ENCOUNTER, ATTACHMENT & SHIFT REPORTING
EMR ORIENTATION GUIDE – TELUS MED ACCESS

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Contents

Overview

DTO and PSP in collaboration with Telus Med Access has developed this EMR orientation guide that outlines how to submit Encounter, Attachment and Shift records using a step-by-step approach. Screenshots have been included to demonstrate how to use the EMR to complete each step.

Encounter and Attachment reporting are the principal mechanism for contracted FPs/NPs and PCN funded RNs and LPNs to report on services provided to patients. Activity reporting through Encounter, Attachment and Shift records are initiated through the clinic electronic medical record (EMR) and collected by the Ministry through Teleplan. Reporting is used for tracking service utilization, understanding panel sizes and attachment gaps, monitoring population health, system planning and resource allocation, and to understand what services are being provided to whom. This Orientation guide has been designed to support you in using your EMR for these reporting purposes.

Who is required to Encounter Report?

1. Contracted physicians
2. Nurse practitioners (contracted and employed)
3. Primary care network (PCN) funded registered nurses (RN), and licensed practical nurses (LPNs)
4. RNs and LPNs funded by the Primary Care Practice Program
5. Locum physicians contracted through the Urban Locum Program (Greater Victoria pilot)
6. Some nurses and allied health professionals under Population Based Funding*

* Please note that this EMR orientation guide does not focus on reporting requirements for health professionals under Population Based Funding. For more information about EMR set up for Population Based Funding it is recommended that you connect with your EMR vendor. General inquires around Population Based Funding can be directed to The Ministry of Health at populationbased.fundingprogram@gov.bc.ca.

Key Steps / Key Tips

- It is strongly recommended to connect with your EMR vendor early, your EMR vendor will help to make sure your EMR is set up to enable Encounter, Attachment and Shift reporting. The EMR Set Up section in this guide provides some set up information.

- If you have contract questions around Encounter, Attachment and Shift reporting, or to clarify which Payee Number you should use and the Payee Status, or which service codes to use, contact your Health Authority Medical Affairs department.

- For assistance or inquiries about the setup of the Payee Number, Teleplan data center number or Facility Number, contact HIBC support: Practitioner Account Service at **604-456-6950** (Vancouver) or **1-866-456-6950** (elsewhere in BC) **option 3** then **option 2**.

- **IMPORTANT**: Before submitting your first Encounter, Attachment and Shift records to MSP/Teleplan, call HIBC support (on the number above) to confirm that your Payee Number is active, linked to your personal MSP number, and is ready for use.

- For your first time submitting records to MSP/Teleplan, it is recommended to only submit a few records to check that they are accepted and not rejected.

- Rejection codes and explanations can be found here. For further questions regarding rejections contact HIBC support (on the number above).

- For more information around Encounter, Attachment, and Shift reporting please see resources located on the PCN toolkit including the Encounter Reporting FAQ.

- **IMPORTANT - Locums**: Before a locum submits any Encounter, Attachment or Shift records (under the contract) or Fee For Service bills (under a Payee Number not their own), the appropriate assignment of payment form (to link their MSP number to the Payee Number) needs to be completed and processed by HIBC.

- **IMPORTANT - Nurses**: If a nurse changes from one type to another, their personal MSP number will change. This includes a change from a Registered Nurse (RN) to a certified Registered Nurse (RN(C)). Before submitting any Encounter, Attachment or Shift records, the appropriate assignment of payment form (to link their new MSP number to the Payee Number) needs to be completed and processed by HIBC.

- **Reflecting patient complexity**: Comprehensiveness and specificity are the best ways to ensure patient complexity is most accurately reflected. Comprehensiveness in diagnostic coding (ICD-9) is important when submitting encounter records, this means multiple codes per visit if multiple conditions or issues are considered. Also, specificity in diagnostic coding, this means using four or five-digit ICD-9 codes when relevant.

IMPORTANT! Payee Status & Payment Mode

It is important to understand the Payee Status (Y or M) of the Payee Number that you are using for your Encounter, Attachment, Shift codes, as this, along with your role (FP, NP, RN or LPN) will dictate the Payment Mode (0 or E) that needs to accompany the submitted code.

For FPs and the limited Fee For Service (FFS) codes they are eligible to bill, the Payment Mode is '0' regardless of the Payee Status (Y or M).

See the table below which summarizes the Payee Status (Y or M) and the Payment Mode (0 or E) by role (FP, NP, RN or LPN).

IMPORTANT! Incorrect combinations could be rejected by MSP/Teleplan.

In this guide, it explains how you adjust the Payment Mode between '0' and 'E'.

PAYEE STATUS	PHYSICIAN FEE FOR SERVICE	PHYSICIAN ENCOUNTER/ATTACHMENT/SHIFT	NP, RN, LPN FEE FOR SERVICE	NP, RN, LPN ENCOUNTER/ATTACHMENT/SHIFT
Y	Payment Mode '0'	Payment Mode 'E'	N/A	Payment Mode 'E'
M	Payment Mode '0'	Payment Mode '0'	N/A	Payment Mode 'E'

Payee numbers direct to whom payments are made and their status determines how they will be remitted.

• If you are unsure about whether your clinic/service location requires a Y-status payee number, please contact your Health Authority Medical Affairs department for support.

