Medicare Billing Information Sessions 2025

SESSION 1 - Medicare Basics & Billing Fundamentals
Tuesday April 1, 2025, 12pm to 12:55pm
SESSION 2 - Family Practice Billing: Review
Tuesday, May 20, 2025, 12pm to 12:45pm
SESSION 3 - Reconciling: Navigating Your Claims Statement
Wednesday, June 11, 2025, 12pm to 12:45pm
SESSION 4 - Family Practice Billing Essentials
Tuesday, September 23, 2025, 12pm to 12:55pm
SESSION 5 - Medicare Claims Entry (MCE) Review: Tips, Templates, and More
Tuesday, Nov 4, 2025, 12pm to 12:45pm

We Want to Hear from you!

Please chat-in any topics you'd like to see included in our session schedule or share them by email at Practicesupport@nbms.nb.ca

New Nouveau Brunswick

Reconciling:
Navigating your Claims Statement

Department of Health

June 11, 2025

Purpose:

Provide a general overview of the claims reconciliation process and a step-by-step guide to reviewing your Medicare reconciliation statement.

Session outline:

- Quick overview– physician payment and claim submission process
- Reconciliation statements
- How to obtain your Reconciliation Statement
- Walkthrough of the sections in your statement
- Common error messages
- Resolving issues and managing canceled claims

Quick overview

Physician remuneration

Salaried (with/without other remuneration):

Practitioners whose main source of income is salaried but may receive fee-for-service for on-call services and services provided to out-of-province patients.

Type of billing: Shadow billing - non-fee-for-service health practitioners submit claims to New Brunswick Medicare for insured services provided to eligible residents. Claims are paid at zero

Fee for Service (FFS):

Income is generated from claims submitted for each insured service per the fee schedule.

Type of billing: FFS – claims for services are paid in accordance with the NB Schedule of fees for insured services provided to eligible residents.

Medicare Fee Schedule

In the NB Physician's Manual, you'll find a code that correlates for every service you provide, each with its own unit value.

Fees for service codes are unit based instead of per dollar. See Chapter 3, Section 1.5 in Physicians' Manual for Unit Values per Specialty.

Fee-for-service practitioners can calculate dollar amount for codes by multiplying the Units (indicated in the Manual beside the service code) by the dollar amount for their specialty based on the table.

Lists	Code	Units Gen	Units An
..B	368	46	7

Claims submission process

- Claim preparation: gather all required information
- Coding requirements: Select accurate service code and ICD10 diagnosis
- Submit claims electronically: May vary depending on whether you use a billing component of your EMR or Medicare Claims Entry (MCE)
- **Deadline for** claims submission: 92-days from date of service

Payment Information & Run Schedule

- Medicare operates on a bi-weekly billing cycle
- Physicians are paid every two weeks
- Practitioner Run schedule can be found on ECP - Electronic Communication for Physicians
- Cut-off for each billing period is every second Thursday at 8am
- Reconciliation statements are made available electronically in ECP bi-weekly on the statement date.

Practitioner Run Schedule - 2025

Cédule de Paiement des Praticiens - 2025

	MP#	Cut-Off Date 8:00AM Thursday for Claims Date d'arrêt 08:00AM	Run Date FRIDAY Date d'exécution	Process Pay Run MONDAY	Statement and Deposit Date FRIDAY Date du Relevé de compte et du dépôt	NOTES ON HOLIDAYS
1	2226	9/Jan/25	10/Jan/25	13/Jan/25	17/Jan/25	
2	2228	23/Jan/25	24/Jan/25	27/Jan/25	31/Jan/25	
3	2230	6/Feb/25	7/Feb/25	10/Feb/25	14/Feb/25	
4	2232	20/Feb/25	21/Feb/25	24/Feb/25	28/Feb/25	
5	2234	6/Mar/25	7/Mar/25	10/Mar/25	14/Mar/25	
6	2236	20/Mar/25	21/Mar/25	24/Mar/25	28/Mar/25	
7	2238	3/Apr/25	4/Apr/25	7/Apr/25	11/Apr/25	
8	2240	17/Apr/25	18/Apr/25	21/Apr/25	25/Apr/25	APRIL 18 - GOOD FRIDAY/APRIL 21 EASTER MONDAY

Reconciliation Process: Ensuring Accurate Payment

- Review Reconciliation Statements regularly.
- Keep track of submitted claims and compare against your paid claims.
- Identify discrepancies – look for unpaid claims, cancelled claims, or reduced claims.
- Investigate and take action to resolve issues - correct and resubmit as needed, and/or contact PELs to request adjustments.
- Monitor future statements to ensure resolution and all services have been paid.

