

Section 5: PHYSICIAN ENROLLMENT AND BILLING PROCEDURES

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5.1 Physician Enrollment

The following practitioners are eligible to enroll with MSP and obtain MSP billing numbers:

- physicians who obtain licensure from the College of Physicians and Surgeons of British Columbia; and
- health care practitioners who provide services insured through MSP's Supplementary Benefits Program (see *Section 3.2: MSP Contacts - Supplementary Benefits Program*) and who are approved for licensure by their College or Association.

Any physician who provides MSP with proof of, or eligibility for, licensure with the College of Physicians and Surgeons, may register with the Medical Services Plan and obtain a billing number. The registration number issued by the College is not the same as the MSP billing number (see the next page).

Enrollment status, and therefore the possession of an active billing number, is contingent upon the physician's continued licensure by the College of Physicians and Surgeons. Any change in licensure, such as the renewal of a temporary licence or specialty, must be reported to MSP to avoid refusal of claims.

Any change in address must be reported to the College of Physicians and Surgeons prior to contacting MSP.

To report changes in address or licensure, contact Provider Programs:

Toll Free:	1 866 456-6950
Vancouver:	604 456-6950
Fax submissions to:	250 405-3592
Mail submissions to:	Provider Programs Medical Services Plan PO Box 9480 Victoria, BC V8W 9E7

MSP Billing Number

Each practitioner enrolled with MSP is assigned an MSP billing number that consists of two numbers:

- a **practitioner number**, which identifies the practitioner rendering the service; and
- a **payment number**, which identifies the person to whom payment is to be made.

The two numbers in the billing number are normally the same. However, they differ in cases where a practitioner designates another practitioner or a group, such as a clinic or hospital, to receive that practitioner's MSP fee-for-service payments (see *Assignment of Payment* later in this section).

The billing number allows the practitioner to bill MSP for providing medically required services to patients who are MSP beneficiaries.

To download a printable application for a MSP billing number, visit the Ministry of Health website at:

www.health.gov.bc.ca/exforms/mspprac/

Change of Address or Licence

If there is a change to your specialty or licence status, advise MSP so that your records can be updated accordingly.

Any change in address or telephone number must be reported to the College of Physicians and Surgeons prior to contacting MSP.

Timely notification of changes enables MSP to provide physicians with accurate and efficient service and helps to prevent unnecessary refusals of claims.

To report changes in address or licensure, contact Provider Programs:

Toll Free: 1 866 456-6950

Vancouver: 604 456-6950

Fax: 250 405-3592

**Mail: Provider Programs
Medical Services Plan
PO Box 9480
Victoria, BC V8W 9E7**

Payment of Fee-for-Service Claims

MSP accepts claims for medically required services that are MSP benefits and provided by physicians who are enrolled with MSP and in good standing with the College of Physicians and Surgeons.

MSP pays physicians' claims in accordance with the provisions of the *Medicare Protection Act* and Regulations, the *MSC Payment Schedule*, and MSP Claims policy and procedures. The fees in the Payment Schedule are established through consultation between MSP and BCMA.

Physicians billing on a fee-for-service basis must submit claims to MSP in a computer-readable format within 90 days of the service date. Claims can be submitted via Web/Teleplan or by contracting with a service bureau equipped to make the submissions.

Physicians submitting claims for fewer than 2,400 services per year and earning less than \$72,000 annually in fee-for-service payments may submit their accounts on claim cards available from MSP. Claims submitted by claim card are subject to a charge of 40 cents per paid service plus applicable GST. MSP deducts these charges from the payment and indicates the deductions on the remittance statement. If you are eligible to submit claim cards, contact Provider Programs as indicated on the next page.

Payment of claims is made **at the middle and at the end of each month**, either by direct bank deposit (electronic funds transfer) or by cheque.

The time required to process claims varies, depending on whether they are submitted electronically or by claim card. A payment for claims submitted via Web/Teleplan normally includes claims received at least seven days prior to the next payment date. However, if the claims information is incomplete or inaccurate, or if the claim requires manual adjustment, processing and payment of the claim may be delayed. Claims submitted by claim card take longer to process.

A few days prior to the payment date, the Claims Processing System issues a **remittance statement** and a payment summary record for the payment period. Physicians billing electronically receive their statements electronically; those billing by claim card receive their statements by mail.

Assignment of Payment

An "assignment of payment" is a legal agreement through which a practitioner designates that MSP payments for his or her services are to be made to another practitioner or to a group such as a clinic or hospital. There are three types of payment assignments:

- **Locum Tenens:** When one practitioner replaces another during holidays or sickness, payment for services may be made either to the principal practitioner or to the practitioner providing the service in the absence of the other.
- **Clinic or Associated Group:** Practitioners may assign payment to a clinic or group practice. Normally the clinic or group has a single payment number. The term of the assignment may be for any period up to, but not exceeding, five years. If the term is to be extended, new assignment forms must be completed and submitted prior to the expiry of the current term.
- **Diagnostic Facility or Hospital:** This type of payment assignment (with its own form) is available only to medical practitioners, who may assign payment to a diagnostic facility or hospital for specific services such as EMG, Laboratory Medicine, Nuclear Medicine, Pulmonary Function Studies, Radiology, and Ultrasound. The term of the assignment cannot exceed two years. If a medical practitioner is providing short-term locum coverage, the assignment must be limited to the specific period of coverage.

Assignment of Payment forms are available from Provider Programs. MSP refuses claims submitted before the assignment processing has been completed.

To download a printable assignment of payment form, visit the Ministry of Health website at:

www.health.gov.bc.ca/exforms/mspprac/index.html

or contact Provider Programs:

Toll Free: 1 866 456-6950

Vancouver: 604 456-6950

Fax: 250 405-3592

**Mail: Provider Programs
Medical Services Plan
PO Box 9480
Victoria, BC V8W 9E7**

Physician Benefits

Physicians enrolled in MSP are eligible to participate in the following benefit programs:

- Physician Disability Insurance Program
- Contributory Professional Retirement Savings Plan (CPRSP)
- Continuing Medical Education (CME) Fund
- Canadian Medical Protective Association (CMPA) Reimbursement

These benefit programs are described on the following pages.

Physician benefits programs are administered by the BCMA. Although all BC physicians are eligible to participate in the benefits programs, the BCMA may charge administrative fees to physicians who are not members of the BCMA.

