ***Medicare Note: This service code IS NOT merely for prescribing/refilling of prescriptions of methadone/alternatives.*** **Medicare Note: Patients must have been diagnosed with an opiate addiction and NPs should adhere to the** *Controlled Drugs and Substances Act (justice.gc.ca)* along with the *Standards for the Practice Of Primary Healthcare Nurse Practitioners (NANB)* which define the scope of nurse practitioner (NP) authority to prescribe controlled drugs.
7	COMPLETE EXAMINATION	Refers to visits where patient presents with symptoms that require multiple systems exams to make a diagnosis. To meet the requirements of service code 7, a complete examination **must** comprise at least the following: -Taking or updating full past patient history (including family history). -Physical examination of multiple pertinent major body systems. -Keep a written record of all findings, lab work, advice, treatment. For NPs accepting new patients in an established practice or new practice, code 7 may be claimed at the first visit **only** if the complete examination is warranted by the nature of the presenting complaint(s). Code 7 cannot be claimed for routinely doing a complete assessment of a new patient. Service code 7 does not apply to a complete examination for the purpose of a periodic check-up, or to a third-party request, as these are excluded services under Medicare. Third-party requests include examinations done in connection with employment, insurance, legal proceedings, admission to educational institution or camp and similar requests.
200	DETENTION (per 15 minutes or part thereof)	For use when the NP is required to spend considerable extra time in immediate attendance on the patient (and to the exclusion of all other work). This code applies only after the appropriate time for a visit has elapsed: -30 minutes for any visit (ex: codes 1, 8101, 3, 16, 19, 5, 2001, 9, 4, 2021, 2858). -1 hour for consultation / complete examination (ex: codes 10, 7, 2000, 15). The billing of the detention claim must indicate the total time including start time, end time, and number of services (per 15 mins): Start time = start of initial service (visit, consult, etc.). End time = end of contact with patient. Number of services = number of 15-minute intervals for extra time above and beyond initial service only (as outlined above).

9142	MEDICAL TERMINATION OF PREGNANCY	Refers to the medical management of non-viable/unwanted pregnancy, including BhCG follow-up for medical termination of pregnancy (with or without success), add to the initial visit or consultation.
15	PRENATAL COMPLETE EXAMINATION	Refers to the first complete prenatal exam after pregnancy has been diagnosed. Billable once per pregnancy.
16	PRE / POSTNATAL VISIT	Refers to pre or postnatal visit, other than the first complete exam.
19	WELL BABY CARE	Refers to growth and developmental examinations of a healthy baby until 12 months of age (includes instructions regarding health care). If the baby is being seen for a medical reason Code 1 would be used. Routine immunization codes can be used in addition to this code perthe Public Health Immunization Schedule.
8803	PATIENT NO-SHOW (per 15 minutes or part thereof)	Refers to occasions when a patient did not present for an appointment. Valid diagnosis is required. If the diagnosis is not available, indicate "Patient No-Show" in the diagnosis field. Even though patient did not present themselves this code requires start time, end time, and number of services per 15 minutes. Ex: **Start time =** time patient was scheduled. **End time =** time next patient was seen, or next patient was scheduled (i.e., 15 mins).

20	PSYCHOTHERAPY (per 15 minutes or part thereof)	Refers to therapeutic interaction between an NP and patient, to provide counseling and address issues/concerns related to mental health, psychological and emotional well-being. This code requires a start time, end time, and number of services per 15 minutes (reflecting total time per 15 mins). Code 20 **cannot** be billed on the same day as a visit (1, 8101, etc.).A Key consideration in selecting the appropriate code: If the primary reason for the visit is psychological, use Code 20 Psychotherapy. If the visit is primarily an assessment, use the visit code.Use **Visit code, instead of code 20** when: • Establishing initial diagnosis, i.e., the patient's assessment includes a history, physical examination and/or lab investigation in order to eliminate or identify potential organic causes. • Seeing the patient for reassessment and/or adjustments to the treatment plan, for example, when modifications to pharmaceutical treatment are made. When psychotherapy is part of the treatment of the patient without any other type of intervention on the NPs part during the encounter in question, code 20 would be more appropriate to shadow-bill than a visit code.
19	WELL BABY CARE	Refers to growth and developmental examinations of a healthy babyuntil 12 months of age (includes instructions regarding health care). If the baby is being seen for a medical reason code 1 would be used. Routine immunization codes can be used in addition to this code per the Public Health Immunization Schedule.
2858	EMERGENCY VISIT –OFFICE	Refers to bona fide emergency visits that are made to the office (NP's primary location). An emergency visit refers to a situation where the demands of the patient and/or the NP's interpretation of the condition require immediate response at the sacrifice of regular office hours or routine. Immediate response is the intended controlling feature. Immediate attendance because of personal choice or availability of the NP is not considered an emergency visit. Urgent visits for acute or chronic conditions, which do not interfere with routine medical practice, do not constitute emergency visits. This code does not apply to unscheduled walk-ins, home visits, nursing homes visits (unless nursing home is the NP's primary location of practice) or to visits in an outpatient department (unless theOPD is considered an extension of the NP's primary location of practice) or emergency department. **All claims for emergency-based visits must show the time of daythe services were rendered (Indicate in Start Time field)**.