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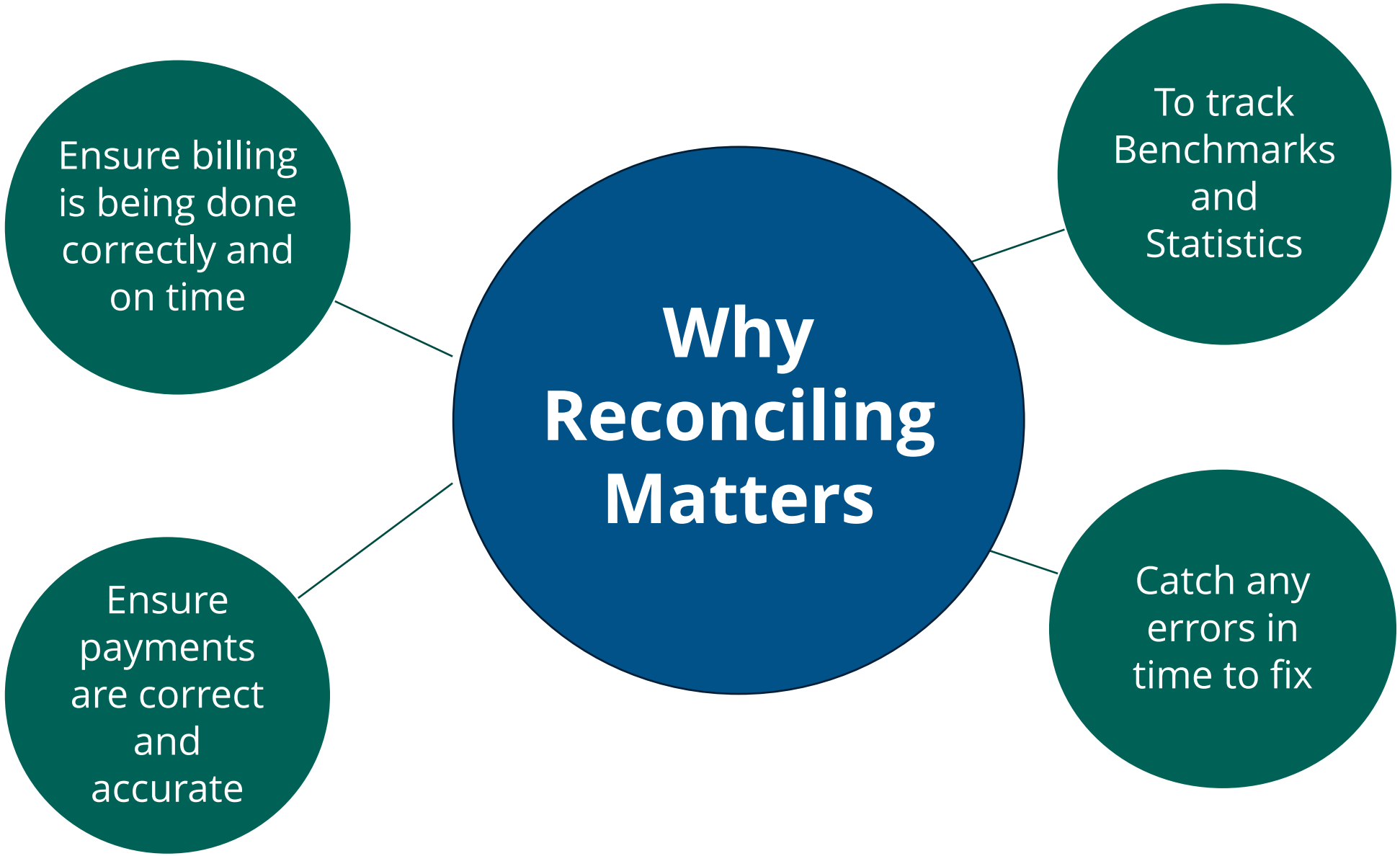
Why Reconciling Matters
Ensure billing is being done correctly and on time
To track Benchmarks and Statistics
Ensure payments are correct and accurate
Catch any errors in time to fix

What is a Reconciliation Statement?

- A payment summary report provided by Medicare that outlines a practitioner's processed claims for a given payment period.

- These reports provide insight on:
  - the status of your claims
  - the reasons for adjustments or non-payment
  - the appropriate course of action to resolve affected claims.