• For assistance in setting up a Y-status payee number please contact your Health Authority Medical Affairs Team. Instructions for creating a Y-status payee number are outlined in the Primary Care Networks: Clinic Setup for Encounter Reporting resource.
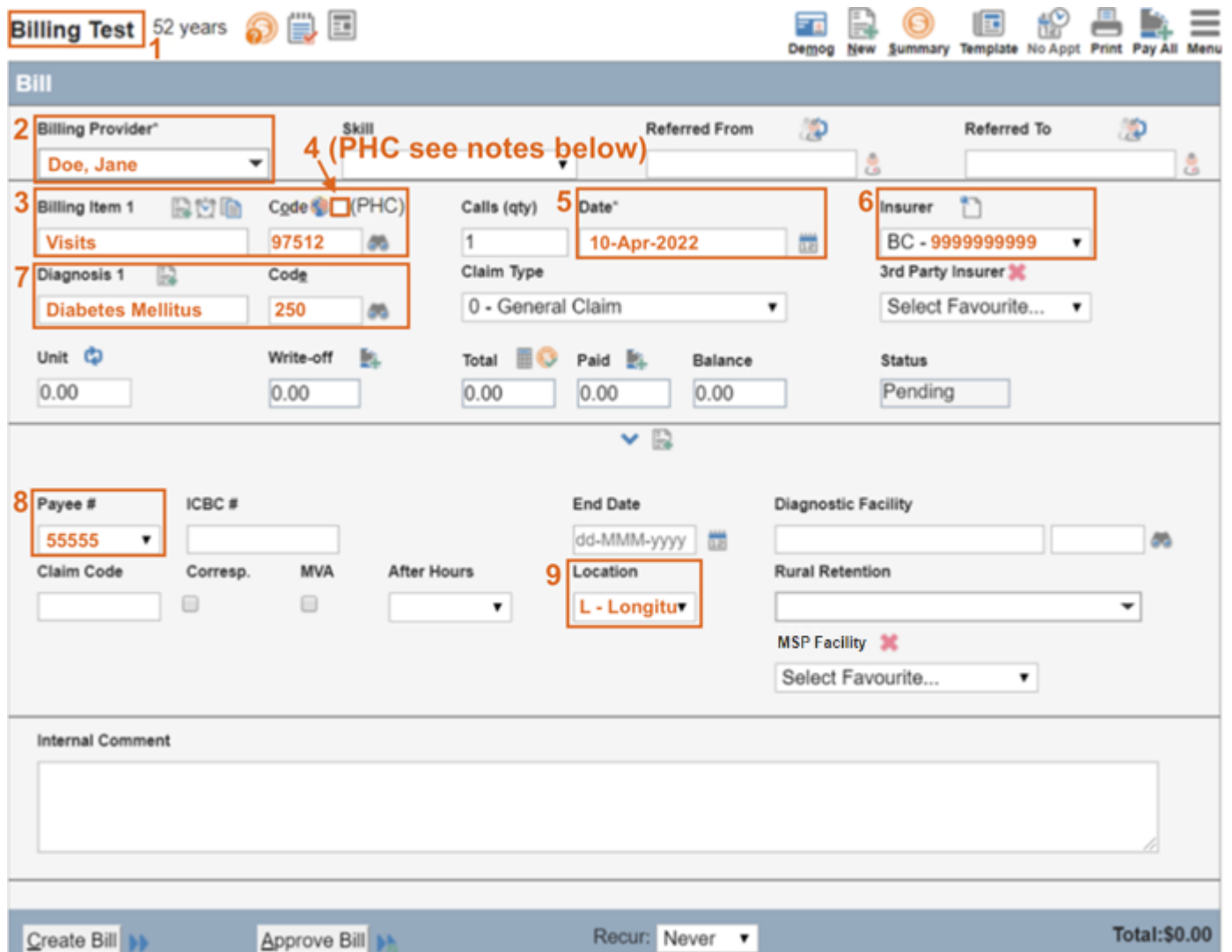
Terminology

As the billing part of the EMR is used to submit Encounter/Attachment/Shift records, the terms 'record', 'claim' & 'bill' can be used interchangeably when applied to submitting Encounter/Attachment/Shift records.

Submitting Encounter/Attachment/Shift Records

1. How to submit an Encounter record?

Access the bill window from the schedule, visit, or patient's chart.

A. From the schedule, click on **Edit** in the Billing Status column.

B. From the visit, click Create Bill .

C. From the Bills tab in the patient chart, click on the icon.

To submit an Encounter record, you populate the bill window as follows:

1. Patients Name will automatically populate.

2. Billing Provider (name) – If not automatically populated, select from the drop down list.
   Note: The provider's MSP number is stored in the providers record in the Billing Number field.

3. Billing Item (Encounter code) – enter the Encounter code in the Code field. Click on the binoculars and the description will automatically populate if the code is in Med Access. Otherwise, a new window will open allowing you to find the correct code. To add additional Encounter codes, click on the ![icon] icon, and a new line will display, repeat step 3.

   For a list of Encounter codes please refer to the following resources: Family Physicians, Nurse Practitioners, and RNs/LPNs.

4. PHC checkbox –
   A. If **FP** using a **M Payee Status**, then **uncheck the PHC box** Code ☐(PHC) . This will ensure that the bill is sent to MSP/Teleplan with the Payment Mode of '0'.
   B. If **FP** using a **Y** Payee **Status**, then **check the PHC box** Code ☑(PHC) . This will ensure that the bill is sent to MSP/Teleplan with the Payment Mode of 'E'.
   C. If **NP, RN or LPN** then **check the PHC box** Code ☑(PHC) . This will ensure that the bill is sent to MSP/Teleplan with the Payment Mode of 'E'.

5. Date (of service) – will automatically populate. You can adjust the date by either typing the date or clicking on the calendar icon and selecting the date.

6. Insurer (and patient's PHN) – will automatically populate with the patient's PHN and insurer, which is based on the patient's PHN number.

7. Diagnosis (ICD-9 code) – enter the diagnosis ICD-9 code in the Code field. Click on the binoculars and the description will automatically populate if the code is in Med Access. Otherwise, a new window will open allowing you to find the correct code. To add additional diagnosis codes, click on the ![icon] icon, and a new line will display, repeat step 7.

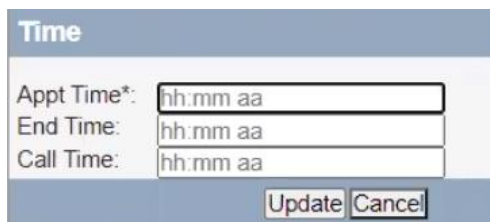   One ICD-9 code is mandatory, up to three ICD-9 codes can be included per Encounter code submitted.

Most frequently used ICD-9 codes can be found in the Appendix.

8. Payee # (MSP payee number) – if the provider only has one payee number, this will be the default. If the provider has more than one payee number, it will default to the payee number that has the lowest sequence number (as set up in the Provider record – see here for more details). Otherwise select the payee number that you are to submit your Encounter record to.

9. Location (service location code) – select the location from the drop down list. 'L - Longitudinal Primary Care Practice', is likely to be the option. However, this is depending on where you are providing the service.

Optional fields to populate depending on the scenario:

10. Referring from – select the provider that you received the referral from. If the referring physician is set up in the patient demographics, this field will be automatically populate with this referring physician.

11. Referring to – select the provider that you are referring the patient to.

12. Appt Time (e.g. start time for counselling) – click on the clock icon to open a new pop up window, and enter the time (e.g. 2:40pm, would be entered as 02:40 PM)

   End Time (e.g. end time for counselling) – enter the time (e.g. 3pm, would be entered as 03:00 PM), click Update to save the time.

Note: Time window will automatically pop up when certain service codes are entered in the bill window. Time window does not open automatically when billing from a visit. Therefore needs to be manually entered in the bill window, or will be rejected by MSP/Teleplan if required for that service code.

Note: If you hover over the clock icon in the bill window, the time entered will pop up, e.g.

```
Click to edit start and end time.
Appt Time: 02:40 PM
End Time: 03:00 PM
Call Time: 02:40 PM
```

13. Notes – click on the note icon ⬛ Insurer 🗋 this will open a pop up window where you can add a note which will be sent along with the record. Click Update to save the note. 'Internal Comment' field is for reference and does not get sent to MSP/Teleplan.

```
Ministry Comment 1
┌──────────────────────────┐
│                          │
│                          │
│                          │
└──────────────────────────┘
         Update
```

14. MSP Facility (Facility Number) – The most efficient way to populate the MSP Facility is to use a bill template with the MSP Facility already prepopulated (see here in the guide how to create a bill template). Otherwise, enter the facility name or part of the name in the MSP Facility field and hit

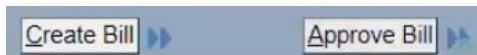enter or click on the facility icon 🏢. Select the name of your clinic's facility.

Note: If you need to set up your Facility Number, please review the section in guide here.
Note: The facility name will be displayed on the bill and not the Facility Number, this is correct.
Note: Facility Number is optional for Encounter codes. However, submitting a Facility Number with an Encounter code is fine.