2 **List C**	INJECTION (List C Procedure)	Refers to administration of intradermal, intramuscular, subcutaneous, and therapeutic injection. **This code cannot be billed in addition to other services such as a visit code. If the patient presents themselves for another medical reason aside from the injection a visit code should be used instead of Code 2.** Ex: B12, Depo-Provera **Note:** Excludes immunizations. Use individual codes assigned for vaccines.
1898 **List C**	WARFARIN SUPERVISION (List C Procedure)	Refers to telephone supervision of long-term therapy of Warfarin. Service must be rendered by the NP. Cannot be shadow billed if other office staff contacts the patient by telephone regarding their anticoagulation therapy. Note: Code can only be used once per month per patient regardless of how many times the NP calls the patient during the month. A valid/acceptable diagnosis must be provided in the ICD 10 diagnosis field of the electronic claim submission. Code 1898 is not billable on the same day as a visit or consultation.
2021	EMERGENCY ROOMVISIT	Refers to all patients seen by NP during a scheduled shift in the ER or Urgent Care centre. Code requires time of day (start time), site code, and location 3 must be used. Procedure codes may be added (refer to the Legend and Rule 13).
4	HOME VISIT	Refers to medically necessary visit to a patient at their personal residence, including special care homes. This does not apply to patients in nursing homes. Represents the first patient seen when providing services in a personal residence or special care home. **Location 4** must be entered on all claims submitted for services provided at home. **Location 9** must be entered on all claims submitted for services provided in a special care home. **Location 0** must be entered on all claims submitted for services provided in outreach visit location (shelter/street) For Medicare purposes, the civic address of the special care home is considered the personal residence of the patient. No site code is needed.

5	HOME VISIT, ADDITIONAL PATIENT	Refers to any additional patients seen during home/special care home visit at same civic address.

EXTRA-MURAL PROGRAM *The following service codes apply exclusively to services related to patients admitted to the Extra-Mural Program.*		
204	EXTRAMURAL HOME VISIT WITH ADMISSION	Refers to medically necessary visit to a patient at their personal residence (including special care home) during which the patient is admitted to the Extramural Program.
205	EXTRAMURAL HOME VISIT TO A PREVIOUSLY ADMITTED PATIENT	Refers to medically necessary visit to a patient previously admitted Extra-Mural Program at their personal residence (including special care home).
206	EXTRAMURAL EMERGENCY HOME VISIT	Refers to an emergent visit to a patient previously admitted Extra-Mural Program at their personal residence (including special care home). An emergency visit refers to a situation where the demands of the patient and/or the NP's interpretation of the condition require immediate response at the sacrifice of regular office hours or routine. Immediate response is the intended controlling feature. Immediate attendance because of personal choice or availability of the NP is not considered an emergency visit. **All claims for emergency-based visits must show the time of day the services were rendered (Indicate in Start Time field)**.
208	ADDITIONAL PATIENT, ADMITTED OR NOT, SEEN DURING A HOME VISIT	Refers to medically necessary visit to an additional patient seen during a home visit at same civic address.

847	PALLIATIVE CARE HOME VISIT	Refers to medically necessary visit to a patient previously admitted Extra-Mural Program at their personal residence (including special care home) who is receiving **palliative care**.
848	PALLIATIVE CARE EMERGENCY HOMEVISIT	Refers to an emergent visit to a patient previously admitted Extra-Mural Program at their personal residence (including special care home) who is receiving **palliative care**. An emergency visit refers to a situation where the demands of the patient and/or the NP's interpretation of the condition require immediate response at the sacrifice of regular office hours or routine. Immediate response is the intended controlling feature. Immediate attendance because of personal choice or availability of the NP is not considered an emergency visit. **All claims for emergency-based visits must show the time of daythe services were rendered (Indicate in Start Time field)**.
207	EXTRAMURAL MILEAGE (per Km)	Can be shadow billed when rendering a service at a patient's residence (including special care home). If the patient's residence is within a 5 km radius of the NP's office, no mileage can be claimed. If the patient's residence is outside a 5 km radius of the NP's office, then 1 unit per km can be claimed for mileage beyond the 5 km radius. Ex: If the total distance to the patient's home equals 15km then 10km can be shadow billed, however you must indicate the total km travelled (15) km in the diagnosis or comments field of the electronic claims submission.
209	VISIT (OTHER THAN HOME VISIT) WITH ADMISSION	Refers to a visit held at a location other than the home, including admission to the Extra-Mural Program.
210	COMMUNICATION INTIATED BY AN EXTRA-MURAL PROGRAM STAFF MEMBER	Refers to communication from an Extra-Mural Program staff member requiring a response from an NP. Communication includes by hardcopy, phone or other means of electronic communication i.e., fax, email, video-conference. One communication represents a contact for any length of time (ex. a 45-minute communication only counts as one).
195	VISIT TO AN NP's OFFICE BY AN EXTRA-MURAL PROGRAM STAFF MEMBER	Refers to a visit to an NP's office by an Extra-Mural Program staff member to discuss health matters in relation to one Extra-Mural Program patient.

