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Primary Care Networks: Clinic Setup For Encounter Reporting

Most physicians within B.C. submit fee-for-service claims to the Medical Services Plan (MSP) through Teleplan. The same process is used to submit encounter records for family physicians (FPs), nurse practitioners (NPs), and nurses hired under the Primary Care Network (PCN). Before practitioners can submit encounter records, they must complete and submit two forms to MSP/HIBC.

Encounter records for all work provided by practitioners engaged or hired as part of a PCN will be reported through site-specific Y-status payee numbers, regardless of profession. Practitioners will complete an Assignment of Payment form (P) or an Encounter Record Submission Authorization form (NP/RN/LPN) for each of the PCN sites they provide care at. Health authority primary care planners / contract managers are directed to contact their health authority's Medical Affairs team to request Ministry-issued Y-status payee numbers for any site within the PCN where PCN-funded practitioners provide services.

For specific instructions on the Y-status payee setup process, please see the document titled *Agency Instructions for Creating Y-Status Payee Numbers,* included as Appendix 1.

Note that any FFS work undertaken by FPs on PCN-funded contracts must be billed to their personal payee number or a separate payee number.

STEP 1: REGISTER THE PRACTITIONER IN THE MEDICAL SERVICES PLAN

To register with the Medical Services Plan, the practitioner will require a personal billing number. A billing number denotes the person providing the service and is required for encounter record submission through the Teleplan system. FPs will typically receive a billing number as part of the licensing process and can skip this step.

The practitioner must complete the *Application For Billing Number* Form.

Health provider	Form Description
Physicians	Application for Billing Number (Form #2991) https://www2.gov.bc.ca/assets/gov/health/forms/2991fil.pdf
Nurse Practitioners, Registered Nurses and Licensed Practice Nurses	Application for Billing Number (Form #2997) http://www2.gov.bc.ca/assets/gov/health/forms/2997fil.pdf

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STEP 2: CONNECT THE PRACTITIONER'S BILLING NUMBER TO THE CLINIC PAYEE NUMBER

To connect the Billing Number to a clinic payee number, the practitioner must complete an *Assignment of Payment Form* (FP) or *Encounter Record Submission Authorization* Form (NP/RN/LPN). The practitioner will then submit this form to their health authority liaison or contract manager.

Upon completion of step 1 and step 2, the health authority will submit both forms to HIBC.

For complete instructions, please refer to Appendix 1.

Health provider	Form Description
Physicians	Assignment of Payment (Form #2875) https://www2.gov.bc.ca/assets/gov/health/forms/2875fil.pdf
Nurse Practitioners, Registered Nurses and Licensed Practice Nurses	Encounter Record Submission Authorization (Form #2871) http://www2.gov.bc.ca/assets/gov/health/forms/2871fil.pdf

For HIBC practitioner assistance and inquiries, contact 1-866-456-6950.

TIPS FOR ENCOUNTER REPORTING

Note: this section is intended for MOAs, billing agents, or other professionals who directly support billing / encounter record submission processes. It is anticipated that in most cases, practitioners will not be directly responsible for this work.

PCN Practitioners use the following Encounter Code sets (available on the PCN Toolkit):

- GP: New Simplified GP Encounter Code Set
- NP: Existing NP Encounter Code Set
- RN/LPN: Existing RN/LPN Encounter Code Set

1. Encounter records must be submitted in the format approved for electronic submission through Teleplan. All encounter record submissions must include the following information unless otherwise stated:

FP/NP	RN/LPN
• Payee Number (clinic payee number)	• Payee Number (clinic payee number)
• MSP Billing Number (of the practitioner)	• MSP Billing Number (of the practitioner)
• Patient's Personal Health Number (PHN)	• Patient's Personal Health Number (PHN)
• Date of Service(s)	• Date of Service(s)
• Encounter Code(s)	• Encounter Code(s)
• Start Time (for that day)	• Start Time (counselling/education codes only)

