Encounter Record Submission Procedures

The record of service provided to a patient by a nurse practitioner (NP) 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 an NP. While similar to physician fee item codes, encounter codes are not used for billing purposes and are assessed at zero dollars.

NPs are required to submit encounter records to the Medical Services Plan/Health Insurance BC (MSP/HIBC). The information included in an NP'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 MSP/HIBC to be equivalent to a medical claim. It is the responsibility of the NP to apply for a billing number and a payee number and complete an Encounter Records Submission Authorization form and send them to MSP/HIBC. It is the responsibility of the NP's employer to establish a mechanism for submission of encounter records through their data centres (electronic record) through Teleplan to the MSP/HIBC.

Purpose of Encounter Records

Encounter records include encounter codes and diagnostic codes) (ICD9 codes). ICD9 codes represent the medical condition and are not the same as encounter codes which represent the service provided.

Encounter records are used for the following purposes:

1. identify the NP 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 of Health (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 NPs.

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

In the event that a medical office assistant submits encounter records to MSP/HIBC directly through an electronic billing software system or through a service bureau on the NP's behalf, the NP rendering the service is ultimately responsible for the information submitted to the MSP/HIBC.

While encounter records do not generate payments, the same rules used to assess physician's fee-for-service claims apply to NP encounter records submitted to the MSP/HIBC Teleplan claims processing system. NPs must be aware of MSP/HIBC requirements, rules, and procedures for encounter records submission.

All records submitted and encounter codes used must be for patient services that are within the NP's scope of practice, as established by the Health Professions Act and the BC College of Nurses and Midwives (BCCNM). For details about NP scope of practice including standards for referrals to physicians and for diagnostic services, please see BCCNM's Nurse Practitioner Scope of Practice: Standards, Limits and Conditions.

Submitting Encounter Records Electronically to Teleplan

NP encounter records are submitted electronically into the MSP/HIBC 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.

NPs' employers (i.e. health authorities) are responsible for providing a mechanism for NPs 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 MSP/HIBC claims processing system and through their employer's electronic billing software system or service bureau, NPs must complete an authorization form and submit it to MSP/HIBC, granting permission for electronic encounter records bearing the NP's billing number to be used by the billing service.

Forms can be obtained from the Ministry's web site at: Forms for Medical & Health Care Practitioners - Province of British Columbia

Description	Forms	Online Submission Form
Application for billing number	Application for MSP Practitioner Number as a Nursing Professional	Form #2998
When an NP is employed and the site has a payee number the NP will use the site's payee number.	Encounter Record Submission Authorization For Non-Physician Provider	Form #2871
Site has no payee number. This will enable the NP to use their personal payee number to submit encounter records.	Application for Teleplan Service	Form #2820

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 NPs 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 NPs may use for over aged (after 90 days) encounter records. The first is Submission Code C, which does not require the NP to write for prior approval. This Code is used when the patient did not have active coverage at the time the service was rendered. The encounter record is now over 90 days old and the coverage has been reinstated. 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 NP 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.

Application for approval to submit over-aged encounter records:
http://www2.gov.bc.ca/assets/gov/health/forms/2943fil.pdf

Clients Eligible for Benefits under the MSP/HIBC
For an encounter record to be submitted to the MSP/HIBC, it must include the Personal Health Number (PHN) of an eligible MSP/HIBC beneficiary. An eligible beneficiary is defined as a person who is a resident of BC and who is enrolled with the MSP/HIBC. If an NP provides care to a patient who is not enrolled with the MSP/HIBC, an encounter record cannot be submitted through the MSP/HIBC 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 Medical Plan for reimbursement.

Verification of BC Services Card

The MSP/HIBC does not pay physicians for uninsured services. NPs will need to discuss with their employers how to proceed with providing care to an uninsured patient and providing uninsured services.

Eligibility Checks
NPs submitting encounter records to the MSP/HIBC for services outlined in s. 22(1) of the Medical and Health Care Services Regulation have a duty to verify enrolment in MSP/HIBC. 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:
    a. Asking to see the person's BC Services Card, or prior to early 2018, their CareCard; or
    b. Asking for the person's PHN, plus an additional piece of identification that shows the person's photograph and legal name; or
    c. Asking for the person's PHN, plus two pieces of identification showing the person's legal name.

If necessary, MSP/HIBC 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 MSP/HIBC. 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 HIBC 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 their name and PHN 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.

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 Interactive Voice Response (IVR) 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 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.