2000	PRE-ADMISSION NURSING HOME COMPLETE	Refers to complete examination required **before** client can be admitted to Nursing Home to determine level of care required (Preadmission Form). **Note:** Not open to nursing homes as exam must be done prior to being admitted to the nursing home. Service may be billed from the office, home, special care home, or ER if Preadmission Form is completed.
2001	NURSING HOME VISIT	Refers to first patient seen during a visit to a designated nursing home. Location 2 and Site Code are required.
9	NURSING HOME VISIT, ADDITIONAL PATIENT	Refers to on-site visit to resident of a nursing home, other than the first resident. For NPs who work primarily in nursing homes this code would be used for visits to patients residing in the nursing home. Location 2 and Site Code are required.
8161	MEDICAL ASSISTANCE IN DYING (MAID) (per 15 minutes or part thereof)	Service code 8161 is only billable by the practitioner who is assessing for and performs MAID services. MAID includes all other procedures, consultations, visits, counseling and administration/attendance with the patient and communication between practitioners and/or other allied health professionals related to the MAID service only. The MAID eligibility criteria must be met along with the appropriate documentation, including the forms duly completed, signed, and maintained in the patient's file. Any services performed by another practitioner must be billed under the appropriate service codes relevant to the service being provided. Code requires start time, end time, and number of services per 15 minutes (reflecting total time).
8162	MAID TRAVEL (mileage, per KM)	Can be shadow billed when providing a service to a patient that meets the MAID criteria if rendered at the patient's resident (or special care home). If the patient's residence is within a 5 km radius of the NP's office, no mileage can be claimed. If the patient's residence is outside a 5 km radius of the NP's office, then 1 unit per km can be claimed for mileage beyond the 5 km radius. Ex: If the total distance to the patient's home equals 15km then 10km can be shadow billed, however you must indicate the total km travelled (15km) in the diagnosis or comments field of the electronic claim submission.

1893	ATTENDANCE FEE - VICTIMS OF ALLEGED SEXUAL ASSAULT	Refers to services provided to sexual assault victims. Includes examination and early attendance to include necessary examinations, medical attendance and patient counseling, as well as taking of specimens, completion of reports and forms and other medico-legal requirements and liaison with other parties. (Rape Kit must be used to use this code). Add a detention if service exceeds two (2) hours.
193	PATIENT COUNSELING (per 15 minutes or part thereof)	Refers to discussion with a patient on health matters dealing with the "family" unit, such as marriage counseling, contraceptive advice and sexually transmitted diseases. This code cannot be used in addition to a visit, or a consultation and detention cannot be applied. Code requires start time, end time, and number of services per 15 minutes (reflecting total time).
216	FAMILY COUNSELLING (per 15 minutes or part thereof)	Refers to discussion of a patient's health with family member(s) when necessary for a treatment decision or for arranging support services. The patient is not present. This service code applies when the **counseling** of a family member is necessary in order for the family to make a treatment or placement decision (ex: DNR, admission to nursing home) on the patient's behalf for patients with severe life-threatening conditions or major chronic health problems. Service is billed under the patient's Medicare number with the following information indicated in the diagnosis or comments field of the electronic claim submission: the patient's actual diagnosis, who the discussion was with (relationship to patient),and what was discussed (treatment, placement, etc.). Code requires start time, end time, and number of services per 15 minutes (reflecting total time). **Explanatory notes:** a) Only informing or discussing with family members a patient's condition, as opposed to formal **counseling**, even in cases of serious illness is considered to be included in patient care fees, and such exchanges cannot be billed to Medicare. However, if counseling of the family members themselves is required for their own mental or emotional wellbeing the services may be billed as Psychotherapy (code 20) under that family member's Medicare number. Except as provided under certain specific codes, the fees for attending children include any exchanges with accompanying persons whenever the interview, advice, etc. would take place with the patient alone were it not for their age. More particularly, family counseling fees do not apply to the parents unless they obtain true **counseling** in serious circumstances as outlined in the above definition.

211	CASE CONFERENCE DEALING WITH FAMILY VIOLENCE (per 15 minutes or part thereof)	Refers to case conference with allied health workers and teachers on behalf of the patient, where suspected family violence is an issue. Code requires start time, end time, and number of services per 15 minutes (reflecting total time).
8104	CASE CONFERENCE WITH COLLABORATING GP (per 15 minutes or part thereof)	Refers to case conference between collaborating practitioner and NP (inperson or by telephone) to review care and treatment plan/decision forcontinuing care in the collaborative model. Both parties bill this service. Must indicate Service Provider Number of GP in the “Referring Practitioner” field of the electronic claim submission. Code requires start time, end time, and number of services per 15 minutes (reflecting total time).
8105	PATIENT TRANSFER TO COLLABORATING GP (per 15 minutes or part thereof)	Refers to time spent with practitioners (in person or by telephone) to review care and treatment plan of a patient when the patient is transferred to the care of the collaborating physician. Both parties bill this service. Must indicate Service provider Number of GP in the “Referring Practitioner” field of the electronic claim submission. Code requires start time, end time, and number of services per 15 minutes (reflecting total time).