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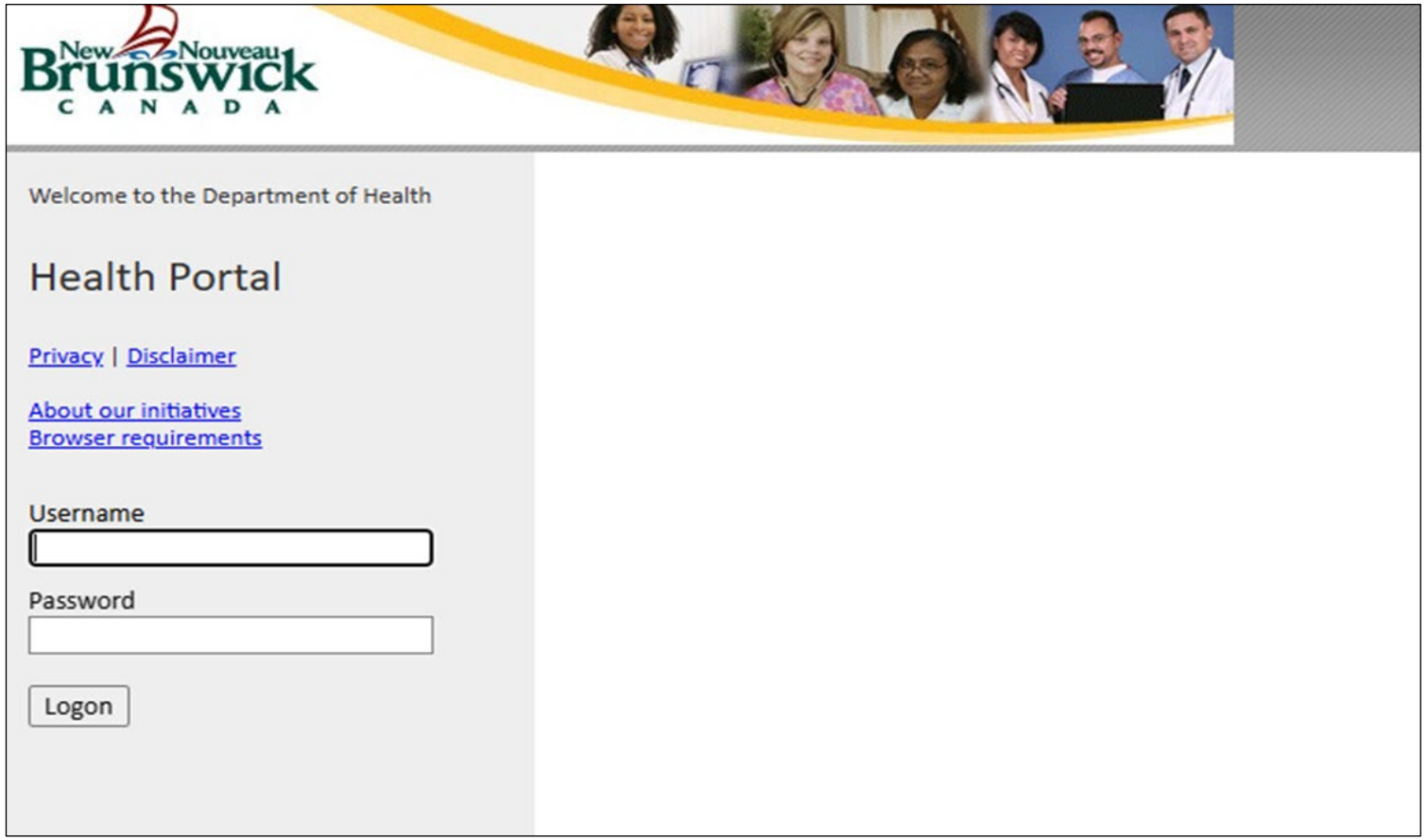
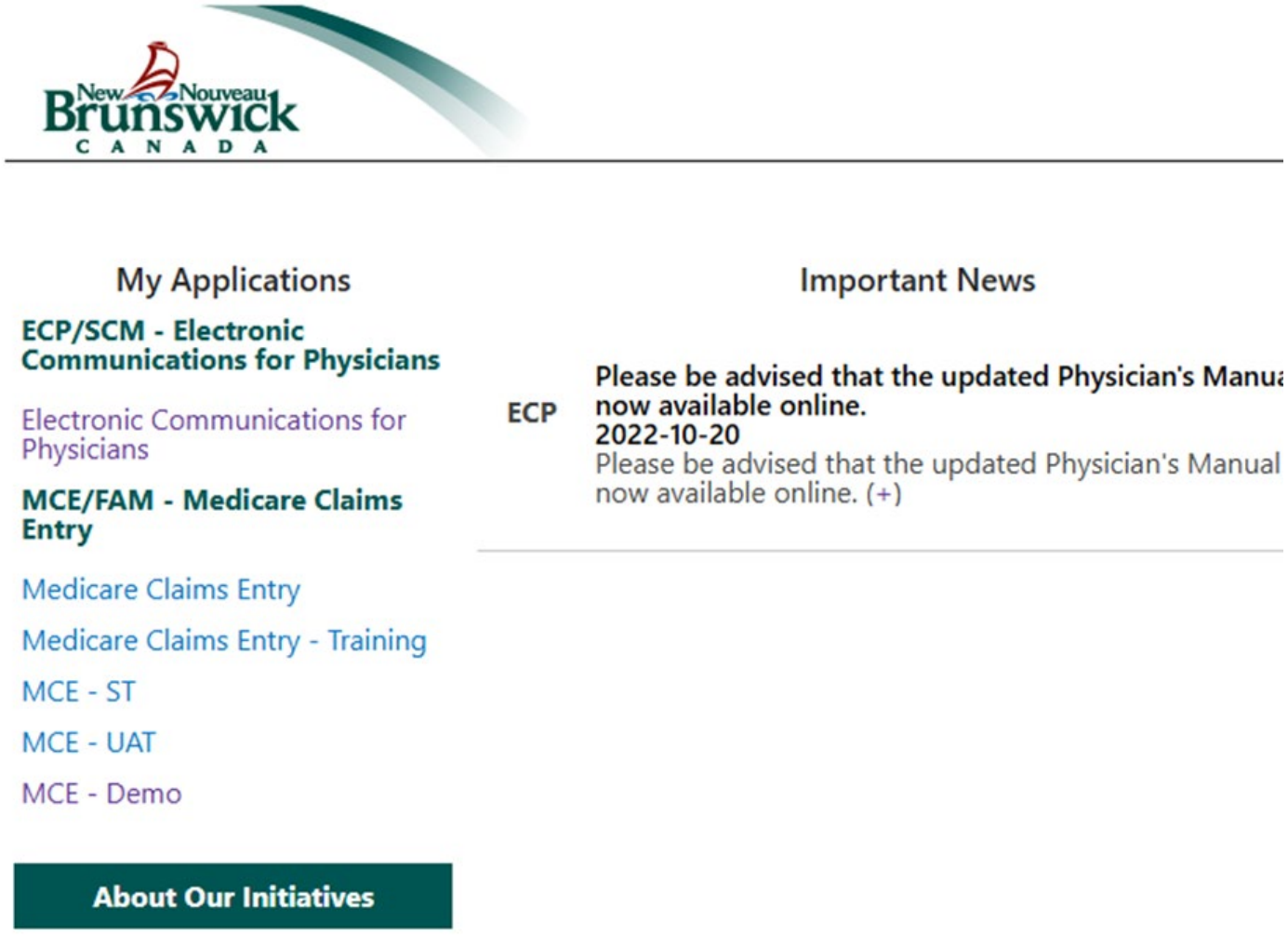
Accessing Reconciliation Statements

[hps.gnb.ca](hps.gnb.ca)