- End Time (for that day)
- ICD-9 Diagnostic Codes (1 mandatory, 3 max)
- Location Code
- Note
- Referring/Referred practitioner number (if the GP/NP is referring patient to or receiving a referral from another practitioner)

- End Time (counselling/education codes only)
- ICD-9 Diagnostic Codes
- Location Code
- Number of Services

2. Pursuant to the Medicare Protection Act and the Medical and Health Care Services Regulation, encounters must be submitted within 90 days of the date of service.
3. For the list of ICD9 Codes please refer to: http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/physicians/diagnostic-code-descriptions-icd-9.

NOTIFICATION OF ENCOUNTER RECORD ACCEPTANCE RETURN (REMITTANCE STATEMENT)

Every clinic that bills fee-for-service, or submits encounter records, receives a remittance statement twice per month from HIBC. In fee-for-service, the remittance statement shows what claims have been accepted and paid to the MSP payee number as well as what claims have been refused. Refusals can happen for a number of reasons, some of which are discussed below.

For clinics that submit encounter records, the remittance statement similarly documents both accepted encounter records and refused encounter records (called returned records). If an encounter record has been returned, an explanatory code is provided to explain why a particular encounter record is refused.

Reasons for encounter record refusal may include:

- 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.

If, after reading the remittance statement Notification of Claim Adjustment/Return, a clinic is still uncertain why an encounter record has been refused or what is required before resubmitting it, contact Health Insurance BC by calling toll free: 1-866-456-6950 or from Vancouver: 405-456-6950.

LOCATION CODES & DESCRIPTORS

(A) Practitioner's Office – In Community

Service is provided in a practitioner's office. (Note: Excludes practitioner's offices that are located within a publicly administered health care facility – see Practitioner's Office – In Publicly Administered Facility. Includes services provided by a nurse, nurse practitioner, physician, chiropractor, dentist, optometrist, podiatrist, physiotherapist, and massage therapist.)

(C) Residential Care/Assisted Living Residence
Service is provided to a patient in a licensed residential care facility or registered assisted living residence. (Note: Excludes small "group homes" where no professional health care support/care is available and includes extended care facility within a hospital.)

(E) Hospital – Emergency Room (Unscheduled Patient)
Service is provided in a hospital emergency department for a patient who presents for emergent or urgent treatment. (Note: Excludes hospital outpatients who receive services on a scheduled basis within an emergency department – see Hospital Outpatient)

(I) Hospital Inpatient
Service is provided for a patient who is an inpatient of a hospital. (Note: Excludes patients located within a designated "extended care unit" within a hospital – see Residential Care/Assisted Living Residence.)

(P) Hospital – Outpatient
Service is provided in outpatient and/or ambulatory clinics where outpatients receive scheduled services including emergency department, or any other hospital setting where outpatients receive services. (Note: Excludes day care surgical patients)

(G) Hospital – Day Care Surgery
Service is provided within a hospital to a patient who is a day care surgery patient. (Note: Includes all patients who are in hospital on a day care basis primarily to receive a "procedure". Excludes scheduled services - see Hospital – Outpatient)

(F) Private Medical / Surgical Facility
Service is provided within a private medical/surgical facility accredited by the College of Physicians and Surgeons of BC.

(R) Patient's Private Home
Service is provided in a patient's own home. (Note: Includes service provided in a "group homes" where on-site nursing or other health professional support care is not provided, but excludes assisted living residences and other residential facilities – see Residential Care/Assisted Living Residence)

(T) Practitioner's Office – In Publicly Administered Facility
Service is provided in a practitioner's office located within a publicly administered health care facility (e.g., Hospital, Primary Care Centre/Clinic, D&T Centre, etc.)