ADMINISTRATIVE CODES When indicated below "dummy patient" may be used in place of actual patient information. Use the Medicare # 111111126. The Name (Services, Admin), DOB (01/01/2005), and Sex (M) will automatically populate with Medicare #.		
8801	PATIENT-CENTERED CARE CONFERENCE (per 15 minutes or part thereof)	*Refers to meetings between interdisciplinary team to discuss one or multiple patients. Meetings may be face-to-face or by audio/video conference.* ***Note:*** *This is separate from the collaborating codes 8104 and 8105.* *This code does not require a valid Medicare and is billed in 15-minute increments using the Medicare # 111111126.*
8802	CLINICAL TEACHING (per 15 minutes or part thereof)	This code refers to time spent teaching students of a health-related discipline concerning a specific patient in a primary care setting. Patients may be present, or teaching may follow the clinical patient service. This code is meant to reflect the EXTRA time it takes to do this teaching in addition to the normal clinical care. *This code may be used with specific patient information including a valid Medicare number and a diagnosis OR by using the Medicare # 111111126 and is billed in 15-minute increments.* Example: **If teaching is done during the encounter with the patient or after several patients are seen in a primary care setting:** • Bill the normal clinical services provided during the encounter with the patient in a primary care setting (ex: visit). • Bill Code 8802 in addition **ONLY** for the additional time spent over and above what it would normally take to render the service. • Additional time spent must be at least 15 minutes and billed in 15 minutes increments. Two options for billing 8802: • Code 8802 can be billed against each individual patient if teaching follows the clinical service or occurs during the service and takes more than 15 minutes above and beyond the clinical service to the patient. (ex: Patient X – code 1 + Code 8802 x 2; Patient Y – Code 1 + Code 8802 x 1). **OR** • The extra time spent teaching throughout the whole day can be added together and billed once as Code 8802 using the "dummy patient" 111111126 even if the teaching did not last 15 minutes per patient. (ex: Patient X – Code 1; Patient Y – Code 1; Dummy patient – Code 8802 x 3).

8893	INDIRECT PATIENTCARE (per 15 minutes or part thereof)	This code is used for any solo activities related to patients when patients are not present. This code does not require a valid Medicare number and is billed in 15 minutes increments: Use Medicare#111111126. Total time is required to be identified in the Count. Examples: • Reviewing charts, laboratory results or patient history. • Telephone contact with patient. • Updating patient charts, dictation, or literature review pertaining to treatment or diagnosis of a patient. Contacting a pharmacy regarding a prescription renewal.
8805	COMMUNICATION WITH ALLIED HEALTH PROFESSIONAL RE. PATIENT (per 15 minutes or part thereof)	This code can be billed when a nurse practitioner initiates or receives written, verbal, or electronic communication (i.e., fax, email) with an allied health professional regarding a specific patient. This communication must relate to the management of a specific patient and represent a reasonable amount of time that is spent communicating about a specific patient. This excludes routine communication with team members who are part of the usual care team for that patient at that time (as this represents usual patient care). This code requires specific patient information including a **valid Medicare number**, start/end time, count per 15 minutes, and a diagnosis. Examples: Contact with Adult Protection Services, another nurse practitioner, practitioner or specialist, the Department of Social Development, an allied health professional working outside the facility, nursing home staff or special care home staff (this is not an exhaustive list).

8886	INDIVIDUAL OR GROUP TEACHING (per 15 minutes or part thereof)	This code refers to teaching any type of learners on an individual or group basis. This code differs from Code 8802 (Clinical Teaching) as it is not to be used for teaching during the encounter with the patient, patient-centered teaching, or "hands-on" teaching. This code does not require a valid Medicare number: Medicare #111111126 is used and is billed for 15-minute increments (start time, end time, and count per 15 minutes is required). Examples: Presentations at grand rounds, journal club, case review sessions. There may be other nurse practitioners, medical or nurse practitioners' students or other allied professionals present at these sessions. • Educational sessions offered by nurse practitioners to members of the community and/or to a group of patients (e.g., regarding chronic diseases management, Crohn's disease, cancer). • Presentations to nurse practitioner students/residents on a variety of topics. • Classroom teaching for NP Program courses. The preparation time for these teaching sessions can also be shadow billed using this code.
8887	ADMINISTRATIVE DUTIES (per 15 minutes or part thereof)	This code is used for administrative duties such as scheduling program development and day to day activities related to managing an office. This code does not require a valid Medicare number: Medicare #111111126 is used and is billed for 15-minute increments (start time, end time, and count per 15 minutes is required). Examples: For non-clinical administrative work, such as reviewing NP's own mail and paperwork (e.g., filling out forms), contact with IT services, scheduling of shifts, vacations, and rotations with colleagues.
8888	RESEARCH (per 15 minutes or part thereof)	The New Brunswick Regulation 84-20 (Schedule 2, f.1 and f.2) under the *Medical Services Payments Act.* indicates that Medicare does not pay for applied research and services that are provided in conjunction with or in relation to applied research; however, this code is to be used when the nurse practitioner is required to spend time in the design and participation of research projects **as directed by the employer.** This code does not require a valid Medicare number: Medicare #111111126 is used and is billed for 15-minute increments (start time, end time, and count per 15 minutes is required). The diagnosis or comments field of the electronic claim submission must be used to indicate the nature of the research.