Click Create Bill, which saves the bill with a Pending status. The Encounter record is now ready to be sent to MSP/Teleplan. See the steps on how to submit records in bulk to MSP/Teleplan here.

If Approve Bill is clicked then the bill will be sent to MSP/Teleplan after 15 minutes.

```
Create Bill ▶▶        Approve Bill ▶▶
```

2. How to submit an Encounter record (RN/LPN with times)?

Access the bill window from the schedule, visit, or patient's chart.

A. From the schedule, click on Edit in the Billing Status column.

B. From the visit, click Create Bill 🔵.

C. From the Bills tab in the patient chart, click on the 📄 icon.

To submit an Encounter record, you populate the bill window as follows:

1. Patients Name will automatically populate.

2. Billing Provider (name) – If not automatically populated, select from the drop down list.
   Note: The provider's MSP number is stored in the providers record in the Billing Number field.

3. Billing Item (Encounter code) – enter the Encounter code in the Code field. Click on the binoculars and the description will automatically populate if the code is in Med Access. Otherwise, a new window will open allowing you to find the correct code. To add additional Encounter codes, click on the icon, and a new line will display, repeat step 3.

For a list of Encounter codes for RNs and LPNs please refer to the following resource: PCN RN & LPN Encounter Codes

4. Time is only required for some RN/LPN Encounter codes (e.g. counselling and education codes have mandatory start and end times).

   Appt Time (e.g. start time for counselling) – click on the clock icon to open a new pop up window, and enter the time (e.g. 2:40pm, would be entered as 02:40 PM)

   End Time (e.g. end time for counselling) – enter the time (e.g. 3pm, would be entered as 03:00 PM), click Update to save the time.

   Note: Time window will automatically pop up when certain service codes are entered in the bill window. Time window does not open automatically when billing from a visit. Therefore needs to be manually entered in the bill window, or will be rejected by MSP/Teleplan if required for that service code.

   Note: If you hover over the clock icon in the bill window, the time entered will pop up, e.g.

5. PHC checkbox –
   A. **RN or LPN** then **check the PHC box** . This will ensure that the bill is sent to MSP/Teleplan with the Payment Mode of 'E'.

6. Date (of service) – will automatically populate. You can adjust the date by either typing the date or clicking on the calendar icon and selecting the date.

7. Insurer (and patient's PHN) – will automatically populate with the patient's PHN and insurer, which is based on the patient's PHN number.

8. Diagnosis (ICD-9 code) – enter the diagnosis ICD-9 code in the Code field. Click on the binoculars and the description will automatically populate if the code is in Med Access. Otherwise, a new window will open allowing you to find the correct code. To add additional diagnosis codes, click on the ![icon] icon, and a new line will display, repeat step 7.

   One ICD-9 code is mandatory, up to three ICD-9 codes can be included.

   Most frequently used ICD-9 codes can be found in the Appendix.

9. Payee # (MSP payee number) – if the provider only has one payee number, this will be the default. If the provider has more than one payee number, it will default to the payee number that has the lowest sequence number (as set up in the Provider record – see here for more details). Otherwise select the payee number that you are to submit your Encounter record to.

10. Location (service location code) – select the location from the drop down list. 'L - Longitudinal Primary Care Practice', is likely to be the option. However, this is depending on where you are providing the service.

Optional fields to populate depending on the scenario:

11. Referring from – select the provider that you received the referral from. If the referring physician is set up in the patient demographics, this field will be automatically populate with this referring physician.

12. Referring to – select the provider that you are referring the patient to.

13. Notes – click on the note icon ![Insurer] this will open a pop up window where you can add a note which will be sent along with the record. Click Update to save the note. 'Internal Comment' field is for reference and does not get sent to MSP/Teleplan.

14. MSP Facility (Facility Number) – The most efficient way to populate the MSP Facility is to use a bill template with the MSP Facility already prepopulated (see here in the guide how to create a bill template). Otherwise, enter the facility name or part of the name in the MSP Facility field and hit enter or click on the facility icon ![facility icon]. Select the name of your clinic's facility.

Note: If you need to set up your Facility Number, please review the section in guide here.

Note: The facility name will be displayed on the bill and not the Facility Number, this is correct.

Note: Facility Number is optional for Encounter codes. However, submitting a Facility Number with an Encounter code is fine.

Click Create Bill, which saves the bill with a Pending status. The Encounter record is now ready to be sent to MSP/Teleplan. See the steps on how to submit records in bulk to MSP/Teleplan here.

If Approve Bill is clicked then the bill will be sent to MSP/Teleplan after 15 minutes.

Create Bill ▶▶   Approve Bill ▶▶

3. How to submit an Attachment record (billing code 98990)?

Access the bill window from the schedule, visit, or patient's chart.

A. From the schedule, click on Edit in the Billing Status column.

B. From the visit, click Create Bill .

C. From the Bills tab in the patient chart, click on the icon.

DTO Doctors Technology Office — A GPSC initiative

PSP Practice Support Program

To submit an Attachment record, you populate the bill window as follows:

1. Patients Name will automatically populate.
   Use one of the patients you have seen during the day, or if no visits and just reviewing labs/documents then use one of the patients that you reviewed a lab/document for.

2. Billing Provider (name) – If not automatically populated, select from the drop down list.
   Note: The provider's MSP number is stored in the providers record in the Billing Number field.

3. Billing Item (Attachment code) – enter the code **98990** (Primary Care Panel Report) in the Code field. Click on the binoculars and the description will automatically populate if the code is in Med Access. Otherwise, a new window will open allowing you to find the correct code.

4. PHC checkbox –

   A. If **FP** using a **M Payee Status**, then **uncheck the PHC box** Code ☐(PHC) . This will ensure that the bill is sent to MSP/Teleplan with the Payment Mode of '0'.

   B. If **FP** using a **Y Payee Status**, then **check the PHC box** Code ☑(PHC) . This will ensure that the bill is sent to MSP/Teleplan with the Payment Mode of 'E'.

   C. If **NP** then **check the PHC box** Code ☑(PHC) . This will ensure that the bill is sent to MSP/Teleplan with the Payment Mode of 'E'.

5. Date (of service) – will automatically populate. You can adjust the date by either typing the date or clicking on the calendar icon and selecting the date.

6. Insurer (and patient's PHN) – will automatically populate with the patient's PHN and insurer, which is based on the patient's PHN number.

7. Diagnosis (ICD-9 code) – enter **780** (general Symptoms) in the Code field. Click on the binoculars and the description will automatically populate if the code is in Med Access. Otherwise, a new window will open allowing you to find the correct code.

8. Payee # (MSP payee number) – if the provider only has one payee number, this will be the default. If the provider has more than one payee number, it will default to the payee number that has the lowest sequence number (as set up in the Provider record – see here for more details). Otherwise select the payee number that you are to submit your Attachment record to.

9. Location (service location code) – select the location from the drop down list. 'L - Longitudinal Primary Care Practice', is likely to be the option. However, this is depending on where you are providing the service.