**For further information about physicians' benefit programs, contact
Membership/Benefits Department or Medical Education Fund at:**

**British Columbia Medical Association
115 - 1665 West Broadway
Vancouver, BC V6J 5A4**

**phone: 604 736-5551
toll free 1 800 665-2262
fax: 604 736-4566**

<http://www.bcma.org/>

Physician Disability Insurance Program

The Physician Disability Insurance Program provides disability insurance for physicians who reside in British Columbia and participate in MSP on either a fee-for-service or sessional basis. Monthly disability benefits are based on the physician's annual MSP income, which includes credit for 100% of services paid under locum tenens agreements.

A joint BCMA-MSP committee oversees the program, which is administered by BCMA. A physician does not have to be a BCMA member to be eligible for this benefit, but non-member fees may apply.

Contributory Professional Retirement Savings Plan (CPRSP)

The CPRSP provides \$25 million annually for deposit directly into physicians' retirement savings plans.

Every summer, a ***Notice of Entitlement*** is mailed to each eligible physician, together with instructions and an application form for claiming the entitlement. The entitlement amount is based on the physician's MSP income and practice type in the previous calendar year. A completed application must be returned to BCMA each year to claim the benefit. CPRSP benefits may be deferred for up to three years.

Amounts may be provided to a physician in two installments, the first payment (up to 50%) in August each year and the remaining portion the following year. Applications received after mid-October are processed in the new year and receive one deposit in January of the year following. Cheques are sent directly to the physician's financial institution.

CPRSP payments are a taxable benefit, and a T4A is issued. The physician can deduct these amounts from the federal limit to offset the T4A.

A physician does not have to be a BCMA member to be eligible for this benefit, but non-member fees may apply.

Continuing Medical Education (CME) Fund

The CME fund is a yearly allotment of monies designed to assist physicians with medical education expenses. The allotment year for the program is April 1 through March 31.

To be eligible for CME benefits, a physician must have practised in British Columbia and been paid by MSP on a fee-for-service and/or sessional basis for a minimum of 12 months. Eligibility for benefits is further determined by the physician's annual MSP income:

- Physicians receiving MSP payments between \$5,000 and \$9,999 annually (gross) are entitled to a 50% benefit.
- Physicians receiving MSP payments between \$10,000 and \$14,999 annually are entitled to a 75% benefit.
- Physicians receiving MSP payments exceeding \$15,000 annually are entitled to a 100% benefit.

Conferences, courses, travel, maintenance, overhead, and computer hardware and software are some of the eligible expenses.

CME entitlements are deferrable for up to three years. The payments are a taxable benefit, but expenses may also be deducted on income tax returns. A T4A is issued unless the payment is made to a corporation.

A physician does not have to be a BCMA member to be eligible for this benefit, but non-member fees may apply.

Canadian Medical Protective Association (CMPA) Reimbursement

This program assists physicians with partial reimbursement of their CMPA dues. Physicians claiming this reimbursement must have received MSP income of at least \$5,000 on a fee-for-service and/or sessional basis in the previous calendar year.

Reimbursement is paid only for those months that the physician resided in British Columbia. Physicians in their first year of practice in BC, and those in their first year after a residency training program, may also apply for the reimbursement on the basis of their current year's income.

Physicians need not submit paper applications for this benefit if they have granted permission to the CMPA in Ottawa to electronically transmit the information required by BCMA for processing the reimbursements.

For other physicians, application forms are mailed out by CMPA in January each year, and must be completed and returned to BCMA by the last working day in February. It is imperative that these physicians provide CMPA with current mailing addresses as the BCMA deadline for receiving applications is not negotiable.

CMPA reimbursements are a taxable benefit, and a T4A is issued unless the payment is made to a corporation.

A physician does not have to be a BCMA member to be eligible for this benefit, but non-member fees may apply.

De-Enrollment and Opting Out of MSP

A physician may:

- **enroll** with MSP (if licensed with the College of Physicians and Surgeons of British Columbia); or
- once enrolled, **opt out** of MSP; or
- once enrolled, **de-enroll** from MSP (cancel the enrollment); or
- **not enroll** with MSP.

A physician who is **enrolled with MSP** must bill MSP directly for all medically required services provided to MSP beneficiaries.

A physician who has **opted out of MSP** is one who has elected to bill patients directly, although opted-out physicians may choose to submit claims to MSP on behalf of patients who are MSP beneficiaries.

Opted-out physicians are prohibited by legislation from charging an MSP beneficiary more than the amount paid by MSP for an MSP-insured service.

- To **opt out of MSP**, the physician must submit a written request, expect a waiting period of 30 to 45 days, and inform patients of the opted-out status and implications.
- To **opt back into MSP**, the physician must submit a written request and expect a waiting period of 60 to 75 days.

A physician who is **not enrolled with MSP** is not permitted to bill MSP for any medical services provided to patients, but must bill the patients directly. The services of a physician not enrolled with MSP are not benefits under MSP. MSP will not reimburse MSP beneficiaries for services received from a de-enrolled or non-enrolled physician.

De-enrolled and non-enrolled physicians may not charge a patient more than the amount permitted by MSP for a service if that service would be an insured service if rendered by an enrolled physician and the service was performed in a hospital or community care facility.

continued →

- To voluntarily **de-enroll from MSP**, the physician must provide 30 days' written notice, and inform patients of the de-enrolled status and implications.
- To **re-enroll with MSP**, the physician must submit a written request no earlier than 12 months after the de-enrollment date.

For more details on extra-billing prohibitions, see:

Section 2.1: Medicare Protection Act - Billing Prohibitions

5.2 Claims Processing

Teleplan

Medical claims are submitted for payment electronically through the Medical Services Plan (MSP) Teleplan system.

Teleplan Introduction

MSP's Teleplan Web Access, (version 4.0), provides a means for you to send and receive your claims-related files securely across the Internet. MSP's Teleplan Web Access application assists practitioners to send their claims to MSP's mainframe (host) computer in a machine-readable format. MSP's Teleplan Web Access v4.0 does not replace the billing software supplied by your vendor.

Teleplan Claims Submission and Processing

Teleplan is a telecommunications system which allows practitioners to securely submit claims, notes, retrieve remittance information and check patient eligibility over an encrypted Internet connection from MSP. The system is built to industry standards for secure Internet communications (like that used for online banking transactions). Teleplan receives and processes over 6 million claims monthly, valued at approximately \$116 million. Approximately 95% of all claims are processed 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 or by cheque.

Teleplan Support Centre

The Teleplan Support Centre handles questions about Teleplan, the Claims Processing System and Teleplan Specifications including:

- electronic billing problems
- electronic remittance statements and refusals
- MSP-practitioner-vendor liaison
- "zapping" claims submitted with incorrect data
- resetting revoked passwords, and
- hardware and software problems.