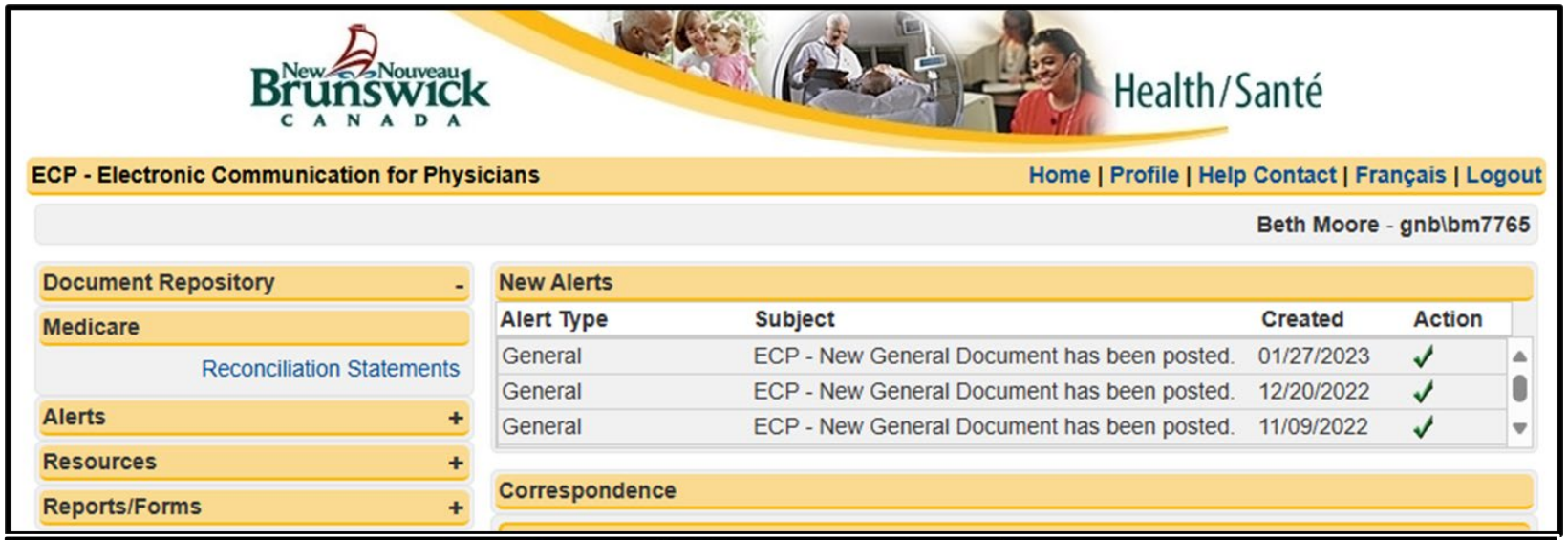


Electronic Communications for Physicians (ECP)

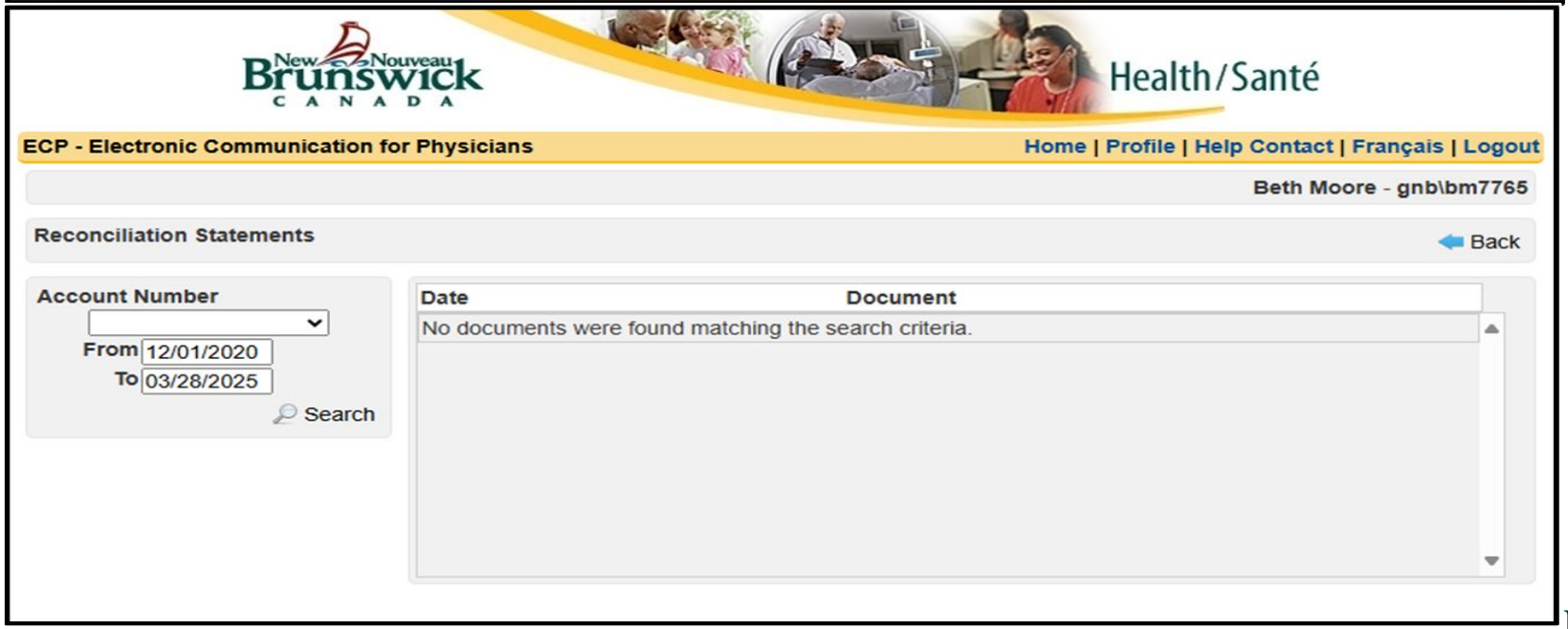
ECP contains Reconciliation Statements, as well as useful documents and forms such as: Practitioner Run Schedule and Practitioner Enquiry form



Reconciliation Statements are available on a bi-weekly basis.



Statements are available for each billing account. You can search and access past statements by selecting a specific date range.