8890	PROFESSIONAL DEVELOPMENT (per 15 minutes or part thereof)	This code is used for activities that develop the nurse practitioner's professional skills and knowledge related to the medical field. This code does not require a valid Medicare number: Medicare #111111126 is used and is billed for 15-minute increments (start time, end time, and count per 15 minutes is required). This may include **attendance** at grand rounds, case presentations, journal clubs, or events that are organized within the facility where the NP is employed, organized by the employer or departments with the intention of developing and maintaining knowledge or skills in a professional area. Examples of such activities, but not limited to are: • Continuing Professional Development activities. • Activities designed to maintain certification required by the employer such as CPR, ACLS, etc. • Nurse Practitioners who are on leave when they travel to a conference supported by the employer and include the travel time and the conference time. Any activities designed to monitor the quality of care/service delivery for a department/facility.
8891	MEETINGS AND COMMITTEES (per 15 minutes or part thereof)	This code is used when attending or preparing for a meeting or committee, as directed by the employer, but does not apply to travel time related to committees or meetings. This code does not require a valid Medicare number: Medicare #111111126 is used and is billed for 15-minute increments (start time, end time, and count per 15 minutes is required). Examples: Department/program/facility meetings or other related committee meetings that the nurse practitioners attend as part of their usual employment.
8892	TRAVEL (per 15 minutes or part thereof)	This code is used when travelling during working hours in order to provide services to patients or attend a required meeting as directed by the employer. This code does not require a valid Medicare number: Medicare #111111126 is used and is billed for 15-minute increments (start time, end time, and count per 15 minutes is required). Examples: Travelling to conduct or participate in a clinic or attend a required meeting. This code does not apply for travel between home and work.

8804	UNPLANNED DOWNTIME (per 15 minutes or part thereof)	This code is used when the nurse practitioner is unable to perform scheduled activities due to a patient not presenting themselves for an appointment or other unforeseen circumstances (e.g., equipment malfunction, storm, etc.) and the nurse practitioner is unable to fill the down time with another activity or service (i.e., paperwork). This code requires specific patient information including a valid Medicare number, a diagnosis, the start/end time, and count per 15 minutes. If the diagnosis is unavailable, indicate "Patient No-Show". Medicare #111111126 may be used if the unplanned downtime is unrelated to a specific patient. If the Unplanned Down Time is a result of a patient not presenting themselves for an appointment, this code would be used in addition to Code 8803 (Patient No-Show).

LEGEND

All procedures listed have been assigned a letter code (A, B, C or D) under the heading "List" to identify how they are processed by the Medicare System. The meaning of these letters is as follows:

"A" & "B" - List A and B procedures may be shadow billed in addition to a visit, consultation, or another List A or B procedure (service with lower fee billed at 75%) on the same day. List B procedures can also be shadow billed in addition to List D procedures (at 75%).

NOTE: Rule 13 - When the performance of a List A or List B procedure is the sole purpose of attendance in an emergency department, the procedure alone should be shadow billed. Also, if any visit or consultation has been submitted during the preceding 30 days, no further visit may be claimed on the day of the List A or B procedure.

"C" - List C procedures **cannot** be shadow billed in addition to same-day visits, consultations, or procedures. They are considered "stand alone" procedures.

"D" - List D identifies surgical procedures, which carry 2-days preoperative restrictions and 14 days postoperative restrictions.Consultations and List B procedures can be billed on the same day but no visits can be billed 30-day prior to the List D procedure or 30 days after.

REPRODUCTIVE SYSTEM		**List**		
1723	DIAPHRAGM FITTING	**A**	**8705**	INSERTION OF PESSARY
2852	INTRA UTERINE CONTRACEPTIVE DEVICE (IUCD) REMOVAL	**B**	**1472**	INTRA UTERINE CONTRACEPTIVE DEVICE (IUCD) INSERTION
	TRAY FEE FOR PAP TESTS		**9148**	CONTRACEPTIVE IMPLANTATION