Teleplan Support Centre Contact Numbers

Victoria:	250 952-2668
Toll Free:	1 800 663-7206

Zapping Erroneous Submissions

If you discover that your Teleplan submission contains incorrect billings, you can arrange to have the submission returned to you for correction before it is processed if you notify the Teleplan Support Centre by 4:30 pm on the same business day that you made the submission.

The entire submission will be "zapped" and returned the next day with the explanatory code **FC**. You can correct and re-submit the claims immediately.

If you discover an incorrect submission after the transmission day but before MSP closes off a claims period to process payments, you may still contact the Teleplan Support Centre for assistance.

You will be asked to identify the specific claims by Data Centre, Payee Number, and Sequence Number. These records will then be rejected, but will not be returned until after MSP has issued your next remittance statement. Again, the explanatory code **FC** will be used for the returned claims.

Teleplan Support Centre	
Vancouver:	604 456-6950
Toll-free:	1 866 456-6950

Claims Processing System

The Claims Processing System processes approximately 98.5% 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 or by cheque.

Claims processing involves four major sequential components.

Step 1: Pre-Edit

This component, which runs nightly against approximately 300,000 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 items).
- 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 physician is authorized to bill for the service.
- Rejects the claim if it does not meet these data requirements.
- Returns erroneous electronic claims to the submitter for re-submission.
- Identifies rejected card claims for manual review.

Step 3: Adjudication

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

- Verifies billings of physicians that are dependent on other physician claims (*e.g.*, surgical billing matches for anesthetic and/or surgical assistant claims).
- Provides electronic explanatory codes for downgraded or refused claims.

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 3 million claims from 12,000 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 four days prior to remittance date, sends electronic remittance statements to submitters, advising of payments to be made on the remittance date (this does not occur for submissions submitted on cards and magnetic tapes).

This component also contains the Broadcast Message program.

Teleplan Support Centre

Vancouver: 604 456-6950
Toll-free: 1 866 456-6950

Mail: Teleplan Support
PO Box 9480
Victoria,
V8W 9E7

5.3 Office Operations

Section 5.3 contains general billing information related to your office operations. The topics are presented in alphabetical order.

Refer to the *Section Contents* for Section 5.3 to find a particular topic.

For additional billing information, see also:

Section 5.5: Reciprocal Billing Agreement

Section 5.6: Guidelines for Billing for Other Agencies

Section 6.1: General Billing Information

***Section 6.2: Billing Guide for Emergency Visits
and Out-of-Office Hours Premiums***

Section 6.3: Billing Guide for Specialty Services

CareCard Verification

MSP is concerned about the misuse of CareCards, and recommends a complete check of CareCard information at all first appointments.

If you suspect the misuse of a CareCard by a person who is not eligible for coverage (*e.g.*, non-resident), request a second piece of picture identification in order to verify that the CareCard is being presented by the person named on the card.

If you have questions regarding the validity of a CareCard or the entitlement of a person to use the CareCard being presented to you, call the designated number below.

If a person's CareCard has been lost or stolen, the person should call the designated number below.

VALIDITY OF CARECARD	ENTITLEMENT TO USE CARECARD or LOST OR STOLEN CARECARD
<p><i>Provider Services Coverage:</i></p> <p>Vancouver phone: 604 456-6950 Toll-free phone: 1 866 456-6950</p>	<p><i>Beneficiary Services:</i></p> <p>Vancouver: 604 683-7151 Toll-free: 1 800 663-7100</p>
<p align="center">Please report any suspected or known misuse of medical service benefits under MSP to the Ministry's Investigations Unit, 24 hours a day: phone: 604 660-2406 fax: 604 660-3083</p>	

Claim Submission Period

The maximum allowable time for claim submission following the service provision date is **90 days**. MSP will not approve requests for exemption from the 90-day limit because of administrative problems originating in the physician or hospital billing office, including staffing and vendor or service bureau problems.

The following **exceptions** to the 90-day limit are permitted and may be submitted using normal submission codes:

- Claims determined to be the responsibility of WCB, for which the submission code is **W** and the insurer code is **WC**.
- Claims refused by WCB and to be re-submitted as MSP claims, for which the submission code is **W**.
- Claims determined to be the responsibility of ICBC, for which the submission code is **I** and the MVA (motor vehicle accident) claim indicator is **Y**.
- Claims for services to a beneficiary whose coverage has been backdated, for which the claim submission date is within 90 days of the coverage reinstatement date and the submission code is **C**.

In such cases, the beneficiary is responsible for contacting the physician's office to advise that the claim may be submitted to MSP. Beneficiaries who fail to do so remain financially responsible for the services received from the physician.

- Claims re-submitted because of the physician's disagreement with MSP adjudication, for which the claim re-submission date is within 90 days of the remittance statement date and the submission code is **X**.

In such cases, additional details to support the claim must be included with the re-submission.

- Claims submitted late because of the billing requirement, such as billing a surgical billing that has been adjusted, for which the submission code is **X**.
- Claims pre-approved by MSP for retroactive billing after a written application to MSP for a claim period exemption, for which the maximum retroactive period is 6 months from the service date or the start of the fiscal year, whichever is sooner.

- A written request for a claim period **exemption** must include a detailed explanation of why approval for retroactive billing is being sought. The request should be mailed to:

Benefits Services
Box 9480, Stn Prov Govt
Victoria, BC V8W 9E7
Fax: 250 405-3593

- Under exceptional cases, exemptions from the 90-day limit will be considered on a case-by-case basis, subject to the approval of MSP's Director of Medical Services Operations and Policy and the support of the BCMA's Director of Professional Relations.

Only cases previously refused an exemption are granted a review by MSP and BCMA.

When requesting a review, the physician must submit a complete list of the claims that are the subject of the request and additional information substantiating the request for reconsideration.

A written request for a claim period exemption request **review** should be forwarded to the Benefits Services address above.

Note: Opted-out physicians should advise patients who are submitting MSP claims on their own behalf of the 90-day claim submission limit.

Direct Bank Deposit (DBD)

MSP can use electronic funds transfer technology to deposit semi-monthly payments directly into a physician's bank account if the account is in one of the financial institutions listed on the following pages.

Taking advantage of this option ensures that MSP payments are deposited on time and eliminates risks associated with mailing cheques.

If you wish to have your payments made by DBD, complete a *Direct Bank Deposit* form and submit it to Provider Programs along with a copy of a void cheque.