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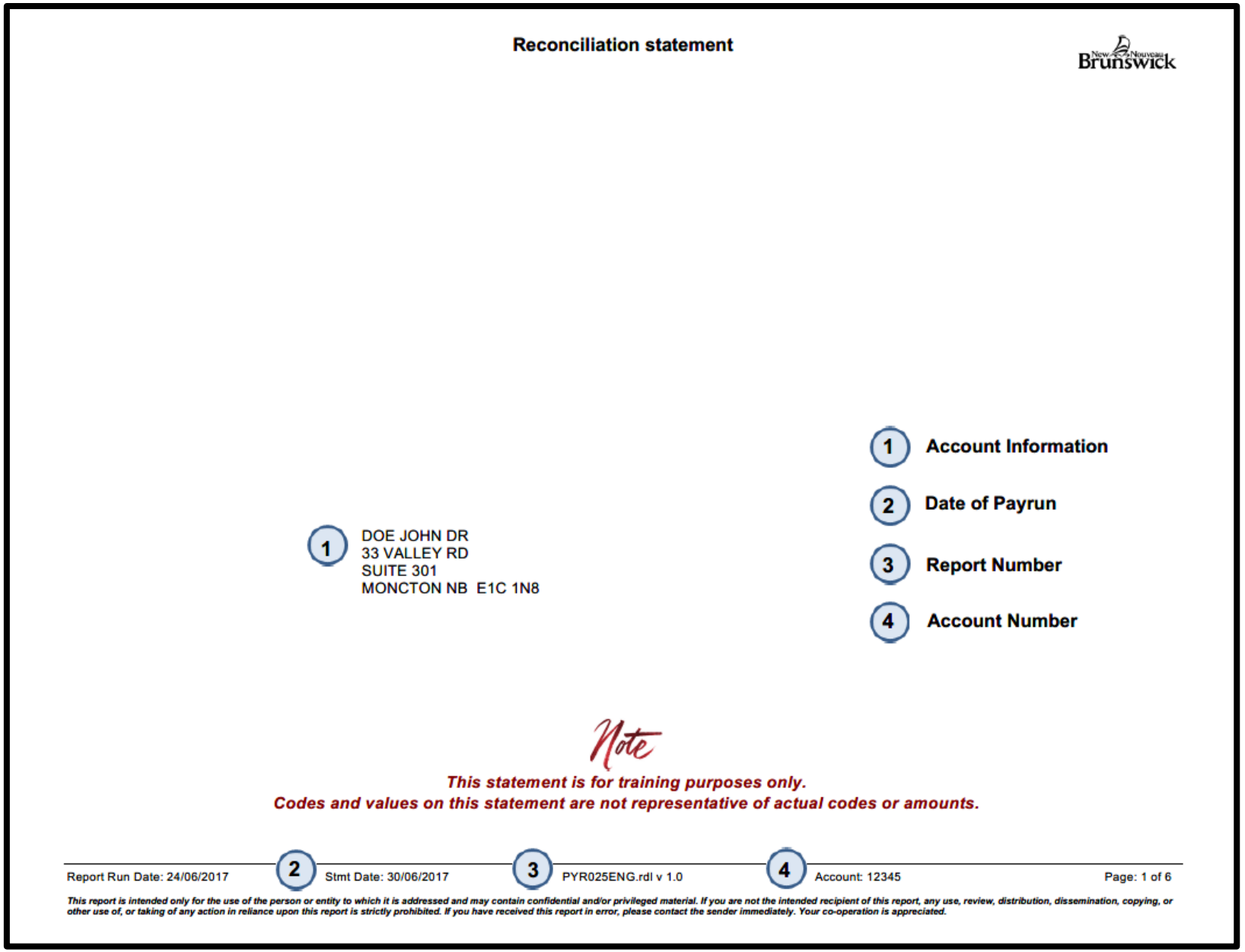
Reconciliation Statement

Practitioner reconciliation statements are available every 2 weeks on ECP and should be reviewed on a regular basis, as it is the most accurate for what has been processed by Medicare and indicates claims that may require action.



Reconciliation statement

New Brunswick

1 DOE JOHN DR
33 VALLEY RD
SUITE 301
MONCTON NB E1C 1N8

1 Account Information
2 Date of Payrun
3 Report Number
4 Account Number

Note

This statement is for training purposes only.
Codes and values on this statement are not representative of actual codes or amounts.

Report Run Date: 24/06/2017 | 2 Stmt Date: 30/06/2017 | 3 PYR025ENG.rdl v 1.0 | 4 Account: 12345 | Page: 1 of 6

This report is intended only for the use of the person or entity to which it is addressed and may contain confidential and/or privileged material. If you are not the intended recipient of this report, any use, review, distribution, dissemination, copying, or other use of, or taking of any action in reliance upon this report is strictly prohibited. If you have received this report in error, please contact the sender immediately. Your co-operation is appreciated.

Claims

Medicare **Reconciliation statement** New Brunswick / Nouveau-Brunswick

Name: **DOE JOHN DR**
Address: **33 VALLEY RD**
SUITE 301
MONCTON NB E1C 1N8

Account: **12345** Journal: **12121212**

This Statement Date: **30/06/2017**
Last Statement Date: **16/06/2017**

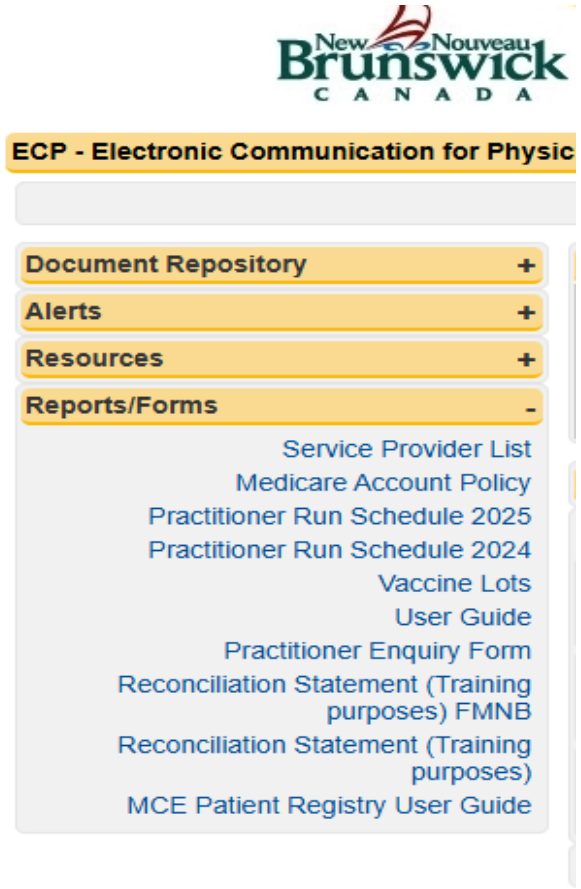
For: **12345 - DOE*JOHN*DR**

Claims ← **This section lists paid/processed claims.**

Claim Number	Medicare Number	UCRN #	Patient	Date of Service	-- Billed -- Code	Unit	--- Paid --- Code	Unit	Original Payment	- Adjusted - Code	Unit	This Payment
XXXXXXXXX	XXXXXXXXX		LASTNAME, FIRSTNAME	25/05/2017	2174	232	2174	232				352.64
	PLEASE NOTE NEWBORN MEDICARE NO.											
XXXXXXXXX	XXXXXXXXX		LASTNAME, FIRSTNAME	26/05/2017	17	70	17	0				60.80
	PATIENT GREATER THAN 3 DAYS OLD											

- Indicates claims paid and processed correctly.
- Requests for adjustments or corrections can be submitted through Practitioner Enquiries and Liaison Services and received within 12 months of the statement date.
- Claims in this section must not be resubmitted electronically as a new claim.
- Questions concerning non-payment of claims must be received within 12 months of the date of service.

