General Practice Services Committee

ENCOUNTER REPORTING FOR PRIMARY CARE NETWORKS:
Frequently Asked Questions - *September 2022*

BRITISH COLUMBIA doctors of bc

Note: For ease of reading this document, the term 'practitioner' applies to both physicians and nurse practitioners who are providing services as the medical practitioner / primary care provider.

1.0 GENERAL REPORTING QUESTIONS

1.1 Who is required to Encounter Report?

- Contracted Physicians
- Nurse practitioners (contracted and employed)
- Primary care network (PCN) funded registered nurses (RN), and licensed practical nurses (LPNs)
- RNs and LPNs funded by the Primary Care Practice Program
- Some nurses and allied health professionals under Population Based Funding.

1.2 What is Encounter Reporting?

Encounter reporting involves submitting information through the Teleplan system for the services a practitioner (e.g., physician, RN, Nurse Practitioner, LPN) provides. It does not mirror the Medical Services Commission Payment Schedule and has no associated dollar value. Encounter reporting involves the submission of information about services provided, but not for the purpose of reimbursement.

1.3 What is an Encounter Record?

Encounter records are the principal mechanism for contracted physicians and health professionals to report on the services they provide under contract arrangements. Activity reporting using encounter records are initiated through clinic electronic medical record (EMR) and collected by the ministry through Teleplan, a process similar to fee-for-service (FFS) claim submission. An encounter record is a claim submitted to Teleplan for a distinct clinical service or activity provided by a practitioner to a patient or group of patients. Encounter records are similar to FFS claims and contain many of the same mandatory fields. Unlike FFS claims, however, encounter records pay $0.

1.4 What is an Encounter Code?

An encounter code is a unique five-digit number which corresponds to a service/activity or group of services/activities and is a mandatory field within each encounter record. These are called "fee items" under FFS.

1.5 What information is included in an encounter record?

Encounter records include the following information:

a. Medical Services Plan (MSP) payee number
b. Practitioner number
c. Patient's/Client's personal health number (PHN)

d. Patient/Client name
e. Date of services
f. Encounter code(s)
g. Start time (for that day)*
h. End time (for that day)*
i. ICD -9 diagnostic codes (1 code mandatory, 3 maximum)
j. Service location code
k. Note
l. Referring/Referred practitioner # (if the physician is referring patient to or receiving a referral from another practitioner)

*note: only specific codes on RN/LPN encounters have mandatory start and end times.

1.6 What is a Service Location Code?

A service location code is a field within each encounter record or FFS claim which identifies where the service was provided (such as the practitioner's office or a hospital). A list of location codes can be found on Clinic Setup for Encounter Reporting.

Effective April 1, 2021, Service Location Code A (Practitioner's Office) for submitting practitioner claims has been replaced with new codes, allowing the Ministry of Health to collect data related to service locations in greater detail.

The new location codes are:

- (B) Community Health Centre
- (J) First Nations Primary Health Care Clinic
- (K) Hybrid Primary Care Practice (part-time longitudinal practice, part-time walk-in clinic)
- (L) Longitudinal Primary Care Practice (e.g., GP family practice or PCN clinic)
- (N) Health Care Practitioner Office (non-physician)
- (Q) Specialist Physician Office
- (U) Urgent and Primary Care Centre
- (V) Virtual Care Clinic
- (W) Walk-In Clinic

The change will be phased in over a six-month period, ending September 30, 2021. Practitioners using Service Location Code A are encouraged to use the new codes starting April 1, 2021; however, it will continue to be valid from April 1, 2021 to September 30, 2021. Claims submitted with Service Location Code A for services provided after September 30, 2021 will be refused.

For more detailed information please refer to this article on the government website.

For a list of all service location codes please refer to Clinic Setup for Encounter Reporting.

