**Medicare Claims Entry Web Service (MCE-WS) Integration**

**Requirements Specifications**

Version 1.2

December 21, 2023

**Version History**

|  |  |  |  |
| --- | --- | --- | --- |
| **Version** | **Type** | **Date** | **Description** |
| 1.0 | Published | February 6, 2023 | Initial version of the MCE-WS Integration Requirements Specifications |
| 1.1 | Published | May 10, 2023 | MCE -2020-2023 Distribution -AHEP- 8 -Increase-Update |
| 1.2 | Published | December 21, 2023 | Update to add requirements for rostering and FMNB |

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# Purpose

This document provides EMR vendors with the Medicare Claims Entry Web Service (MCE-WS) business, functional and technical integration requirements needed to successfully submit and reconcile claims through MCE-WS for all remuneration (billing) models (Fee for Service, Salaried, and FMNB). Rostering functionality and supporting web services are defined to support FMNB remuneration models.

All integrated EMR vendors will need to implement Core EMR requirements; whereas, EMR vendors who are choosing to support the FMNB Program must additionally implement the FMNB requirements.

## Scope

This document describes the MCE-WS solution, which includes all the MCE claim processing components required for:

* all remuneration models,
* patient rostering,
* claim unit calculations,
* claim submission and associated claim return (errors, warnings, broadcast),
* payment reconciliation, and
* Open Data Gateway (ODG) tables and associated synchronization processes.

## Additional Resources

This section identifies, links, and describes the additional resources necessary to review alongside this specification document, or referenced within this specification document.

|  |  |
| --- | --- |
| **Resource Name / Link** | **Description** |
| [MCE-WS Integration Glossary](https://hpspub.gnb.ca/MCE/WebServices/Site/Glossary.html) | A glossary of terms and definitions to support the EMR vendor’s understanding of MCE-WS integration. |
| [MCE-WS Integration Portal](https://hpspub.gnb.ca/MCE/WebServices/index.html) | A web portal that provides all the information and documentation required for an EMR to integrate successfully with MCE-WS. |
| [MCE-WS Unit Calculation](https://hpspub.gnb.ca/MCE/WebServices/Docs/MCE-WS%20Unit%20Calculation.docx) | A document containing the unit calculation logic that EMRs must implement for accurate claim submission to Medicare. |
| [MCE Core API](https://hpspub.gnb.ca/MCE/WebServices/Help.html) | A page of the MCE-WS Integration Portal that contains the list and description of the available MCE Core API. |
| [MCE FMNB API](https://hpspub.gnb.ca/MCE/WebServices/FMNB/index.html) | A page of the MCE-WS Integration Portal that contains the list and description of the available MCE FMNB API. |
| New Brunswick Physicians’ Manual ([EN](https://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/en/Physicians/new_brunswick_physicians_manual.pdf) | [FR](https://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/fr/Medecins/manual_des_medecins_du_nouveau-brunswick.pdf)) | The official manual containing the complete details of the negotiated services and fees for medical services payable by the Medicare system. |
| [Open Data Gateway](https://hpspub.gnb.ca/MCE/WebServices/Site/OpenDataGateway.html) | A page of the MCE-WS Integration Portal that contains the list and descriptions of the available MCE ODG tables. |

# Remuneration Models

Medicare supports many types of remuneration models. Those affecting billing calculations in the EMR are identified in this section. Individual providers may bill using one or more remuneration models. Providers working in the same EMR instance (at one or more locations) may bill under a combination of remuneration models, some of which are group-based and affect how providers in the same group bill. The EMR needs to account for multiple providers working in a variety of remuneration models.

## Fee For Service (FFS)

FFS is the main method of remuneration under the Medicare Compensation model. Providers bill Medicare for entitled services rendered to individuals in accordance with the New Brunswick Physicians’ Manual.

## Salaried (SAL)

SAL providers are required to “shadow bill” claims, which means they are submitted to Medicare with the **HistoryFlag** set to **True** via the Claim Submission MCE-WS. Claims that are “shadow billed” are paid at $0.

## Family Medicine New Brunswick (FMNB)

FMNB is a team-based practice and payment model for family medicine in NB. Eligible providers who are participating in FMNB, known as FMNB Providers, work in an FMNB Group. FMNB providers must explicitly roster their patients and provide services to other rostered patients within their FMNB Group when required. Regardless of physical location, providers in the same FMNB Group work in the same EMR instance and share their patients’ electronic medical records. One or many FMNB Groups may co-exist in a single EMR instance. For claim purposes, a patient's current roster status with a specific FMNB Provider in the FMNB Group applies to all FMNB Providers in the same FMNB Group who are billing for that patient.

### Blended Payment Model (BPM)

FMNB Providers are generally paid using the BPM. This payment model is made up of two components: reduced fee-for-service and capitation for rostered patients. Capitation is paid to providers as a form of guaranteed income to incent quality of care, while a percentage of fee-for-service is paid to providers to encourage volume. Rostering is a key component to this remuneration model.

### Transitional Payment Plan (TPP)

FMNB also offers a transition option for providers entering FMNB, called TPP. This remuneration model is meant to support new-to-practice FMNB Providers over a negotiated transitional period, while they establish their roster, after which they transition to the BPM. Rostering is a key component to this remuneration model as well. TPP is very similar to BPM, as it is also made up of capitation and reduced FFS. The difference is that the reduced FFS rate is different than the BPM. It is generally higher and could be up to 100% (not reduced). All other BPM billing rules still apply while a provider is on the TPP.

### getGroupProviderConfig Web Service

To support the EMR in defining FMNB Group configurations within an EMR instance (Org ID), the EMR needs to be aware of the FMNB Groups (one or more), memberships of their providers, as well as reduction percentages for any providers on the TPP. The FMNB Configuration information for all FMNB Groups within an EMR instance needs to be synchronized automatically and kept up to date on a daily basis. The EMR should also allow on-demand synchronization as needed for all FMNB Groups within the EMR instance, a specific FMNB Group, or a specific provider. This can be accomplished using the getGroupProviderConfig WS automatically, in place of manual configuration.

# Rostering

Rostering patients is an essential component of EMR billing requirements for certain remuneration models in the province. The EMR must support all rostering functionalities for providers who are required to roster as per their method of remuneration. Requests to the rostering web services are sent by the EMR, and all validations are handled in the web service and sent back via the rostering web service responses. The EMR must fully integrate with these web services to accurately synchronize with the Roster Registry data, request patient roster eligibility, and update patient roster statuses. The EMR needs to be able to receive and interpret the responses from the rostering web services and display validation messaging to the users when required.

## Roster Statuses

Based on their remuneration model, a provider may be required to roster their patients to submit accurate Medicare billing claims based on roster status. Currently, a roster status can only be applied to a patient who is a Resident.

Roster statuses, or the absence of a roster status, will affect the [**MCE-WS Unit Calculation**](#_Medicare_Unit_Calculation) under certain remuneration models.

Roster statuses that need to be available in the EMR for selection by the EMR User are available in the FMNB\_ROSTER\_STATUS ODG table. Certain roster statuses are subject to business rules that require a roster exception reason to be provided. The list of current roster exception reasons is available in the FMNB\_ROSTER\_EXCEPTION\_REASON ODG table. These also need to be available in the EMR for selection by the EMR User.

The absence of a roster status for a patient can be the result of any one of the following scenarios:

* The patient is new to their provider (not yet rostered),
* The patient’s roster status has surpassed its termination date with their provider (no longer rostered),
* The patient does not have active Medicare coverage (not able to be rostered), or
* The patient’s provider is not participating in rostering patients (rostering is not applicable).

A patient’s roster status with their provider can be updated or terminated at any time.

## Rostering Web Services

The following rostering web services facilitate the EMR communicating with the central Roster Registry, which is considered the source of truth for the official roster status of a patient. The rostering web services need to consider various EMR User workflows, as well as automated and EMR User-invoked requests. All Medicare responses to EMR User-invoked requests, such as validation messaging for rejected requests, need to be displayed to the EMR User immediately for review and correction. EMR workflow considerations for the unavailability of the Medicare system at the time of a request also needs to be accounted for, as the EMR User will need to be able to continue with their required workflows.

### syncRoster Web Service

There may be cases when a provider’s roster in the EMR does not align with what is captured in the central Roster Registry. This can occur as a result of changes to a provider’s roster from sources external to the EMR instance (e.g. a patient moves and decides to roster with a provider in a different city, or Medicare changes a patient’s roster status due to eligibility changes). If a provider’s roster data becomes corrupt in the EMR, they may also need to manually re-synchronize their roster data. The EMR needs to be able to synchronize a provider’s roster from the source of truth regularly and as needed. This can be accomplished using the syncRoster WS.

The EMR will need to retain the date and time of the last successful synchronization. This facilitates efficient roster synchronization, synchronizing only what has changed since the passed-in date. The EMR will take the synchronization data and locate matched patients within the EMR and replace their roster data and history. For any unmatched patients (such as patients who do currently exist in the EMR, or patients who may have duplicate records), the EMR will keep a record of the unmatched patients from the Roster Registry along with their roster data and history and facilitate an easy way for EMR Users to either add these patients or reconcile the duplicates by merging the patients then synchronizing with the new unique patient record. This web service will also be the method for which a provider will front-load their initial roster.

The precondition for invoking syncRoster from the EMR is that all prior roster events for a provider’s patients need to be completed (successful or fail).

The diagram below outlines the high-level required workflow for syncing a provider’s roster.



**Figure 1**: Sync Provider Roster Flow

The table below describes the steps in the above diagram. Note that the specifics of how these steps are implemented can vary depending on the specific EMR product.

| **S.no.** | **Step** | **Description** |
| --- | --- | --- |
|  | Precondition | All prior roster events for each patient on that provider’s roster must be completed (successful or fail). If some have been queued due to issues connecting to the service, the EMR must ensure they are retried and processed as part of the same events that triggers the scheduled or user initiated Roster Sync. |
| 1. | Initial / EMR User Roster Sync | The EMR User sends a request to synchronize the provider’s roster with the Roster Registry. This can be as needed or for an initial provider roster sync.  **syncRoster Request** invoked by EMR User |
| 2. | Scheduled Roster Sync | The EMR automatically invokes the syncRoster Web Service on a schedule once every 24 hours.  **synRoster Request** invoked by EMR |
| 3. | Process syncRoster | The Roster Registry processes the request from the EMR and determines the response. If there are changes to the provider’s roster, a response message is created for the changes. If there are no changes, a response message containing no changes is created. The response is then sent back to the EMR.  **syncRoster Response** sent back from the Roster Registry |
| 4. | EMR Processes syncRoster Response | The EMR processes the response and identifies matched and unmatched patients. Matched patients have their roster data and history replaced. Unmatched patients are recorded and readied for EMR User processing/reconciling.  The EMR retains the date and time of the last successful roster synchronization. |
| 5. | Process/Reconcile Unmatched Patients | The EMR User will review the recorded unmatched patients and either add the unmatched patients to the EMR or reconcile the patient (e.g., merge duplicate patients) for re-synchronization. |

### syncResident Web Service

As a result of changes that can occur to a patient’s roster data from sources external to the EMR (e.g. a patient moves and decides to roster with a provider in a different city, or Medicare changes a patient’s roster status), the EMR needs to be able to synchronize an individual patient’s roster data and history with the Roster Registry. An EMR User may need to synchronize a patient’s roster data prior to their appointment, anytime during their clinical visit, prior to updating their current roster status, or any time they perceive that the patient’s roster data may no longer be accurate within the EMR. The EMR also needs to automatically synchronize a patient’s roster data with the Roster Registry prior to submitting a claim for a rostered patient to ensure that accurate claims are submitted to Medicare. This can be accomplished using the syncResident WS.