10. MSP Facility (Facility Number) – **Facility Number is required for 98890 codes**. The most efficient way to populate the MSP Facility is to use a bill template with the MSP Facility already prepopulated (see here in the guide how to create a bill template). Otherwise, enter the facility

    name or part of the name in the MSP Facility field and hit enter or click on the facility icon ⊞ . Select the name of your clinic's facility.

    Note: If you need to set up your Facility Number, please review the section in guide here.
    Note: The facility name will be displayed on the bill and not the Facility Number, this is correct.

Optional fields to populate depending on the scenario:

11. Notes – click on the note icon [Insurer] this will open a pop up window where you can add a note which will be sent along with the record. Click Update to save the note. 'Internal Comment' field is for reference and does not get sent to MSP/Teleplan.
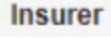
Ministry Comment 1

Update

Click Create Bill, which saves the bill with a Pending status. The Attachment record is now ready to be sent to MSP/Teleplan. See the steps on how to submit records in bulk to MSP/Teleplan here.

If Approve Bill is clicked then the bill will be sent to MSP/Teleplan after 15 minutes.

Create Bill ▶▶   Approve Bill ▶▶

4. How to submit a Shift record?

Access the bill window from the schedule, visit, or patient's chart.

A. From the schedule, click on Edit in the Billing Status column.

B. From the visit, click Create Bill.

C. From the Bills tab in the patient chart, click on the icon.

To submit a Shift record, you populate the bill window as follows:

1. Patients Name will automatically populate.

   Note: Use any patient seen on the day or any patient where the chart has been reviewed under the contract hours.

2. Billing Provider (name) – If not automatically populated, select from the drop down list.
   Note: The provider's MSP number is stored in the providers record in the Billing Number field.
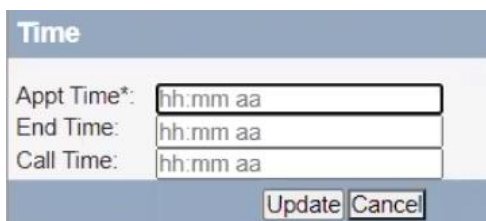
3. Billing Item (Shift code) – enter the Shift code in the Code field. Click on the binoculars and the description will automatically populate if the code is in Med Access. Otherwise, a new window will open allowing you to find the correct code.

   FPs enter **97570**, **NPs** enter **97572**.

4. Appt Time (Start Time for that day) – click on the clock icon 🕐 to open a new pop up window, and enter the time (e.g. 2pm, would be entered as 02:00 PM)

   End Time for that day – enter the time (e.g. 6:30pm, would be entered as 06:30 PM), click Update to save the time.

   Note: Enter the start and end times rounded to the nearest quarter of an hour (e.g. 10:00, 10:15, 10:30, 10:45), otherwise the shift code could be rejected by MSP/Teleplan.

Time	
Appt Time*:	hh:mm aa
End Time:	hh:mm aa
Call Time:	hh:mm aa
	Update Cancel

   Note: Time window will automatically pop up when certain service codes are entered in the bill window. Time window does not open automatically when billing from a visit. Therefore needs to be manually entered in the bill window, or will be rejected by MSP/Teleplan if required for that service code.

   Note: If you hover over the clock icon 🕐 in the bill window, the time entered will pop up, e.g.

   Click to edit start and end time.
   Appt Time: **02:00 PM**
   End Time: **06:30 PM**

5. PHC checkbox –

   A. If **FP** using a **M Payee Status**, then **uncheck the PHC box** Code 🌐 ☐ (PHC) . This will ensure that the bill is sent to MSP/Teleplan with the Payment Mode of '0'.

   B. If **FP** using a **Y Payee Status**, then **check the PHC box** Code 🌐 ☑ (PHC) . This will ensure that the bill is sent to MSP/Teleplan with the Payment Mode of 'E'.

   C. If **NP** then **check the PHC box** Code 🌐 ☑ (PHC) . This will ensure that the bill is sent to MSP/Teleplan with the Payment Mode of 'E'.

6. Calls (qty) (billed service units) – enter the number of 15 minutes worked, excluding breaks (e.g. worked from 2:00pm to 6:30pm, with 30min break, therefore worked 4 hours, which equals 16 billed service units).

   Note:
   - 1 billed service unit = 15 minutes of contract eligible services.
   - For a partial billed service unit, 8 or more minutes is rounded up to 1 billed service unit, whereas 7 minutes or less is rounded down.
   - Any time on breaks (e.g. lunch) or time spent billing FFS or third party billings would be excluded from the billed service units.

7. Date (of service) – will automatically populate. You can adjust the date by either typing the date or clicking on the calendar icon and selecting the date.
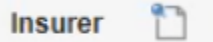
8. Insurer (and patient's PHN) – will automatically populate with the patient's PHN and insurer, which is based on the patient's PHN number.

9. Diagnosis (ICD-9 code) – enter **780** (General Symptoms) as the diagnosis ICD-9 code in the Code field. Click on the binoculars and the description will automatically populate if the code is in Med Access. Otherwise, a new window will open allowing you to find the correct code.

10. Payee # (MSP payee number) – if the provider only has one payee number, this will be the default. If the provider has more than one payee number, it will default to the payee number that has the lowest sequence number (as set up in the Provider record – see here for more details). Otherwise select the payee number that you are to submit your Shift record to.

11. Location (service location code) – select the location from the drop down list. 'L – Longitudinal Primary Care Practice', is likely to be the option. However, this is depending on where you are providing the service.

Optional fields to populate depending on the scenario:

12. Notes – click on the note icon this will open a pop up window where you can add a note which will be sent along with the record. Click Update to save the note. 'Internal Comment' field is for reference and does not get sent to MSP/Teleplan.

13. MSP Facility (Facility Number) – The most efficient way to populate the MSP Facility is to use a bill template with the MSP Facility already prepopulated (see here in the guide how to create a bill template). Otherwise, enter the facility name or part of the name in the MSP Facility field and hit enter or click on the facility icon . Select the name of your clinic's facility.

Note: If you need to set up your Facility Number, please review the section in guide here.
Note: The facility name will be displayed on the bill and not the Facility Number, this is correct.
Note: Facility Number is optional for Shift codes. However, submitting a Facility Number with a Shift code is fine.

Click Create Bill, which saves the bill with a Pending status. The Shift record is now ready to be sent to MSP/Teleplan. See the steps on how to submit records in bulk to MSP/Teleplan here.

If Approve Bill is clicked then the bill will be sent to MSP/Teleplan after 15 minutes.

5. How to submit records in bulk?

First, a bill template is needed. Second, the process to apply a bill to a list of patients is done using the reporting tool. Third, the bills are submitted in bulk.

Step 1 - How to create a bill template?

See the steps in the guide here.

Step 2 - How to create a patient list for bulk billing (using Reports)?

1. From the main EMR page click on the Reports icon .

2. Select the criteria from the left side to pull the desired patient list.

3. Click on the binoculars to run the search

4. This will list all the patients that meet the search criteria.

5. Adjust the limit to show additional patients on the screen by selecting from the drop down list . Note: the batch process will only apply to the patients displayed on the screen.