1.7 What documents are currently available to support PCNs with encounter reporting?

Instructional resources and training materials can be found on the Primary Care Network Toolkit website. Please refer to the following documents for step-by-step instructions:

- Attachment Reporting and Attachment Records
- Clinic Setup for Encounter Reporting
- Encounter Reporting for FP Contracts
- Encounter Reporting for NP Contracts
- Changes to attachment reporting procedures for PCN NPs

1.8 When would a PCN practitioner begin encounter reporting?

When a practitioner is hired under a contract, the encounter reporting should coincide with the contract start date or the date at which they begin providing patient services.

When a practitioner is hired under the PCN (e.g., RN/LPN), encounter reporting should begin upon their start date or the date at which they begin providing patient services.

1.9 At what frequency are the New to Practice contract, Established Family Physician Group contract and Nurse Practitioner contract expected to submit their reporting?

Please refer to Appendix 1 of this document for an outline of the contract reporting requirements.

1.10 What is the difference between a practitioner/billing number and a payee number?

The practitioner number is the billing number given to the physician/provider when they enrol in MSP. The payee number is where Health Insurance BC (HIBC) payments are made. Each provider will have a personal payee number associated with their billing number, but they may choose to associate their billing number with a different payee, such as a health authority payee, or a broader clinic payee. Often, contracted providers are required to submit billings or encounters through a payee different from their personal payee number and are instructed to review the contract for further guidance.

1.11 Should a practitioner encounter report on all services provided to a patient or just the predominant service?

Practitioners should choose the encounter codes to submit on the basis of the services provided during the patient visit. This may include the submission of multiple encounters per visit (e.g., when an immunization is provided as part of a regular office visit where other conditions are managed), or the submission of a single encounter when multiple conditions are managed (e.g., the submission of an office visit encounter when a patient's COPD and anxiety are actively managed).

2.0 CLAIM REJECTIONS, OVER-AGE APPROVAL REQUESTS, AND ENCOUNTER CODE GROUPINGS

2.1 What is an over-age claim?

Section 33 of the Medical and Health Care Services Regulation states that a physician has 90 days, from the date the service was provided, to submit a claim for reimbursement through the medical services plan. The same rule applies to NP, and RN/LPN encounter codes. Claims for service provided greater than 90 days in the past are referred to as over-age claims.

2.2 How do I submit an over-age claim for approval?

In order to have an over-age claim approved the clinic must submit a request form to HIBC. Please contact **HIBC's billing support team at 1-866-456-6950** or Vancouver 604-456-6950 using Option 1 in our phone menu or fax the form https://www2.gov.bc.ca/assets/gov/health/forms/2943fil.pdf to (f) 1 (250) 405-3593. The form must be submitted within 6 months from the date of service.

2.3 How is a clinic notified of an encounter record rejection?

Clinics will be notified of rejections the following day through Teleplan.

2.4 Why would encounter records be rejected through the MSP Teleplan system?

Rejections can occur for a number of reasons including, but not limited to:

- A claim being submitted more than 90 days past the date-of-service;
- A claim duplicates or overlaps a previous claim for the same service;
- A claim is not accurate; for example, it contains an incorrect PHN or encounter code number;
- HIBC did not receive and/or process the form (Encounter Record Submission Authorization) to connect the nurse's billing number to the payment/payee number.

Refused encounter records are returned with an explanatory code, which explains why the encounter record is refused. A list of explanatory codes can be found: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/claim-submission-payment/explanatory-codes

2.5 Who do I contact for assistance with billing or claim rejections?

HIBC can provide assistance with any billing or encounter record rejections. Please contact HIBC at MSP Teleplan Inquiries and Support:

MSP Teleplan Inquiries and Support
(p) 604 456-6950, option 3, and then 2
(p) 1 866 456-6950, option 3, and then 2 (toll free)
(hrs) Mon. to Fri., 8:00 am to 4:30 pm

2.6 Does 97517 – Telehealth GP Visit cover services provided by both phone and video?

The simplified encounter codes do not mirror the MSC payment schedule. If a service was provided via video encounter 97517 – Telehealth GP Visit would be submitted, if the service was provided by phone with a patient, then 97521 – GP Telephone services (with patient) would be submitted.