The precondition for invoking syncResident from the EMR is that all prior roster events for the patient need to be completed (successful or fail).

### getRosterability Web Service

In the case where a patient’s roster eligibility is unknown (e.g. when seeing the provider for the first time before joining their roster), the EMR needs to be able to check a patient’s roster eligibility. This can be accomplished using the getRosterability WS.

### registerRosterEvent Web Service

When a new patient needs to be assigned a roster status or an existing patient needs to have their roster status updated, an EMR User will submit a request via the registerRosterEvent WS to update the Roster Registry with the patient’s new roster data. This involves sending the patient’s new roster status, an exception reason (if required, depending on roster status), and their provider in the EMR to the Roster Registry to process the update. If the request to update the patient’s roster data returns a successful response from the Roster Registry, then the patient’s new roster data and history can then be applied in the EMR. In the case where the Roster Registry rejects a roster status update for a patient, the update also needs to be rejected in the EMR resulting in no changes to the patient’s roster data or history and immediately advising the EMR User of the Roster Registry’s response.

### Patient Visit Suggested Workflow

The diagram below outlines a suggested high-level workflow of the Rostering Web Services specific to a patient used within the context of a patient visit.



**Figure 2**: Patient Visit Flow

The table below describes the steps in the above diagram. Note that the specifics of how these steps are implemented can vary depending on the specific EMR product.

| **S.no.** | **Step** | **Description** |
| --- | --- | --- |
|  | Precondition | A patient has arrived at the clinic for a patient visit. |
| 1. | Rostered Patient? | The EMR User reviews whether the patient is rostered.  If they are not, the EMR User can check the roster eligibility of the patient to a provider.  **getRosterability Request** invoked by EMR User  If they are rostered, the EMR User can synchronize the patient with the Roster Registry to ensure their status has not changed.  **syncResident Request** invoked by EMR User  Precondition: All prior roster events for the patient need to be completed (successful or fail). |
| 2. | Process getRosterability | The Roster Registry processes the request from the EMR and determines the response. A response reflecting whether the patient can be rostered to the provider is returned.  **getRosterability Response** sent back from the Roster Registry |
| 3. | Process syncResident | The Roster Registry processes the request from the EMR and determines the response. If there are changes to the patient’s roster data and history, a response message is created for the changes. If there are no changes, a response message containing no changes is created. The response is then sent back to the EMR.  **syncResident Response** sent back from the Roster Registry |
| 4. | EMR Processes getRosterability Response | The EMR processes the response and displays the patient’s roster eligibility for the provider to the EMR User for review. |
| 5. | EMR Processes syncResident Response | The EMR processes the response, and if there is a change, the roster data and history of the patient are replaced.  The EMR retains the date and time of the last successful patient synchronization. |
| 6. | Clinical Visit / Review Rostering with Patient | The patient proceeds to their clinical visit and may review their roster status with an EMR User (e.g., their provider) as a result of the service. |
| 7. | Change Patient Roster Status? | The EMR User determines whether a change in roster status is required.  If a change is required, they submit a roster status update for the patient.  **registerRosterEvent Request** invoked by EMR User  If a change is not required, the patient visit can be completed. |
| 8. | Process registerRosterEvent | The Roster Registry processes the request from the EMR and determines the response. If the roster status update is accepted, a response message is created for the changes. If it is not accepted, a response message is created with validation messaging. The response is then sent back to the EMR.  **registerRosterEvent Response** sent back from the Roster Registry |
| 9. | EMR Processes registerRosterEvent Response | The EMR processes the response. If the roster status update was accepted, the roster data and history of the patient are replaced. If the roster status update was not accepted, validation messaging is displayed to the EMR User for review and reconciliation.  The patient visit can be completed. |

# Claims Processing

The diagram below outlines the high-level MCE claim submission and reconciliation processes. This is a proposed workflow, however, the specifics of how a claim is prepared, edited and submitted for a patient visit can vary depending on the capabilities of the EMR. The claim submission workflow variations must still meet all the requirements identified in the section below.



**Figure 3**: Claim Processing Flow

The table below describes the steps in the above diagram.

| **S.no.** | **Step** | **Description** |
| --- | --- | --- |
|  | Precondition | For FMNB claims, the roster status of the patient needs to be synchronized with the FMNB Roster Registry in order to support claim unit calculation. This can be accomplished through the mandatory daily sync or through additional syncResident invocations as part of the claim preparation process that aligns with EMR workflows. |
| 1. | Prepare claim | Create the claim submission call to MCE using EMR User-entered values and calculations. |
| 2. | Send claim to MCE | Invoke the Claim Submission MCE-WS to Send the claim to MCE for processing. |
| 3. | Authenticate access | Validate the Org ID, Token, and Certificate through the provincial integration engine. |
| 4. | Validate claim/ Check for Errors | Validate the claim through the MCE rules engine using a series of structural and business logic. |
| 5. | Return claim receipt | Return the MCE claim "receipt" including a list of warnings, errors (if any) based on the results of the rules engine, and broadcast messages (if any) in response to a claim submission call. |
| 6. | Process claim receipt | Process the claim receipt, including errors, warnings (if any) and broadcasts (if any). For more details on errors/warnings and broadcasts, refer to sections [4.2.1](#_Errors_and_Warnings) and [4.2.2](#_Broadcast), respectively. |
| 7. | Fix errors (if any) | Present the errors in the claim receipt to the EMR User in response to the claims submission and resubmit the claims after EMR User fixes the errors. |
| 8. | Request reconciliation | Process EMR User requested reconciliation by invoking MCE-WS Get EMR Reconciliation to get the reconciliation report. For more details on reconciliation request, refer to [section 4.4](#_Errors/Warnings). |
| 9. | Prepare and return the reconciliation report | Generate and return the reconciliation report based on the date range passed in the Get EMR Reconciliation MCE-WS. |
| 10. | Process reconciliation report | Present reconciliation results to the EMR User. Claim payment details provided in the report may result in the EMR User taking further actions, including Medicare inquiry, submitting additional claims, etc. |

## Claim Submission

Claims are submitted to MCE by calling the Claim Submission MCE-WS and validated through the MCE rules engine using structure and business logic. MCE returns a claim "receipt" acknowledging the data elements received and stored for each claim, a list of errors and warnings (if any), and broadcast messages (if any). If the claim is submitted successfully (with no errors), the MCE claim receipt will contain an MCE claim number.

The diagram below shows the detailed end-to-end flow of the claim submission process between a clinic and MCE.



**Figure 4:** Claim Submission Flow

MCE offers two modes for claim submission: ***Validate-only*** and ***Submit*** to the Medicare system.

From the EMR, a claim request may be sent to MCE in *Validate-Only* mode, which performs a comprehensive validation of the claim record without saving the claim in MCE. A claim receipt document is returned with the results of the claim validation and includes the successful claim status or errors and warnings related to the claim. If there are any active MCE broadcasts, the information will be sent back in the claim receipt document.

Claims submitted with *Validate-Only*=TRUE are validated but not saved in MCE. The claim receipt for *Validate-Only* claims does not contain the MCE claim number because MCE claim numbers are only generated for claims successfully submitted (saved) in MCE.

If the *Validate-Only* flag is FALSE and the claim record passes claim validation without warnings or errors, the claim request is accepted and recorded in MCE. An MCE claim number is assigned, and a claim receipt document is returned to the EMR. In addition to the claim status and MCE claim number, the claim receipt document will include all the data stored in MCE.

### Errors and Warnings

MCE returns a list of warnings and errors (if any) as a response to the claim submission by the EMR User. If warnings or errors are detected, the affected fields are identified along with the associated error or warning messages (in both English and French).

If the claim contains a warning, then the EMR User can choose to correct the cause of the warning and resubmit the claim. Alternatively, they could resubmit the claim with the *Ignore-warnings* flag set to true, so the claim is submitted to MCE regardless of the warnings detected. The EMR can be configured to ignore warnings by default. The warnings will still be added to the claim receipt document, but the claim will be accepted into MCE. If the claim contains errors, MCE will reject the claim. The claim must be corrected and resubmitted.

Not all errors/warnings may be present upon the first claim submission attempt. Different validation paths in the MCE rule engine can result in many errors, whether structural (e.g., date is invalid) or business related (e.g., service code is not valid for patient gender). Since structural rules are given priority in the MCE rules engine, business related rules will not be validated until all structural issues are corrected. It may take multiple attempts at fixing errors in the claim before it is successful.

### Broadcast

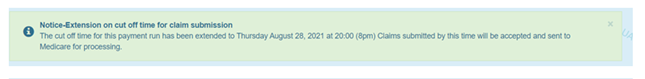
Broadcast messaging is implemented by including active broadcasts as a response to the claim submission by the EMR User. Typical broadcasts contain information such as details about planned MCE outage times or notifications of claim validation rule changes. Broadcasts are global in nature and are attached to every claim receipt returned for their active duration as defined by the “Active timestamp” and “Expiry time stamp”.

Each broadcast contains the following:

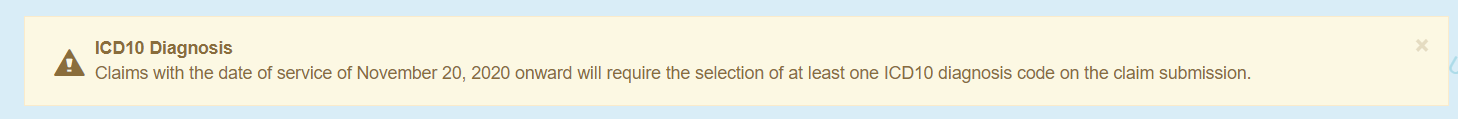
* A unique Broadcast ID
* French and English text for the broadcast
* An indicator of severity (urgent, warning, notification)
* Active time stamp
* Expiry time stamp

Below are examples of Broadcasts of various severities (Notification, Warning and Urgent) and suggested visual indicators to represent the severity:

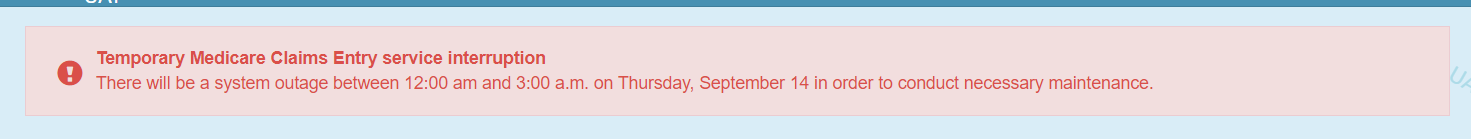
* **Notification**: A published statement informing the user of a matter of interest. Refer to the image below, for example:



* **Warning**: A notice or bulletin that alerts the user of an issue or billing instruction. Refer to the image below for example:



* **Urgent**: Message that requires immediate attention. Refer to the image below for example:



EMRs are expected to process and present broadcasts to users, and if possible, by severity. For example, “notification” severity broadcasts might be displayed as a banner and then disabled once the EMR User has seen it a few times; however, more important broadcasts could require an acknowledgement asking the EMR User to click “ok” to proceed.