6. All are selected by default. Select/unselect as needed.

7. Click on services .

8. Type - From the drop down list, select Apply Bill.

9. Select the Billing template.

10. Select the Service Date.

11. For Patients Primary Provider - If you would like the patients primary provider to be the provider in the billing template, check this box.

   WARNING! – there is no UNDO for this process, be careful when choosing the list of patients to add a bill for.

12. Click on the Gears icon to apply the bill template to the selected patients. Repeat the process as required.

Step 3 - How to Bulk Approve bills already created?

1. Note: you will need to have administrative access to Batch Update bills.

2. From the main EMR page, click the My Bills icon .

3. Using the filters (Date of, Start, End, Status, etc), filter the list to the desired list of bills. Ensure that Status is set to 'Pending'. If only approving bills for one provider, set the Attending Provider to that provider.

4. Any actions will only apply to the bills listed on the first page. If you want to Bulk Approve all bills in the list then you need to expand the number of bills displayed on a page.

5. To show all the filtered bills on a single page. Hover over the right arrow . The number of bills will be displayed (e.g.). Click on the down arrow, and then select the number to increase the page limit so it is above the total number of bills in the list (e.g. 100 in this example).

6. Click on the Batch icon . This displays the Batch Update and Bulk Approve options.
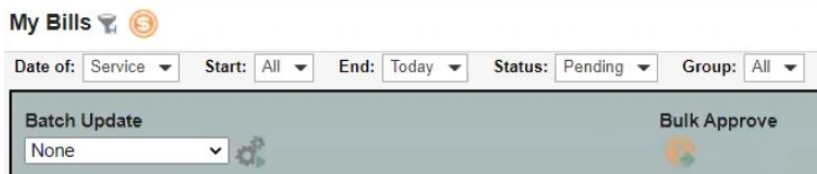
7. Click the Bulk Approve icon . This will approve all the bills in the list.

Useful Batch Update option:

WARNING! – there is no UNDO for this process, be careful when choosing the list of bills to update.

For example, update a list of Bills with a different Claim Type (e.g. 'Set Claim Type' - for over age claims for example).

1. As above, filter the bills to the desired list.

2. Batch Update – select 'Set Claim Type' from the drop down list.
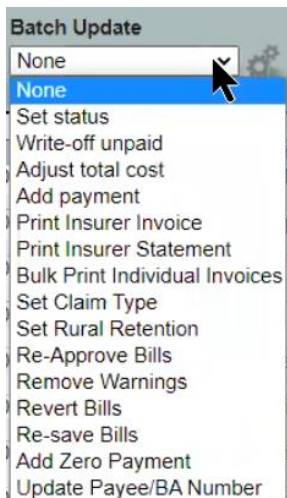
3. Choose the Claim Type.

4. Click on the Gears icon to update the Bills in the list.

Different Scenarios

6. How to submit occasional FFS bills?

Note: When a contract physician bills FFS on the same day as a clinical shift is worked, the start and end times must be included in the FFS claim. Note that this means the block of time spent delivering services under FFS, not individual start and stop times on each claim.
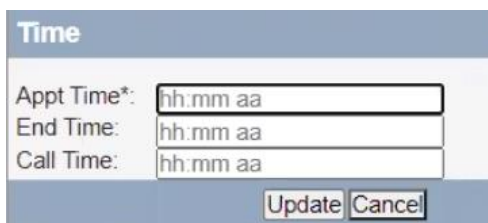
• E.g. if a physician worked a 4-hour walk-in shift from 4pm to 8pm under FFS after their regular clinic day under the contract, they would submit all FFS claims with, start 1600 and end 2000, to denote the excluded time. This could potentially overlap with the shift code submitted for the day (e.g. if the physician billed third party in the middle of their shift), however, in the case of the walk-in shift the times would not overlap.

If the physician has a different Payee Number for submitting FFS, this will need to be set up (in the provider record) so they are able to select this Payee Number (in the Bill window) for FFS.

1. Open the Bill window for the patient.

2. Populate the Bill with the FFS information.

3. Time is required for all FFS codes (see note above).
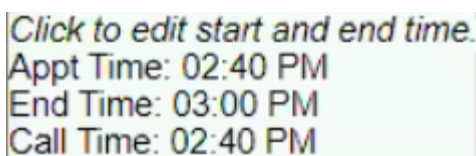
   Appt Time (e.g. start time for the FFS block of time) – click on the clock icon to open a new pop up window, and enter the time (e.g. 2:40pm, would be entered as 02:40 PM)

   End Time (e.g. end time for the FFS block of time) – enter the time (e.g. 3pm, would be entered as 03:00 PM), click Update to save the time.

   Time

Appt Time*:	hh:mm aa
End Time:	hh:mm aa
Call Time:	hh:mm aa
	Update Cancel

   Note: Time window will automatically pop up when certain service codes are entered in the bill window. Time window does not open automatically when billing from a visit. Therefore needs to be manually entered in the bill window, or will be rejected by MSP/Teleplan if required for that service code.

   Note: If you hover over the clock icon in the bill window, the time entered will pop up, e.g.

   Click to edit start and end time.
   Appt Time: 02:40 PM
   End Time: 03:00 PM
   Call Time: 02:40 PM

4. PHC checkbox – **FP** using a **Y or M Payee Status**, then **uncheck the PHC box** Code ☐(PHC) .
   This will ensure that the bill is sent to MSP/Teleplan with the Payment Mode of '0'.

5. Payee # - select the payee number that you are to submit your FFS to.

Payee #

6. Click Create Bill. This bill is Pending and ready to be approved. If Approve Bill is clicked then the bill will be sent to MSP/Teleplan after 15 minutes.

Create Bill ▶▶   Approve Bill ▶▶

Troubleshooting

7. How to adjust and resubmit a rejected record?

Note: Rejection codes and explanations can be found here.

1. From the home page, click the My Bills icon My Bills .

2. The window opens and automatically displays the bills that need action, Status = 'Action Required'.

My Bills ⓢ

Date of: Service ▼   Start: All ▼   End: Today ▼   Status: Action Required ▼

   The Explan. column **Explan.** will display the rejection code (e.g. AA, 'PHN is missing or invalid.')

3. To further filter the results, use the Status drop down list (e.g. 'Refused').

4. Any bills with warnings will display the Warning icon ⚠ .

5. To edit a rejected bill, click on the edit icon .

6. The bill will open and you can adjust as required based on the rejection code.

7. Once corrections have been made you click on Reapprove Bill.

8. How to submit records over 90 days old?

Step 1 – approval from HIBC is required first before any over age Encounter/Attachment/Shift records are submitted. The form required to be completed can be found here.

1. For general questions around submitting records/claims over 90 days old please contact your Health Authority Medical Affairs department for support. For specific questions you can contact HIBC support at 1-866-456-6950.

2. HIBC are likely to provide you with the Claim Type code to use.

Step 2 – Once you have approval to submit these over age claims, you can prepare the Bills as follows.

1. Prepare the Encounter, Attachment, or Shift records as detailed earlier in this guide. However, there is one difference in the Claim Type.