2.7 Can PCNs access encounter reporting data for their practitioners?

The Ministry can produce monthly encounter data reports for PCNs. The report lists the total services, by month and sometimes a breakdown of services by types for the contracted practitioners (e.g., general practitioner (GP), nurse practitioner (NP), RN). Any PCN data requests can be sent to Central Intake: MOHAnalytics@gov.bc.ca

2.8 Are there any additional reporting requirements for FFS physicians who are participating in a PCN?

FFS physicians who are participating in a PCN are required to submit attachment records to identify any new patients who are attached to their practice. FFS physicians are not required to retroactively submit attachment records for those patients who joined their panels prior to their participation in the PCN.

3.0 NURSE PRACTITIONERREGISTERED NURSES, LICENSED PRACTICAL NURSES AND ALLIED HEALTH SPECIFIC REPORTING QUESTIONS

3.1 Are PCN nurses (RNs/LPNs) and allied health professionals required to submit encounter reporting?

PCN funded RNs and LPNs are required to encounter report through the MSP Teleplan system using their own list of encounter codes. Allied health professionals are not currently required to encounter report via Teleplan as a condition of PCN funding.

3.2 When a nurse provides care to a patient and the patient's care is discussed with a contracted physician or NP, would both the physician or NP, and the nurse submit an encounter record? Or just the nurse, seeing as they are the primary provider for the visit?

The answer would depend on whether the FP/NP provided a service to the patient. For example:

- If the RN discusses the patient's care with the physician but the physician does not see the patient or provide a service for them, the RN would submit the encounter record. The FP would submit the appropriate encounter code or FFS claim for consulting with the RN.
- If, after discussing with the FP, it is determined the FP needs to see the patient, the RN would submit 38071 "NIPCP Referral to in-clinic team member" and the FP would submit the appropriate encounter code or FFS claim for the service provided.

3.3 When a PCN-funded nurse performs a procedure, how is the tray fee compensated?

A tray fee cannot be billed for procedures provided by a nurse. As part of the PCN funding, overhead is considered and includes all equipment needed by the nurse to provide services, including trays for procedures.

3.4 What are the reporting requirements for PCN allied health professionals?

Allied health professionals are required to report the number of patient visits and unique number of patients seen. Allied health practitioners are not currently required to encounter report any services provided through the MSP Teleplan system.

4.0 BILLING AND PAYEE NUMBER

4.1 When do I need a Y-status payment number?

Agencies that hire or contract health professionals to deliver services that require encounter reporting may report to Teleplan through a Y-status payee number, if a shared clinic payment number is not already available. Whether a Y-status payee number is required depends on the billing arrangements of the clinic/service location in question as well as which practitioners are doing the encounter reporting. FFS Clinics typically use either a shared M-status payee, or the physicians bill to their own payees.

- Physicians on the Group Contract for Practicing Family Physicians require a shared M-status payee.
- Physicians on the Individual Contract for New to Practice Family Physicians can use either a M-status payee or a Y-status payee. If encounter reporting through a Y-status payee, third party billings should be billed to a separate payee (e.g., their personal billing number).
- NPs, RNs and LPNs can encounter report through either a M-status payee or a Y-status payee.

As such, for primary care encounter reporting, a new Y-status payee is only required when there is no shared payee already in place, and only to facilitate encounter reporting.

If you are unsure about whether your clinic/service location requires a new Y-status payee number, please contact PCN.Compensation@gov.bc.ca for support.

4.2 What is the difference between Y-Status and M-Status payees?

Historically, Y-status payees have been used to support Alternative Payment Program contracts for physicians. The differences between a Y-status payee and a M-status payee are:

- 50% of third-party billings are automatically remitted to the ministry on Y-status payees
- Shadow billing can only be reported to a Y-status payee number
- Y-status payees may be owned by the health authority when used solely for encounter reporting

4.3 How do I get a Y-status payee number activated?

In order to get a Y-status payee number activated, please follow the steps listed in Appendix 1: https://www.pcnbc.ca/en/pcn/permalink/pcn91

- Contact the compensation analyst at the Alternative Payments Program (APP) in the Ministry of Health assigned to your agency to request a Y-status payee
- APP will reserve the Y-status payment number and send associated forms to the agency
- Agency works with provider to complete the forms (Application for Additional Payment Number – this form is required to activate the reserved payee, Assignment of payment (FPs) or Encounter Record Authorization Form for Non-Physician Providers – these forms are required to connect the practitioner number to the payment number to allow for the submission of encounters.
- Health authority/clinic send completed forms directly to HIBC for processing
- HIBC activates new payee number and attaches practitioners to the payment number via a completed assignment of payment (FPs) or an encounter record authorization form (RN, LPN, NPs).