Once a Broadcast expires, the ID will never be reused. Using the unique message ID, the EMR can accurately manage broadcast information for their EMR Users.

### Claim Numbering

MCE-WS allows EMRs to apply their own claim numbering scheme to the claims they submit to support reconciliation processes. This is accomplished with a set of two related fields used to record claim IDs from external coding systems. The fields are embedded in the claim submission using the following fields:

1. Org ID (this is set in the header of the claim message)
2. ExternalSystemClaimNumber (the claim number or unique identifier issued by the EMR)

These fields let EMRs attach their own internal claim number to claims. MCE and the Medicare system guarantee that the contents of these fields will not be modified in processing the claim and will be submitted back to the EMRs on the claim receipt documents.

Using the Org ID and the ExternalSystemClaimNumber allows EMRs to receive digital reconciliation data containing their own claim numbers.

The EMR should record the MCE claim number returned upon a successful claim submission to MCE. However, in cases where the EMR does not have the capacity to record the MCE claim number, MCE offers a Web Service that will produce a cross-reference of ExternalSystemClaimNumber to MCE claim numbers. This will aid the clinic in communicating with the Medicare team’s enquiries because the Medicare system works exclusively with the MCE claim number.

## Cross-Ref MCE Web Service

MCE provides a Cross-Ref MCE-WS that offers a cross-reference of MCE claim numbers and the associated External System claim numbers issued by the EMR. This service restricts the cross-reference to the submitted claims within the specified date range if a date range is included.

## Payment Reconciliation Request

EMR software should retrieve reconciliation data using the Get EMR Reconciliation MCE-WS. This service returns all reconciliation information on claims submitted from a specific Org ID.

In addition to the reconciliation data, the claim receipt document will also contain, for each claim: the Org ID, external system claim number, and MCE claim number allowing the EMR to reconcile using their own claim processing regime. Reconciliation will be available for all claims submitted by that EMR.

# Open Data Gateway (ODG)

The MCE ODG is a mechanism whereby MCE data that drives claim calculations and submission can be shared with EMRs in real time. This approach removes the requirement for EMRs to “hard-code” these values, and enables them to continuously stay in lockstep with MCE without the need for software releases.

ODG data tables are maintained and updated regularly (sometimes daily) in response to Medicare business changes (e.g., yearly Medicare negotiations) and EMRs are expected to automatically synchronize these tables and make that data (e.g., Immunization Vaccines and Lot numbers, Service Codes and associated units, etc.) available to providers for billing.

Through the ODG, MCE publishes these data tables and other digital support materials for EMRs to synchronize via Web Services. The published data can be retrieved as either XML or JSON. Some of the published ODG tables are updated very infrequently (e.g., Specialty Rate), while others can be updated weekly or even daily (e.g., Vaccine Lot).

## Version and Vintage Control

The Get Available Tables MCE-WS returns two details that can be used by the EMR to determine if the ODG table needs to be refreshed: the version and vintage of that table. Version refers to the structure, while Vintage refers to the content of a table.

Adding columns, deleting columns, or changing a data type of a column constitutes a change to the table’s structure; this will cause the ***Version***to be incremented.

A ***Version*** is a number whose value will be either a date-time stamp (YYYYMMDDMMSS) or a sequential integer. This value indicates the highest level of structural change for this table, and a higher value indicates a more recent structural change occurred. The Version is structured so that the versions can be compared with a *Greater-Than* expression.

The EMR User can expect a Version Description field to be returned with the version value for all but the first version of the table. The Version Description will describe the modifications to the table’s structure (with the previous version of the table) and is returned with each Get Table MCE-WS execution.

Adding rows, deleting rows, or modifying existing rows constitutes a change of table contents; this will cause only the ***Vintage***to be changed.

A ***Vintage*** is a number, and it indicates the most recent addition or modification to the *content* of rows in the table.

The value of vintage is standardized such that the value can be compared to any other vintages with a simple *Greater-Than* expression. Vintages are expressed as dates in the following format YYYYMMDDMMSS, which compares naturally with all collating sequences.

The value will be either a date-time stamp (YYYYMMDDMMSS) or a sequential integer.

If the EMR keeps track of this information each time an ODG table is synchronized from MCE, the EMR only needs to compare the *Version-Vintage* of the current MCE table to the *Version-Vintage* of the last synch (the Get Table MCE-WS will also calculate this for the clinic) to confirm if the table has been modified. If either value differs from the values of the previous table synch, a table refresh is needed to keep the EMR current with MCE.

**NOTE**: Given a version update is a structural change to the table, EMR vendors will be informed ahead of the change to allow them to make any necessary updates to their software (if any) ahead of the release of this table change.

## Get Available Tables MCE Web Service

The Get Available Tables MCE-WS returns the ID, name, description, vintage, and version of each table that is available for synchronization. The EMR can use this information to determine available tables and if these tables have been modified/updated since the EMR last synchronized the table. This facilitates efficient synchronization of the ODG tables, that is, synchronizing only the tables that have changed since the last synchronization.

## Get Table MCE Web Service

Each table in the list returned by Get Table MCE-WS is available for synch by the EMR. The EMR needs to call the Get Table MCE-WS with the table's ID. This first synchronization request (initializing the tables in the EMR) needs to be made *without* specifying the vintage (see [Version and Vintage Control](#_Version_and_Vintage) section) to ensure that the EMR retrieves the latest version. The table's vintage will be returned with the table's contents, and this vintage should be stored in the EMR with the target data set. The EMR is then ready to participate in the cyclic ODG table synchronization processes.

All subsequent synchronization requests should include the vintage recorded in the previous data set synch. If the vintage in the ODG is equal to the vintage declared by the calling EMR, then an empty (null) response is returned. However, if the ODG has a more recent copy of the data set, then the data set will be encoded as a document and embedded in the response to the Web Service. The EMR should then record the updated vintage value in preparation for the synchronization cycle for the next day.

# MCE-WS Unit Calculation

The following section describes the inputs, elements, and considerations to Medicare’s unit calculation logic, and it should be reviewed alongside the MCE-WS Unit Calculation document, which fully defines the logic to be implemented in the EMR as well as the supporting ODG tables. To assist in understanding, this section contains examples of services claimed. These examples are used solely to exemplify the logic. The data may not be aligned to the currently negotiated services and fees as defined in the New Brunswick Physicians’ Manual.

## Unit Calculation Inputs

The following inputs influence the calculation of units claimed for eligible services in MCE:

* Service Code and Service Date
* Service Count
* Provider Role
* Remuneration Model
* Manual Percentage
* Anaesthesia Duration and Modifiers
* Premiums

## Service Code and Date of Service

Service Code and Date of Service are inputs that are used to further determine whether a service may be eligible or whether other conditions may apply to the EMR unit claim calculations.

### Service Eligibility

The Service Code and Date of Service are inputs used to determine Service Eligibility. Service Eligibility is the first step in the unit calculation logic, as it provides the following elements used in the calculations:

* Basic Units
* Anaesthesia Units
* Exclude Duration flag
  + Identifies which service eligibilities are flagged not to use Anaesthesia duration (anaes time) in calculations
    - For example, service code 2449
* Service Interval
  + Identifies the duration, in minutes, used for payments in service codes that use the Anaesthesia Duration in the calculations but do not follow the Basic Anaesthesia Duration calculation.
    - For example, service code 1793 – Continuous Epidural infusion, labour, **per half-hour**, (maximum 22 units)
* After Hours Emergency Premium
* Cancer Premium
* Base Code Percent

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| **Example 1**: Service Eligibility claimed units based on Date of Service | |
| **Description** | **Value** |
| Date of Service | 01/05/2020 (DD/MM/YYYY) |
| Service Code | 1 - GP OFFICE VISIT |
| Service Count | 1 |
| Role | 0 |
| Units Claimed | 31 |

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| **Example 2**: Service Eligibility claimed units based on Date of Service | |
| **Description** | **Value** |
| Date of Service | 01/05/2022 (DD/MM/YYYY) |
| Service Code | 1 - GP OFFICE VISIT |
| Service Count | 1 |
| Role | 0 |
| Units Claimed | 32 |

### Base Code Percent

MCE contains a list of service codes associated with the percentage (%) related service code you are billing. To determine if a service code uses the base code functionality, a BASE\_CODE\_PERCENT field is available on the SERVICE\_ELIGIBILITY table. If the EMR User selects one of the service codes with a BASE\_CODE\_PERCENT set, the list of service codes they can choose is available in the SERVICE\_BASE\_CODE table.

Example:

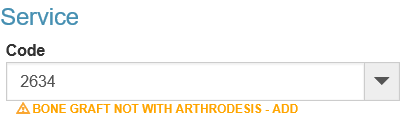
| **SERVICE\_CODE** | **EFFECTIVE\_DATE** | **TERMINATION\_DATE** | **BASE\_SERVICE\_CODE** |
| --- | --- | --- | --- |
| 2634 | 16/08/2018 0:00 | 31/12/9999 0:00 | 565 |
| 2634 | 16/08/2018 0:00 | 31/12/9999 0:00 | 1978 |
| 2634 | 16/08/2018 0:00 | 31/12/9999 0:00 | 2004 |
| 2634 | 16/08/2018 0:00 | 31/12/9999 0:00 | 2606 |
| 2634 | 16/08/2018 0:00 | 31/12/9999 0:00 | 2607 |
| 2634 | 16/08/2018 0:00 | 31/12/9999 0:00 | 2637 |
| 2634 | 16/08/2018 0:00 | 31/12/9999 0:00 | 2665 |
| 2634 | 16/08/2018 0:00 | 31/12/9999 0:00 | 2741 |
| 2634 | 16/08/2018 0:00 | 31/12/9999 0:00 | 2750 |
| 2634 | 16/08/2018 0:00 | 31/12/9999 0:00 | 2754 |
| 2634 | 16/08/2018 0:00 | 31/12/9999 0:00 | 2805 |

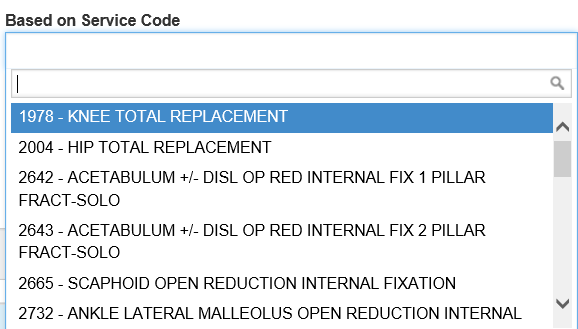
In the example above, if the user selects 2634 on or after August 16th, they can select one of 565, 1978, 2004, 2606, 2607, 2637, 2665, 2741, 2750, 2754, or 2805 as the base code to determine the units.