1999	***Exception**: Cannot be used alone. Must be used with another code.	**C**	**9149**	CONTRACEPTIVE REMOVAL
INTEGUMENTARY SYSTEM		**List**		
2227	SUTURE – FIRST 5cm - FACE	**D**	**2487**	SUTURE > 5cm – FACE - Not exceeding 10 cm.
99	SUTURE - FIRST 5cm. (other areas of body – excluding face)	**D**	**2488**	SUTURE > 5cm. (other areas of body – excluding face) Not exceeding 10 cm.
Refers to areas other than the face. Face is defined for this purpose as the area situated above the mandibular angle, in front of the ears, and up to (but not including) the scalp. This includes follow-up for removal of sutures.				
355	INCISION, ABSCESS SUBCUTANEOUS, LOCAL	**C**	**362**	INCISION HAEMATOMA LOCAL
Skin Lesions – Papilloma, naevi, moles, sebaceous cysts and other non-malignant lesions or tumors of the skin and/or subcutaneous tissue.				
369	BIOPSY BY EXCISION / TOTAL EXCISION of MINOR SKIN LESION (Only if suspected cancerous – max 3 per day)	**C**	**2089**	REMOVAL of MINOR SKIN LESION by NON-SURGICAL METHODS - electrocautery,curettage, cryotherapy

Since September 15, 1994, the removal of skin lesions is not an insured service except when cancer is suspected or more specifically:

a) Medicare Covers:

1. The removal of lesions recognized as presenting a significant risk of producing malignant lesions. Examples are neurofibromatosis (Von Recklinghausen's disease), keratosis in chronic dialysis patients and actinic keratosis.

2. The removal of non-malignant skin lesions which, because of their location or size, result in significant functional problems, recurrent frequent bleeding or recurring infections that do not respond to medical management.

b) Medicare does not cover:

1. The removal of benign skin lesions which do not carry a significant risk of becoming malignant nor causing functional problems (for example: common warts, skin tags, papillomata, sebaceous cysts, seborrheic keratosis).

Chronic irritation, by itself, is not an example of medical necessity for Medicare coverage purposes. Prior submissions for approval may be made to Medicare in special or unusual situations.

367	REMOVAL FOREIGN BODY LOCAL	**B**	
837	DIAGNOSTIC PUNCH SKIN BIOPSY	**A**	
EYE		**List**	
1620	CORNEA REMOVAL FOREIGN BODY MAGNET	**C**	
EAR		**List**	
1669	OTOSCOPY REMOVAL of FOREIGN BODY - EXTERNAL EAR	**C**	Note: Removal of Cerumen is included in office visit

DIAGNOSTIC & THERAPEUTIC TESTS		**List**		
2477	INSERT INTRAVEN CATHETER PERIPHERAL	**A**	**1901**	ASPIRATION BURSA
1914	BCG VACCINATION	**B**	**1948**	INJECTION OF MEDICATION (bursa, ganglion, joint, including preliminary aspiration, if necessary, not intramuscular injection).
2050	VENIPUNCTURE (not open to office locations or billable with a visit on same day)	**C**		
MUSCULOSKELETAL SYSTEM				
Upper Extremities		**List**		

507	FINGER, THUMB DISLOCATION CLOSED RED.	**D**		
2139	SPLINT, ELBOW.	**A**	**2140**	SPLINTS, SHOULDER.
516	CASTS, EXTREMITIES, UPPER.	**A**	**2138**	SPLINTS, UPPER LIMB, HAND, AND WRIST.
Lower Extremities		**List**		
2142	SPLINTS, BELOW KNEE.	**A**	**2141**	SPLINTS, LOWER LIMB.
517	CASTS, EXTREMITIES, LOWER.	**A**		

IMMUNIZATIONS

Only those immunizations covered by Medicare require Shadow Billing. For immunizations **not** covered by Medicare, there is no need to Shadow Bill.

The attached list of vaccines has been provided by Public Health Services. Vaccine Lot Number is required for all immunizations billed. Only active lots can be submitted.

Submit a claim for each immunization given.

Claims for the provincially funded immunizations require that these billings:

1- Meet the criteria for vaccines supplied by the Public Health Services; and
2- The product name and vaccine lot number must be indicated in the appropriate field designatedfor this purpose on the electronic claim submission. Lot number must be active on date of service, not expired.

Note: When the location is invalid for the Service Code used, submitted claims get pulled out for manualreview by Medicare, and may be cancelled.

Immunizations **with a visit** are open to locations 1, 4 and 9.
Immunizations **without a visit** are open to locations 1, 2, 3, 4 and 7.

This section also contains information regarding **Eligibility Criteria for Publicly Funded Vaccines/Biologics** and Hepatitis guidelines.

