

Medical Services Plan

MSP Explanatory Codes

June 1, 2025



Ministry of
Health

| Code | Description |
|-------------|---|
| *A | Our records indicate patient deceased. Please contact MSP. |
| *B | Patient's eligibility with MSP is in question. Please have patient contact MSP. |
| *C | MSP is unable to locate patient. Please have patient contact MSP. |
| *D | MSP has been unable to contact patient. Please have patient contact MSP. |
| *E | Our records indicate patient has permanently moved out of BC. Please have patient re- apply for coverage if applicable. |
| *F | Patient has opted out of MSP. Patient should be billed directly. |
| *G | Our records indicate MSP is not the primary insurer for this patient. |
| *H | Our records indicate the patient requested coverage to be cancelled. |
| *I | Date of service is prior to coverage effective date. |
| *L | Lab Volume Discount (excluded). |
| AA | PHN is missing or invalid. |
| AB | PHN is not on our records. |
| AC | This is not a valid PHN for MSP. |
| AD | This is an incorrect PHN for this patient. |
| AE | This claim is the responsibility of the interim Federal Health Program. |
| AF | This patient does not have coverage for the DOS. |
| AG | This service billed as "A Donor" coverage. |
| AH | Dependent number is missing or invalid. |
| AI | Dependent is not registered. |
| AJ | This is an incorrect dependent number. |
| AK | Coverage for this dependent has been cancelled. |
| AL | This dependent is not eligible for coverage with MSP. |
| AM | Dependent number and/or initial(s) do not match our records. |
| AO | First name or initial(s) does not match our records. |
| AP | Initials and/or surname are missing or invalid. |
| AQ | Surname does not match our records. |
| AR | Birthdate missing or invalid. |
| AS | Baby not registered. |
| AU | A claim for this service has been paid on the mother's PHN#, under dependent 66. |
| AV | Technical difficulties with coverage check. Contact Teleplan support. |

| Code | Description |
|-------------|--|
| AW | Claim must be submitted with PHN. |
| AX | Province contacted, name and health number not matching. |
| AY | Provincial/insurer or institution code missing or invalid or fee item not valid for insurer. |
| A1 | Patient signature required on pay patient account. |
| A2 | Patient address required on pay patient account. |
| A5 | Referred to or by doctor number is not valid for DOS. |
| A6 | Child is over-age for dependent 66. |
| A7 | Dependent 66 - PHN submitted is registered to male. Please resubmit using mother's PHN and dependent 66. |
| A9 | PHN not approved for ICBC claim number. |
| BA | Initials and/or surname changed to match BC Services Card. Please confirm correct initials and surname with patient. |
| BB | PHN changed to match BC Services Card. |
| BC | Surname/initials and PHN changed to match BC Services Card. |
| BD | Child not registered. Processed under dependent 66. |
| BE | PHN changed to newborn's PHN. |
| BF | Claim is held for future processing. |
| BG | Amount adjusted to the rate effective for this DOS. |
| BH | This claim will be processed on a future remittance statement. Please do not rebill. |
| BI | Fee item and diagnosis do not correspond. |
| BJ | Fee item and amount billed do not correspond. |
| BK | Your claim submission is being held pending WorkSafeBC notice of approval. |
| BL | Massage therapy discounted. |
| BN | The maximum number of additional areas has been paid for this date of service. |
| BP | Birthdate submitted does not match our records. |
| BR | Please clarify the date of service. |
| BU | Claim was received prior to date of service. |
| BV | Service date exceeds allowable claim submission period. |
| BW | Hospital visits must be submitted with each month on a separate line. |
| BX | Claim is being held pending ICBC notice of approval. |
| BZ | MSP has consolidated two PHNs held by this person. Please update your records to the PHN indicated. |

