

3. MSP ENROLLMENT AND CLAIMS SUBMISSION PROCEDURES

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3. MSP ENROLLMENT AND CLAIMS SUBMISSION PROCEDURES

3.1 Obtaining a Practitioner Number with MSP

Nurse practitioners are eligible to enroll with MSP and obtain a MSP practitioner number when they have obtained full nurse practitioner registration with the College of Registered Nurses of BC (CRNBC).

It is the NP's responsibility to enrol with MSP. MSP/HIBC. Enrollment forms will be sent to eligible nurse practitioners by the CRNBC.

Enrollment status with MSP, and, therefore, the possession of an active practitioner number, is contingent upon the nurse practitioner's continued practicing registration with the College. The nurse practitioner is responsible for reporting any changes in registration status to MSP. The CRNBC will notify MSP in cases where registration is suspended under professional conduct review.

NP Certification

Specific activities performed by NPs (e.g. casting) require certification as described in the CRNBC *Standards, Limits and Conditions*. When a NP becomes certified, it is their responsibility to notify MSP/HIBC and submit a copy of their certification

Practitioner Number

Each nurse practitioner registered with MSP is assigned a MSP practitioner number. The practitioner number allows the nurse practitioner to submit encounter records through the MSP claims processing system for services provided to eligible MSP beneficiaries.

Payee Number

In order to facilitate submission of encounter records and allow for accurate data collection, MSP/HIBC requires that your practitioner number be associated with the payment number assigned to your employer (e.g. clinic, facility, health authority) by linking to your employer. For nurse practitioners, the payment number, also called the payee number, simply identifies the clinic, facility or health authority where the nurse practitioner is working. This enables the Ministry of Health to track an individual nurse practitioner's activity to that particular employer. Should a nurse practitioner change jobs, the practitioner number stays the same, but the payee number would change to that of the new employer.

To be assigned to a payment number, completion of an Assignment of Payment form is required. Again, in the case of nurse practitioners, this number is not used for payment purposes but simply to associate NP activity with an employer.

Both the practitioner number and the payee number are required when submitting encounter records to MSP (see *Section 5.3: Information Required for Claims Submission to MSP*).

Samples of these forms are included at the end of this section. Forms can also be obtained from the Ministry of Health web site at:

<http://www.health.gov.bc.ca/exforms/mspprac/index.html>

Change of Address

If you change your address or telephone number, please advise MSP so that your practitioner file can be updated accordingly. Timely notification of changes ensures that you obtain accurate information and efficient service. You should also notify the CRNBC of your address change at the same time.

How to Contact MSP / HIBC

Telephone:

Greater Vancouver area: 604 456-6950
Elsewhere in BC (toll-free): 1 866 456-6950

Facsimile: 250 952-3101

Mailing address: HIBC/Medical Services Plan
PO Box 9480 Stn Prov Govt
Victoria, BC V8W 9E7

Web site: www.healthservices.gov.bc.ca/msp/infoprac/

3.2 Submission of Encounter Records to Teleplan

Nurse practitioners are required to provide information about the services they provide, called encounter records, to MSP. It is likely that office staff of your employer will submit the coding details to the Teleplan claims processing system directly through their electronic billing software system or through a service bureau on your behalf. However, the nurse practitioner rendering the service is ultimately responsible for the information submitted to MSP.

While encounter records do not generate payments, the same rules used to assess physician's fee-for-service claims apply to nurse practitioner encounter records submitted to the MSP Teleplan claims processing system. For these reasons, you should be aware of certain MSP requirements, rules, and procedures related to claims submission and payment.

For details about submitting encounter records to MSP, see *Section 4.5: Information Required for Submission of Encounter Records*.

For details about referrals to physicians and for diagnostic services, please see *Section 4.4: Services that May be Referred by Nurse Practitioners*.

Submitting Claims Electronically to Teleplan

All encounter records for nurse practitioners are submitted electronically into MSP's claims processing system by connecting directly through a private Internet Service Provider (ISP) through dial-up or high-speed access (cable or ADSL).

The Teleplan web interface allows practitioners to securely submit claims and check patient eligibility over an encrypted Internet connection. It has been built to industry standards for secure Internet communications - like that used for online banking transactions.

Encounter Record Submission Authorization

In order to have their encounter records submitted to the MSP/HIBC Teleplan claims processing system through their employer's electronic billing software system or service bureau, NPs must complete an authorization form and submit it to HIBC/MSP, granting permission for electronic encounter records bearing the NP's practitioner number to be used by the billing service. A sample of the form is included on the following page.



