



Mastering BC Medical Billing: A Comprehensive Webinar on Common Questions and Solutions

Practical insights for physicians and clinics optimizing billing practices in British Columbia.

March 11, 2026



Today's Agenda

01

LFP Billing Questions

Out-of-province patients, time codes, and more.

03

Other Billing Scenarios

FFS and NTP

02

Rejection Questions

Common fixes for OOP, LFP issues and general fixes

04

Wrap-up & Q&A

Interactive session with your questions





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LFP vs. FFS vs. NTP



The Different Payment Models in BC

Fee-for-Service (FFS)

Bill only for services performed: office visits, procedures, etc.

LFP

Bill for visits, patient care time, panel management, and admin tasks.

NTP / PCN

Same as LFP but uses \$0 "shadow billing" codes.



What is the LFP Payment Model?

The Longitudinal Family Physician Payment Model: A blended payment system replacing traditional fee-for-service.

Alternative to Fee-for-Service

Comprehensive compensation that pays physicians for direct care, panel management, and admin tasks

Stabilizing Family Practice

Designed to retain physicians and strengthen family practice in BC

Focus on Longitudinal Care

Encourages relationship-based, continuous care for patients

Improved Outcomes & Reduced Burden

Predictable funding helps improve patient outcomes and reduce administrative workload

Three Key Features of LFP Billing



Billing for Time

Covers direct patient care and indirect care

Max 14 hours/day, 120 hours/14 days

Non-overlapping start/end times required



Patient Interactions

Higher-value codes for complex procedures; lower-value for minor ones.

Max 50 interaction codes/day

Temporary codes for certain immunizations



Panel Payments

Quarterly payments for empanelled patients

Minimum 250 patients required

Uses patient numbers and **Adjusted Clinical Group (ACG)** system to measure complexity

LFP Model Success

4,300+

Physicians
Enrolled

Since February 2023 launch

+1,000

New Doctors
Added

Longitudinal doctors to BC

250K

Patients
Connected

Now have family doctors

\$385K

In Annual Earnings



LFP Billing Questions



What are time codes?

Units are billed in **15-minute increments**, always rounded down. If you spend 10 min in the morning + 20 min in the afternoon = 30 min total → bill **98010** × 2. At 29 minutes, only **one unit** is billable.

98010

Direct Patient Care — face-to-face time with the patient.

98011

Indirect Patient Care — chart reviews, care coordination.

98012

Clinical Administrative Time — physician-level admin supporting patient care.

98119

Travel Time — only when the visit is home-visit eligible.

📄 No premium for working extra hours. Maximum: **14 hours/day** or **120 hours in a 14-day period**.



How do I bill multiple claims of the same LFP time code?



01

Enter start/end times

Each claim must have specific time periods

02

Ensure no overlap

Times between claims cannot overlap

03

Use submission code "D"

Prevents rejection for duplicate claims

Do doctors get paid a premium if they work a certain number of hours?

Under the LFP payment model, there is no premium pay specifically tied to working a certain number of hours. Physicians are compensated based on their panel size and clinical activities, not the duration of their workdays.

Maximum Work Hour Limits

LFP physicians must strictly adhere to a maximum of **14 hours per day** and **120 hours within any 14-day period**. These limits are essential for managing physician workload, preventing burnout, and ensuring the delivery of high-quality patient care.

How do I bill out-of-province patients under the LFP model?

Cannot Use LFP Model

Services for other provinces/territories excluded from LFP billing

Use Fee-for-Service Instead

Bill using patient's out-of-province PHN

- 00100 - Office visit
- 13437 - Telehealth visit

Special Cases

Quebec patients & international visitors: Bill patient directly

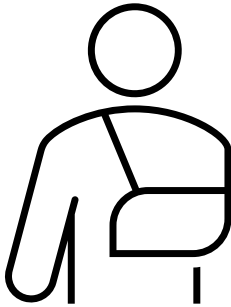
Record Keeping

Record start & end times on all FFS claims.

Deduct non-LFP service time from total units billed under 98010.

How do I bill 98011 if a doctor is behind on charting notes?

Fee code **98011** is the LFP Indirect Patient Care Time Code for “patient-specific services provided when the patient is not present.



Fee Code	What it covers	Billing Rate	Requirements	MOA Billing Tips
98011	<ul style="list-style-type: none">• Reviewing labs• Coordinating care• Charting notes	\$32.50 per 15-minute unit	<ul style="list-style-type: none">• Bill within 90 days• 14-hour daily maximum• Document start and end times	<ul style="list-style-type: none">• Create a fake patient appointment• MOA bills accordingly

How do I bill for multiple 98022 Minor Procedure or Diagnostic Tests in the same visit?