5.0 SHIFT REPORTING, ATTACHMENT CODES AND EMR

5.1 What is Shift Reporting / What are Shift Codes?

Shift reporting is a requirement under the NTP contract, the Group Contract for Practicing Full Service Family Physicians, and the Nurse Practitioner Contract. Shift reporting involves the submission of an administrative record through the Teleplan system which documents a block of a practitioner's contracted clinical time. A shift record is similar to an encounter record or a FFS claim and has many of the same mandatory fields. Start and stop times are required on shift reporting to document the block of time. A shift code, like an encounter code or fee item, is the unique five-digit number which corresponds to the service or activity provided, which in this case is a contracted clinical shift. There are two different shift codes currently in use – 97570 and 96995. Practitioners should consult their contract for specific shift reporting requirements.

5.2 Longitudinal providers do not usually work in shifts and often that means the end time is not known at the start of the day. Meanwhile, EMR software is designed to support submitting billing and encounter codes once documentation is complete.

Contracted practitioners are sometimes required to enter the contracted clinical shift code (97570/96995) for each day during which services are provided under the contract. Contracted practitioner are encouraged to incorporate the daily submission of shift codes into their regular workflows to ensure the correctness and accuracy of shift code submissions.

For example: The contracted clinical shift code can be submitted at the start of the following day or end of each day, whichever is preferred. If a practitioner worked on a Monday, they submit Monday's shift

code on Tuesday as the physician would know the actual start and end time of the shift and total billed service units.

5.3 What is meant by billed services?

A billed service value, up to a maximum of 96 (24 hours), must be submitted with each Teleplan shift code (97570 only). Each billed service value represents a 15-minute increment (or greater portion thereof) of services claimed under the contract, and the total billed service value for each submitted shift code must not exceed the difference between shift start time and end time.

An example of billed services shift scenarios are:

- 8:00 – 12:00 = 16 billed service units
- 3:15 – 3:30 = 1 billed service unit
- 5:00 – 6:30 – 6 billed service units
- 10:45 – 11:30 = 3 billed service units
- 10:45 – 10:53 = 1 billed service units

To illustrate, consider the following scenarios:

- A contracted practitioner works a shift from 9 a.m. to 2 p.m., but only wishes to claim a total of four contract hours. The remaining shift hour was spent doing third-party work or not providing services. The billed service value on the code submitted for this contract shift is 16.
- A contracted practitioner works a shift from 2 pm to 8 pm and wishes to claim a total of six contract hours. The billed service value on the code submitted for this contract shift is 24.

For quick calculations, billed service value = [number of hours worked] * (times) four.

5.4 If a practitioner is working a full day (8:30 a.m. to 5:30 p.m.) and takes a 30-minute lunch, should the shift code be submitted once for the day or twice, once for each half day?

The shift code should only be submitted once per 24 hours. In the scenario outlined, the shift code would be submitted once, excluding 30 minutes (two billed service units), leaving 8.5 hours (34 billed service units) for the shift. Multiple submissions per day will be accepted through Teleplan, but this practice should be avoided where possible.

5.5 How are shift codes to be submitted on days that a practitioner reviews labs/reports/chart, but does not have a patient encounter?

The practitioner would enter the shift code for the time worked using the PHN of one of the patients whose lab/report or chart was reviewed.