Practitioner Enquiry forms can be sent in by email, fax or mail



Practitioner Enquiry Form
Practitioner Liaison Services - Medicare
P.O. Box 5100 Fredericton, N.B. E3B 5G8 (fax) 506-453-5332
Email: PELS.DRPL@gnb.ca

Demande de renseignements du praticien
Services de liaison auprès des praticiens - Assurance-maladie
C.P. 5100 Fredericton (N.-B.) E3B 5G8 (téléc.) 506-453-5332
Courriel: PELS.DRPL@gnb.ca

New Nouveau Brunswick Health Santé

Date _____

Practitioner Name
Nom du praticien _____

Address/
Adresse _____

Telephone No/
No de téléphone _____

Practitioner Number
Numéro du praticien _____

Postal Code/
Code postal _____

Patient's Name/ Nom du patient	Medicare Number/ N° d'Assurance-maladie	Date of Birth/ Date de naissance	Claim # (11 Digits)/ N° de facture (11 chiffres)	Service Date/ Date du service	Remarks/Remarques

Please note that: Resubmissions under a "different Medicare Number" must be submitted electronically. If the date of service is greater than 92 days, please submit the claim electronically and then complete the Practitioner enquiry form making reference to the previous claim number in the remarks section. This will override the 92 days rule. Failure to follow this process will result in zero payment of your claim.

Veuillez noter : La présentation d'une nouvelle demande sous « un numéro d'assurance maladie différent » doit être faite électroniquement. Si la date de service remonte à plus de 92 jours, il faut soumettre la facture électroniquement, remplir le formulaire de demande de renseignement du praticien et nous fournir le numéro de la facture précédente dans la section des remarques. Ceci dépassera la règle de 92 jours. Le manque de suivre ce processus aura comme conséquence un paiement de zéro de votre réclamation.