1

Maximum 2 Units Per Day

Must be different procedures/tests

2

Example: Valid Billing

1 injection + 1 pregnancy test =
98022 × 2 units

Example: Invalid Billing

3 allergy injections = 1 unit only

3

How to bill

Enter 98022, set units to 2, and include appropriate ICD-9 codes.

Can I bill LFP fee code 98022 with a virtual visit?

Fee code 98022 is billable along with the following in-person interaction codes:

In-person interaction codes

98031, 98020, & 98021

Note: Combining an in-person and virtual visit code on the same claim is a frequent mistake and is not billable together.

What is 98012 – Clinical Administration?

Code 98012 covers activities that don't involve a specific patient but require physician expertise to manage your panel and practice effectively.

1

Proactive Panel Management

Reviewing patient populations for cancer screenings, immunizations, or chronic disease care.

2

Quality & EMR Management

Medical audits, peer reviews, or updating records where clinical judgment is essential.

3

Governance Roles

Duties such as Medical Director or Clinic Privacy Officer responsibilities.

This is a **representative**, not exhaustive, list. Use your professional judgment to bill for tasks that necessitate your expertise to keep the practice running effectively.

What does NOT qualify

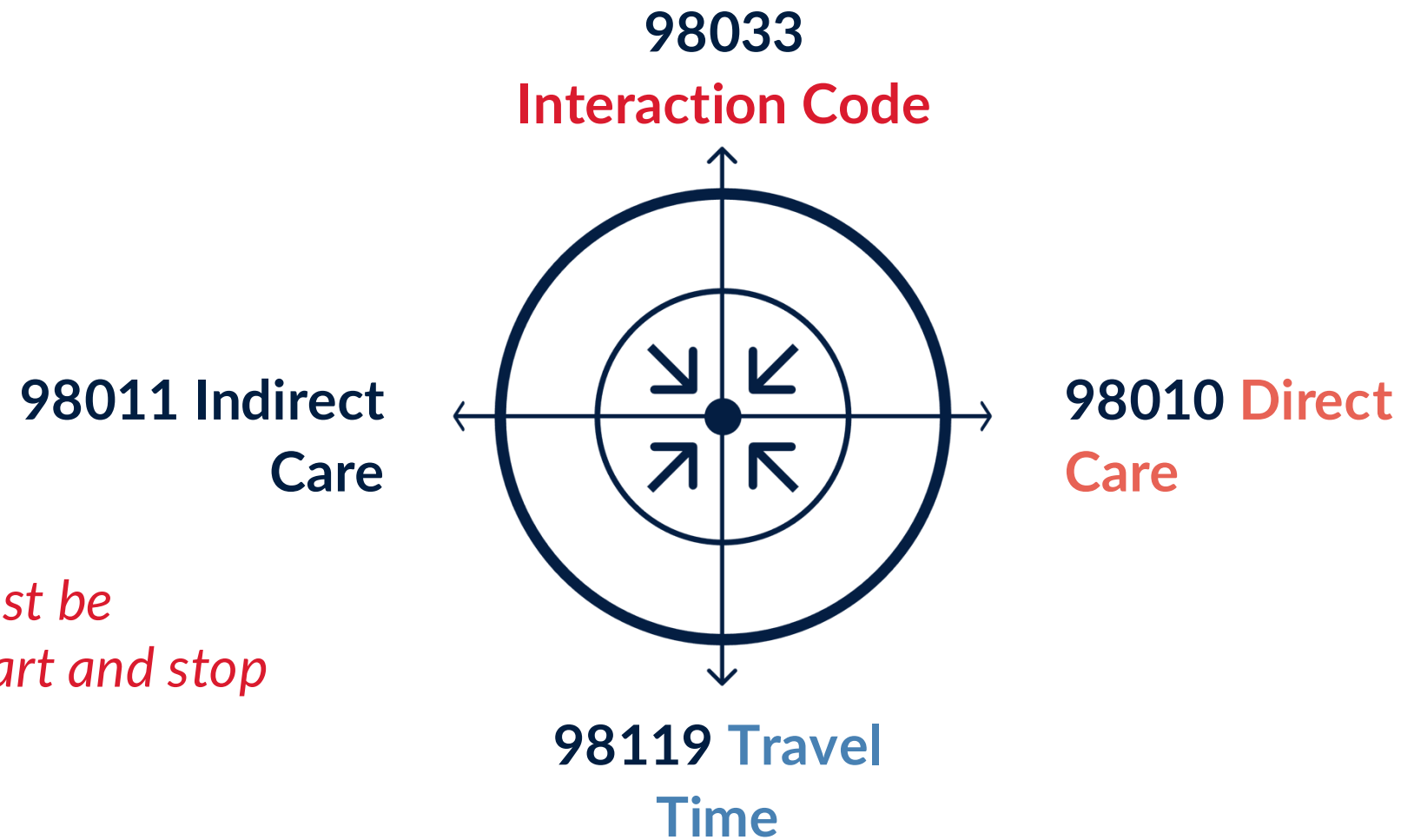
- General inbox clearing
- Staff administrative work
- ICBC report writing
- Routine lab review with no action required

Guideline: 98012 time should typically not exceed approximately 10% annually relative to the physician's total direct and indirect clinical time. Excessive or disproportionate use may trigger review.