ENCOUNTER RECORD SUBMISSION AUTHORIZATION

BETWEEN _____
"Practitioner"

and _____
ENCOUNTER RECORD BILLING SITE ("the Site")

I, _____
Practitioner Name

hereby authorize _____
Site Name

to submit electronic encounter records bearing my practitioner number _____
and "the Site" payee number _____ to the Medical Services Commission.

This Authorization shall remain in force and for all encounter records submitted with
"the Site" payee number _____ and my practitioner number

_____ from _____ to _____.
Practitioner Number Effective Date (month/day/year) Cancel Date (month/day/year)

Dated this _____ day of _____, 20_____.

Signature of Nurse Practitioner

Signature of Witness

*Signature of Payee Number
Signing Authority for "the Site"*

Provider Programs
Health Insurance BC
716 Yates Street
Victoria BC V8W 1L4
1 866 456-6950
Vancouver (604) 456-6950

Claims Submission Period

Claims (encounter records) must be submitted **within 90 days of the date of service**. Claims for services to a beneficiary whose coverage has been backdated are exempted. Claims or encounter records submitted with a service date that precedes the date of submission by longer than 90 days are automatically rejected by the Teleplan claims processing system. The accurate and timely submission of encounter records is the responsibility of nurse practitioners and their employer.

Erroneous Submissions

If a Teleplan submission contains incorrect information, it can be returned for correction before it is processed if the Teleplan Support Centre is notified by 4:30 pm on the same business day that you made the submission.

The entire submission will be removed from the queue for claims processing and returned the next day with the explanatory code FC. The claim can then be corrected and re-submitted immediately.

An incorrect submission can also be corrected after the transmission day, but before MSP closes off a claims period. The specific claim needs to be identified according to its Data Centre, Practitioner Number, and Sequence Number. The records is then be rejected, but is not returned until the next remittance statement has been issued. Again, the explanatory code FC will be used for the returned claims.

Detailed Teleplan claims submission instructions can be found at:

<http://www.healthservices.gov.bc.ca/msp/infoprac/teleplan.html>

To contact Teleplan Support:

Greater Vancouver area: **604) 412-0910**

Elsewhere in BC (toll-free): **1-800-663-7206**

3.3 Teleplan Claims Processing

The following information is provided to acquaint you with how the Teleplan electronic claims processing system works. Please note that NP encounter records undergo the same electronic processing as claims for payment, but there is no payment amount assigned. Payment Mode is entered as 'E' and the amount billed is always '0' (zero).

The Teleplan Claims Processing System processes approximately 95% of all claims within 30 days, with the majority being paid within 14 days. Processing times depend on the timing of the submissions and the complexity of the claims.

Payments are made at the middle and end of each month, either by electronic funds transfer (direct deposit) or by cheque.

Claims processing involves four major sequential components.

Step 1: Pre-Edit

This component, which runs nightly against approximately 250,000 electronic claims, performs the following tasks for each claim:

- Verifies the billing number to ensure that it is approved for that site.
- Checks all fields to ensure that values have been submitted in the correct format and with valid codes (e.g., valid PHN, valid fee item).
- Checks mandatory fields to ensure that they contain data.
- Rejects the claim if it does not meet these data requirements.
- Codes the rejected claim to indicate the rejection reason and returns it to the submitter electronically.

Step 2: Eligibility Edit

This component, which runs nightly against both electronic and card claims, performs the following tasks for each claim:

- Verifies the match between the PHN and the patient name.
- Verifies that the amount billed is consistent with the fee item.
- Verifies that the practitioner is authorized to bill for the service.
- Rejects the claim if it does not meet these data requirements.
- Returns erroneous claims to the submitter for re-submission.

Step 3: Adjudication

This component, which runs twice monthly, uses approximately 5,000 automated payment rules in assessing claims:

- Verifies billings of practitioners that depend on other practitioner claims
- Provides electronic explanatory codes for downgraded or refused claims.

Note: Fewer than 2% of claims are adjudicated manually.

Step 4: Payment and Remittance

This component, which runs twice monthly, performs the following tasks with each run:

- Processes over 2.5 million claims from more than 10,000 practitioners.
- Processes all third-party and audit-recovery items.
- Handles adjustments that may be applied to gross payments, including retroactive payments, interest, card-keying changes, and GST charges.
- Approximately 4 days prior to remittance date, sends electronic remittance statements to submitters, advising of payment to be made on the remittance date.

Note: This component also contains any broadcast messages.

The *Teleplan Electronic Medical Claims System: Inbound and Outbound Record Specifications, Version 4.0* describes the technical requirements and provides instructions about submitting electronic claims to MSP.

To view manual online:

<http://www.healthservices.gov.bc.ca/msp/infoprac/teleplanspecs/>