2. For the majority of your over age claims, it is likely that you will use Claim Type = 'A - Pre-Approved Claim'.
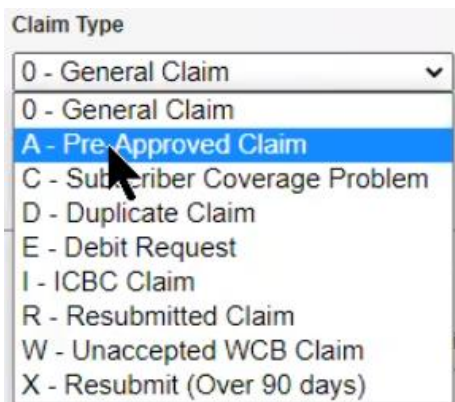
3. Notes – If needed, additional notes can be provided with the claim. Click on the note icon

 this will open a pop up window where you can add a note which will be sent along with the claim. Click Update to save the note.

Running EMR Reports

9. Steps to run a monthly report for any service code?

From the main EMR page, click on the Reports icon ![Reports icon] .

Note: If accessing reports from a bill window then this will open the reports window with the billing defaults. Opening the billing criteria on the left side, and displaying the billing report type options on the right side.

1. In the criteria section on the left side, click on the ⊕ in the Billing section to expand the criteria.

2. Billing Item – enter the code in the box adjacent to the binoculars (e.g. 97562).

   To add multiple service codes, click on the ⊕ next to Billing Item

3. Bill date is the date of service. Click on the calendar icon 📅 to change the options to dates. Click in the first date field, it will open a calendar for you to select the 'Date From'. Repeat for the 'Date To'

4. Attending Provider, select an individual provider, or All, for all providers.

5. To run the report, click on the Searching down arrow [Searching ∨], to expand the box, and then click on the binoculars to run the search.

6. The patients that meet the criteria are displayed.

7. If required, you can adjust the report criteria and rerun the report.

8. Adjust the limit to show additional patients on the screen by selecting from the drop down list .

9. To export the results, click on Excel to export the list as an Excel spreadsheet file, or PDF to export as a PDF document.

10. Alternatively, you can select from one of the premade report options. Click on Reports down arrow , to expand the box.

11. Type - Select alternative report outputs from the drop down list. Click on the Print icon to generate the report and export the report to your computer. One option in the Billing Reports section is 'Claim Report CSV'. Note: this particular report is a monthly report.

How to create a report template?

If you are regularly running the same report, you can create a template.

Note: You need to have Template administrative access to create Templates.

1. Once you have selected your report criteria and you have chosen the report Type (if required), you can create a template from this report by clicking on the Create New Template From Existing icon .

2. Choose a name for the report template and save.

3. Note: Custom created report templates will appear at the top of the drop down list.

EMR Set Up

This section of the EMR orientation guide is for clinics that are new to Encounter, Attachment and Shift reporting and have not yet set up the EMR or would like some background information around the set up. It is strongly recommended that you connect with your EMR vendor as they will be able to support you through this process**.**

10. How to set up the Facility Number?

NOTE: A Facility Number is required when submitting the 98990 (Primary Care Panel Report) code. Facility Number is not required for submitting Encounter or Shift codes, however it is fine to submit these codes with the facility number.

A provider can obtain the Facility Number from the provider responsible for administration of the clinic.

For any questions on the Facility Number, you can contact Teleplan support at 1-866-456-6950.

If your clinic does not have a facility number - apply for one here.

How to set up the Facility Number?

NOTE: Site Administrator access is required to create or update a Facility.

1. From the main EMR page, click on the Providers icon   Providers   .

2. Click on the Facilities icon Facilities .

3. Either create new, by clicking on the New Facility icon New Facility , or update an existing facility.

4. Name – enter a name for the Facility.

5. Facility Number – this is provided by HIBC when applying for the Facility.

6. Billable – uncheck this box. This is to ensure the Facility Name will appear when you search for the MSP Facility on a Bill.

7. If creating a new Facility, click the Create Facility button. If updating a Facility, click the Update button.

11. How to enable the option (PHC) to adjust the payment mode, if required?

Telus Med Access Support will need to set this up for the clinic.

The important feature that needs to be switched on is the Bill Using PHC. This enables records to be sent with the Payment Mode of 'E'.

In the Billing section of the Site Settings, the Bill Using PHC needs to be checked **Bill Using PHC:** ☑ .

If the practice has not been assigned a Facility Number, then the PHC Facility Number needs to be 0 (zero) PHC Facility Number: 0 .

12. How to set up a physician so they can submit occasional FFS?

Note: this depends on your situation, some physicians will have a separate Payee Number for their FFS billings.

How to update a provider with multiple payee numbers (and set the default Payee number)?

1. Note: Site Administrator access is required to update a provider.

2. From the main EMR page, click on the Providers icon Providers .

3. For the provider that you wish to update, click on the provider icon , which opens the Update Provider window.

4. Billing Number – the providers own MSP number is entered in this field.

5. Payee Number – the payee number that the physician will use most frequently (e.g. clinic payee number for Encounter reporting) is entered in this field.

6. To add another payee number, update an existing payee number, or set the default payee number, click on the Identifier List button, which opens the Provider Identifier List window.

A. To update an existing payee number, click on the edit icon ⎙, or to add a new payee number, click on the ⎙ New button. Both open the Identifier window.

B. Identifier – enter the Payee Number.

C. Identifier Type 'Group' – select Payee Number.

D. Sequence Number – the lower the number the higher up the Payee Number appears in the drop down list in the Bill window. The lowest number will be the default Payee Number that you use most frequently.

E. Click Save, to save the Identifier.

F. Click the Return icon ↩ Return to return to the Provider Update window.

7. Click Update Provider, to update the Provider.

13. How to set up a Locum so they can bill FFS?

Note: Locums can also bill under the contract and would assign encounters to the clinic's payee and submit encounters in the same manner as the contract physician.

When setting up a locum, ensure that the Payee Number entered is set up for FFS billings.

How to set up the locum as a Provider?

Note: see the comprehensive Med Access help files on 'Adding Locums'. The steps below only reference the Billing Number and Payee Number.

1. Note: Site Administrator access is required to create a new provider or update an existing provider.

2. From the main EMR page, click on the Providers icon   Providers .

3. If setting up a new provider, click on the New Provider icon New Provider . If updating an existing provider, click on the provider icon , which opens the Update Provider window.

Update Provider

Identification	
Linked to user: Doe, Jane	
Last Name	First Name
Doe	Jane
Location Code	Gender
Billing Number	Payee Number
11111	77777

Address & Phone

Address	City	Province
123 The Drive	Victoria	British Columbia
	Country	Phone #
	Canada	
Address Type		Site Reference
Office		
Default eFax Category		Default eFax Assignee
Business Registry ID	MedDialog	
	☐	

Notes & Misc.

Notes

Update Provider

4. Billing Number – enter the locum's own MSP number.

5. Payee Number – enter the FFS payee number for the locum.

6. Click Update Provider, to update the Provider.

7. The locum will now be able to use this Payee Number when submitting FFS bills.

8. Note: When billing FFS, a **locum** using **M Payee Status**, needs to **uncheck the PHC box**
   Code ⊕☐(PHC) . This will ensure that the bill is sent to MSP/Teleplan with the Payment Mode of
   '0'.

