Health Insurance BC
Ministry of Health Services

Over-age Claims
Submission of Claims over 90 days

Pursuant to section 27(3) of the *Medicare Protection Act*, section 33 of the Medical and Health Care Services Regulation prescribes 90 days as the period of time within which a claim for payment must be submitted to the Medical Services Commission. Pursuant to section 27(5) of the *Medicare Protection Act*, the Commission may, in its discretion, pay claims submitted outside of the prescribed period. The following information provides an overview of the appropriate use of submission codes C, X, I, W and A when billing claims over the 90 day limit for claim submissions.

SUBMISSION CODE C

The patient did not have active coverage at the time the service was rendered. The claim is now over 90 days old and the coverage has been reinstated.

- No need to write for prior approval
- Use Submission Code C
- Note record required: "coverage reinstated"

If you are having difficulty confirming coverage, there are a number of ways to obtain this information:

Obtain patient information prior to the visit

- When booking an appointment, ask the patient for their name and PHN (Personal Health Number) exactly as it appears on their CareCard.
- Remind each patient to bring their CareCard with them to the appointment.
- Enquire whether the patient has made any changes to their name or coverage since their last visit.

Confirm patient coverage prior to the visit

- Teleplan's Batch Eligibility function provides overnight verification of patient eligibility. There is no limit to the number of verification requests and the information will be made available to you the following morning.

Confirm patient information at the time of the visit

- Teleplan's Immediate Online Eligibility function provides coverage information while the patient is at your office. Up to 40 requests can be processed at one time.

Automated Coverage Enquiry Line

Our automated service handles coverage enquiries using an Interactive Voice Response (IVR) system. The patient's Personal Health Number (PHN) must be provided. This service can also provide information on a patient's surname and initials.

Victoria	250 383-1226
Vancouver	604 669-6667
Other areas of BC (toll-free)	1 800 742-6165

If the PHN is unknown you may fax the request on a coverage research form to 250 405-3592.

SUBMISSION CODE X

The claim is over 90 days old but you disagree with the adjudication of the claim:

- No need to write for prior approval
- Use Submission Code X
- Include a note record and any additional information required to re-adjudicate the claim
- Resubmit claim within 90 days from the remittance date of the original claim

SUBMISSION CODE I

The claim is over 90 days old but since originally submitted, has been either refused or accepted by ICBC:

- No need to write for prior approval
- Use Submission Code I
- Claims must be submitted within 90 days of being advised of ICBC decision

SUBMISSION CODE W

The claim is over 90 days old but since originally submitted, has been either refused or accepted by WorkSafe BC (WSBC):

- No need to write for prior approval
- Use Submission Code W
- Claims must be submitted within 90 days of being advised of WSBC decision

SUBMISSION CODE A

Submission Code A is to be used only when a claim does not meet the criteria for the other submission codes (C, X, I and W).

- Written request is required
- Requests must include detailed explanation for late submission
- Requests must include the date range of the claims, number of claims, value of claims and the fee items involved.
- **Administrative issues such as staffing problems, clerical errors, lost or forgotten claims, system or service bureau problems do not qualify for exemption.**

Note: When a written application is approved for retroactive billing, the maximum retroactive period will be six months from the date of approval. Only in very exceptional circumstances will claims be approved beyond six months. In those exceptional circumstances due to system restrictions the maximum retroactive period granted will be18 months.

Approved Claims

The approval applies only to the exemption to the 90-day submission limit and does not guarantee payment. All claims billed are subject to the usual processing and adjudication rules and regulations.

For more information contact:

Practitioner and Patient Claims Support
Phone: 1 866 456-6950 or
604 456-6950 (Vancouver)
Use billing prompts
Fax: 250 405-3593

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