| Code | Description |
|-------------|---|
| B2 | Previous PHN has been replaced with PHN indicated. Please update your records. |
| B3 | In future, please bill multiple services of the same fee item on one line (e.g., 13621 X 3). |
| B4 | Patient now has BC coverage. Please contact patient and rebill under the correct PHN. |
| B5 | Child is over-age for billing under mother's identity number under the reciprocal agreement. |
| CA | Fee item and time stated do not correspond. |
| CB | Number of services and time stated do not correspond. |
| CC | Please state time anesthetic commenced. |
| CD | Date of service and fee item billed do not correspond. |
| CE | Dos was not a Saturday, Sunday or Statutory holiday. |
| CF | Time service was rendered is missing or invalid. |
| CG | Each service must be on a separate line. |
| CH | Please clarify billing; writing is illegible. |
| CI | Number of services and amount billed do not correspond. |
| CJ | Date of service and amount billed do not correspond. |
| CK | Practitioner number is invalid for this payment number and date of service. |
| CL | Payment number is invalid for this date of service. |
| CM | Specialty is invalid for this date of service. |
| CN | Practitioner is not registered with the College of Physicians and Surgeons or not active with MSP for this date of service. |
| CO | MSP is unable to request information by mail due to an invalid address on file. Please update your address with the College of Physicians and Surgeons of BC. |
| CP | Practitioner status invalid for date of service and type of submission. |
| CQ | Practitioner is not licensed to bill for this service. |
| CR | (531) WorkSafeBC incentive applied for proof submission. Please refer to the contract for more information. |
| CS | (530) WorkSafeBC penalty applied for invoice submission. Please refer to the contract for more information. |
| CT | (532) WorkSafeBC amount adjusted to non contracted rate. |
| CU | We are unable to process this account as this is an invalid referral. |
| CV | (534) WorkSafeBC adjusted at timeliness level set in WORKSAFEBC contract. please refer to contract for more information. |
| CW | Telephone advice fees may not be charged when another service was provided on the same day. |

| Code | Description |
|-------------|--|
| CX | (529) WorkSafeBC incentive applied for invoice submission. Please refer to the contract for more information. |
| CY | (527) WorkSafeBC invoice amount was adjusted to contract rate. |
| CZ | (562) WorkSafeBC amount adjusted to \$0.00 refer to fee schedule or contract. |
| C1 | Contact with invalid. |
| C2 | Special program name invalid. |
| C3 | Assessment diagnostic invalid. |
| C4 | Treatment plan prescription missing or invalid - please specify. |
| C5 | Primary disposition missing or invalid. |
| C6 | (524) WorkSafeBC Daily maximum for good/service has already been reached. |
| C7 | (525) WorkSafeBC invoiced units reduced to approved units for good/service. |
| C8 | (528) WorkSafeBC invoice amount was adjusted to the Fee schedule. |
| C9 | (532) WorkSafeBC penalty applied for proof submission. Please refer to the contract for more information. |
| DJ | This claim is the responsibility of ICBC. |
| DP | Your claim has been debited as our records show that the patient was out of province for the date of service. |
| DR | Debit adjustment. See secondary explanatory code(s). |
| DS | Account debited to agree with fee item paid to surgeon. Please rebill for payment. |
| DV | Item 00012 is not payable with laboratory blood work or visit fee charges to the same or an associated physician on the same date. |
| DW | Debit adjustment of MSP claim as WorkSafeBC hospital emergency per diem rate billed for same date of service. |
| DX | ICBC has refused responsibility for your office visit (insurer responsibility has been adjusted to MSP). Therefore, 13075 does not apply and has been withdrawn. |
| D0 | Match found for debit request record. |
| D1 | Debit request record did not meet Pre-Edit or Edit requirements |
| D2 | No match found for debit request record. |
| D3 | Payment withdrawn per debit request record. |
| D4 | Unable to perform debit request at this time. Claim is currently in process. Please review account when processed. |
| D8 | Debit adjustment of account paid at GP rates. |
| D9 | Original claim is at WorkSafeBC and your debit request has been forwarded to WorkSafeBC. |

