

Primary Health Care-Specific MSP Claims Explanatory Codes

CODE	DESCRIPTION
CF	<p>Time Called or Time Service Rendered is missing or invalid.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> Time of Service is missing from the claim, or was not reported in the correct format – i.e. the correct format uses the 24 hour clock, in the format hhmm, and can be rounded to the nearest hour if desired. Time of Service is required on all claims for the identified PHC core and extended services whether they are submitted as Fee-for-Service or Encounter claims. <p><i>Note:</i></p> <ul style="list-style-type: none"> Effective November 1, 2000
CQ	<p>Practitioner is not licensed to bill for this service.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> The practitioner is not licensed to bill for this service. The service provider is not approved to bill fee-for-service.
HV	<p>A claim for this service has been previously processed.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> A registration record was submitted for a PHN that is currently registered to the Primary Health Care Organization (PHCO) for the given time period.
K7	<p>Patient not registered. Third and subsequent visits will be paid at 50%.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> This is the second fee-for-service claim submitted for a core service for this unregistered patient living in the catchment area, for services received from the PHCO during the current 6 calendar month period. Any subsequent fee-for-service billings during the current 6 month period will be reduced to 50% of the normal fee item amount. <p><i>Note:</i></p> <ul style="list-style-type: none"> This explanatory code will only be returned on the semi-monthly remittance statements, not as part of the nightly edits/refusals. The rule was suspended for most PHCOs as of November 1, 2004 until further notice.
K8	<p>Patient not registered. Claim has been reduced to 50% payment.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> This is the third (or subsequent) fee-for-service claim for a core service for this unregistered patient living in the catchment area. <p><i>Note:</i></p> <ul style="list-style-type: none"> This explanatory code will only be returned on the semi-monthly remittance statements, not as part of the nightly edits/refusals. The rule was suspended for most PHCOs as of November 1, 2004 until further notice.

CODE	DESCRIPTION
P0	<p>Claim for a non-physician and/or billed fee item does not meet conversion to fee for service criteria.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> • An encounter record submitted by a Primary Health Care Organization or other authorized clinic, for a non-registered patient, for a Core or Extended Service which would be eligible for conversion to Fee-for-Service, was: <ul style="list-style-type: none"> • Missing one or more data elements required to enable to conversion to Fee-for-Service, and payment of the Fee-for-Service claim; or • Contained invalid data elements, which could not be matched to the conversion logic, in order to enable Fee-for-Service conversion and payment of the Fee-for-Service claim. <p><i>Note:</i></p> <ul style="list-style-type: none"> • Effective 1 August 2000.
P5	<p>Not approved for service.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> • An encounter record (non-fee-for-service claim) was submitted for a non-core service. • The service provider (practitioner) is not approved for the core service group.
P6	<p>PHN not registered to Primary Care Organization.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> • An encounter record (non-fee-for-service claim) was submitted for a service to a PHN that is not registered to the Primary Health Care Organization (PHCO). • A de-registration record (registration cancellation record) was submitted for a PHN that is not registered to the PHCO.
P7	<p>Invalid/missing data in Note Record.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> • A registration or de-registration record was submitted with an invalid registration code value (attn. vendors: 'R', 'D', 'X', or 'Y' are valid values), or other invalid data in the Note Record. • A registration record was submitted with no address. • The "Note Explanation" was missing on a registration override record or de-registration override record. The note explanation must be present with an Override Code of 'A'. • A registration override record or de-registration override record was submitted with the Override Code of 'A'. These reject for review of the accompanying note explanation. • An invalid Registration Override Code or De-registration Override Code was submitted on a registration or de-registration override record. • An invalid Administrative Code was submitted on a registration record.

CODE	DESCRIPTION
P8	<p>Invalid registration cancel date/cancel reason code.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> • A registration record was submitted with an invalid registration/cancellation date. • A de-registration record (registration cancellation record) was submitted with an invalid cancellation date. • A de-registration record was submitted with an invalid cancellation reason code.
P9	<p>Registration not eligible for PCO site.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> • A registration record was submitted for a PHN that is currently registered to another PHCO. • A registration override or de-registration override record was submitted, but no pending registration/de-registration record exists for this PHN.
PH	<p>PCO Registration submitted for a PHN that is currently registered to an associated Primary Care Organization.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> • PHCO Registration submitted for a PHN that is currently registered to a linked Primary Care Organization. <p><i>Note:</i> Effective January 1, 2005</p>
PI	<p>Adjustment due to PHC Registration Change - NEW</p> <p><i>Possible Cause:</i></p> <p>The registration effective and/or cancel date of a PHCO Registration has been changed resulting in an adjustment to claims previously submitted.</p> <p><i>Note:</i></p> <p>Effective for claims with Dates of Service of April 1, 2005 on</p>
PJ	<p>PHN not registered on service date. Claim for a non physician and/or billed fee item does not meet conversion to fee for service criteria.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> • This is not a refusal code. • An encounter record submitted by a Primary Health Care Organization or other authorized clinic, for a non-registered patient, for a Core or Extended Service: • For a non-medical practitioner (e.g. nurse practitioner): The claim is accepted as an encounter. • For medical doctors: If the encounter does not have a fee for service equivalent, the claim is accepted as an encounter.