To request a *Direct Bank Deposit* form, call:

Vancouver: 604 456-6950

Toll Free: 1 866 456-6950

Fax submissions to: 250 405-3592

**Mail submissions to: Provider Programs
Medical Services Plan
PO Box 9480
Victoria, BC V8W 9E7**

To print a Direct Bank Deposit form, visit the Ministry of Health web site at:

www.health.gov.bc.ca/exforms/mspprac/index.html

DBD Financial Institutions

MSP can make direct bank deposits into physicians' accounts in these financial institutions:

Financial Institution	Code
BANK OF MONTREAL	001
BANK OF NOVA SCOTIA	002
ROYAL BANK OF CANADA	003
TD CANADA TRUST	004
NATIONAL BANK	006
CANADIAN IMPERIAL BANK OF COMMERCE	010
HONGKONG BANK	016
HONGKONG BANK OF CANADA	026
CANADIAN WESTERN BANK	030
LAURENTIAN BANK	039
ALBERTA TREASURY BRANCH	219
PROVINCE OF ONTARIO SAVINGS	239
BANCA ITALIANA	249
BANK CREDIT & COMMERCE	251
CITIBANK CANADA	260
CITIZENS BANK OF CANADA	309

PRESIDENTS CHOICE FINANCIAL	326
FIRST CITY TRUST CO	512
CTRL GUARANTY TRUST	519
CO FIDUCIE GUARDIAN	523
MANULIFE BANK OF CANADA	540
MONTREAL TRUST CO	550
METROPOLITAN TRUST	552
NATIONAL VICT & GREY	556
NORTH WEST TRUST CO	558
PRENOR TRUST CO	562
CIE TRUST ROYAL	570
ROYAL TRUST CORP	580
YORKSHIRE TRUST CO	584
NATIONAL TRUST CO	590
ING	614
HOUSEHOLD TRUST CO	630
ALL CREDIT UNIONS	809
CAISSE, POPULAIRE DESJARDINS D'OUTREMONT	815
UKRAINIAN CREDIT UNION LTD	828
KELVINGTON CREDIT UNION	889
EDMONTON CREDIT UNION	899

DBD Emergency Payments

MSP has developed an emergency payment system to ensure that there is no disruption in payments to physicians.

If claims cannot be processed because of computer problems or because of a labour disruption, MSP issues emergency payments to physicians who receive direct bank deposit payments.

Once MSP is able to process claims again, the amounts of the emergency deposits are recovered from payments of the claims that MSP was unable to process during the disruption.

Electronic Debit Request Record

You can submit requests to debit claims billed in error, whether the claim is in process or has been paid, except for institutional claims with identity number 10000008. When you successfully submit a debit request record, MSP refuses the in-process claim or debits the paid claim.

The submission of a debit request record is actually a re-submission of the original claim but with submission code **E**. The following rules apply:

- Submission date of the debit request record must be within 12 months of the payment date of the original claim.
- Submission code must be **E**.
- The field known as Original, MSP File Number must contain:
 - Original Data Centre Number of submitted claim to be withdrawn;
 - Original Data Centre Sequence Number of claim to be withdrawn;
 - Date or approximate date when the claim was submitted or paid (zeroes are accepted when the date is unknown).
- A note record or claim comment is mandatory to explain the reason for the withdrawal of the claim. Statements such as "Incorrect date of service" or "Incorrect practitioner number" are sufficient.

Debit request records can be submitted on a daily basis. Submissions that do not pass the edit checks are refused and returned as normal refusal records (C11) with explanatory code **D1**. Accepted records are processed for the next payment period.

When re-billing claims for service dates outside the 90-day limit, use submission code **X** and indicate "Re-submission with matching Debit Request Record" in the note record or claim comment field.

- Notes:**
- 1) Opted-out physicians cannot debit claims electronically.
 - 2) Do not use the debit request record if you disagree with MSP's adjudication of a claim.

Rather, submit a new claim with additional information in a note record, and the claim will be reassessed.

Debit Request Record Remittance Statements

Remittance statements for **debit request records** have these characteristics:

- A matched record is determined by the Original Data Centre and Sequence Number identified on the debit request record. A matched request record is returned as a remittance payment (S02) with explanatory code **D0**.
- If MSP cannot match the debit request record to an in-process or paid claim, the request record is returned as a remittance refusal (S03) with explanatory code **D2**.

Remittance statements for **original claims** have these characteristics:

- If the original claim has not yet been paid but has passed the pre-edit checks, it is returned as a remittance refusal (S03) with explanatory code **XH**. It contains the Original Sequence and Claim Number.
- If the original claim has already been paid, it is returned as a remittance payment (S02) with a negative dollar value and explanatory code **D3**. It contains the Original Sequence and Claim Number.

Debit Request Record Explanatory Codes	
D0	Match found for Debit Request Record.
D1	Debit Request Record did not meet pre-edit or edit requirements.
D2	No match found for Debit Request Record.
D3	Payment withdrawn as indicated in Debit Request Record.
XH	Claim returned as indicated in Debit Request Record.

Incorporation

MSP recognizes the incorporation of a physician or a group of physicians.

If you wish to apply for recognition as a corporation, send a written request to Provider Programs with a letter of approval from the College of Physicians and Surgeons of British Columbia.

You will be required to apply for an "Additional Payment Number" so that MSP can issue a new payment number for the corporation. If two or more physicians incorporate under the same company, each physician must complete and submit an *Assignment of Payment* form.

If your payments are currently deposited directly into your bank account electronically, you should also complete a new *Direct Bank Deposit* form and submit it to Provider Programs.

To contact Provider Programs regarding incorporation, call:

Vancouver phone: 604 456-6950

Toll Free phone: 1 866 456-6950

Fax submissions to: 250 405-3592

**Mail submissions to: Provider Programs
Medical Services Plan
PO Box 9480
Victoria, BC V8W 9E7**

To download printable Assignment of Payment and Direct Bank Deposit forms, visit the Ministry of Health web site at:

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

Interest

Interest is payable on all claims that are submitted "correctly" and remain outstanding for more than 60 days.

The rate of interest paid is prime plus 3%, and the rate is adjusted quarterly.

Interest payments appear as a lump-sum payment in the semi-monthly remittance statement under adjustment code **04**.

Interest is not paid if:

- claims processing is delayed because of an uncontrolled work stoppage such as a strike or a retroactive increase in fees;
- the physician has an outstanding advance payment; or
- the delay in payment was due to an incorrectly submitted claim.

Locum Tenens

When one physician replaces another because of vacation, illness, or personal leave, arrangements can be made for the principal physician rather than the locum physician to receive payment for the medical services provided to patients by the locum physician.

- For details on assignment of payment, see *Section 5.1: Physician Enrollment with MSP - Assignment of Payment*.

Payment Restrictions

A payment restriction limits MSP payments for a beneficiary to one primary care physician.