(D) Diagnostic Facility
Service is provided in a facility that primarily/exclusively provides diagnostic testing and has been granted a Medical Services Commission Certificate of Approval. (Note: Excludes diagnostic tests provided in practitioner's office. Also excludes diagnostic services provided in/by hospital and/or D&T centre facilities)

(M) Mental Health Centre
Service is provided in a publicly administered mental health centre to an outpatient. (Note: Excludes mental health facilities that are primarily residential in nature – see Residential Care/Assisted Living, includes CRESST Facilities.

(Z) Other (e.g., accident site, etc.)
Service is provided in any other location such as a temporary community or school clinic, ambulance, accident site etc.

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APPENDIX 1

Agency Instructions for Creating Y-Status Payee Numbers

Agencies that hire or contract health professionals to deliver services that require encounter reporting must report to Teleplan through a Y-Status Payee number. This document explains how Y-status payee numbers are provided to contracting agencies for encounter reporting purposes.

1. Contact the Compensation Analyst at the Alternative Payments Program in the Ministry of Health that is assigned to your Agency.

To receive a Y-status payee number, contact the Alternative Payments Program (APP) compensation analyst at the Ministry of Health assigned to your agency. If you do not have this contact information, your agency's Medical Affairs Department or equivalent will be able to provide you with it.

When contacting APP staff to set up a payee, please provide a description of:

- Which professions are being hired that require encounter reporting
- What services are being provided
- When the hired employee / contractor will be delivering services
- Where the contracted services will be delivered

Requests for new Y-Status Payees should only be made by Agency employees via APP. **Y-status payee requests should not be made directly to Health Insurance BC (HIBC) by agencies, care providers, or billing agents**.

2. Agency receives payee information and associated forms from APP Compensation Analyst

Upon receiving a request for a new Y-Status Payee number, the APP compensation analyst assigned to your agency will compare your request to all existing Y-Status Payee numbers to ensure no existing payee can support encounter reporting at the site / in the program. If no suitable existing Y-Status Payee numbers are found, the analyst will contact HIBC and request that a new Y-Status Payee number be reserved for the agency. The analyst will then send this new number and a copy of each of the following forms to you, the Agency:

- Form HLTH 2875 Assignment of Payment (for Physicians)
- Form HLTH 2871 Encounter Record Submission Authorization for Non-Physician Providers
- Form HLTH 2876 Application for Additional Payment Number

3. Agency helps Care Providers to Complete Forms

Once the HA has received the new Payee number and the required forms, they should then work with the care providers who will be assigning encounters to the new Payee to ensure they complete the forms. Please refer to the following guidelines when completing the forms.

1. Form HLTH 2875 Assignment of Payment.

    a) Each physician who will be assigning encounters to the new Payee must complete a copy of Form 2875.
    b) Each nurse practitioner, registered nurse, and licensed practical nurse who will be assigning encounters to the new Payee must complete a copy of Form 2871.
    c) An Assignment cannot be for a period of longer than 5 years.

2. Form HLTH 2876 Application for Additional Payment Number.

    a) For Payees where the care providers will be submitting $0 encounters only and where no single provider under the Payee can be considered the Most Responsible Physician, Section E can be signed by the contract manager at the HA.
    b) For Y-status Payees where a payment is generated out of Teleplan (e.g. fee for service top-up) the Most Responsible Physician **must** be a care provider who is also assigned to that payee.

4. HA Sends Completed Forms to HIBC

Once the forms are completed, the HA collects the forms and scans and emails (or faxes if they prefer) these to HIBC at: provider.program@hibc.gov.bc.ca.

5. HIBC Activates the New Payee Number

Upon receiving the forms, HIBC will activate the new Y-Status Payee in Teleplan and assign the signatory care providers. At this point the Payee will become '**Active'** and can have billings and/or encounters submitted under it.

6. (ONGOING) As Contracted Care Providers Enter / Leave the Program

When new care providers are hired to provide services for the program, they must sign an Assignment of Billing form (2875 or 2871) in order to submit encounter reporting under the program's Y-Status Payee number. The Agency should provide the care provider a copy of form 2875 and ensure it is submitted to HIBC prior to their contract's start date.