Follow the links below for further information:

http://www2.gnb.ca/content/gnb/en/departments/ocmoh/for_healthprofessionals/cdc.html

http://www2.gnb.ca/content/gnb/en/departments/ocmoh/cdc.html

http://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/en/CDC/Immunization/RoutineImmunizationSchedule.pdf

http://www.phac-aspc.gc.ca/im/is-vc-eng.php

Service Code payable with visit (8 units)	Service Code – solo visit (Not payable with office visit) (13 units) List C Procedure	Description	Product Name
8630	8660	Diphtheria, tetanus, acellular pertussis, inactivated polio	• QUADRACEL
8631	8661	Diphtheria, tetanus, acellular pertussis, inactivated polio, *Haemophilus influenzae* type b	• PEDIACEL
8632	8662	HEPATITIS A	• HAVRIX 720 JUNIOR • HAVRIX 1440 • VAQTA PEDIATRIC/ADOLESCENT • VAQTA ADULT
8633	8663	HEPATITIS A & B	• TWINRIX JUNIOR • TWINRIX
8634	8664	HEPATITIS B	• RECOMBIVAX HB PEDIATRIC • RECOMBIVAX HB ADULT • RECOMBIVAX HBDIALYSIS • ENGERIX-B PEDIATRIC • ENGERIX-B ADULT
8635	8665	HAEMOPHILUS INFLUENZAE TYPE B	• ACT-HIB • HIBERIX
8636	8666	HUMAN PAPILLOMAVIRUS	• GARDASIL • GARDASIL 9

Service Code payable with visit (8 units)	Service Code – solo visit (Not payable with office visit) (13 units) List C Procedure	Description	Product Name
8637	8667	INFLUENZA	• AGRIFLU • FLUVIRAL • VAXIGRIP • FLUZONE QUADRIVALENT • FLULAVAL TETRA
8638	8668	INACTIVATED POLIO	• IMOVAX POLIO
8639	8669	MEASLES, MUMPS RUBELLA	• M-M-R II • PRIORIX
8640	8670	MEASLES, MUMPS, RUBELLA, VARICELLA	• PRIORIX-TETRA • PROQUAD
8641	8671	MENINGOCOCCAL CONJUGATE MONOVALENT	• NEIS VAC-C • MENJUGATE
8642	8672	MENINGOCOCCAL CONJUGATE QUADRIVALENT	• MENVEO • NIMENRIX
8643	8673	MENINGOCOCCAL POLYSACCHARIDE	• MENOMUNE
8644	8674	PNEUMOCOCCAL CONJUGATE 13-VALENT	• PREVNAR 13
8645	8675	PNEUMOCOCCAL POLYSACCHARIDE 23-VALENT	• PNEUMOVAX 23
8646	8676	RABIES	• IMOVAX RABIES
8647	8677	TETANUS, DIPHTHERIA (REDUCED)	• TD ADSORBED

Service Code payable with visit (8 units)	Service Code – solo visit (Not payable with office visit) (13 units) List C Procedure	Description	Product Name
8648	8678	TETANUS, DIPHTHERIA (REDUCED), ACELLULAR PERTUSSIS (REDUCED)	• ADACEL • BOOSTRIX
8649	8679	TETANUS, DIPHTHERIA (REDUCED) ACELLULAR PERTUSSIS (REDUCED), INACTIVATED POLIO	• ADACEL-POLIO • BOOSTRIX-POLIO
8650	8680	VARICELLA	• VARILRIX • VARIVAX III
8651	8681	MULTICOMPONENT MENINGOCOCCAL B VACCINE	• BEXSERO
8652	8682	LIVE ATTENUATED ROTAVIRUS VACCINE (ORAL SUSPENSION 1.5 ML)	• ROTARIX (effective June 1, 2017) • ROTA TEQ

REMINDER:

Claims for the provincially funded immunizations require that these billings:

1- Meet the criteria for vaccines supplied by the Public Health Services; and
2- The product name and vaccine lot number must be indicated in the appropriate field designated for this purpose on the electronic claim submission. Lot number must be active on the date of service, not expired.

FREQUENTLY ASKED QUESTIONS

Cancelled Claims

What do I do when a claim has been cancelled by Medicare?

If a claim appears on the “Claims to Correct” section of the NP’s Reconciliation Statement, it has been cancelled and will not appear in the shadow billing statistics.

Review the message below the cancelled claim to determine if the claim needs to be resubmitted with corrected information. If a claim has been cancelled because it is against an Assessment Rule or is a duplicate claim, it should not be resubmitted. Otherwise, the claim should be submitted as a new electronic claim with the corrected information as indicated in the message.

Location Code

What location code is appropriate to use?

The location code refers to the location the service was rendered. With the exception of NPs who work in the ER (location 3), “Location 1 – Office” will be used for the NPs primary location.

Location 1 – Office; Location 2 – Nursing Home; Location 3 – Emergency Room; Location 4 – Home; Location 9 – Special Care Home; Location 10 – Cardiac Wellness; Location 11 – Sexual health Clinic.

If a nurse practitioner works primarily in one nursing home but also renders services at another Location 2 would be used for the secondary nursing home along with the appropriate site code.

Site Codes

When do I use site codes and service codes?

Site codes are not required for the majority of nurse practitioner codes as the services are rendered in the office location. Site codes are required for services rendered in the Emergency Room, designated walk-in clinics, and nursing homes (when they are not the NPs primarylocation). Site codes are not required for Community Health Centres.

Group Sessions

Is there a code for group/health promotion sessions?