The *MSP Bulletin*, which is distributed regularly with the *Physician's Newsletter*, identifies beneficiaries whose MSP benefits are subject to payment restrictions.

The bulletin lists all currently restricted PHNs for beneficiaries who have signed the legal *Agreement of Limitation* form that limits MSP payments for the beneficiary to one primary care physician.

If another physician provides medical services to a person with a restricted PHN, the physician must charge the patient for the services. MSP will not accept responsibility for the payment unless the services were warranted by special circumstances, and these are adequately documented with the claim.

Example:

If medical care is provided to a person with a restricted number by a casualty officer in a hospital emergency room, and the circumstances are adequately documented, MSP may accept responsibility for payment.

You can find the most current copy of the Bulletin on the MSP web site at the Physicians' Newsletter link:

<http://www.health.gov.bc.ca/msp/infoprac/physnews/index.html>

Remittance Statements

The remittance statement is a record of a physician's paid claims and adjustments for a given payment period. Payment and remittance statements are issued at the middle and end of each month. Depending on whether the physician bills electronically or by claim card, MSP issues the remittance statement electronically or by mail.

The remittance statement displays the total gross and net amounts billed and paid for each payment, and shows adjustments such as interest payments and the Rural Retention Premium. See the following pages for a list of remittance statement adjustment codes.

If you bill **electronically**, your remittance statement is transmitted to you electronically. The statement layout varies, depending on the billing software you use. If you wish to receive printed copies of your remittance statements on an on-going basis, you can arrange to have Provider Programs mail them to you for 4 cents per service line.

To inquire about your electronic remittance statement, contact your vendor or service bureau, or contact MSP's Teleplan Support Centre at:

Vancouver phone: 604 456-6950
Toll-free phone: 1 866 456-6950

If you are billing by **claim card**, a printed remittance statement is mailed to you free-of-charge.

MSP maintains remittance records on microfiche. If you require a printed copy of a previous remittance statement, you can arrange to have Provider Programs mail it to you for \$1.28 per page.

To request printed remittance statements, call Provider Programs:

Vancouver phone: 604 456-6950
Toll-free phone: 1 866 456-6950

Remittance Statement Adjustment Codes

Adjustment Code	Report Message
01	NORTHERN ALLOWANCE
02	PRORATION
03	RECOVER ADVANCE
04	INTEREST
05	MSP DEDUCTION
06	AUDIT RECOVERY
07	RECEIVER GENERAL PAYMENT
08	ICBC DEMAND RECOVERY
09	ASSIGNMENTS-DEMANDS
10	MSP GROUP PREMIUM DEDUCTION
11	ASSIGN MID-MONTH PAYMENT
12	DEMAND-ASSIGN-PAYMENT
13	REVENUE CANADA ADJUSTMENT
14	FEE SCHEDULE CHARGE
15	MSP REFUND
16	GST ON FEE SCHEDULE
17	PAYMENT-OVERAGE CLAIM
18	DEBT RECOVERY - %
19	DEBT RECOVERY - \$
20	BCMA LIFE ASSURANCE
21	CLEAR DEBIT BALANCE
22	DISCOUNT ADJUSTMENT REPAYMENT
23	CARD KEYING CHARGE
24	PAPER REMIT STATEMENT CHARGE
25	DEDUCT DEBIT BALANCE
26	FICHE REMIT STATEMENT CHARGE

Section 5: PHYSICIAN ENROLLMENT AND BILLING PROCEDURES

27	COURIER CHARGE
28	LUMP-SUM PAYMENT
29	ASSIGN END-MONTH PAYMENT
30	BCMA STAFF RETIRE
31	WCB LIFT
32	DISCOUNT
33	THRESHOLD PRORATION
34	GEOGRAPHIC PAYMENT RATE
35	FEE ITEM PRORATION
36	LAB REFORM REDUCTION
37	EMERGENCY MEDICAL
38	PRAC/PAYEE DISCOUNT
39	RURAL RETENTION PREMIUM
40	BCMA GROUP DISABILITY
41	LOCUM 60/40
42	LOCUM - \$750
43	LOCUM - TOP UP
44	LOCUM - STANDBY
45	RETENTION PREMIUM G.P. (+)
46	RRP FLAT FEE (+)
47	PRACTITIONER PRORATION
48	CONTINUING MEDICAL EDUCATION (+)
49	MID-MONTH %
50	BCMA ANNUAL DUES
59	EMERGENCY PAYMENT
60	EMERGENCY ADVANCE RECOVERY
74	SPECIALIST 60/40

76	RRP RECOVERY
77	PREMIUM ADJUSTMENT RECOVERY
78	NIA RECOVERY
79	DISCOUNT ADJUSTMENT RECOVERY
80	RETROACTIVE PAYMENT
81	NEGATIVE RETROACTIVE ADJUST
82	NIA RETROACTIVE ADJUSTMENT
83	RETENTION RETRO
84	WCB ADJ RETRO
85	GST ON CARD KEYING
86	GST ON PAPER REMIT STATEMENT
87	GST ON FICHE REMIT STATEMENT
88	RECIPROCAL PAYMENT
89	SESSIONAL PAYMENT
90	TRAVELLING EXPENSES
91	TRAVELLING TIME

Re-Submitting Claim for Reassessment of Payment

If you disagree with how MSP has paid a claim, the most effective way to have the claim reassessed is to re-submit the claim with a note record indicating that you are requesting a reassessment and including a brief explanation.

Example:

An office visit claim was refused because it occurred during the 42-day post-operative period. However, the reason for the visit was unrelated to the surgery. Re-submit the claim with a note record indicating the reason for the visit.

If you are still dissatisfied with the outcome after re-submitting the claim, advise Claims Billing Support by phone or fax as indicated below.

MSP is committed to ensuring timely and accurate payment of claims, although inadvertent errors do occur from time to time because of the volume and complexity of claims submitted. If you are routinely re-submitting a certain type or combination of claims because of incorrect payment, advise the Billing Support Supervisor at the address indicated below.

To dispute a reassessment outcome, contact Claims Billing Support:

Vancouver phone: 604 456-6950

Toll Free phone: 1 866 456-6950

To report a repeating adjudication problem, mail your submission to:

Billing Support Supervisor

Medical Services Plan

PO Box 9480

Victoria, BC V8W 9E7

Payment Dispute Process

1. If a physician disagrees with MSP's payment of a claim, **the physician re-submits the claim to MSP** with a note record explaining the details (as indicated on the previous page) and additional information as appropriate.

If paper correspondence related to the re-submission is being submitted, "correspondence sent" should be indicated in the claim comment field.