5.6 What is Attachment Reporting / What are Attachment Records?

Attachment reporting involves the submission of an administrative record through the Teleplan system which documents a patient attachment to a physician or a NP. An attachment record is similar to an encounter record or a FFS claim and has many of the same mandatory fields. An attachment code, like an encounter code or fee item, is the unique five-digit number which corresponds to the service or activity provided, which in this case is the patient attachment conversation. The PCN attachment codes are community specific, except in the case of the 97701 PCN Existing Panel Or Panel Transfer Report, which is to be used by PCN NPs only to report non-net-new patient attachments. Please consult the documents listed above for the appropriate code for your community, and for additional guidance on attachment reporting.

5.7 How would I submit encounter reporting and patient attachment reporting if I do not have an EMR, or my EMR does not interface with Teleplan?

The use of an EMR is a requirement for contracted FPs and NPs working in PCNs, as is the submission of encounter reporting and attachment reporting through Teleplan. It is expected that PCNs will serve to enhance informational continuity by, among other things, working towards linked electronic medical records. Further, providers should strive to incorporate the 12 attributes of a patient medical home (PMH) into their own practices, including being information technology enabled via an EMR that is able to link appropriately with other providers and parts of the system. Generally, a Teleplan compliant EMR is the easiest and most efficient way to achieve these aims and submit the above reporting.

Practitioners can use the manual online claims submission process (form HLTH 1915) if they are submitting a small number of records or claims. Refer here for form HLTH 1915: https://www.health.gov.bc.ca/msp/forms/hlth1915/intro.health

If support is required for using this process, please contact HIBC provider services: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/contact-us

5.7 Who do I contact if I'm having issues entering encounter records in my EMR system?

For any EMR-related supports, users should contact the EMR vendor. In some cases, the GPSC Practice Support Program or Doctors Technology Office may also be able to assist clinics with navigating supports for EMR related questions.

5.8 Should the attachment code be submitted for all patient attachments or net new attachments?

The answer to this question depends on the type of contract:

- Contracted FPs who are **new to practice** and working in a PCN submit an attachment record for each patient who becomes part of their panel, after having an explicit attachment conversation. As the practitioners are NTP they would attach each patient to their panel – one time per attached patient.

- **PCN NPs** (whether contracted or employed) and NPs practicing in PMHs, urgent and primary care centres (UPCCs), community health centres, NP Primary Care Clinics, and First Nations Primary Care Clinics must submit the PCN Attachment code for all net-new patient attachments, and submit the PCN Existing Panel Or Panel Transfer Report code (97701) for all non-net-new patient attachments. The difference is as follows:
    - Non-net-new attached patients are those who were already attached to the NP before the NP joined the PCN/clinic, and who have chosen to stay attached to the NP when he/she joined the PCN/clinic; or were transferred to the NP from another most responsible provider (e.g., a retiring physician) in the same PCN.
    - Net-new attached patients are any individuals who do not fit into either of the above situations.
- FPs on the **Group Contract for Practicing Full-Service Family Physicians** submit attachment records to identify new patients attached to their practice, as well as those patients who were members of their existing practice (using the generic attachment code - 97700). Attachment codes should be submitted once per patient, per year after having an explicit attachment conversation with the patient to confirm attachment.
- FPs on **FFS or other compensation models** submit attachment records to identify only new patients who are attached to their practice and are not required to retroactively submit attachment records for those patients who joined their panels prior to their participation in the PCN. Practitioner submits the attachment codes for newly attached patients only. If an FFS physician retires and another physician takes over the practice they would not submit attachment codes for the panel they have taken over. An attachment code would be submitted for any new patient added to that panel.

For a list of PCN-specific attachment codes please see: PCN Attachment Reporting and Attachment Records

5.9 For some clinics, patients are attached at the clinic level, not to a most responsible provider (MRP). Are the attachment codes and encounter codes attributable to the provider who happens to see them that day, or to the clinic as a whole?

The answer to this question varies slightly depending on the contract model being used.

In a scenario where the Group Contract for Established Family Physicians is used, attachments are to the individual MRP, but payments are made at the clinic level. In this case, attachment records should be submitted bearing the practitioner number of the attaching physician and the clinic's payee number.