Yes, Code 8886 – “Individual or Group Teaching” may apply.

New Patients

Is there a code for a new patient or for opening a new file on a patient?

No, this is included in visit, consult, or complete exam code. Medicare can track new patients based on patient history. A complete exam cannot be routinely claimed for doing a complete assessment of a new patient and/or comprehensive initial documentation unless it meets the criteria outlined under Code 7 – "Complete Exam". If the visit takes more than 30 minutes or the complete exam takes more than 1 hour, Code 200 – "Detention" may apply.

Advocacy

Is there a code to use when a nurse practitioner advocates on behalf of a patient with mental illness?

No, this is considered part of a visit/consult code. If the patient is present and advocacy takes more than 30 minutes, Code 200 – "Detention" may be used.

Special Tests – i.e., Ankle Brachial Index, Spirometry Testing

Is there a code for special tests such as ankle brachial index or spirometry testing?

No, Ankle Brachial Index and Spirometry testing are part of a visit, complete exam, or consultation code. There is not a separate code for tests unless otherwise specified.

Immunizations

Are all immunizations recorded in shadow billing?

No, only those immunizations covered by Medicare require Shadow Billing. As an example, Zostavax is not covered by Medicare, so it should not be shadow billed. Immunizations for travel purposes and immunizations outside the Public Health regulations should not be shadow billed.

Does the nurse practitioner shadow bill for an immunization, even if she does not actually give it?

Yes, this is a requirement of Public Health for publicly funded vaccines. NPs should be advised that ordering immunizations alone can't be shadow billed; however, the administering of immunization and/or the on-site supervision of registered nurses who administers the immunization would qualify as services that should be shadow billed. The date of service should be the date of the administration and not of the ordering of immunizations.

Pap Tray Fees

When a Pelvic exam is done, why bill for a Pap tray fee for a specific test (Pap test) rather than a procedure?

This is an exception and is one way of showing women's health interventions.
NB: Code 1999 *Tray Fee for office Pap Tests* is an add-on code to either an office visit, a consultation fee or minor procedures/surgery (i.e. IUCD insertion, removal of cervical polyp, etc.) **when a pap smear is actually performed**. It is not intended as a tray fee for any other procedure when a pap smear is not performed (i.e., IUCD insertion alone).

Provision of information to care providers

Is it possible to capture information sharing regarding patients? Example: A NP cares for a patient in a Special Care home (SCH). The patient was discharged from the hospital and the SCH worker requests the NP to call in regard to the patient's care?

Yes, Code 8805 – "Communication with Allied Health Professionals" will advise Medicare that information is being shared with another health professional regarding a specific patient.

Manual Forms

Are manual forms available to resubmit codes not accepted in Purkinje?

No, manual forms are not an option. Users should contact the FacilicorpNB representative in their region with questions regarding resubmission or any other Purkinje related questions/concerns.

Purkinje and Medicare Shadow Billing databases

Is all shadow billing information from Purkinje crossing to the Medicare shadow billing database?

These data were reviewed with nurse practitioners who had questions. No errors were found; therefore, it appears that Purkinje information is being captured accurately.

SERVICE PROVIDER NUMBER

What is a Service Provider Number?

A newly employed NP must complete and submit an “Application for Nurse Registration” to Medicare. The Medicare Service Provider Registrar will issue a letter of confirmation, along with Medicare Service Provider Number for the purpose of submitting Shadow Billing Claims. This process generally takes 3-5 weeks. The Service Provider Number is also the NP’s Medicare Account number.

Medicare offers training to NPs on the submission of shadow billing claims as well as the use of Medicare Claims Entry (MCE) billing system. Submission of claims through other independent providers is not part of the training provided. Once an NP has received confirmation of registration from the Service Provider Registrar and has received a Medicare Service Provider Number, he/she should contact a Medicare Practitioner Liaison Officer at (506) 457-6450 to arrange training. See additional information under “*What is a prescriber number?”*

Prescriber Number

What is a prescriber number?

As of May 3rd, 2016, the government of New Brunswick no longer issues a prescriber number. Instead of a prescriber number, nurse practitioners will be identified in the system, by their NANB registration number. Therefore, NPs are to include their registration number from NANB when filling out prescriptions.

Note: The Prescriber Number is different from the Service Provider Number.

CONTACTS

Practitioner Liaison Officer

Medicare.Training.Formation@gnb.ca

Practitioner Enquiries

(506) 444-5876 (Bilingual)(506) 457-7572 (English)
(506) 444-5860 (English)

Email: PELS.DRPL@gnb.ca

FAX (506) 453-5332

Provincial Health Application Services User Support

(506) 453-8274
#1 for Accounts
#4 for User Support

Electronic Communications for Physicians (ECP) / Medicare Claims Entry (MCE):

https://hps.gnb.ca

Medicare website Quick Links:

http://www.gnb.ca

- Medicare - Health Professionals
- Nurse Practitioner Medicare Registration Form
- Medicare Payments, Account and Delegate Authorization Forms
- Practitioner Enquiries Form