The claim is then reviewed by one or more of MSP's medical or surgical advisors.

2. If a physician disagrees with the payment recommended by the medical or surgical advisors, **the physician requests a review directly to the Reference Committee.**

BCMA's Reference Committee meets approximately three times a year to review disagreements between physicians and MSP regarding payments made by MSP for specific services, and recommends resolutions to these disputes. The physician submits details of the service and claim to the Committee, and MSP submits details of its adjudication and adjustment or refusal of payment.

3. **The Reference Committee submits its recommendations** to MSP.

4. Although the Committee's recommendations are not binding, MSP tries to follow them as closely as possible when making its decision. MSP may refer Payment Schedule interpretation issues to the Tariff Committee for comment, and may refer significant controversy to the Medical Services Commission for a final decision.

For further information about the payment dispute process, contact:

**Reference Committee
British Columbia Medical Association
115 - 1665 West Broadway
Vancouver, BC V6J 5A4**

**phone: 604 736-5551
fax: 604 736-4566**

5.4 Rural Programs

Programs under the Subsidiary Agreement for Physicians in Rural Practice

Northern and Isolation Travel Assistance Outreach Program (NITAOP)

The NITAOP covers travel expenses and travel time for visiting specialists to rural and remote communities and for family medicine practitioners providing service to Rural Subsidiary Agreement communities without a family medicine physician.

Communities/health authorities are responsible for recruiting and scheduling the visits; however, the approved visiting physicians are paid directly by MSP upon receipt of travel expense forms and applicable receipts. The physicians are also entitled to a travel time honorarium of up to \$1500 per return trip, based on travel time.

The Joint Standing Committee on Rural Issues, a joint committee of the Ministry of Health and the B.C. Medical Association (BCMA), reviews and evaluates requests and recommends funding.

The maximum number of eligible specialist visits per community is 24 per year. The maximum number of eligible family medicine visits per community is 48 per year. In exceptional circumstances the joint committee may recommend funding for a family medicine physician/community or additional visits which do not meet the eligibility criteria.

For further information call Provider Programs:

Toll Free: 1 800 663-7100

Fax submissions to: 250 405-3592

**Mail submissions to: MSP/Provider Programs
PO Box 9480
Victoria, BC V8W 9E7**

For further program information call Rural Practice Programs:

Victoria: 250 952-3588

Rural GP Locum Program (RGPLP)

The Rural Locum GP Program (RGPLP) is a program through which eligible rural physicians can request up to four weeks of locum services per year. Each request must be for a minimum period of five days, except under the weekend coverage which is for 1800 hours Friday to 0800 hours Monday (or 0800 hours Tuesday when there is a statutory holiday).

The criteria for obtaining locum assistance from the program are as follows:

- You must be a general practitioner or family practitioner licensed to practise medicine in British Columbia.
- You must be a member in good standing with the Canadian Medical Protective Association (CMPA), or carry alternative medical malpractice insurance.
- You must reside and practise full-time in a RSA community with seven or fewer physicians.

The advantages of using the program are:

- There is no fee for using the program.
- The principal physician retains 40% of the MSP-paid claims to cover overhead.
- MOH/MSP pays the locum and covers the travel costs and travel time (see claims information on the next page).
- The locums have rural training/and or experience.

To obtain more information or a *Request for Locum Assistance* form, contact:

Phone: 250 952-1104

Fax submissions to: 250 952-3486

**Mail submissions to: Rural GP Locum Program
3-1: 1515 Blanshard Street
Victoria, BC V8W 3C8**

RGPLP Claims and Payment Processes

1. The locum/replacement physician completes an *Assignment of Payment Due to Practitioner (Locum Program)* form, and faxes the form to RGPLP at 250 952-3486.
2. Claims are submitted using the locum/replacement physician practitioner number and the principal physician payment number.
3. The principal physician submits claims within two weeks of the end date of the locum assignment, and submits refused claims within two weeks of the refusal date.
4. The principal physician sends the RGPLP program a detailed report of the locum's daily claims submission at the end of the assignment.
5. The principal physician provides the locum/replacement physician with a detailed reconciliation of claims submitted.
6. The principal physician receives 40% of paid claims, and MSP makes the payments on regular payment dates.
7. The locum/replacement physician is paid by the Rural GP Locum Program.
8. Reimbursement of services not covered by MSP (*i.e.*, private, ICBC, WCB, and reciprocal billings) is paid directly to the locum/replacement physician by the principal physician, less the amount recovered for overhead prior to the date on which the locum physician leaves the locum assignment.
9. The Health Authority/host physician is responsible to ensure that the applicable on-call rate and retention premiums are paid to the locum/replacement physician.

Locum Opportunities

Physicians can apply to the Rural GP Locum Program for short-term assignments in rural settings. Compensation includes a guaranteed daily rate of \$750 for each day on assignment (including on-call days), travel expenses, and up to \$600 per return trip calculated on the basis of travel time.

Other benefits of providing services through the program include:

- automatic MSP payment every two weeks for days worked, with no requirement to submit claims to MSP (claims are handled by the principal physician, not the locum physician);
- RGPLP arrangement for all assignments, and assistance with hospital privileges;
- accommodation pre-arranged by the principal physician and/or the community being served; and
- independent contractor status with RGPLP (not employee status), with flexibility for time off.

To qualify for assignment as a RGPLP locum/replacement physician:

- You must be eligible for licensure by the College of Physicians and Surgeons of British Columbia.
- You must be a member in good standing with the Canadian Medical Protective Association (CMPA), or carry alternative medical malpractice insurance.
- You must have Advanced Cardiac Life Support and Advanced Trauma Life Support certification, or be willing to obtain the certification.
- You must participate in a conference call interview.

**To obtain more information or request an application form,
contact RGPLP at:**

Victoria phone: 250 952-1104

Fax submissions to: 250 952-3486

**Mail submissions to: Rural GP Locum Program
3-1 1515 Blanshard Street
Victoria, BC V8W 3C8**

Programs of the Subsidiary Agreement for Physicians in Rural Practice

Rural Retention Program (RRP)

Annual retention benefits are paid to physicians working in eligible communities covered under the Rural Subsidiary Agreement (RSA). This incentive program was designed to enhance the supply and stability of physicians in Rural Practice.

Rural Education Action Plan (REAP)

The Rural Education Action Plan supports the training needs of physicians in rural practice. The program was established as a result of the Rural Subsidiary Agreement (RSA) and is managed by the Joint Standing Committee on Rural Issues (JSC).

There are two Continuing Medical Education (CME) programs that fall under the Rural Education Action Plan. These programs are open only to physicians living and practising in the eligible RSA communities.