CODE	DESCRIPTION
PZ	<p>Please resubmit with Child’s PHN. Consider registering PHN with the Primary Care Organization.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> • A fee-for-service or encounter record was submitted for a service to a newborn, using the mother’s PHN and dependent code ‘66’, and without an explanatory note record. • If the same record is resubmitted as a fee-for-service claim, with a brief note record describing why the mother’s PHN is being used, and why the child should not be registered to the PHCO, the record will be accepted.
RE	<p>Encounter received.</p> <p><i>Note:</i></p> <ul style="list-style-type: none"> • This is NOT a refusal code, it is an explanatory code returned on all accepted AND refused encounter (non-fee-for-service) records, and can be used to identify the claim type (e.g. encounter, versus fee-for-service). • On the semi-monthly remittance statements, accepted encounter records are returned with ‘RE’ and no additional explanatory codes. ‘RE’ with no other explanatory code represents a “paid” encounter claim (e.g. a zero-dollar paid claim). • ‘RE’ will also be returned on refused encounter records as part of the nightly edits/refusals process. In this case, it will be accompanied by one or more other explanatory codes describing the reason(s) for the refusal.
RF	<p>Encounter required – patient registered to Primary Care Organization.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> • A fee-for-service claim was billed for a core service for a PHN registered to the Primary Care Organization.
RG	<p>Encounter record converted to Fee-for-Service.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> • An encounter record was submitted by a Primary Health Care Organization or other authorized clinic, for a non-registered patient, and the “fee-item” in the encounter record met all appropriate conversion criteria (e.g. a PHC core or extended service, provided by a physician). <p><i>Note:</i></p> <ul style="list-style-type: none"> • This explanatory code will only be returned on the semi-monthly remittance statements, not as part of the nightly edits/refusals. • Effective for claims with Dates of Service of April 1, 2005 on - may be accompanied by a PI explanatory code
RH	<p>Amount greater than \$0 billed on an encounter record.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> • In an encounter record, the amount recorded in the “amount billed” field was greater than \$0. All encounter records must be submitted with \$0 amount billed.

CODE	DESCRIPTION
RJ	<p>Practitioner not allowed to have Assigned Patients. (Draft Only)</p> <p>Possible Cause:</p> <ul style="list-style-type: none"> • Formerly, “Registration must be submitted by a medical doctor” • The practitioner identified on the registration record is not currently allowed to have assigned patients at this PHCO e.g. locum, non-medical practitioner • <u>If this is incorrect, please contact PHC to correct the error.</u> <p>Note:</p> <p>Proposed Implementation September 2005.</p>
RK	<p>Fee-for-Service record converted to an Encounter record.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> • A fee-for-service record was submitted by a Primary Health Care Organization or other authorized clinic, for a registered patient, and the fee-item in the fee-for-service record met all appropriate conversion criteria (e.g. a PHC core to a registered patient). <p><i>Note:</i></p> <ul style="list-style-type: none"> • This explanatory code will only be returned on the semi-monthly remittance statements, not as part of the nightly edits/refusals. • Effective for claims with Dates of Service of April 1, 2005 on - may be accompanied by a PI explanatory code
X2	<p>Facility number is missing or invalid</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> • Facility number is missing, invalid, or not authorized for this MSP Payee/Payment number. • Facility number is a required field for all fee-for-service and encounter claims from PHCOs.
X3	<p>Sub-facility number invalid</p> <ul style="list-style-type: none"> • Sub-facility or second facility number is missing, invalid, or not authorized for this MSP Payee/Payment number. • Sub-facility numbers are not currently in use for PHCOs.
XM	<p>ICBC has refused responsibility for this claim.</p> <p><i>Possible Cause:</i></p> <ul style="list-style-type: none"> • The Primary Health Care Organization was paid fee-for-service for an MVA related claim for a core service to a registered patient. ICBC has subsequently refused the claim. This refusal code indicates that the payment for this claim has been debited from the Primary Care Organization’s payee number. • Precedes a “credit” record as documented by explanatory code XN.

CODE	DESCRIPTION
XN	<p data-bbox="375 275 1408 342">Encounter record created to replace fee-for-service claim refused by ICBC.</p> <p data-bbox="375 363 542 388"><i>Possible Cause:</i></p> <ul data-bbox="375 392 1408 548" style="list-style-type: none"><li data-bbox="375 392 1154 422">• Follows a “debit” record documented by explanatory code XM.<li data-bbox="375 430 1408 548">• An encounter record was created to replace a debited fee-for-service claim: i.e. a paid fee-for-service claim for an MVA related core service to a registered patient was subsequently refused by ICBC. The encounter record replaces the original paid fee-for-service record of the core service to the registered patient.