Reviewing normal labs with no action is considered routine panel management and is not billable under 98012.

Which codes do I bill for home visits?

Under LFP, home visits use the standard time-based framework plus travel when eligible. Every home visit requires **four components**.



Each component must be documented with start and stop times.

98033 – The Interaction Code

Every home visit begins with **98033** – the anchor code that captures the patient encounter outside the clinic.

One per patient per date

Bill 98033 once per patient, per date of service.

Medically necessary

The visit must reflect a medically necessary encounter.

Documentation required

Chart must clearly state "**Home Visit**" and the location of the visit.

98010 & 98011 – Direct & Indirect Care

98010 – Direct Patient Care

Bill for all face-to-face time including:

- Assessment & examination
- Medical decision-making
- Treatment & counselling

Time is **cumulative**. Document start and stop times.

98011 – Indirect Care

Bill after the visit if additional medically necessary indirect care is required:

- Care coordination
- Urgent documentation tied to clinical decisions
- Specialist communication
- Medication adjustments after new information

❏ Routine charting in regular workflow is **not** separately billable.

98119 – Travel Time

Bill 98119 for travel outside your clinic when eligibility criteria are met. **Start and stop times are required.**

→ **Clinic to patient's home**

Travel from your clinic to attend a home visit.

→ **Between home visits**

Travel between multiple patient homes during active clinical service.

→ **Hospital/clinic to patient's home**

Travel from a hospital or clinic to a patient's home.

 Travel is billable **only during the physician's working day** and must not be considered regular commuting.

Clinical Example – Putting It All Together

Scenario: Physician visits an 84-year-old frail patient at home for worsening CHF.

35 min

Face-to-face assessment and management

20 min

Total travel time (to and from patient's home)

15 min

Urgent cardiology coordination and medication adjustment after visit

Code	Units	Description
98033	1	Interaction code – home visit
98010	2	30 min direct care (rounded down)
98119	1	15 min travel time
98011	1	15 min indirect care post-visit

How do I bill WorkSafeBC claims under the LFP model?

Cannot be claimed under LFP

WCB services **must** be billed using Fee-for-Service billing

Form 8/11 Required

Submit within 3 days via Teleplan, including:

Claim number, injury date, nature of injury, body parts code and diagnosis code.

Use correct fee codes

19937 (initial report) or 19940 (progress report)

Note: Deduct non-LFP service time from total units billed under 98010

Record start and end times on all FFS claims

Can an LFP interaction be billed on the same day that a WorkSafeBC service is provided?

Here's how to bill both claims:

1 Bill WCB service using FFS code

2 Use different ICD-9 codes

3 Record start and end times

4 Bill an LFP interaction code for unrelated condition

5 No LFP time codes for WCB portion

What are the ICBC billing changes? (Effective Feb 23, 2026)

Most clinical services related to motor vehicle accidents are **no longer excluded** from the LFP model.

✓ Now IN – LFP Billable

- Office and virtual visits (routine follow-ups, initial assessments)
- Counselling
- Eligible minor procedures

Use standard LFP interaction codes: **98031** (in-person) or **98032** (virtual) alongside clinical time codes.

✗ Still OUT – Direct ICBC Invoice

Physician Reports remain **outside** the LFP model. Invoice ICBC directly via Teleplan for:

- **A94564** – Standard Medical Report
- **A94565** – Extended Medical Report
- **A94566** – Reassessment Report

📄 **Golden Rule:** Never include report-writing time under 98010 Direct Patient Care. Clinical care = LFP. Paperwork = ICBC Direct.

ICBC + Unrelated Condition in the Same Visit

Scenario: Patient attends post-MVC but also needs diabetes follow-up. Under LFP, this is one visit, not two billings.



Document
Both

Bill One Code

Submit Total
Time

❑ **Key Rule:** One visit → one LFP submission. If an ICBC physician report is required, invoice it **separately to ICBC**. Never include report-writing time under 98010.

Billing a Drivers Medical

Billing Rules

- Fee code: **96220** (\$75 subsidized)
- Enter the **7-digit driver's license number** in the Teleplan comment field – #1 reason for rejection if missing
- Submit within **45 days** of the request

If Other Medical Issues Also Addressed

- Bill **96220** for the form
- Bill the **LFP interaction code** separately for clinical assessment
- Include start & end times on LFP claim
- **Do NOT** include form-completion time in LFP time calculation



When and why should I add multiple ICD-9 codes to a claim for an in-person or Telehealth interaction?