1. Undergraduate Teacher's Stipend
2. Advanced Skills and Training

Rural Education Action Plan CME programs are administered by the BCMA.

Rural Continuing Medical Education (RCME)

The Rural Continuing Medical Education (RCME) program provides physicians with funding opportunities for medical practice to update and enhance medical skills and credentials required for rural practice. These benefits are in addition to the CME entitlement provided for in the Working Agreement between the Government and the British Columbia Medical Association (BCMA).

Recruitment Incentive and Contingency Funds

Physicians recruited to fill vacant and pending vacancies in RSA communities may be eligible for up to \$10,000. There is also additional contingency funding to assist communities, health authorities or physician groups where the difficulty in filling a vacancy is especially severe or where failure to do so in a timely manner will negatively impact the delivery of care.

Isolation Allowance Fund

Physicians providing necessary medical services in eligible RSA communities with fewer than four physicians, no hospital and who do not receive on call, call back or Doctor of the Day payments may be eligible for isolation allowance funding.

For further information, contact Rural Practice Programs:**Victoria: 250 952-3588****Fax: 250 952-3486****Mail: Rural Practice Programs
Ministry of Health Services
3-1, 1515 Blanshard Street
Victoria, BC V8W 3C8****Travel Assistance Program (TAP)**

The Travel Assistance Program (TAP) works with several public and private transportation carriers who offer to provide travel cost discounts for eligible BC residents who must travel to obtain non-emergency medical services not available in their home community.

The participating transportation partners include:

Harbour Air

BC Ferries

VIA Rail

Central Mountain Air

Angel Flight

Malaspina Coach Lines

Pacific Coach Lines

When patients travel with one of these carriers to obtain medical services outside their community, the referring physician completes Part One of the *Request for Travel Assistance* form and issues it to the patient at the time of referral.

The patient completes the form and calls MSP for pre-approval of the TAP request. This service is available 24 hours a day, 7 days a week. However the automated line may be unavailable some weekends due to systems maintenance.

To be eligible for TAP, the referral must be to the closest specialty service.

For more information, or to obtain TAP forms, call:

Toll-free: 1 800 661-2668

5.5 Reciprocal Billing Agreement

Residents of all the Canadian provinces and territories except Quebec are covered under the Reciprocal Agreement.

The agreement does not apply to hospitals, for which there is a separate inter-hospital agreement regarding services provided to out-of-province patients.

To be eligible to have a physician's services billed under the Reciprocal Agreement, an out-of-province patient must **present** a valid, non-expired health care identification card. It is not acceptable for the patient to cite a number without presenting a card.

When checking the patient's card, ensure that the coverage has not expired. Some provinces issue renewable rather than lifetime registration numbers.

In the spirit of the *Canada Health Act*, MSP encourages physicians to bill reciprocally when an out-of-province patient presents a valid health care card.

If a patient does not present a valid health care card, the services are not eligible for reciprocal billing and must be billed to the patient. Patients who are billed directly are entitled to subsequently seek reimbursement from their home province medical plans.

MSP does not accept reciprocal claims submitted after the expiry of the 90-day submission time limit.

See the following pages for details on submitting reciprocal claims.

For more information on submitting reciprocal claims, call Billing Support:

Vancouver phone: 604 456-6950

Vancouver phone: 1 866 456-6950

Reciprocal Claims for Out-of-Province Patients

Reciprocal claims can be billed either electronically or by card.

When submitting a claim for an out-of-province patient who has presented a valid health care card, include the following information:

- the code for the province or territory in which the patient resides (see codes listed on the next page);
- the patient's registration (identity) number;
- the patient's name, sex, and date of birth; and
- the patient's home or British Columbia address.

When entering the patient's registration (identity) number:

- enter it into the "Reciprocal Registration Number" field (for assistance, check with your vendor or refer to your billing software guide); and
- ensure that the number has 12 digits by entering the number "flush right" and backfilling empty spaces at the left (front) of the 12-character field with zeroes.

Example: Enter 987654321 (9 digits) as 000987654321 (12 digits).

Province and Territory Codes and Registration Numbers

Province or Territory	Code	Registration Number
Alberta *	AB	9 digits
Manitoba	MB	9 digits
Newfoundland	NF	12 digits
New Brunswick	NB	9 digits
Northwest Territories	NT	7 digits
Nova Scotia	NS	10 digits
Nunavut	NU	9 digits
Ontario **	ON	10 digits
Prince Edward Island	PE	8 digits
Saskatchewan	SK	9 digits
Yukon	YT	9 digits
<p>* Alberta provides each family member with a unique lifetime personal health number.</p> <p>** Ontario is issuing photo health cards to beneficiaries over the age of 16 years. Most beneficiaries over 16 years of age now have photo health cards.</p>		

Reciprocal Claims for Patients Moving into BC

For beneficiaries moving from one province or territory to another, each province and territory generally provides coverage for the balance of the month of departure, plus two months. The use of reciprocal health numbers for reciprocal claims is appropriate during this period.

To ensure that there is no lapse in coverage, and to serve as a reminder that the reciprocal health number is only temporary, we recommend that you do **not** enter reciprocal numbers into your database.

We suggest that you record reciprocal numbers in a written file for reference until the patient moving into BC acquires a valid CareCard with a PHN, at which time the PHN can be entered into your database.

Physician Services Excluded from the Reciprocal Agreement

For non-residents of BC, the following services are **not** covered by the Reciprocal Agreement and should be billed directly to the patients. Patient may be eligible for reimbursement under their provincial plan for medically necessary services. Prior approval by the home province authority may be required.

1. Surgery for alteration of appearance (cosmetic surgery).
2. Sex-reassignment surgery.
3. Surgery for reversal of sterilization.
4. Therapeutic abortion.¹
5. Routine periodic health examinations, including routine eye examinations.
6. In-vitro fertilization; artificial insemination.
7. Lithotripsy for gall bladder stones.
8. Treatment of port-wine stains other than on the face or neck, regardless of the modality or treatment.
9. Acupuncture; acupressure; transcutaneous electro-nerve stimulation (TENS); moxibustion; biofeedback; hypnotherapy.
10. Services to persons covered by these agencies:
 - RCMP
 - Canadian Armed Forces
 - Workers' Compensation Board
 - Veterans Affairs Canada
 - Correctional Services of Canada (federal penitentiaries)
11. Services requested by a third party.
12. Team conferences.
13. Genetic screening and other genetic investigations, including DNA probes.
14. Anesthetic services and surgical assistant services associated with all of the excluded services mentioned above.

¹ British Columbia and the Yukon have a separate reciprocal agreement to cover abortion services.