In a scenario where a standard (Alternative Payments Subsidiary Agreement) group contract model is used, and where attachment is to the clinic as opposed to individual MRPs, attachment records should be submitted bearing the practitioner number of the physician who happened to see the patient and the clinic's payee number. Only the clinic payee number would be used to attribute attachments for reporting purposes.

In both cases, an attachment conversation between the patient and the provider must occur prior to the submission of attachment records. When attachment is to a group rather than to an individual MRP, the group collectively assumes the responsibilities of the MRP.

Service-level encounter reporting should **always** bear the practitioner number of the practitioner who provided the service(s), regardless of whether they are the patient's MRP.

6.0 REFERRALS AND TEAM-BASED CARE

NOTE: *The following section is intended only for scenarios where an RN or LPN is required to encounter report and is working in a setting where physicians bill FFS. It is important to note that although the RN and LPN encounter codes were developed originally for the nurse-in-program, these encounter codes are now being used in PCNs, UPCCs and other service delivery models.*

6.1 What if the RN/LPN sees the patient but needs to consult with the physician?

There are cases when there will be a clinical need for the physician to see a patient who has also seen the nurse during the same visit. When this occurs, it is expected that the physician will bill for any services they provide to the patient, and the nurse must submit encounter 38071 - NIP referral to in-clinic team member.

6.2 If a patient is seen by an RN/LPN but requires a prescription from the physician or NP, should the physician/NP bill an office visit?

If the nurse provided a service to a patient and it was determined by an FP or NP consultation the patient required a new prescription (or change in dose/frequency of a prescription) the nurse would submit encounter code 38071 - NIP referral to in-clinic team member. The physician or NP must then see the patient and would be eligible to bill or submit an encounter record for the office visit.

If the nurse is seeing a patient whose prescription needs to be refilled (no change in medication or dose/frequency), and it has been predetermined by the physician that no further physician consultation is needed (e.g., if it is not medically necessary for a patient to be personally reassessed prior to prescription renewal), and the clinic had developed protocols and clinic support tools to assist the RN in prescribing in specific pre-determined circumstances[1], the nurse would submit encounter code 38070 - NIP Requesting Advice from an NP/FP and the physician would not bill (as per section C.5 of the MSC payment schedule).

6.3 Can a physician bill FFS for services provided by the nurse?

Any service provided exclusively by the nurse cannot be billed by the physician. If the nurse needs the patient to be seen by the physician, then the nurse must submit encounter code "38071 - NIP referral to in-clinic team member" and the physician can then see the patient and bill for the appropriate service

provided. This applies to all nursing visits, including but not limited to visits for counselling, education, and procedures.

Example: Fee Item G14066 - (Personal Health Risk Assessment):

- This fee item requires the physician to undertake a personal health risk assessment in one of a number of targeted populations (e.g., obesity, smoking, etc.) and develop a plan that has patient specific targeted actions.
- If the physician does the work, then this fee item can be billed. However, if a nurse does the work, then the fee item cannot be billed by the physician.

Note:

For the purposes of its incentives, GPSC defines allied care providers (ACPs) "employed within" a physician practice as ACPs who are employed by and work directly within a family physician practice team, with no cost recovery either directly or indirectly from a third party.

ACPs "working within" a physician practice work directly with a family physician practice team with costs paid by the practice or a third party (directly or indirectly). For example, ACPs employed by a health authority and assigned to work with a family physician practice to support ongoing care of its patients are considered working within the practice team. ACPs who are not assigned to work with the team but who provide services to patients on a referral basis are not considered to be "working within" the practice.

Please see the GPSC website and billing guides for more information on team-based care incentives

If you have any further questions regarding encounter reporting please email PCN.Compensation@gov.bc.ca or contact your regional GPSC Primary Care Transformation Partner.

