

ENCOUNTER RECORD SUBMISSION PROCEDURES

The record of service provided to a patient by a nurse practitioner is called an encounter record. Encounter codes and diagnostic codes (ICD9 codes) are included in the encounter record and are used to represent the service performed by a nurse practitioner. Encounter codes are used to capture nurse practitioner practice activities and while similar to physician fee item codes they are not used for billing purposes and are assessed at zero dollars.

Nurse practitioners are required to submit encounter records to the Medical Services Plan /Health Insurance BC. The information included in a nurse practitioner's encounter record serves the same purposes as a medical claim submitted by a physician or other health care practitioner. Therefore, for administrative purposes, an encounter record is considered by the Medical Services Plan /Health Insurance BC to be equivalent to a medical claim. It is the responsibility of the nurse practitioner to apply for a **practitioner number** and a **payee number** and complete an Encounter Records Submission Authorization form <https://www.health.gov.bc.ca/exforms/practitioner.html#2871> and send them to Medical Services Plan /Health Insurance BC. It is the responsibility of the nurse practitioner's employer to establish a mechanism for submission of encounter records through their data centres (electronic record) through Teleplan to the Medical Services Plan /Health Insurance BC.

Purpose of Encounter Records. Encounter records include encounter codes and diagnostic code(s) (ICD9 code(s)). Diagnostic code(s) (ICD9 code(s)) represent the medical condition and are not the same as encounter codes which represent the service provided.

Encounter records (which include diagnostic and encounter codes) are used for the following purposes:

- (1) identify the nurse practitioner providing services;
- (2) provide the location of services, e.g. practitioner office, hospital inpatient, residential care, etc.;
- (3) provide patient data, e.g. age, diagnosis, etc.;
- (4) provide information for MSP/HIBC administrative purposes;
- (5) assist the Ministry to evaluate NP patterns of practice and project funding requirements; and
- (6) allow specialists, GPs and diagnostic facilities to be paid for services referred by nurse practitioners.

Submission of Encounter Records to Medical Services Plan /Health Insurance BC

In the event a medical office assistant submits encounter records to the Medical Services Plan /Health Insurance BC claims processing system directly through electronic billing software system or through a service bureau on the nurse practitioner's behalf, the nurse practitioner rendering the service is ultimately responsible for the information submitted to Medical Services Plan /Health Insurance BC.

While encounter records do not generate payments, the same rules used to assess physician's fee-for-service claims apply to nurse practitioner encounter records submitted to

the Medical Services Plan /Health Insurance BC Teleplan claims processing system. Nurse practitioners must be aware of Medical Services Plan /Health Insurance BC requirements, rules, and procedures for encounter records submission.

All records submitted and encounter codes used must be for patient services that are within the nurse practitioner’s scope of practice, as established by the Health Professions Act and the College of Registered Nurses of British Columbia. For details about nurse practitioner scope of practice including standards for referrals to physicians and for diagnostic services, please see College of Registered Nurses of BC’s *Nurse Practitioner Scope of Practice: Standards, Limits and Conditions*
<https://crnbc.ca/Standards/NPScopePractice/Pages/Default.aspx>.

Submitting Encounter Records Electronically to Teleplan

Nurse practitioner encounter records are submitted electronically into the Medical Services Plan /Health Insurance BC claims processing system by connecting directly through a private Internet Service Provider (ISP) portal. The Teleplan web interface is a secured encrypted Internet connection for record submission and to verify patient eligibility. It has been built to industry standards for secure Internet communications, like that used for online banking transactions. Information about the Medical Services Plan /Health Insurance BC’s Teleplan claims submission and processing is found at:
<http://www.health.gov.bc.ca/msp/infoprac/teleplan.html>.

Nurse practitioners’ employers (i.e. health authorities) are responsible for providing a mechanism for nurse practitioners to submit encounter records to the Medical Services Plan /Health Insurance BC.

Encounter Record Submission Authorization

In order to have their encounter records submitted through Teleplan to the Medical Services Plan /Health Insurance BC’s claims processing system and through their employer’s electronic billing software system or service bureau, nurse practitioners must complete an authorization form and submit it to Medical Services Plan /Health Insurance BC, granting permission for electronic encounter records bearing the nurse practitioner’s practitioner number to be used by the billing service.

Forms can be obtained from the Ministry’s web site at:
<https://www.health.gov.bc.ca/exforms/practitioner.html>

Online Submission Form	Title	Description
Form # 2997	Application for MSP Billing Number (Nurse Practitioners) https://www.health.gov.bc.ca/exforms/practitioner.html#2997	Application for practitioner/payee number.
Form # 2871	Encounter Record Submission Authorization https://www.health.gov.bc.ca/exforms/practitioner.html#2871	When an NP is employed and the site has a payee number the NP will use

		the site's payee number.
Form # 2820	Application for Teleplan Service-Opted In (for Medical and Health Care Practitioners) https://www.health.gov.bc.ca/exforms/practitioner.html#2820	Site has no payee number. This will enable the NP to use his/her personal payee number to submit encounter records.

Encounter Record Submission Period

Encounter records must be submitted within 90 days of the date of service. Encounter records for services to a beneficiary (patient/client) whose coverage has been backdated are exempt from the 90 day submission limit (submission code C). Encounter records submitted with a service date that precedes the date of submission by longer than 90 days are automatically refused by the Teleplan claims processing system. The accurate and timely submission of encounter records is the responsibility of nurse practitioners and their employer.