| Code | Description |
|-------------|---|
| EA | Fee items 00101, 12101, 12201, 13201, 15201, 15301, 16101, 16201, 17101, 17201, 18101 or 18201 are not payable to emergency room physicians. |
| EB | Standby time is not payable by the Plan. |
| EC | Services provided by the Canadian Blood Services are not a benefit of the Plan. |
| ED | There is insufficient medical necessity to process this claim. |
| EE | This service is not an insured benefit of the plan. |
| EF | Not a benefit under the Reciprocal Agreement. |
| EG | This service is the responsibility of WorkSafeBC. |
| EH | Mileage is not a benefit except for unusual emergencies. |
| EI | Service not listed in the Payment Schedule. Please contact your Association. |
| EJ | Services at the request of a third party are not an insured benefit of the Plan. |
| EK | Claim refused because the Assignment of Medical Services Plan Benefits to Opted Out Practitioners form was not signed/dated. |
| EL | Claim refused because the Assignment of Medical Services Plan Benefits to Opted Out Practitioners form was after the date of service (on the claim). |
| EM | Service unrelated to MVA injury. |
| EN | Claim refused because of an inadequate medical record. |
| EP | (512) WorkSafeBC service is not allowed with another service already paid on this date of services. Please refer to the contract. |
| EQ | (573) WorkSafeBC first form 8 submitted by a worker's regular physician is paid the form 8 rate. See WorkSafeBC-DOCTORSOFCBC agreement. |
| ER | (520) WorkSafeBC pre-requisite item not received or rejected, please check contract for pre-requisite required and your previous billing information. |
| ES | This service is not an insured benefit of the plan. |
| ET | (516) WorkSafeBC invoiced units reduced to remaining approved units. |
| EU | (574) WorkSafeBC invoiced units reduced to the maximum number allowable. |
| EX | This account has been paid as a WorkSafeBC account. |
| EZ | These fees are not a benefit when used for overtime compensation. |
| E1 | This service appears to be performed during your app contracted hours – therefore is not billable to MSP. |
| E2 | (521) WorkSafeBC limit 1 form 8 per claim. rate adjusted to form 11 fee. |
| FA | Previous claim incorrectly refused/adjusted by the plan. |
| FB | This is a duplicate claim. An identical claim is being processed. |

| Code | Description |
|-------------|---|
| FC | This account has been paid/refused in accordance with previous correspondence, phone call or note record. |
| FE | Payment adjusted per information received. |
| FF | Payment for the full fee has been paid to another physician; we do not split the fees. |
| FG | Age of patient does not correspond with the fee item billed. |
| FH | Service by definition is bilateral or multiple. |
| FI | Services rendered to a physician's own family member are not payable. |
| FJ | 00112, 01200-01202 only applies to the first patient treated. |
| FK | This account was billed under the wrong PHN or dependent number. |
| FL | Professional/technical fee paid to another facility. Total fee not payable. |
| FM | Repeat graded exercise tests require an explanation of the medical necessity. |
| FN | Previously paid service(s) considered to be included, have been deducted. |
| FO | The sex of patient does not correspond with the fee item/diagnostic code. |
| FP | This patients care is restricted to another physician. Please refer to the MSP bulletin. |
| FQ | Adjustment made because of additional in formation received. |
| FR | See explanatory letter. |
| FS | Service is refused or adjusted. Information requested has not been received. |
| FT | Additional information was not received. |
| FV | This service is included in a previously paid item. |
| FW | Rebilling submitted to change insurer responsibility. |
| FX | This is a reciprocal claim. |
| FY | This claim normally requires manual processing. It has been computer paid and is subject to review at a later date. |
| FZ | This claim normally requires manual processing but has been computer adjusted or refused. If you disagree please resubmit with details in the claim comment/note field. |
| F1 | Included in WorkSafeBC hospital emergency per diem rate. |
| F2 | Time/date does not correspond with related claims. |
| F3 | Your rebilling is being processed. |
| F4 | Operative/procedural report does not substantiate the fee item billed. |
| F5 | Group therapy is not paid for more than one member of a family per session. |
| F6 | Please check patient identification. This card has been reported lost or stolen. |
| F7 | Payment records show that this patient is seeing multiple general practitioners. |