14. How to create a Bill template?

Note: bill templates can be used when applying a bill to individual patients (via patient's chart, visit, etc.), which can save time with data entry and mouse clicks. E.g. create a bill template for your 98990 attachment record, which is prepopulated with the Billing Item, Diagnostic Code, Location, and MSP Facility.

1. Note: You need to have Template administrative access to create Templates.

2. From the main EMR page, Click on the Templates icon Templates .

3. This opens the Template Management window. Select the Bills tab.

Template Management

Demog	Visits	Tasks	Bills

4. Click on the New icon New . This opens a new Bill Template window.

5. Click on down arrow icon [icon] to show the other fields.

6. Template Name – enter a name for the template.

7. Populate all the desired fields: e.g. Billing Provider (if left blank then any provider can use the template, if populated then for a specific provider), Billing Item, Insurer (set to Ministry), Location, MSP Facility etc.

8. To save the template click the Create Bill button [Create Bill].

9. It's recommended to make the Template a favourite by clicking on the User Favourite icon .

The icon is pink when it is a favourite .

How to use a Bill template?

1. In a Bill window, click on the Template icon .

2. If the Template is a favourite:
   A. Select the Template in the list simply by clicking on the Template name.

   B. This will apply the Template to the Bill.

3. If the Template is not a favourite:

   A. Click on Find Bill Template .

   B. In the Name field enter the name (or part of the name) for the Template and click on the binoculars.

   C. Select the Template in the list simply by clicking on the template name.

   D. Note: In the Billing Template window you can make the Template a favourite by clicking on the User Favourite icon . The icon is pink when it is a favourite .

15. How to run (and check) the Teleplan fee code update?

This is automatically updated in Med Access on the 1st of the month. The clinic can not manually run this update.

How to check when the last updated occurred?

1. Need to have Template permissions to be able to check when the last update was done.

2. From the main EMR page, click on the Templates icon .

3. Select the Bills tab.

Template Management

4. Click on Procedures icon .

5. Hover over the Billing Procedures icon
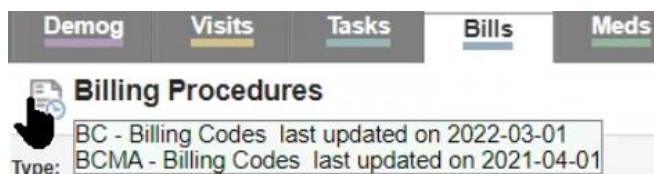
16. How to add missing service codes?

Med Access is updated on the 1st of the month, which includes all the latest service codes. If you are unable to find the service code please contact Telus Med Access.

17. How to add missing ICD9 codes?

All the ICD-9 codes are already in Med Access.

How to add a synonym description to an existing ICD-9 code?

1. From a Bill window, click on the binoculars for the Billing Item.
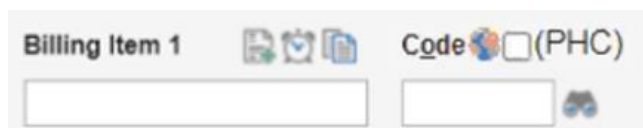
2. This opens the ICD9-BILL Management window, where you can search for ICD-9 codes.

3. Use the Description or the Code boxes to search for the desired code. Click on the Binoculars to search.

4. To add a synonym for an ICD-9 code, click on the Add Synonym icon

5. Add Synonym - Enter the synonym description, and click the Add icon

18. How to check (and update) Location codes?

Location Codes are managed by Telus Med Access Support, and therefore the clinic can not update them. If all the required Location Codes are not in the EMR, please reach out to Telus Med Access Support.

To check which Location Codes are in Med Access, in any Bill window, click on the Location field to view the drop down list.
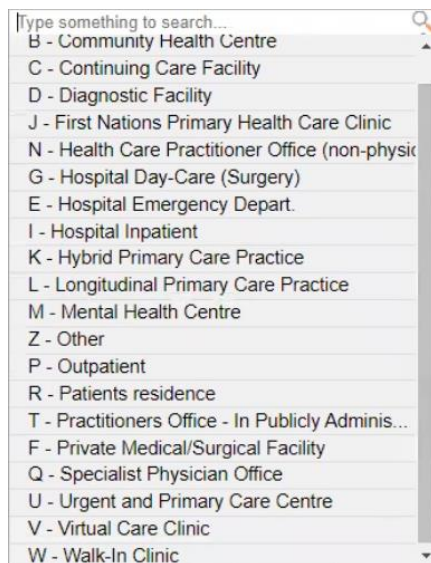
Where To Access Extra Support

- Contract related questions (including: payee numbers, payee status, & service codes)
  - First point of contact – Health Authority Medical Affairs department
  - Second point of contact – PCN.Compensation@gov.bc.ca
- EMR vendor support – Telus Med Access Support Desk 1-888-781-5553
- Specific billing questions – HIBC Support 1-866-456-6950
- Technical troubleshooting or workflow support – Practice Support Program PSP@doctorsofbc.ca
- Provincial Attachment System (PAS)
  - Information can be found here
  - For support HealthBcSupport@phsa.ca

Appendix

Frequently used ICD-9 codes for Family Practice

Please see the following two pages.

GENERAL CODES

GENERAL SYMPTOMS NYD	**780**
ALLERGY SHOT	32A
INJECTION - OTHER	33A
SUTURE REMOVAL	31A
DRESSING CHANGE	43A
ALLERGY RXN	995
INJURY	959
CHILDHOOD GROWTH	05A
OBESITY	278
ANOREXIA	307
MED. COMPLICATIONS	999

BREAST

MASTITIS	675
BREAST DISORDER	611
BENIGN BREAST EXAM	610

BIRTHCODES NEWBORN

NEWBORN CARE	08A
RDS	769
JAUNDICE	774
HYPOXIA	768
BIRTH TRAUMA	767
IMMATURITY/LOW BIRTH WEIGHT	765
LONG GESTATION/HIGH BIRTH WEIGHT	766
OTHER PERINAT PROB.	779

CARDIOVASCULAR

CARDIOVASCULAR SYMPTOMS	**785**
HYPERTENSION	401
ANGINA	413
MYOCARD INFARCT	410
DYSRYTHMIA	427
HEART FAILURE	428
PERIPH VASC DIS	443
PHLEBITIS	451
ARTERY DISORDER	447
OTHER ISCHEMIC HEART	414
ATHEROSCLEROSIS	440

EAR-NOSE-THROAT

HEAD AND NECK SYMPTOMS	**784**
HEAD AND NECK SYMPTOMS	784
EAR DISORDER	388
OTITIS MEDIA	382
EXT EAR DIS	380
EUSTACIAN TUBE DIS	381
SINUSITIS	461
EPISTAXIS	12A
HAYFEVER	477
RHINITIS	472
PHARYNGITIS	462
TONSILITIS	463
URI	465

EAR-NOSE-THROAT continued

MOUTH DISORDER	528
TONGUE DISORDER	529
TEETH DISORDER	522
VIRAL URI/COLD	460
EAR SYRINGING	06B
DISORDERS TEETH	521

ENDO/HEMATOLOGY

ANEMIA	285
IRON DEF. ANEMIA	280
PURPURA	287
BLOOD DISORDER	289
COAGULATION DEFECTS	286
IMMUNE DISORDER	279
ENDOCRINE DIS	259
LIPID DISORDER	272
DIABETES	250
THYROID DIS	246
HYPOTHYROIDISM	244