**MCE Online Example:**

Below is an example of how MCE online represents the Based on Service Code Field.

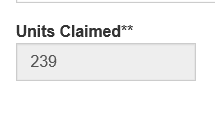
The user is billing for procedure code 1978 and code 2634 (separate claims). When submitting the claim for code 2634, the user also selects from the dropdown table (‘Based on Service Code’ field) code 1978; the units claimed will automatically populate with 239 units (35% of 682).







Units claimed are automatically calculated at 35% of the basic units for code 1978 ( 682 X 35%)



## Service Count

The Service Count reflects the total number of services performed for the service being claimed. This will affect the total calculation as displayed to the EMR User.

## Provider Role

The role-based unit calculation is dependent on the provider’s role and remuneration model with Medicare. There are a few options for this calculation, and this will determine the unit value to display in the EMR to the EMR User for the claim.

For instance,

* Role 0 – General
  + Units claimed in the EMR are dependent on the provider’s remuneration model, which either reflects basic units (e.g. FFS) or a percentage of the basic units (e.g. BPM, TPP).
* Role 1 – Surgeon
  + Used for surgery codes.
* Role 2 – Anaesthetist
  + Units claimed in the EMR are dependent on Anaesthesia Calculations, for example:
    - Exclude Duration Anaesthesia Calculations - Used for Service Eligibilities with an Exclude Duration flag of 1 (true). If these services also have a Special Interval value that is not null, ignore it.
    - Special Service Interval Anaesthesia Calculations - Used for Service Eligibilities with an Exclude Duration flag <> 1 (or null) and a Service Interval value not null, > 0.
    - Default Service Interval Anaesthesia Calculations - Used for all other Service Eligibilities billed with a role of 2.
* Role 3 – Assistant
  + Multiply the calculated value by 33%, round (Except service codes 8133 and 9159 = 100%)
* Role 6 – Collaborating Surgeon
  + Multiply the calculated value by 70%, round (Except service codes 8134 and 9160 = 100%).
* Role 7 – Nurse Service-FMNB
  + Nursing Units are claimed in the EMR, and they can only be claimed by an FMNB Provider for rostered patients. If a patient is not rostered to a provider in the FMNB Group, or if they don’t have a roster status that can claim Nursing Units, then this will result in a $0 claim.

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| **Example 1**: Claim submission for Role 3 (Surgical Assist) billing with After Hours Emergency Premium (Midnight to 6:59 AM) + Multiple Anaesthesia Modifiers | |
| **Description** | **Value** |
| Date of Service | 01/10/2022 (DD/MM/YYYY) |
| Service Code | 2004 – HIP TOTAL REPLACEMENT |
| Basic Units | 682 |
| Service Count | 1 |
| **Role** | **3** |
| After-Hours Emergency Premium | Midnight to 6:59 Premium |
| Units Claimed | 506 |
| **Calculation** | [ [Basic Units] \* Assist Percentage] + Midnight to 6:59 Premium |

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| **Example 2**: Claim submission for Role 6 (COLLABORATING SURGEON) billing with After Hours Emergency Premium | |
| **Description** | **Value** |
| Date of Service | 01/01/2022 (DD/MM/YYYY) |
| Service Code | 2004 – HIP TOTAL REPLACEMENT |
| Basic Units | 682 |
| Service Count | 1 |
| **Role** | **6** |
| After-Hours Emergency | After-Hours Emergency |
| Units Claimed | 763 |
| **Calculation** | [ [Basic Units] \* Collaborating Percentage] + After hours Premium |

## Remuneration Model

A provider’s remuneration model dictates the percentage of units (100% or a reduced percentage) to bill for a service. Remuneration models that incorporate a percentage reduction that affects unit calculations in the EMR are identified in this section.

### FMNB BPM Unit Calculations

FMNB BPM unit calculations in the EMR are dependent on a patient’s roster status with their FMNB Provider. Certain roster statuses affect a percentage reduction in the basic unit rate that needs to be reflected in the units calculated in the EMR and displayed to the EMR User. There are also certain scenarios identified in the unit calculation logic that are considered exceptions to the defined rules, but still considered part of the BPM.

As a patient's roster status with their provider can change at any time during their clinical service, the BPM unit calculations in the EMR need to be able to be refreshed automatically if the change occurs on the Date of Service. The EMR User also needs to be alerted to any changes affecting unsent claims by having these claims flagged for review.

FMNB Providers who are Nurse Practitioners will still have their units calculated based on the BPM; however, they will shadow bill like SAL providers.

### FMNB TPP Unit Calculations

FMNB TPP unit calculations follow the exact same rules as FMNB BPM unit calculations in the EMR, with the only difference being a different percentage reduction of the basic unit rate being used. The TPP uses a reduction override percentage (up to 100%) for a transitional period of time after which the provider switches over to the BPM percentage reduction rate.

## Manual Percentage

When multiple operative procedures are performed on the same day/same patient, the secondary procedure is payable at a lesser fee (unless indicated in the New Brunswick Physicians’ Manual). When the EMR User selects the appropriate percentage, the EMR calculates accordingly. Adding the manual percentage field for the EMR User to choose the appropriate percentage would eliminate the need for manually calculating the units.

The Manual Percentage values available are listed below. For the calculated values, a precision of 4 decimal points must be used.

* 100 % (implied)
* 75% (refer to example 1 below)
* 50%
* 40%
* First at 100%, subsequent at 75% (100/75) (refer to example 2 below)
* First at 100%, subsequent at 50% (100/50)

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| **Example 1**: Claim submission values for Code 1630 PLASTIC OPER LID OR ORBIT MINOR - Basic Units 48, billed at 75%: | |
| **Description** | **Value** |
| Date of Service | 25/07/2022 (DD/MM/YYYY) |
| Service Code | 1630 PLASTIC OPER LID OR ORBIT MINOR |
| Service Count | 1 |
| Role | 1 |
| **Manual percent (%) selected** | **75** |
| Units Claimed | 36 |
| Calculation | [[Basic Units] \* Service Count] \* (75% = 0.75) |

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| **Example 2**: Claim submission values for the same service code billed more than once on the same day/same claim for Code 1630 PLASTIC OPER LID OR ORBIT MINOR - Basic Units 48, billed first at 100% and additional at 75%: | |
| **Description** | **Value** |
| Date of Service | 25/07/2022 (DD/MM/YYYY) |
| Service Code | 1630 PLASTIC OPER LID OR ORBIT MINOR |
| Service Count | 2 |
| Role | 1 |
| **Manual percent (%) selected** | **First at 100%, subsequent at 75% (100/75)** |
| Units Claimed | 84 |
| Calculation | [[Basic Units] \* Service Count] \* (First at 100%, additional at 75% each = 0.875) |

## Anaesthesia Duration and Modifiers

An Anesthesia time is required for services with a provider Role of 2 in the calculation logic. Some exceptions are made for service eligibilities with override values in the Exclude Duration flag and Service Interval fields. The Exclude Duration flag identifies which service eligibilities are flagged not to use Anaesthesia duration (anaes time) in the calculations. Anesthesia Modifier Codes may also be added on to a claim and need to be reflected in the EMR’s calculation.

***For more information, refer to Chapter 5, Section 2 of the New Brunswick Physicians’ Manual (***[***EN***](https://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/en/Physicians/new_brunswick_physicians_manual.pdf) ***|*** [***FR***](https://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/fr/Medecins/manual_des_medecins_du_nouveau-brunswick.pdf)***).***

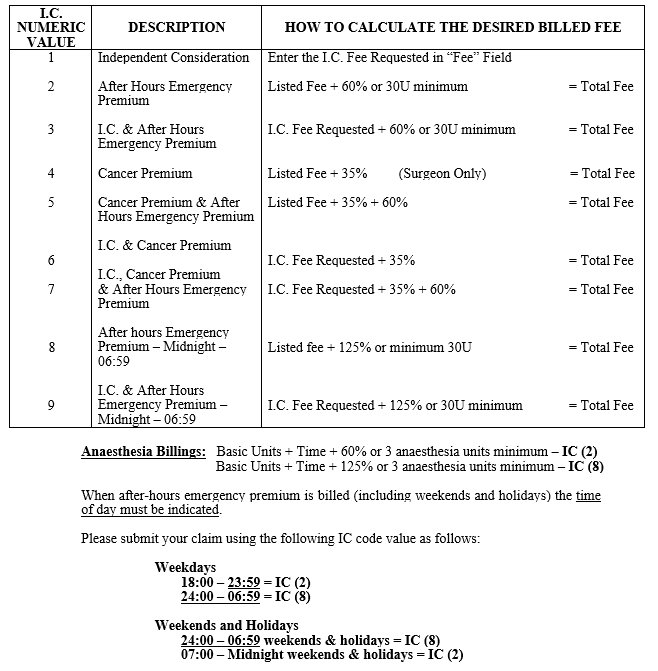
|  |  |
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| **Example 1**: Claim submission for Role 2 (Anaesthesia) billing with After Hours Emergency Premium | |
| **Description** | **Value** |
| Date of Service | 01/01/2022 (DD/MM/YYYY) |
| Service Code | 2004 – HIP TOTAL REPLACEMENT |
| Anaesthesia Units | 13 |
| Service Count | 1 |
| **Role** | **2** |
| Anaes Time | 0200 |
| **After-Hours Emergency Premium** | After-Hours Emergency - |
| Units Claimed | 34 |
| Calculation | [ Anaes Basic Units + Anaes Time Units] + After-hours Premium |

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| **Example 2**: Claim submission for Role 2 (Anaesthesia) billing with After Hours Emergency Premium + Multiple Anaesthesia Modifiers. | |
| **Description** | **Value** |
| Date of Service | 01/01/2022 (DD/MM/YYYY) |
| Service Code | 2004 – HIP TOTAL REPLACEMENT |
| Anaesthesia Units | 13 |
| Service Count | 1 |
| **Role** | **2** |
| Anaes Time | 0200 |
| **Anaes Modifiers** | **2 and 7** |
| Units Claimed | 59 |
| **After-Hours Emergency Premium** | After-Hours Emergency |
| Calculation | [ Anaes Basic Units + Anaes Time Units + Anaes Mod[2] + Anaes Mod[7]] + After hours Premium |

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| **Example 3**: Claim submission for Role 2 (Anaesthesia) billing with After Hours Emergency Premium (Midnight to 6:59 AM) + Multiple Anaesthesia Modifiers. | |
| **Description** | **Value** |
| Date of Service | 01/10/2022 (DD/MM/YYYY) |
| Service Code | 8961 - ARTHRODESIS SINGLE HIND FOOT FUSION |
| **Anaesthesia Units** | **7** |
| Service Count | 1 |
| **Role** | **2** |
| Anaes Time | 0220 |
| AHEP | Midnight to 6:59 |
| Anaes Modifiers | 2, 10, 13 |
| Units Claimed | 99 |
| Calculation | [ Anaes Basic Units + Anaes Time Units + Anaes Mod [2] + Anaes Mod [10] + Anaes Mod [13]] + Midnight to 6:59 Premium |

## Premiums

The claimed values in the Medicare system could be altered by applying a valid combination of the Premiums. For additional information, refer to the table below, which can also be found in the New Brunswick Physicians’ Manual.