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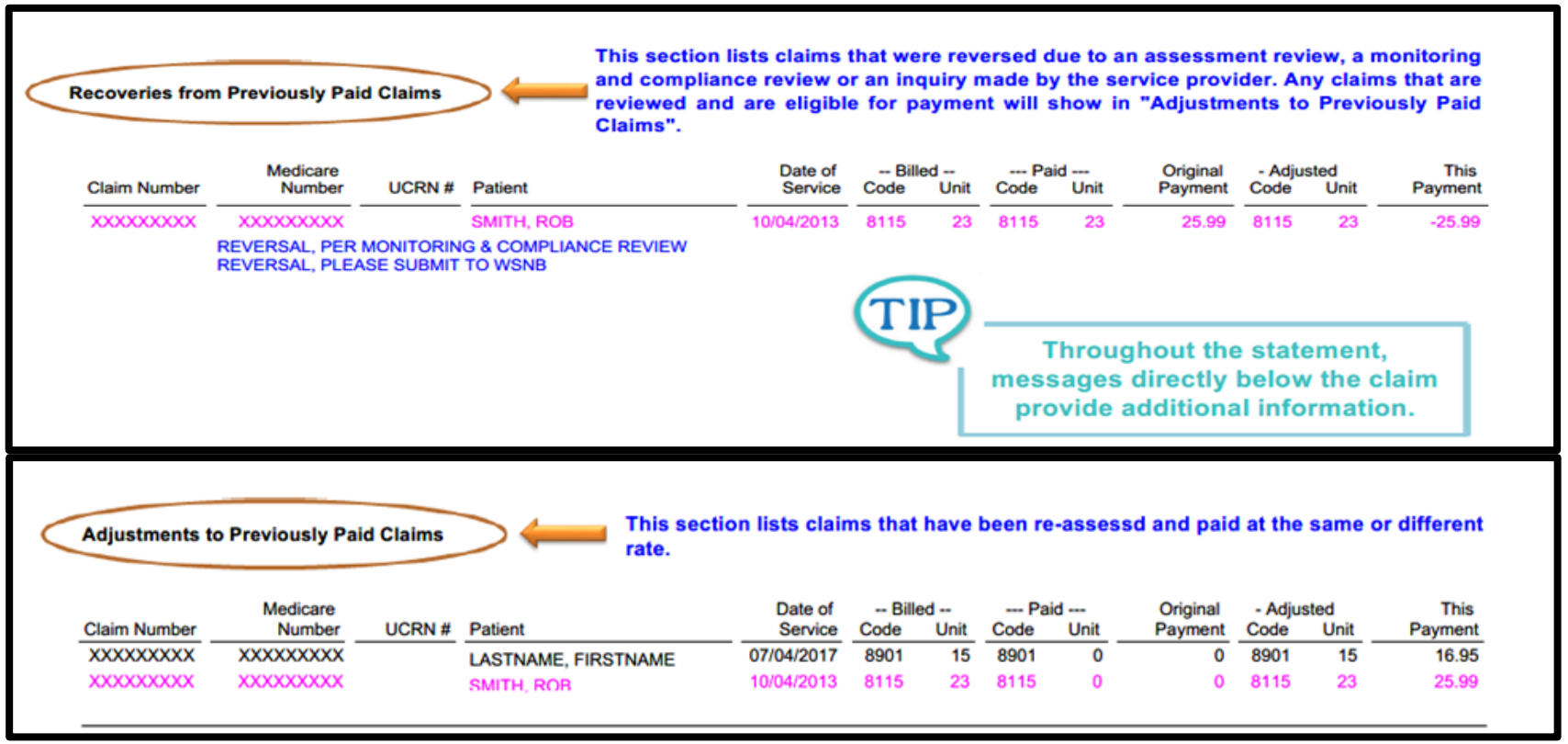
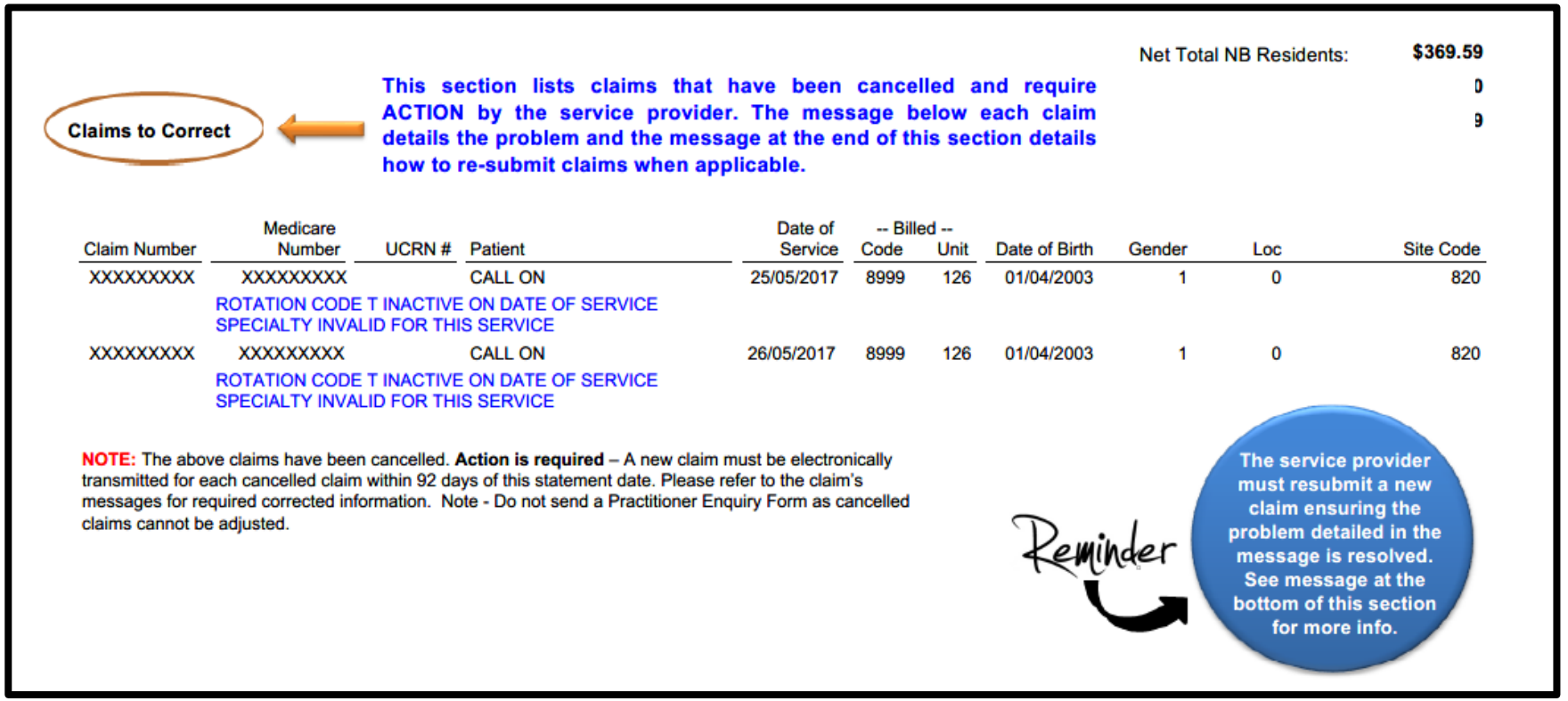
Recoveries and adjustments to previously paid claims



- Indicates claims that previously appeared in the Claims section but have been re-assessed, recovered, reversed or adjusted.
- This can be due to various reasons such as invalid or unacceptable diagnosis or Monitoring and Compliance reviews.
- If a claim has been reversed, it may require action from the practitioner or billing staff.

Claims to Correct



Net Total NB Residents: $369.59
0
9

Claims to Correct

This section lists claims that have been cancelled and require ACTION by the service provider. The message below each claim details the problem and the message at the end of this section details how to re-submit claims when applicable.

Claim Number	Medicare Number	UCRN #	Patient	Date of Service	-- Billed -- Code	Unit	Date of Birth	Gender	Loc	Site Code
XXXXXXXXX	XXXXXXXXX		CALL ON	25/05/2017	8999	126	01/04/2003	1	0	820
	ROTATION CODE T INACTIVE ON DATE OF SERVICE SPECIALTY INVALID FOR THIS SERVICE									
XXXXXXXXX	XXXXXXXXX		CALL ON	26/05/2017	8999	126	01/04/2003	1	0	820
	ROTATION CODE T INACTIVE ON DATE OF SERVICE SPECIALTY INVALID FOR THIS SERVICE									