Submission of over aged encounter records (after 90 days). There may be extenuating circumstances when a record must be submitted after 90 days (over aged encounter records). There are two submissions codes nurse practitioners may use for over aged (after 90 days) encounter records. One is because at the time the service was rendered the patient did not have active coverage. The encounter record is now over 90 days old and the coverage has been reinstated. There is no need to write for prior approval instead, use Submission Code C. In the note record field on the electronic submission insert *"coverage reinstated."*

The second is Submission Code A. This Code is used only when a record does not meet the criteria for the Submission Code C, and is not related to coverage. In order to use Submission Code A, the nurse practitioner needs to provide a written request including a detailed explanation for the late submission and include the date range of the records, number of records, and the encounter codes involved.

Administrative issues such as staffing problems, clerical errors, lost or forgotten records, system or service bureau problems do not qualify for exemption or use of Submission Code A.

The approval of late submissions applies only to the exemption to the 90-day submission limit and does not guarantee a successful submission.

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 encounter records be approved beyond six months. In those exceptional circumstances due to system restrictions the maximum retroactive period granted will be 18

months.

http://www.health.gov.bc.ca/msp/infoprac/physnews/july_2009_submission_claims.pdf

Application for approval to submit over aged encounter records:

<https://www.health.gov.bc.ca/exforms/practitioner.html#2943>

Clients Eligible for Benefits under the Medical Service Plan/Health Insurance BC

For an encounter record to be submitted to the Medical Services Plan /Health Insurance BC, it must include the Personal Health Number (PHN) of an eligible Medical Services Plan/Health Insurance BC beneficiary. An eligible beneficiary is defined as a person who is a resident of BC and who is enrolled with the Medical Services Plan /Health Insurance BC. If a nurse practitioner provides care to a patient who is not enrolled with the Medical Services Plan /Health Insurance BC, an encounter record cannot be submitted through the Medical Services Plan /Health Insurance BC Teleplan claims processing system. The exception is for residents of other Canadian provinces/territories (except Quebec) for which a reciprocal billing system is in place. For billing reciprocal encounters, the patient's medical insurance number (same as personal health number in BC) from their home province/territory, birth date, and provincial code should be entered in the 'other insurer ' portion of the Teleplan C02 record.

Medical or diagnostic services referred for patients who do not have valid medical coverage with BC or one of the provinces/territories covered under the reciprocal claims processing agreement are the responsibility of the individual patient. Patients covered under the Quebec Medical Plan may submit directly to the Quebec plan for reimbursement.

Verification of BC Services Card

The Medical Services Plan/Health Insurance BC does not pay physicians for uninsured services. Nurse practitioners will need to discuss with their employers how to proceed with providing care to an uninsured patient and uninsured services.

Eligibility Checks Nurse practitioners submitting encounter records to the Medical Services Plan /Health Insurance BC for services outlined in s. 22(1) of the *Medical and Health Care Services Regulation*, have a duty to verify enrolment in Medical Services Plan /Health Insurance BC. Eligibility may be confirmed as follows:

1. If a person has a previously scheduled appointment, the practitioner must take reasonable steps to verify enrolment in advance or:
2. If a person does not have a previously scheduled appointment, the practitioner must verify enrolment at the time the person presents for health services by:
 - Asking to see the person's BC Services Card, or prior to early 2018, their CareCard; or
 - Asking for the person's PHN, plus an additional piece of identification that shows the person's photograph and legal name; or,

- Asking for the person's PHN, plus two pieces of identification showing the person's legal name.

If necessary, Medical Services Plan /Health Insurance BC eligibility may be checked by using the individual's date of birth, legal name, gender or address.

The Ministry's Investigations Unit conducts investigations into matters involving the possible abuse of the Medical Services Plan /Health Insurance BC. The Ministry is concerned about BC Services Card misuse. Health care providers who suspect that a person is attempting to access or has accessed health care services inappropriately are required by regulation to report this to Health Insurance BC at 604-456-6950 (Metro Vancouver) or 1-866-456-6950 (elsewhere in B.C.).

Verifying Coverage Prior to a Visit

When booking an appointment, ask the patient for his/her name and PHN (Personal Health Number) exactly as it appears on their BC Services Card. Remind each patient to bring their BC Services Card with them to the appointment. If it is a current patient of the facility, ask the patient if they have had a name or coverage change since their last 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 the following morning. Additional details are provided in chapter 2 of the Teleplan Specifications: <http://www.health.gov.bc.ca/msp/infoprac/teleplanspecs/ch2.pdf>

Two alternatives for an immediate reply to an Eligibility Coverage Request are:

- (1) The online Check Eligibility Request option available in Teleplan, and
- (2) MSP's IVR (Interactive Voice Response) systems.

The online request provides the same function as the nightly Batch Eligibility Coverage Request but information is returned immediately, rather than overnight. The Teleplan Check Eligibility function and equivalent function in the API is intended for real-time Point-of-Service checks only. Automated calls and batching of patients to check eligibility are NOT ALLOWED. This action can result in significant delays and ongoing monitoring of your operations by health representatives.

Automated Coverage Enquiry Line

The 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 a coverage research form may be faxed to 250-405-3592.

<https://www.health.gov.bc.ca/exforms/practitioner.html#2717>