EMR Users need to have the ability to perform the following on claim submission to MCE-WS:

* Select a valid combination of all premiums.
* Attach documents and add comments to support the Independent Consideration (IC) requests.
* Overwrite the calculated Units Claimed.

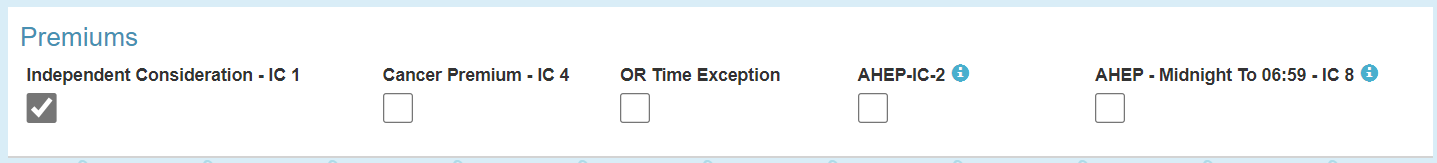
MCE-WS will validate the claim, determine which Premium values can be billed together, and return an error for invalid combinations (For example, ***After Hour Emergency*** and ***AHEP – Midnight to 6:59 AM*** cannot be billed together).

The values representing the Premiums in the **Claim Submission MCE-WS** are listed below:

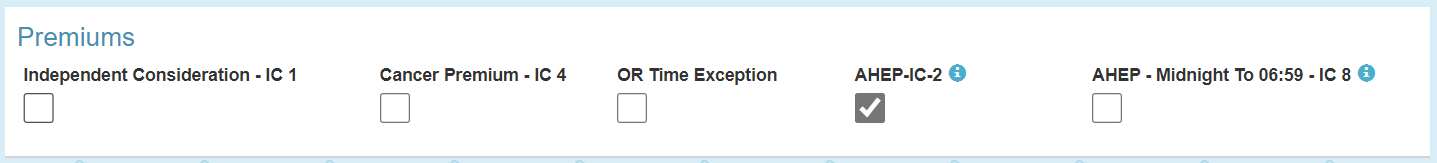
* IsAfterHoursEmergency
* IsCancerPremium
* IsIndependentConsideration
* IsMidnightTo0659
* IsFMNBPremium

See below for some examples of how MCE-Online represents the Premiums in a User Interface and how they map to the legacy IC Premium codes:

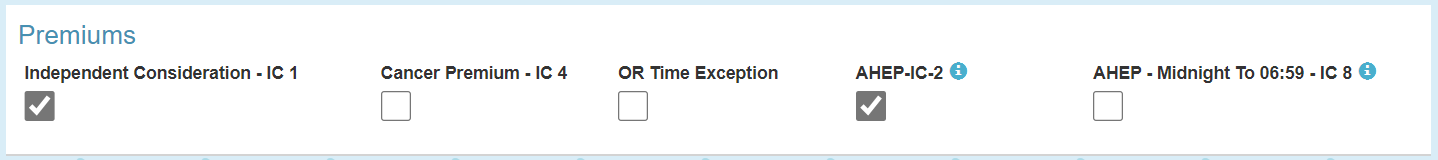
**IC 1 à Independent Consideration (IC)**

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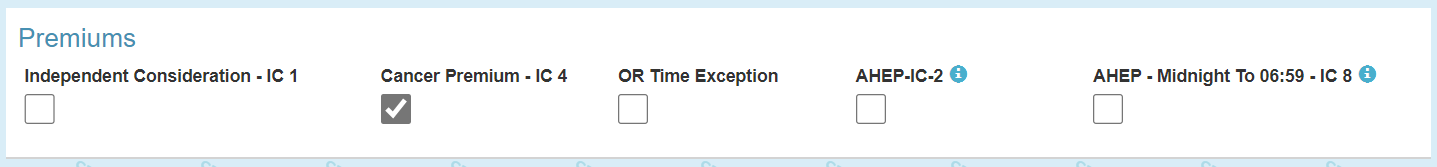
**IC 2àAfter Hours Emergency Premium (AHEP)**

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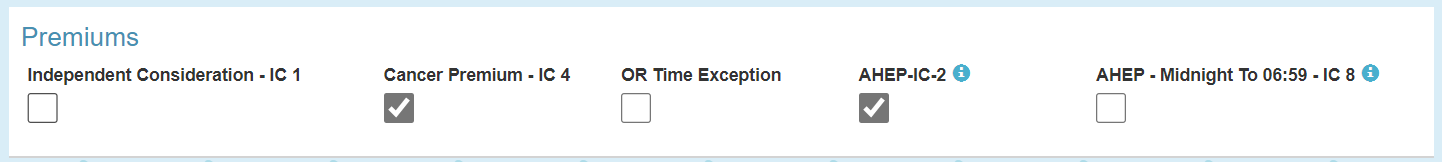
**IC 3 à Bill both IC and AHEP**

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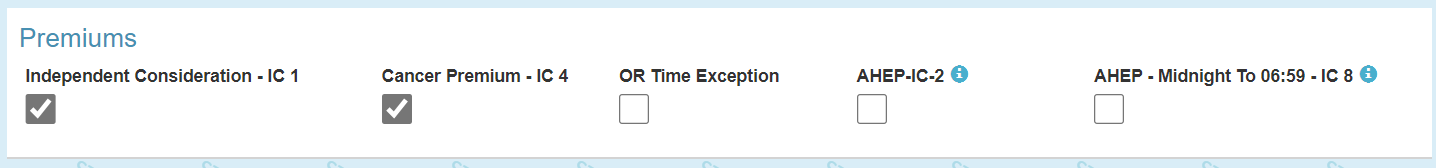
**IC 4 à Cancer Premium**



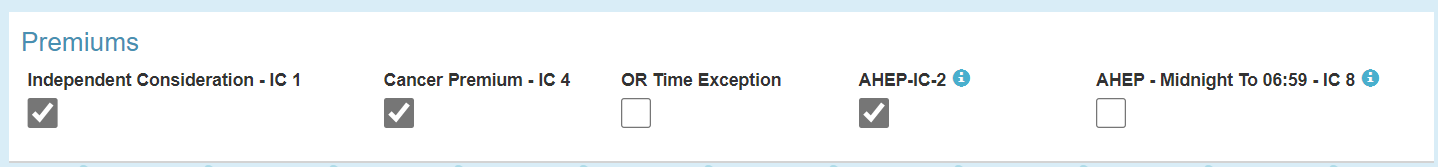
**IC 5 à Bill both Cancer Premium and AHEP**

******

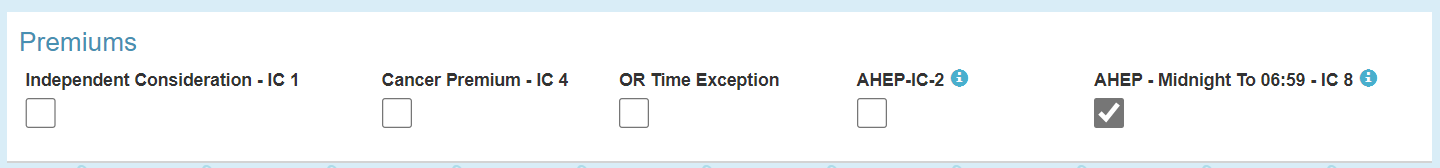
**IC 6 àBill both IC and Cancer Premium**

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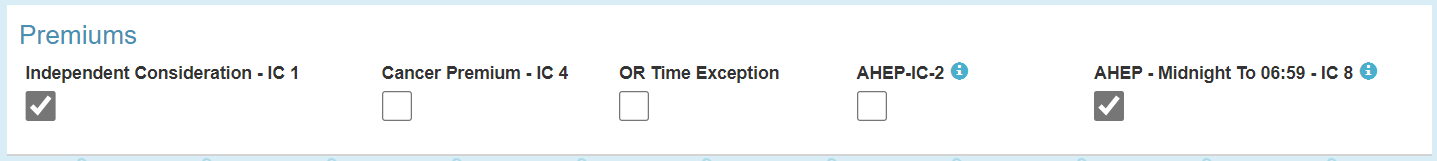
**IC 7à Bill IC, Cancer Premium, and AHEP**

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**IC 8à AHEP Midnight to 6:59**

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**IC 9àIC and AHEP Midnight to 6:59**

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### Independent Consideration (IC) Examples

In situations where exceptional circumstances warrant a greater fee than identified in the Fee Schedule, a claim should be submitted with the IC Premium, and the Units Claimed value should be overwritten with the desired claimed value. In addition, a provider must support the IC request by providing additional documentation in the form of comments and/or attachments.

Cancelled claims that are over 92 days and *need to be re-submitted under a different Medicare Number* must be marked for IC with an explanation.

# Immunizations

The product name and vaccine lot number must be indicated in the appropriate field designated on the claim when billing for an immunization. Below are the possible combinations:

* Each immunization product has 2 service codes
* Each immunization code has one to many products
* Each product has one to many lot #’s

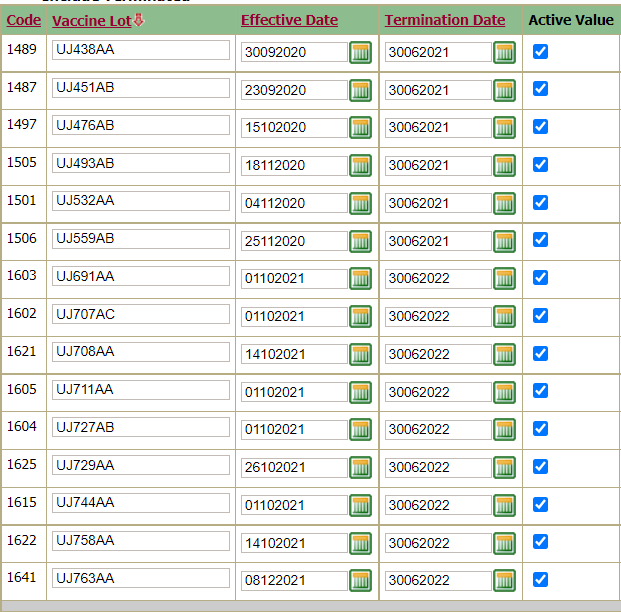
For additional information, refer to the IMMUNIZATION\_PRODUCT table.