APPENDIX 1: REPORTING REQUIREMENTS FOR THE NEW CONTRACTS (NEW-TO-PRACTICE, ESTABLISHED GROUP, AND NP)

Report	**Description**	**New to Practice Contracted Physician**		**Established Family Physicians Group Contract**		**Nurse Practitioner**	
		Frequency	**Submit to**	**Frequency**	**Submit to**	**Frequency**	**Submit to**
Attachment Reporting	Practitioners will confirm each patient they have attached during the year by submitting the appropriate PCN Attachment Code through Teleplan (as stated in the contract). (For NPs, the PCN Attachment Code is only to be used for net-new attachments, while the PCN Existing Panel Or Panel Transfer Report code (97701) should be used for non-net-new patient attachments.)	Once per patient	Medical Services Plan (MSP)/Health Insurance BC (HIBC) through Teleplan	Once per patient, annually (by contract year end), for current and new patients.	MSP/HIBC through Teleplan	Once per patient	MSP/HIBC through Teleplan
Patient Attachment Verification	Each attached patient must be given the opportunity to verify their attachment to their most responsible provider. Where attachment is verified, the form of verification must be kept in the patient file and be made available to the ministry on request. The ministry suggests the use of this form to verify attachment: https://www2.gov.bc.ca/assets/gov/health/forms/2989fil.pdf (Note: Physicians may choose to use their own method to confirm and document patient attachment).	N/A	N/A	Completed and kept in patients file	Ministry on request, or in case of audit.	N/A	N/A
Encounter Reporting	Practitioners will submit encounter records to MSP/HIBC for services provided under the contract using the simplified encounter codes. * For physicians, services outside the contract must be submitted as fee-for-service (FFS) claims. Note: start and end times are required when services outside the contract are provided on the same day that services are provided under the contract.	**Frequency** For all services provided under the contract – daily (within 90 days) **Submitted to** MSP/HIBC through Teleplan					

Report	Description	New to Practice Contracted Physician		Established Family Physicians Group Contract		Nurse Practitioner	
		Frequency	**Submit to**	**Frequency**	**Report to**	**Frequency**	**Report to**
Hours Reporting/ Invoice	**Hours:** Practitioners will provide their health authority with an hourly report with respect to services provided under the contract. Refer to the contract for further details. **Invoice:** The NTP Practitioner will invoice the health authority for all the services provided in a form acceptable to the health authority. As stated in the contract: biweekly/monthly/other. Note: the hours reporting, and invoice can be combined on the same form, but must include all the required information.	**Hours:** Monthly: (Appendix 5A) **Invoice:** As stated in contract (Appendix 3A)	Health Authority Medical Affairs	**Hours:** Quarterly (within 30 days of the end of the completed quarter) Appendix 5A	Health Authority Medical Affairs	**Hours:** Monthly **Invoice:** NPs will keep invoices on file	Health Authority Medical Affairs
Shift Code Reporting	Each Practitioner will submit a shift code fee item for each period of time under which contract services are provided which identifies: • Date of service • Start and end time for that day • Billed Service Time Units (an estimate of 15-minute time units spent providing Services under the contract)	**Frequency** Daily (for each 24-hour period where hours are claimed under the contract) **Submitted to** MSP/HIBC through Teleplan					
QI Reporting	Physicians will provide a report to the health authority (validated by the General Practice Services Committee/Practice Support Program) on the quality improvement services completed. Up to one hour per week/per FTE can be included in the contract hours reporting on the hours reporting template.	Within 30 days after the end of each year of the Term	Health Authority Medical Affairs	Within 30 days after the end of each year of the Term	Health Authority Medical Affairs	N/A	N/A
Access Reporting for	For group contract physicians the 3rd Next Available Appointment form can be found here:	N/A	N/A	Quarterly - submissions: due	Health Authority Medical Affairs	N/A	N/A

3rd Available Appointment	https://www2.gov.bc.ca/assets/gov/health/forms/2990fil.pdf			within 30 days after the end each quarter during the Term.			

* A practitioner may submit a maximum of three diagnostics codes on each encounter record reported through Teleplan, if those conditions are actively managed during the visit.

For a complete list of the reporting requirements for each contract please see Appendix 5 “Reporting” in the respective contract.
For additional resources on reporting please refer to https://www.pcnbc.ca/pcn (under resources)