GASTROINTESTINAL

GASTROINTESTINAL SYMPS	787
ABDOMINAL PAIN	02A
APPENDICITIS	540
ESOPHAGEAL PAIN	530
ACID PEPTIC DIS	533
BILLIARY DIS	576
LIVER DISORDER	573
PANCREATITIS	577
IRRITABLE BOWEL	564
INTESTINAL DISORDER	569
GASTROENTERITIS	009
ANAL DISORDER	565
HEMORRHOIDS	455
CANCER COLON	153
INGUINAL HERNIA	550
HERNIA OTHER	553
GASTRITIS	535
COLITIS	558
NEONATAL JAUNDICE	774
HEPATITIS	070

INFECTIOUS DISEASE

VIRAL INFECTION	078
CHICKEN POX	052
HERPES SIMPLEX	054
HERPES ZOSTER	053
MONONUCLEOSIS	075
INFLUENZA	487
SEPTICEMIA	038

MALIGNANCIES

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BREAST	174
THYROID	193
TRACHEA/LUNG	162
PROSTATE	185
COLON	153
ESOPHAGUS	150
STOMACH	151
RECTUM/ANUS	154
LIVER PRIMARY	155
PANCREAS	157
BONE/CARTILAGE	170
MALIGNANT MELANOMA	172
CANCER SKIN – OTHER	173
UTERUS	179
CERVIX	180
OVARY	183
BLADDER	188
MALIGNANCY OF BRAIN	191
LYMPHOID	202
MULTIPLE MYELOMA	203
LYMPHOID LEUKEMIA	204
MYELOID LEUKEMIA	205

MUSCULO-SKELETAL

MUSCULOSKELETAL SYMPTOMS	**781**
ANKYLOSING SPONDYLITIS	720
ARTHRITIS	716
BACK DISORDER	724
BONE DISORDER	733
CONNECTIVE TISSUE DIS.	710
RA/INFLAMMATORY ARTH	714
DISC DISORDER	722
FRACTURE	829
FRACTURE WRIST	813
GOUT	274
JOINT DISORDER	719
TENDON-BURSITIS	727
OSTEOARTHRITIS	715
OSTEOPOROSIS	733
OTHER SOFT TISSUE DIS	729
OTHERDIS.GANGLION/TEND.	727
POLYMYALGIARHEUMATICA	725
ROTATORCUFF SYNDROME	726
SCOLIOSIS	737
MSK SPRAINS/STRAINS:	
SHOULDER STRAIN/SPRAIN	840
ELBOW STRAIN/SPRAIN	841
WRIST STRAINS/SPRAINS	842
HIP STRAIN/SPRAIN	843
KNEE SPRAIN/STRAIN	844
ANKLE/FOOT SPRAIN	845
SACROILIAC STRAIN	846
BACK STRAIN/SPRAIN	847

NEUROLOGICAL

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CEREBRAL PALSY	343
CEREBROVASC. DISEASE	437/430
CNS DISORDER	349
DEMENTIA	331
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MENINGITIS	320
MENTAL RETARDATION	319
MIGRAINE	346
MOVEMENT DISORDER	333
MULTIPLE SCLEROSIS	340
MUSCULAR DYSTROPHY	359
NEUROLOGICAL SYMPT.	781
PARKINSON'S	332
STROKE	434
TIA	435
TRIGEMINAL NEURALGIA	350
VERTIGO	01A

OB/GYN

PELVIC SYMPTOMS	789
MENSTRUAL DIS	626
PELVIC PAIN	625
VAGINITIS/CERVICITIS	616
PID	614
STD	99
MENOPAUSAL DIS	627
PROLAPSE	618
OVARIAN DIS	620
CONTRACEPT ADVICE	34A
DYSPLASIA CERVIX	622
ABORTION THREAT	640
UNCONFIRMED PREG	36B
SPONT. MISCARRIAGE	634
ECTOPIC PREGNANCY	633
PRENATAL CARE – OFFICE	30B
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NORMAL DELIVERY	650
ANTEPARTUM BLEEDING	641
PIH	642
HYPEREMESIS	643
PROLONGED PREGNANCY	645
MULTIPLE GESTATION	651
MALPRESENTATION	652
DISPROPORTION	653
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POLYHYDRAMNIOS	657
PREM. RUPTURE MEMB	658
OBSTRUCTED LABOUR	660
PROLONGED LABOUR	662
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RETAINED PLACENTA	667

OPHTHALMOLOGY

EYE DISORDER	379
CONJUNCTIVITIS	372
CATARACT	366
UVEITIS-IRITIS	364
VISUAL DISTURB	368
INJURY EYE	918
FOREIGN BODY – EYE	930
BLEPHARITIS	373

PSYCHIATRY

ANXIETY DISORDERS	300/50B
ADJUSTMENT DISORDERS	309
ACUTE STRESS DIS./PTSD	308
ATTENTION DEFICIT DIS	315
BEHAVIOR PROB	312
BIPOLAR DISORDER	296
COGNITIVE DISORDERS	290
DEMENTIA	331
CYCLOTHYMIA	301
DEPRESSION	311
DISSOCIATIVE DISORDERS	300
DYSTHYMIC DISORDER	300
EATING DISORDERS	307
MOOD DISORDER DUE TO MEDICAL COND.	293
SCHIZOPHRENIA & PSYCHOTIC DISORDERS	295
SLEEP DISORDERS	327
SOMATIFORM DISORDERS	300
SUBSTANCE-RELATED DIS.	292
ALCOHOL DEPENDENCE SYNDROME	303
DRUG DEPENDENCE SYND	304
DRUG ABUSE, NON-DEPEND	305

RESPIRATORY

RESPIRATORY SYMPTOMS	786
ASTHMA	493
BRONCHITIS	466
PNEUMOCOCCAL PNEUMONIA	481
VIRAL PNEUMONIA	480
OTHERBACTERIALPNEUMONIA	482
PNEUMONIA NYD	483
COPD	496
CROUP	464
INFLUENZA	487
CHRONIC BRONCHITIS	491
EMPHYSEMA	492
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SKIN

ABSCESS	682
SKIN SYMPTOMS	782
SKIN DISORDER	709
CELLULITIS	681
SEBACEOUS DIS	706
DERMATITIS	702
NAIL DISORDER	703
ATOPIC DERM	691
PSORIASIS	696
URTICARIA	708
CONTACT DERMATITIS	692
SKIN LESION	35A
PLANTAR WART	45A
VIRAL RASH	057
INFESTATION	134
INSECT BITE	66B
INFECTION SKIN	686
BURN	949
TUMOR SKIN BEN	216
OPEN WOUND	879
SUTURE REMOVAL	31A
DRESSING CHANGE	43A

UROGENITAL

URINARY SYMPTOMS	788
OTHER URINARY DIS.	599
CYSTITIS	595
MALE GENITAL DIS.	608
PROSTATE DISORDER	602
PROSTATE CANCER	185
KIDNEY STONE	592
CHRONIC KIDNEY DISEASE	585