**Example of Immunization Billing:**

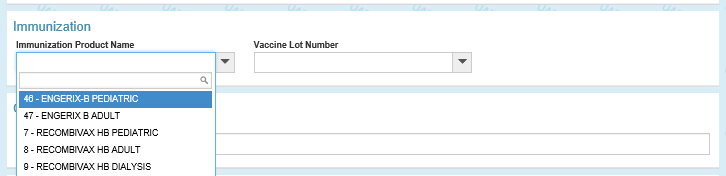
Service Codes: 8637- INFLUENZA - WITH VISIT and Code 8667- INFLUENZA

Immunization Product: FLUZONE QUADRIVALENT

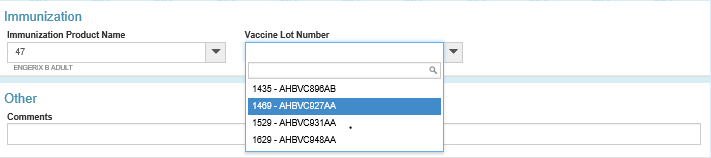
Lot #’ for: FLUZONE QUADRIVALENT



Once the service code is entered (in this case, code 8637), the EMR should display only the active products based on the date of service on the claim.



Once the product is selected, the EMR should only display the active lot #s on the date of service associated with that product.



Refer to Chapter 4 of the New Brunswick Physicians’ Manual for additional information regarding immunization.

# Reporting

The EMR must support EMR Users in producing reports. All reports must be able to be generated by the EMR User, displayed on-screen in a user-friendly format, and printable.

## Rostering Report

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| **Name of Report** | **Description of Report** |
| **Current Roster Status Report** | The EMR must be able to produce a report, at any time as requested by an EMR User, on the current roster status of all patients with a specific provider or group of providers that the EMR User selects. The EMR User must also be able to select specific roster statuses (one or many) and produce a report only for patients with those statuses.  The report must include, at minimum:   * Provider full name * Patient full name * Patient address * Patient phone number * Patient Medicare Number * Patient current roster status * Roster exception reason (if applicable) * Effective date * Termination date * Patient status in EMR (e.g. active, inactive, causal, deceased)   **Note:** Termination dates that represent the end of time (e.g., 12/31/9999) do not need to be displayed in the report (leaving this date empty would signify a current status)  **Format:**    **Example:** |

# EMR Vendor Requirements

This section summarizes the requirements described in the above sections.

## Requirements Structure

For ease of review and understanding, all system integration and business requirements are documented consistently. For each requirement, the following information is provided:

* **ID** – a unique identifier assigned to the requirement
* **Requirement** – a concise statement describing the requirement
* **Status** – each requirement is identified as:
  + Previous – introduced in the past published iteration of this document on the MCE Web Portal
  + New – introduced in the most recent iteration of this document
  + Retired <version> – retired in the tagged version of the document
  + Updated – when the document stays fundamentally the same, but it is updated with clarifications in the current iteration of the document, or if the priority has changed (moved from optional to mandatory)

NOTE: New and Updated pertain to changes made in the most current version; they will become “Previous” in future versions.

* **Guidelines/Additional Notes –** these additional instructions constitute part of the requirement and are relevant to the implementation of the requirement.
* **Priority** – each requirement is identified as Mandatory (M) or Optional (O).
* **Category** – each requirement is categorized as either a Core MCE requirement or an FMNB requirement. Note that EMRs implementing FMNB must also first implement all Core requirements.

**Note**: Optional requirements may become mandatory in future releases of this specification.

**Note**: For requirements that are categorized as both Core/FMNB the EMR must implement the Guidelines that align to their selected implementation (for example, if an EMR only implements Core they must only connect to Core Web Services and sync the Core ODG tables, whereas if an EMR implements Core and FMNB they must connect to all Web Services, implement all workflows, including FMNB and synchronize all ODG tables, including those in the FMNB namespace.

## Requirements

The EMR vendors are to meet the following requirements.