Why Add Multiple ICD-9 Codes?

Multiple issues discussed in the visit

- Higher patient complexity score
- Increased Panel Payment
- Better compensation for complex cases

Requirements

- Maximum 3 codes per interaction
- Must document all issues discussed

Can a locum register under the LFP model?

Yes, Locums can register for the LFP payment model. A precise workflow ensures proper payment processing and avoids rejections.

01

Submit 98005 Enrollment

Initiate registration using the 98005 enrollment code.

02

Use Host Facility Number

Always utilize the correct host facility number for your claims.

03

Confirm Enrollment Approval

Verify full enrollment processing **before** submitting any billings.

 **Avoid:** Billing before approval is a common error, resulting in immediate claim rejections.

Pro-Tip: For all Locum time code claims, enter the host physician's MSP number in the 'referred by' field.

The 70% Panel Rule – Effective April 1, 2026

LFP physicians must ensure at least 70% of LFP services are provided to panel patients. Non-panel services cannot exceed ~30% of total LFP billings.

Important Exclusions (Do NOT Count Toward 30%)

- **Colleague's Patients:** Patients registered to another FP/NP within your same LFP clinic.
- **Maternity & Newborn Care:** Clinic-based pregnancy, newborn care, and complex contraception services.
- **Home-Bound Patients:** Care provided in a patient's private residence (non-facility).

General Billing Questions



Attaching a Patient – Code 98990

01

Confirm eligibility

Patient intends to receive ongoing, comprehensive primary care from this physician.

02

Document in chart

Confirm physician acceptance and that the patient understands this is their most responsible provider.

03

Submit 98990

Submit via MSP/Teleplan with physician billing number and patient PHN. This is a **one-time submission** – not billed per visit.

Billing for New to Practice (NTP) Physicians

No, New to Practice physicians cannot bill using LFP or FFS codes.

How NTP Physicians Are Paid

NTP doctors and Nurse Practitioners are paid a **salary** and bill using **\$0 shadow billing codes** for encounters and clinical shift reports.

Clinical shift reporting tracks hours worked — but physicians are **not paid per hour**.

On-Call Example

If an NTP doctor takes a call from a patient not attached to them while on call, they **can bill an encounter code** for that interaction.

However, there is **no additional pay** for time spent or for the encounter itself — shadow billing is \$0.

Multiple Services & Procedures (Fee-for-Service)

When a visit becomes more than just a visit:

- Unrelated procedure provided at same visit
- Office lab test provided
- Unrelated service when primary visit billable to ICBC/WCB
- Uninsured services in addition to visit

 **Recommendation for billing procedures:** Bill highest service fee at 100%, lower value at 50%

LFP & FFS Billing Updates

 February 23, 2026

Updates to LFP time billing and ICBC billing for both FFS and LFP. Code **98101** (LFP Respiratory Immunization by Allied Care Provider) ends **March 31, 2026**.



Common Rejection Questions

Identifying & Correcting Rejections

Under LFP's time-based model, MSP validation is stricter than ever. Most rejections are preventable.

Missing Start/Stop Times

LFP codes require **actual clock times** (e.g., 10:02–10:22), not just duration. Fix: update chart, correct claim, resubmit with code "D". Never submit a new claim – that creates a duplicate.

Overlapping Timestamps

Billing Patient A 10:00–10:20 and Patient B 10:15–10:35 is flagged as impossible. Fix: confirm actual times, adjust to sequential care, resubmit with code "D".

Duplicate Time Codes

Same time code billed twice for the same patient on the same date. Fix: verify what was accepted in Teleplan, remove the duplicate, or correct original with code "D".

Generic PHN

LFP Time Codes: Effective February 23, 2026, claims for LFP time codes must use the generic PHN 9646191917 with the patient name "LFP Time" (DOB: Jan 1, 2005)

Over-Age "BV" Rejection

Claim submitted after the **90-day limit**. Submit an Over-Age Claim form to MSP only if there is an acceptable reason (e.g., sudden illness).

WorkSafeBC Rejections

When a WorkSafeBC claim is denied, you can rebill the WorkSafe visit to Medical Services Plan (MSP).

The WCB rejection code **"WD"** specifically means the claim was **"rejected or disallowed."**

Both ClinicAid and OSCAR allow you to submit this claim to MSP after correcting the billing details.

Best Practices for Accurate WCB Billing

Use Correct Fee Codes

Refer to latest WorkSafeBC fee schedules

Incorrect codes cause delays/rejections

Submit Forms Promptly

0-3 days: Paid in full

3-6 days: Discounted rate

After 6 days: \$0 paid

Include Required Information

Worker details, claim number, injury date, diagnosis, body parts affected



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