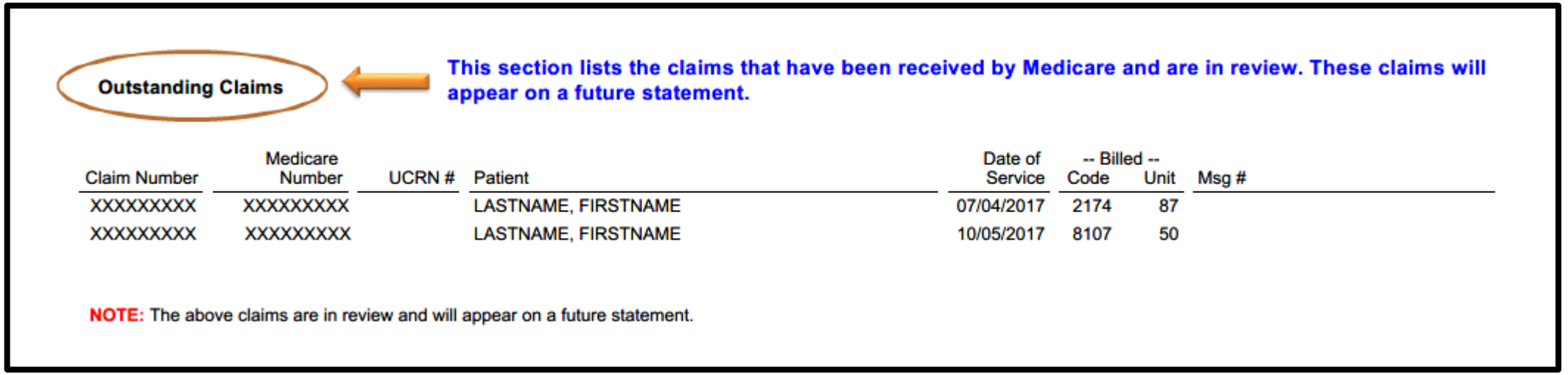
NOTE: The above claims have been cancelled. **Action is required** – A new claim must be electronically transmitted for each cancelled claim within 92 days of this statement date. Please refer to the claim's messages for required corrected information. Note - Do not send a Practitioner Enquiry Form as cancelled claims cannot be adjusted.

Reminder

The service provider must resubmit a new claim ensuring the problem detailed in the message is resolved. See message at the bottom of this section for more info.

- Indicates claims that have been **cancelled.**
- A message will appear below the claim explaining why it was cancelled.
- These claims will not be considered for payment or appear in the practitioner's benchmarks/statistics unless they are **resubmitted** electronically within 92 days of the statement date.

Outstanding Claims



- Indicates claims that have been received but not yet processed for payment by the Medicare system.
- No action is required to be taken for claims in this section.
- Claims will be listed in this section until they are paid/processed and then will appear in “Claims” section on a future statement.

Payment messages

Payment Messages on Statement	Possible reason(s) for message
Too Many Visits same day	More than one visit billed for the same patient on the same day
Apparent Duplicate billing	Duplicate claim submitted (same patient, same codes, same dates)
Resident not eligible, Patient to contact Medicare	Patient's Medicare coverage is expired, and they need to contact Medicare or SNB to have it renewed
Hospital care billed by different physician	Another physician has billed for daily care of patient causing overlap in billing
Add on visit, no related claim	Add on code billed without primary code (ex Code 8101 but no Code 1)
Please send Operative Reports	Operative Reports required to assess claim, will not be considered for payment until received
Paid on claim #	Service was paid on claim # listed
Circumstances of emergency visit not identified	Diagnosis given does not indicate an emergency visit was required
Included in post operative period	Service billed in post-op period (14 days after surgery), Assessment Rule 27

Payment Messages on Statement	Possible reason(s) for message
Service code and fee adjusted	Wrong code billed, service code adjusted, and fee adjusted to match new service code
Service count has been adjusted	Service count has been changed to match the number of services indicated by time billed (ie, detention, hospital care days)
Service date has been adjusted	Date of service has been changed (ie, hospital care billed for day billed by another physician)
Service fee has been adjusted	Service fee adjusted from what was originally billed
Multiple procedures 75% payment	Multiple List A or B procedures billed, first paid at 100%, additional paid at 75%
Patient medically discharged	Patient has been medically discharged and awaiting placement
No indication of “bilateral” (left and right)	Code 1948 billed twice (two separate claims or count of 2) and no notes' indicating injection was done bilaterally
First ½ hour included in visit	Code 200 Detention billed on Code 1 but no start and end time indicated, first half hour will be removed to account for visit time

WSNB messages

Payment messages on statement	Possible reason(s) for message
Reversal, Please submit to WSNB	Claim has been reversed and should be submitted to WSNB
Payable by WSNB	Service is payable by WSNB
Paid by WSNB	Service has already been paid by WSNB
WSNB Refusal letter >92 days old from claim submission date	Refusal letter provided is greater than 92 days old from the original claim submission date
Do not rebill – WSNB refusal requires Enquiry, refusal letter & clm #	Need to contact Practitioner Enquiries, provide refusal letter and claim # for payment consideration

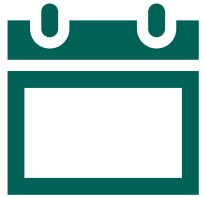
Summary: Actions Steps Based on Claim Status

Processed claims

Action: Contact Practitioner Enquiries if any questions or corrections required.

Cancelled Claims

Action: Resubmit new claim within 92 days of the statement date.



Outstanding Claims

No action required.

Tips to prevent Claims Rejections and Delays

- ✓ Verify patient information: confirm Medicare coverage at each visit
- ✓ Submit claims electronically: use Medicare Claims Entry (MCE) or third-party billing software (component of EMR).
- ✓ Ensure timely submissions: 92 days from Date of service
- ✓ Choose accurate billing codes and ICD10 diagnosis codes
- ✓ Review your Reconciliation Statement regularly
- ✓ Identify discrepancies, follow up on unpaid claims and resolve any issues promptly
- ✓ Manage cancelled claims – make necessary corrections and resubmit promptly
- ✓ Arrange training for billing staff:
    - Medicare PL provides billing training and code review, MCE training,
    - Contact EMR provider/third party to request training

New Nouveau Brunswick

Medicare Contacts

Who	When	How
Practitioner Enquiries	Questions regarding submitted claims (adjustments, corrections, cancel claims) Questions regarding Reconciliation Statements	pels.drpl@gnb.ca (506) 444-5860 (English only) (506) 457-7572 (Bilingual) (506) 444-5876 (Bilingual) (506) 453-5332 (Fax)
Medicare Payments	Anything pertaining to accounts and/or banking information	DHMedPay@gnb.ca
MCE Admin	Technical issues with MCE, account issues or to reset password	MCEAdmin@gnb.ca
Practitioner Liaison	To request billing/MCE training or refresher	Medicare.Training.Formation@gnb.ca
Service Provider Registrar	First point of contact with Medicare	medicare.spregistrar@gnb.ca

New Nouveau Brunswick

Let us know how we can improve!

Evaluation Survey:

https://forms.office.com/r/DaSzE1aaG0

Questions?