| **ID** | **Requirement** | **Status** | **Guidelines/Additional Information** | **Priority** | **Category** |
| --- | --- | --- | --- | --- | --- |
|  | **Claims:** The EMR User must be able to submit all claim fields as defined in the Claim Submission MCE-WS.  **Note:** The Medicare team is not responsible for omitting or adjusting any claims submitted incorrectly due to incorrect unit values or percentages used/calculated by EMR vendors. | Updated | For additional information on required fields, refer to Claim Submission MCE-WS  For calculations, refer to the [MCE-WS Unit Calculation](#_Claims_Calculations_logic) section of this document.  The EMR must include The ICD10-CA code field for claim submission and align with the version supported by Medicare.  As noted, not all fields are needed for all claim submissions. For example, comments are not required on all claim submissions but are required when billing an IC. | M | Core |
|  | **Claims:** The EMR must have the ability to submit a claim for a Non-Resident. | Previous | The EMR must support Non-Resident claims through the MCE web service. A Non-Resident claim is submitted by identifying the Out-of-Province (OOP) Health Care Number and the Province. | M | Core |
|  | **Claims:** The EMR User must be able to overwrite the calculated units claimed on the claim submission. | Previous |  | M | Core |
|  | **Claims:** The EMR User must be able to choose from validate-only and submit modes when submitting a claim. | Previous | For additional information, refer to the [Claim Submission](#_Claim_Submission) section of this document. | M | Core |
|  | **Claims:** The EMRs should apply their own claim numbering scheme to the claims they submit. | Previous | For additional information, refer to the [Claim Numbering](#_Claim_Numbering) and the [Cross-Ref MCE Web Service](#_Cross-Ref_MCE_Web) sections of this document.  For additional information on the cross reference between the EMR claim numbering and the MCE claim numbering see the Cross-Ref MCE-WS. | O | Core |
|  | **Claims:** The EMR must record the MCE claim number returned upon a successful claim submission to MCE. | Updated |  | M | Core |
|  | **Claims:** The EMR should only display active immunization products associated with the selected service code and the date of service. | Updated | For additional information, refer to the [Immunization](#_Immunizations) section of this document.  For additional information on Product and Immunization tables, refer to the ODG table IMMUNIZATION\_PRODUCT | O | Core |
|  | **Claims**: The EMR should only display active vaccine lot numbers associated with the selected immunization product and date of service. | Updated | For additional information, refer to the [Immunization](#_Immunizations) section of this document.  For additional information on Immunization Product and Vaccine Lot tables, refer to the ODG tables IMMUNIZATION\_PRODUCT and  VACCINE\_LOT | O | Core |
|  | **Claims**: The EMR must allow the users to submit a claim as Independent Consideration (IC) when the After-Hours Emergency Premium (AHEP) is not open to a surgical/ procedure service code. The EMR must calculate accordingly, including the AHEP. | Previous | For additional information, refer to the [Premiums](#_Premiums) section of this document. | M | Core |
|  | **Claims**: The EMR must allow the EMR User to submit a claim as Independent Consideration (IC) when the service code billed as role 0 or 1 is not open to a specialty. The EMR must calculate appropriately. | Previous | For additional information, refer to the [Premiums](#_Claiming_IC_/) section of this document. | M | Core |
|  | **Claims:** The EMR must automatically calculate the correct units for claims. | New | For additional information, refer to the [MCE-WS Unit Calculation](#_Claims_Calculations_logic) section of this document. | M | Core |
|  | **Claims:** The EMR must allow the EMR User to choose the appropriate percentage used to calculate the units for a claim. | New | For additional information, refer to the [Manual Percentage](#_Calculations_Specifications_and) section of this document.  For additional information, refer to the ODG table AMOUNT\_PERCENTAGE. | M | Core |
|  | **Claims:** The EMR must be able to accommodate a single provider billing under any one or more of NB’s remuneration models. | New | All remuneration models should be accounted for.  Core EMRs must implement everything except FMNB remuneration models; whereas, FMNB-enabled EMRs will need to support all remuneration-based calculations (including FMNB BPM and TPP).  For additional information, refer to the [Remuneration Models](#_Remuneration_Models) section of this document. | M | Core / FMNB |
|  | **Claims:** The EMR must allow multiple providers working in the same EMR instance to bill under any combination of NB’s remuneration models, regardless of location. | New | e.g., Multiple providers in a single EMR instance (spanning one or more locations) may bill under FFS, SAL, BPM, TPP, etc. All remuneration models should be accounted for.  Core EMRs must implement everything except FMNB remuneration models; whereas, FMNB-enabled EMRs will need to support all remuneration-based calculations (including FMNB BPM and TPP).  For additional information, refer to the [Remuneration Models](#_Remuneration_Models) section of this document. | M | Core / FMNB |
|  | **Claim Receipt - Broadcast**: The EMR must process and present all broadcasts to users. | Previous | For additional information, refer to the [Broadcast](#_Broadcast) section of this document. | M | Core |
|  | **Claim Receipt - Broadcast**: The EMR should process and present the broadcasts to users according to their severity. | Previous | For additional information, refer to the [Broadcast](#_Broadcast) section of this document. | O | Core |
|  | **Claim Receipt - Errors and Warnings:** The EMR must display all errors and warnings returned from MCE to the EMR User. | Previous | Provide a user-friendly means to update/resubmit the claim in response to the error and warnings.  For additional information, refer to the [Errors and Warnings](#_Errors/Warnings) section of this document. | M | Core |
|  | **Claim Receipt - Errors and Warnings:** The EMR must provide an EMR User-driven configuration to globally ignore warnings at claim submission on a provider level. | New | For additional information, refer to the [Errors and Warnings](#_Errors_and_Warnings) section of this document. | M | Core |
|  | **Payment Reconciliation:** The EMR should present the claim reconciliation information for processing and remediation. | Previous | Provide a user-friendly means to address claim payment remediation based on the reconciliation information presented (e.g., submitting a new claim based on info provided in the reconciliation data).  For additional information, refer to the [Payment Reconciliation Request](#_Payment_Reconciliation_Request) section of this document.  For additional information on Get EMR Reconciliation Webservice, refer to Get EMR Reconciliation MCE-WS | M – Mandatory for Certified EMRs (Prerequisite of EMR Certification)  O – Optional for non-certified EMRs and Billing Systems | Core |
|  | **ODG Tables Sync:** The EMR must use an automated process to synchronize all ODG tables daily. | Updated | For additional information, refer to the [Open Data Gateway](#_Open_Data_Gateway) section of this document.  For additional information on the Get Available Table Webservice, refer to Get Available Tables MCE-WS.  For more information regarding the ODG tables, refer to Open Data Gateway.  Core EMRs need to synchronize all ODG tables with the exception of what resides in the FMNB namespace; whereas, FMNB-enabled EMRs need to synchronize all ODG tables, including those that reside in the FMNB namespace. | M | Core / FMNB |
|  | **ODG Tables Sync:** The EMR User must be able to synchronize and update any existing tables on-demand as and when required. | Updated | e.g., when the Medicare business team communicates the negotiation cutover instructions and timing to vendors as they occur, a synchronization and update may be required on-demand.  For additional information on Get Table Webservice refer to Get Table MCE-WS  Core EMRs need to synchronize all ODG tables with the exception of what resides in the FMNB namespace; whereas, FMNB-enabled EMRs need to synchronize all ODG tables, including those that reside in the FMNB namespace. | M | Core / FMNB |
|  | **ODG Tables Sync:** The EMR should maintain the version and vintage information for each ODG table and use this information to selectively synchronize only the tables that have been modified. | Updated | By maintaining and using the version and vintage information, the EMRs can reduce the amount of data required for processing.  For additional information, refer to the [Version and Vintage Control](#_Version_and_Vintage) section of this document.  Core EMRs need to maintain this information for all ODG tables with the exception of what resides in the FMNB namespace; whereas, FMNB-enabled EMRs need to maintain this information for all ODG tables, including those that reside in the FMNB namespace. | O | Core / FMNB |
|  | **ODG Tables Sync:** The EMR must keep all the supporting ODG tables and their entire history to support claim submission and resubmission, which is based on the values on the Date of Service. | Updated | e.g., The EMR must maintain all the data in the service code tables; for instance, the entire Service\_Eligibility table.  When a claim is billed, it must use the correct service eligibility for the Date of Service (DOS).  For additional information, refer to the ODG table [SERVICE\_ELIGIBILITY](https://hpspub.gnb.ca/MCE/WebServices/Site/OpenDataGateway.html#SERVICE_ELIGIBILITY).  For additional information, refer to the [MCE-WS Unit Calculation](#_Claims_Calculations_logic) section of this document.  Core EMRs need to keep this information for all ODG tables with the exception of what resides in the FMNB namespace; whereas, FMNB-enabled EMRs need to keep this information for all ODG tables, including those that reside in the FMNB namespace. | M | Core / FMNB |
|  | **ODG Tables Sync:** The first synchronization request (initializing the tables in the EMR) must be made *without* specifying the vintage. | Updated | This is to ensure that the EMR retrieves the latest version.  For additional information, refer to the [Version and Vintage Control](#_Version_and_Vintage) section of this document.  Core EMRs need to implement this for all ODG tables with the exception of what resides in the FMNB namespace; whereas, FMNB-enabled EMRs need to implement this for all ODG tables, including those that reside in the FMNB namespace. | M | Core / FMNB |
|  | **MCE Software and Integration:** The EMR software must support TLS 1.2. | Previous | MCE only supports **TLS 1.2** | M | Core |
|  | **MCE Software and Integration:** The URLs specific to the MCE Web APIs in the EMR should be coded as configurable items in the billing system. | Updated | While rare, it is possible there may be changes to URLs in the future.  Core EMRs should implement this only for Core Web APIs; whereas, FMNB-enabled EMRs should implement this for all Web APIs, including FMNB.  For additional information on URLs refer to MCE Web APIs. | O | Core / FMNB |
|  | **MCE Software and Integration:** The EMR must support the required MCE Web Services HTTP headers. | Previous | Here are additional guidelines on the Web Services HTTP headers.   |  |  | | --- | --- | | **Header** | **Required** | | Content-Type | Yes -Post Only | | Accept | Optional | | Org ID | Yes | | Token | Yes |   **Content-Type**: No assumptions are made in the content type of the request. Accepted formats: text/XML, application/JSON.  **Accept**: Acceptable content types for the response. Accepted formats: text/XML, application/JSON. By default, MCE returns the response in JSON format.  **Org ID**: The EMR ID of the vendor. If not provided an authorization error response is returned.  **Token**: A security token provided to the vendor. | M | Core |
|  | **MCE Software and Integration:** The EMR Claim Submission web service must support the submission of optional file attachments. | Updated | For additional information, refer to [ClaimAttachment](https://hpspub.gnb.ca/MCE/WebServices/Help/ResourceModel9c97.html?modelName=ClaimAttachment). | M | Core |
|  | **MCE Software and Integration – Services Unavailable:** The EMR must be able to ensure that all EMR User workflows can continue and rostering events are queued in the event that the MCE Web Services are unavailable. The order of the rostering events must be maintained. The EMR User must also be alerted in a user-friendly way when MCE Web Services are unavailable at the time of their request. | New | Core EMRs must ensure that all Core EMR User workflows can continue, except for FMNB workflows; whereas, FMNB-enabled EMRs will need to ensure that all EMR User workflows can continue and all rostering events are queued and the order maintained. | M | Core / FMNB |
|  | **MCE Software and Integration – Services Unavailable:** When the MCE Web Services are unavailable, the EMR must retry sending any queued or scheduled (e.g. daily ODG and Roster Syncs) web service requests at regular intervals until a response is received from the web service. For roster events, the order must be maintained on retry. The EMR User and/or EMR Vendor must be alerted in a user-friendly way once all retries have been exhausted and the web services are still unavailable. | New | Core EMRs must retry sending only Core scheduled web service requests; whereas, FMNB-enabled EMRs must retry sending all queued and scheduled web service requests, including FMNB.  In the case of failure for queued web service requests, the EMR must retry 5 times at increasing time intervals between each retry. Suggested retries: immediately, 10 seconds, 1 minute, 10 minutes, 1 hour. | M | Core / FMNB |
|  | **Table Domains**: EMR vendors should assign EMR tables to a domain. | Retired (v1.0) | This is a simple grouping method. A domain is a classification for multiple tables. | O | Core |
|  | **FMNB – Rostering (Roster Management)**: The EMR must allow a provider to create and maintain their provider roster within the EMR. | New | A provider must be able to add new patients to their roster, terminate/remove existing patients from their roster, or otherwise update the status of existing patients using the EMR.  For additional information, refer to the [Rostering](#_FMNB_Reporting) section of this document. | M | FMNB |
|  | **FMNB – Rostering (Roster Sync):** The EMR must use an automated process to synchronize a provider’s roster with the Roster Registry daily. | New | For additional information, refer to the [syncRoster Web Service](#_syncRoster_Web_Service) section of this document. | M | FMNB |
|  | **FMNB – Rostering (Roster Sync):** The EMR User must be able to synchronize a provider’s roster data with the Roster Registry on demand using a passed-in date (either a user-specified date or the last successful synchronization date stored in the EMR). | New | For additional information, refer to the [syncRoster Web Service](#_syncRoster_Web_Service) section of this document.  The EMR User may wish to specify a date to support initial roster synchronization or if a provider’s roster in the EMR becomes corrupted and needs to be overwritten by the Roster Registry. | M | FMNB |
|  | **FMNB – Rostering (Roster Sync – Matched Patients):** As part of the roster sync response, the EMR must have a mechanism to match a patient using their Medicare Number, Date of Birth, and Gender sent from the Roster Registry with a single existing patient in the EMR. If a patient matches, they must have their roster data and history replaced automatically with the data in the response. | New | For additional information, refer to the [syncRoster Web Service](#_syncRoster_Web_Service) section of this document.  This includes the scenario where a provider is front-loading their roster either for the first time (initial roster synchronization) or to add additional assigned patients. | M | FMNB |
|  | **FMNB – Rostering (Roster Sync – Unmatched Patients):**  As part of the roster sync response, the EMR must record unmatched patients sent from the Roster Registry along with their roster data and history for review and processing by the EMR User in a prominent location. There must be a mechanism for unmatched patients to be easily reconciled or added to the EMR with their roster data and history. | New | For additional information, refer to the [syncRoster Web Service](#_syncRoster_Web_Service) section of this document. | M | FMNB |
|  | **FMNB – Rostering (syncRoster and syncResident Requests – Precondition):** The EMR must complete (successful or fail) all prior roster events for a patient before submitting a new syncRoster or syncResident request to the Roster Registry. | New | There should be no outstanding roster events for the patient in queue from the EMR to the Roster Registry when a new syncRoster or syncResident request is submitted.  For additional information, refer to the [syncRoster](#_syncRoster_Web_Service) and [syncResident](#_syncResident_Web_Service) sections of this document. | M | FMNB |
|  | **FMNB – Rostering (Patient Sync):** The EMR User must be able to synchronize a patient’s roster data and history with their associated provider in the EMR instance on demand with the Roster Registry. | New | For additional information, refer to the [syncResident Web Service](#_syncResident_Web_Service) section of this document. | M | FMNB |
|  | **FMNB – Rostering (Roster Eligibility Check):** The EMR User must be able to request a check of the patient’s roster eligibility status to a provider on demand with the Roster Registry. | New | For additional information, refer to the [getRosterability Web Service](#_getRosterability_Web_Service) section of this document. | M | FMNB |
|  | **FMNB – Rostering (Roster Status Update):** The EMR User must be able to request an update to a patient’s roster status with their associated provider in the EMR instance on demand with the Roster Registry. These requests must be queued as requested (order maintained). | New | For additional information, refer to the [registerRosterEvent Web Service](#_registerRosterEvent_Web_Service) section of this document. | M | FMNB |
|  | **FMNB – Rostering (Roster Status Update):** The EMR must allow the EMR User to manually select from the list of available roster statuses, roster exception reasons (when required), and providers within the EMR instance when updating a roster status for a patient. | New | For additional information, refer to the [Roster Statuses](#_Roster_Statuses) and [registerRosterEvent](#_registerRosterEvent_Web_Service) sections of this document. | M | FMNB |
|  | **FMNB – Rostering (Duplicates):** The EMR must prevent submitting a request to synchronize a patient’s roster data, update a patient’s roster status, or get the roster eligibility of a patient if the patient is identified as a duplicate patient in the EMR or they are using the same NB Medicare Number as another patient in the EMR. A user-friendly message should be displayed to the EMR Users to advise them of the situation and their request not being sent. | New | e.g., Babies using their mother’s NB Medicare Number or two instances of the same patient exist in the EMR.  EMR Users will need to reconcile the patient records and retry sending the synchronization request. | M | FMNB |
|  | **FMNB – Rostering (EMR Response):** The EMR must automatically replace a patient's EMR roster data and history with the response message data when the response has a PROCESSED status and there are roster data changes identified for a patient. | New | This includes changes to the patient’s roster data and history for retroactive updates. For instance, to account for the scenario when a patient’s active status with Medicare is retroactively updated affecting a change to their current roster status data and history.  For additional information, refer to the [syncRoster](#_syncRoster_Web_Service), [syncResident](#_syncResident_Web_Service), and [registerRosterEvent](#_registerRosterEvent_Web_Service) sections of this document, as this applies to the responses from these web services. | M | FMNB |
|  | **FMNB – Rostering (EMR Response):** The EMR must automatically reject any EMR User-submitted changes or synchronizations to the patient’s EMR roster data when the associated response message returns a REJECTED or ERROR status. | New | For additional information, refer to the [syncRoster](#_syncRoster_Web_Service), [syncResident](#_syncResident_Web_Service), and [registerRosterEvent](#_registerRosterEvent_Web_Service) sections of this document, as this applies to the responses from these web services. | M | FMNB |
|  | **FMNB – Rostering (EMR Response):** The EMR must display any returned rostering web service response messages immediately to the EMR User for review in context with the EMR action that resulted in that response message. | New | For additional information, refer to the [Rostering Web Services](#_Rostering_Web_Services) section of this document, as this applies to all rostering web services. | M | FMNB |
|  | **FMNB – Rostering (User Interface – Roster Status):** The EMR must display the patient’s current roster status with their associated provider in the EMR instance in a prominent location within the patient chart for EMR Users to easily review. | New | For additional information, refer to the [Roster Statuses](#_Roster_Statuses) section of this document. | M | FMNB |
|  | **FMNB – Rostering (User Interface – Roster Status Termination Date):** The EMR must display the patient’s current (or upcoming) roster status termination date in a prominent location within the patient chart for EMR Users to easily review. | New | For additional information, refer to the [Roster Statuses](#_Roster_Statuses) section of this document.  Termination dates that represent the end of time (e.g., 12/31/9999) do not need to be displayed to the EMR User. And blank termination date field indicates a current record. However, all such notations must match the EMR context. | M | FMNB |
|  | **FMNB – Rostering (User Interface – Roster Status Termination Indicator):** The EMR must have a visual indicator in a prominent location within the patient chart to alert EMR Users if the patient’s roster status will expire within 3 months. | New | For additional information, refer to the [Roster Statuses](#_Roster_Statuses) section of this document. | M | FMNB |
|  | **FMNB – Rostering (User Interface –Patient Roster History):** The EMR must capture and display the patient’s Roster History as it applies to all FMNB Providers within the FMNB Group in the EMR instance. If the patient has a roster history with more than one FMNB Provider in the FMNB Group, then that history must be available for review by EMR Users with appropriate privileges. | New | The Patient’s Roster History must include the following data, at minimum:  - Patient full name  - Provider full name  - Roster status  - Roster exception reason description (if applicable)  - Effective date  - Termination date  A Patient’s Roster History may be amended by Medicare for various reasons, one example being to account for when a patient’s active status with Medicare is retroactively updated affecting a change to their roster history.  For a proposed representation, refer to the Appendix’s [Patient Roster History](#_Patient_Roster_History_1) section of this document.  For additional information, refer to the [syncRoster](#_syncRoster_Web_Service), [syncResident](#_syncResident_Web_Service), and [registerRosterEvent](#_registerRosterEvent_Web_Service) sections of this document, as this applies to the responses from these web services. | M | FMNB |
|  | **FMNB – Rostering (User Interface – Roster Log):** The EMR must keep a user-friendly and filterable Roster Log of all Rostering Web Services requests sent and responses received for all providers and patients within the EMR instance. | New | The Roster Log must include the following data, at minimum:  - Web Service Message Type  - Message Status  - Date Message Sent  - Date Response Received  - Response Code (if applicable)  - Response Message (if applicable)  - Patient full name  - Patient Medicare Number  - Provider full name  For additional information and a proposed representation, refer to the Appendix’s [Roster Log](#_Roster_Log) section of this document. | M | FMNB |
|  | **FMNB – Rostering (User Interface – Labels):** The EMR must label all rostering and configuration components consistently according to the defined FMNB Labels. | New | Refer to the Appendix’s [FMNB Labels](#_FMNB_Labels) section of this document for the defined FMNB Labels. | M | FMNB |
|  | **FMNB – Rostering (Claims):** The EMR must immediately reflect an updated roster status in any unsent Medicare Billing claims if the patient's roster status with their provider changes at any time during their clinical service’s Date of Service affecting a change in the calculations. These claims must also be flagged for review by the EMR User. | New | Must be applied to the claim payment detail.  e.g., if the Roster Status of a patient is updated after a synchronization task, any unsent Medicare claims for that patient must be updated accounting for the updated roster status. | M | FMNB |
|  | **FMNB – Rostering (Reporting):** The EMR must be able to generate the Current Roster Status Report. |  | For additional information, refer to the [Rostering Reports](#_Rostering_Reports) section of this document. | M | FMNB |
|  | **FMNB – Group (FMNB Configuration Sync)**: The EMR must use an automated process to synchronize the FMNB Configuration information for all FMNB Groups within the EMR instance daily. | New | For additional information, refer to the [getGroupProviderConfig](#_getGroupProviderConfig_Web_Service) section of this document. | M | FMNB |
|  | **FMNB – Group (FMNB Configuration Sync)**: The EMR should be able to synchronize the FMNB Configuration information for all FMNB Groups within the EMR instance, a specific FMNB Group, or a specific provider on demand as needed. | New | For additional information, refer to the [getGroupProviderConfig](#_getGroupProviderConfig_Web_Service) section of this document. | O | FMNB |
|  | **FMNB – Group (Association)**: The EMR must be able to identify a provider as belonging to an FMNB Group. | New | For additional information, refer to the [Family Medicine New Brunswick (FMNB)](#_Toc149122290) and [getGroupProviderConfig](#_getGroupProviderConfig_Web_Service) sections of this document. | M | FMNB |
|  | **FMNB – Group (Composition)**: The EMR must be able to support multiple FMNB Groups working and billing within the same EMR instance. | New | For additional information, refer to the [Remuneration Models](#_Billing_Models_and) and [getGroupProviderConfig](#_getGroupProviderConfig_Web_Service) sections of this document. | M | FMNB |
|  | **FMNB – Group (Access):** The EMR must allow all providers within the same FMNB Group to access and update the medical records, provide services, and bill for all patients rostered to providers in the FMNB Group. | New |  | M | FMNB |
|  | **FMNB – Group (Billing)**: The EMR must allow all providers within the same FMNB Group to bill their FMNB Remuneration Model from the same EMR instance, regardless of physical location. | New | For additional information, refer to the [Family Medicine New Brunswick (FMNB)](#_Family_Medicine_New) section of this document. | M | FMNB |
|  | **FMNB – Group (Billing):** The EMR must apply a patient's current roster status with their provider in the FMNB Group and the associated billing rules to all providers in the same FMNB Group when billing. | New |  | M | FMNB |