5.6 Guidelines for Billing Other Agencies

Federal Government

Individuals whose health care benefits are a federal responsibility are not eligible to receive MSP benefits.

The federal government is responsible for health care benefits provided to:

- members of the RCMP;
- members of the Canadian Armed Forces; and
- inmates in federal penitentiaries (Correctional Services of Canada).

WorkSafe BC - Workers' Compensation Board (WCB)

MSP accepts WorkSafe BC claims from physicians enrolled in MSP who submit claims electronically.

Before you can submit WorkSafe BC claims, your billing software must be modified. All medical software developers, vendors, and service bureaus are aware of the technical specifications for making this option available to clients who wish to bill WorkSafe BC through Teleplan. If you do not already have this capability and would like to acquire it, contact your vendor directly.

WorkSafe BC claims submitted via Teleplan to MSP are subject to the normal pre-edit, edit, and eligibility checks to ensure that claims are formatted correctly for processing and that the patient is registered with a valid PHN:

- Claims that do not pass the checks are refused and returned electronically each night with explanatory refusal codes.
- Claims that do pass the checks are forwarded electronically each night to WCB for their authorization. After WorkSafe BC assesses the claims, they are returned electronically to MSP with processing instructions.

If WorkSafe BC accepts responsibility, MSP adjudicates the claim in accordance with *MSC Payment Schedule* Preamble rules and WorkSafe BC payment rules, and issues payment, usually in the payment cycle during which WorkSafe BC authorization was received. The 8 % WCB fee differential is paid as a lump-sum payment under adjustment code **31** on the remittance statement. WCB is identified by insurer code **WC** and adjustment indicator **W**. If claims are submitted from WorkSafe BC's W0001 data centre the lift is 6%.

If WCB does not accept responsibility for the claim, WCB instructs MSP to refuse the claim and return it to the submitter. WCB-refused claims can be re-submitted as MSP claims if appropriate.

- | |
|--|
| <p>Notes:</p> <ol style="list-style-type: none">1) Questions about claims submission, the claims edits, and claims adjudication should be directed to MSP.2) Questions about WCB refusals should be directed to WCB.3) Although MSP can process WCB form fees, contact WCB directly to obtain current form fees, including electronic versions. |
|--|

Insurance Corporation of British Columbia (ICBC)

Physicians should use the following guidelines when submitting claims for medical services related to a motor vehicle accident (MVA):

1. All cases directly related to an MVA for which ICBC insurance coverage applies should be identified with a **Y** indicator in the "Claim" field, whether the claim is submitted via Teleplan or by claim card.
2. All such cases should be coded **Y** to indicate MVA, regardless of whether the patient is seen in an office, hospital, emergency, lab, or x-ray facility. Surgery or procedures performed in regard to these cases should also be coded **Y** to indicate MVA.
3. Attach ICBC claim number, if available, to each MVA claim in the billing.
4. When one visit encompasses both MVA and non-MVA related conditions, the physician must determine which condition required the major portion of the service provided, and bill only one visit under the appropriate insurer. See also *6.1: General Billing Information - Multiple Insurers*.

If a visit and a procedure are both provided on the same date for **unrelated reasons**, both may be claimed, the lesser at 50% of its listed fee. The claim may be divided between insurers as appropriate. Even when ICBC is billed for one of the services, *MSC Payment Schedule* Preamble rules still apply. For example, procedures normally included in the fee for an office visit, such as a blood pressure check, may not be billed separately to the second insurer.

Example:

Fee Item	Amount	Bill Under
00190	100% ICD9 35A	MSP
00100	50% ICD9 847	MVA (ICBC)
or		
13611	100% ICD9 873	MVA (ICBC)
00100	50% ICD9 401	MSP

5. If the patient is from another province, use the normal reciprocal billing process. ICBC does not honour reciprocal billing claims.
6. If the patient does not have a MSP personal health number (PHN) bill ICBC directly.
7. If the MVA is **work-related**, bill WCB.
8. Physicians are accountable for correct MVA identification, and claims are subject to audit.

Institutional Billing

Claims for patients who reside in a provincial institution other than a correctional facility are submitted under the common identity number **10000008**.

Each institution is identified by a unique 2-digit number:

Institution	Number
Forensic Psychiatric	12
Riverview Hospital	30
Woodlands	35
Willow Chest Centre	40
Fraser House	51
Miracle Valley	52

See the following pages for claim submission details.

Submitting Claims Electronically

When submitting institutional claims electronically, use the Reciprocal Claim Record (RCP), and complete the claim as follows:

- In the RCP Province/Alternative Insurer Code field, enter **IN** for "Institution."
- In the RCP Registration Number field, enter the identity number **0010000008** followed by the 2-digit institution number.

Example:

The Registration Number for a patient residing in Woodlands is 001000000835. (Some software programs may automatically enter the identity number for you.)

- In the RCP Birthdate field, enter the patient's day, month, and year of birth.
- In the RCP First Name field, enter the patient's full first name.
- In the RCP Second Name field, enter the initial for the patient's second name, if known. Otherwise, leave this field blank.
- In the RCP Surname field, enter the patient's full surname.
- In the RCP Sex Code field, enter M or F.
- The RCP Address fields are optional for institutional claims.

Institutional claims are returned on electronic remittance statements as full-detail records.

Submitting Claims by Claim Card

When submitting institutional claims by claim card:

- Enter **0010000008** for the identity number.
- Enter the institution number for the dependent number.
- Enter the patient's full first name, the middle initial if known, and full surname.
- Enter the patient's complete birthdate.

Correctional Facilities

Note: **Submit claims for inmates as for any BC resident.**
 Do NOT bill as a Reciprocal Claim Card Record (RCP).

Each inmate residing in a provincial correctional facility is assigned a correctional services number, commonly known as the "CS" number. It consists of 5, 6, or 7 digits, and is used as the inmate's MSP ID number during the period of incarceration.

Submitting Claims Electronically

- In the Personal Health Number field, zero-fill the "CS" number to the left (front) of the number.
- In the Dependent Number field, enter 2 zeroes.
- Some software programs may automatically enter the required zeroes.

Example:

If the "CS" number is 123456 (6 digits), it must be backfilled with 4 zeroes at the left (front), and sent to MSP as follows:

<u>PHN (field)</u>	<u>DEP (field)</u>
0000123456	00

Submitting Claims by Claim Card

When submitting correctional facility claims by claim card:

- Enter the inmate's "CS" number for the Personal Health Number.
- Enter **00** for the Dependent Number.
- Enter the inmate's full first name, the middle initial if known, and full surname.
- Enter the inmate's complete birthdate.