# Appendix

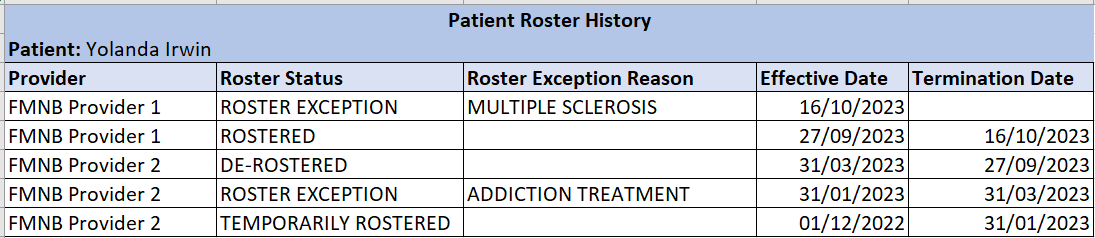
## FMNB Labels

This section identifies the FMNB labels to use consistently within the EMR for easy reference and understanding of EMR Users.

|  |  |  |
| --- | --- | --- |
| **English Label** | **French Label** | **Label Use** |
| Configuration Sync | Sync de configuration | For the button/functionality in the EMR that invokes the getGroupProviderConfig web service. |
| Roster Sync | Sync de la liste | For the button/functionality in the EMR that invokes the syncRoster web service;  What the EMR User sees for the syncRoster message type in the Roster Log. |
| Patient Sync | Sync du patient | For the button/functionality in the EMR that invokes the syncResident web service;  What the EMR User sees for the syncResident message type in the Roster Log. |
| Roster Status Update | Mise à jour du statut de la liste | For the button/functionality in the EMR that invokes the registerRosterEvent web service;  What the EMR User sees for the registerRosterEvent message type in the Roster Log. |
| Roster Eligibility Check | Vérification de l'éligibilité de la liste | For the button/functionality in the EMR that invokes the getRosterability web service;  What the EMR User sees for the getRosterability message type in the Roster Log. |
| Roster Status | Statut de la liste | For all labels in the EMR that refer to the patient’s Roster Status. |
| Roster Exception Reason | Raison de l'exception de la liste | For all labels in the EMR that refer to the patient’s Roster Exception Reason. |
| Effective Date | Date d'effet | For all labels in the EMR that refer to the patient’s Roster Status Effective Date. |
| Termination Date | Date d'expiration | For all labels in the EMR that refer to the patient’s Roster Status Termination Date. |
| Patient Roster History | Historique de la liste du patient | The name of the window/view that displays the Patient Roster History in the EMR’s user interface. |
| Roster Log | Registre de la liste | The name of the window/view that displays the Roster Log in the EMR’s user interface. |
| Current Roster Status Report | Rapport sur l'état actuel de la liste | The name of the Current Roster Status Report that is generated in the EMR. |

## Patient Roster History

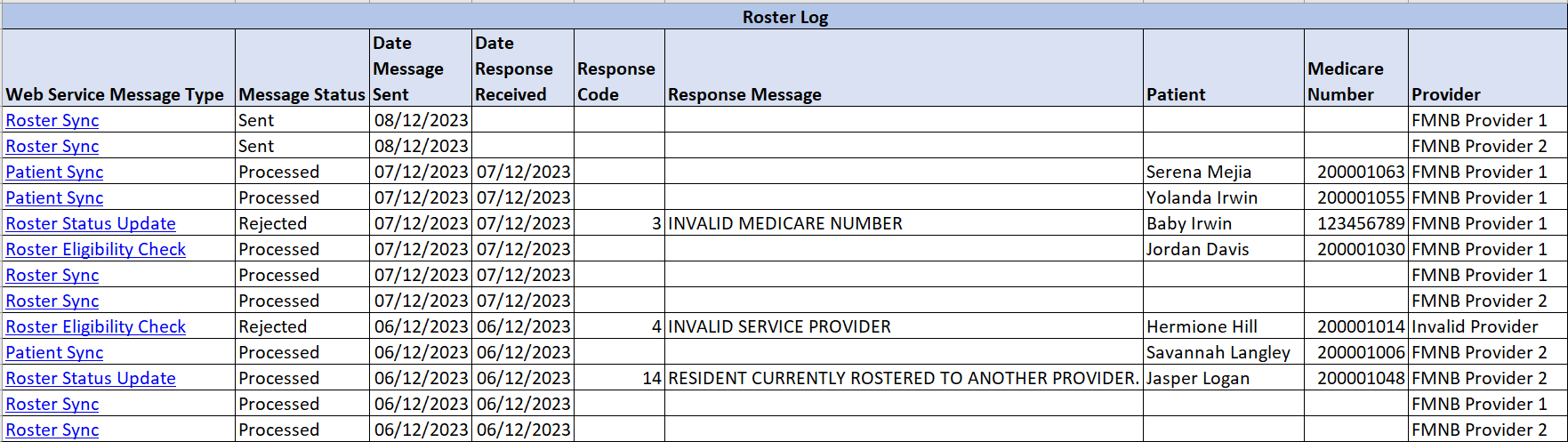
The following is a proposed representation of the Patient Roster History. It should display the most recent roster status for the patient first and all historical roster data (including synchronization data) for review in chronological order for all providers in the EMR instance.



**Note:** Date formats for user interface display purposes should match the date format in the EMR. Termination dates that represent the end of time (e.g., 31/12/9999) do not need to be displayed to the EMR User.

## Roster Log

The following is a proposed representation of the Roster Log. It should display the most recent rostering web services for review in chronological order for all providers and rostered patients in the EMR instance. The information in this view needs to be filterable and each web service message should be selectable/linkable and provide additional information or functionality. For instance, clicking on a Roster Sync message should provide the details of the matched and unmatched patients; Patient Sync or Roster Status Update should provide the before and after patient roster data summary; and Roster Eligibility Check should display the contents of the message that was received regarding the patient’s roster eligibility.



**Note:** Date formats for user interface display purposes should match the date format in the EMR.