| Code | Description |
|-------------|--|
| F8 | An adjustment is in process for the remainder of this claim. |
| F9 | Payment/refusal of the original claim cannot be reviewed until receipt of a rebilling plus additional details and/or operative/pathology report, if applicable. |
| GA | A new consultation is not allowed when a group of physicians routinely working together provide a call for each other. Your claim was refused or reduced. |
| GB | A referral had not been received at the time of processing. |
| GC | A major consultation is not payable if the patient has been seen within 6 months for the same condition. |
| GD | This item is payable once per hospitalization. otherwise, consultation preamble rules apply. if you disagree with this refusal please resubmit with a note. |
| GE | Claim has been refused or adjusted as the service is included in the dialysis fee. |
| GF | A there is no indication of medical necessity for a new consultation, your account has been adjusted to the appropriate visit fee. |
| GG | This fee is included in the consultation or visit fee. |
| GH | Consultation/visit is included in the fee for the procedure. |
| GJ | Our records indicate this is a referred case. |
| GK | Referral now received. |
| GL | A consultation is not payable to the family physician. |
| GM | Specialist discharge care plan for complex patients has already been paid to you or another specialist. |
| GN | Specialist discharge care plan for complex patients is only payable on inpatients. |
| GO | Specialist advance care planning discussion is not paid while patients are receiving critical or intensive care in the hospital. |
| GP | Services billed on the same day as an LFP service require start and end times. |
| GQ | Referral now received computer generated code. |
| GR | Directive care is payable at 2 visits per week. |
| GS | Directive care is payable after surgery unless the patient is seen for a different condition. |
| GT | (250) WorkSafeBC refused – electronic report submission incomplete form transmission. |
| GU | (508) WorkSafeBC payee is not authorized for date of service. For more information contact corporate and health care purchasing. |
| GV | (514) WorkSafeBC service is not approved or outside allowable entitlement period. |
| GW | (501) WorkSafeBC information missing. Please resubmit with missing information. |
| GX | Your LFP claim has been refused as the associated WSBC/ICBC service does not indicate start/end times. Please rebill with additional details in the note record. |

| Code | Description |
|-------------|---|
| GY | This consultation has been paid although it looks like transfer of care (>3 consults/same specialty in 14 days). |
| G1 | (157) WorkSafeBC refused - electronic report submission included an invalid date format. |
| G2 | (201) WorkSafeBC refused electronic report submission incomplete required information missing, employer's name. |
| G3 | (563) WorkSafeBC GST amount exceeds maximum allowable amount. |
| G4 | (209) WorkSafeBC refused-electronic report submission incomplete, required information missing, employees address. |
| G5 | (227) WorkSafeBC refused electronic report submission incomplete required information missing, estimated time off work. |
| G6 | (233) WorkSafeBC refused - electronic report submission incomplete required information, work restrictions. |
| G7 | (564) WorkSafeBC total amount must be greater than federal tax amt. |
| G8 | (565) WorkSafeBC total amount must be greater than provincial tax amt. |
| G9 | (566) WorkSafeBC PST amount exceeds maximum allowable amount. |
| HA | This claim has been paid to you. |
| HB | This claim has been paid to you, please note the change in name/PHN. |
| HC | This claim has been paid under the indicated fee item. |
| HD | This claim has been paid to an associated doctor or alternate payment number. |
| HE | A retro adjustment has been applied to this paid claim. |
| HF | This account has been paid to the physician providing locum services. |
| HG | Your account has been refused or debited as the patient was out of the province on this/these dates. |
| HH | Payment reversed at the request of WorkSafeBC. |
| HI | Referral has now been received. Payment will remain at specialist rates. |
| HJ | This fee has been paid to another physician or facility. |
| HK | Credit adjustment - see secondary code for explanation. |
| HL | This claim has been paid for a different date of service. |
| HM | This claim does not meet the overaged submission requirements. |
| HN | The information provided does not correspond with our records on file. |
| HO | This claim was paid as an ICBC account. |
| HP | Your note comment/correspondence has been considered, however, we are unable to alter our previous decision. |
| HQ | Computer generated credit. |

| Code | Description |
|-------------|--|
| HR | This procedure is normally performed once in a lifetime. Please resubmit with an explanation for the repeat procedure. |
| HS | A credit adjustment has been processed for this claim. |
| HT | This account has been overpaid in error. |
| HU | Previously paid amounts for individually billed services exceed per diem rate. |
| HV | A claim for this service has previously been processed. |
| HW | (507) WorkSafeBC duplicate service. A service was already paid for this date of service. please do not rebill. |
| HX | This claim has been paid to you. Computer refusal. |
| HY | Balance payment. Amount previously paid for individually billed services deducted from per diem rate. |
| HZ | Payment for this account was previously withdrawn per your debit request record. If requesting payment, please resubmit with an explanation in your note record. |
| H1 | Daily volume limit exceeded. Payment discounted by 100%. |
| H2 | Clinic registry fee already paid to the same or different prac/payee or facility ID. |
| H5 | Daily volume limit exceeded. Payment adjusted. |
| H8 | Daily limit exceeded, paid at 50%. |
| H9 | Daily limit exceeded, paid at 25%. |
| IA | "B" prefixed or asterisk items are included in visit/procedure fee. |
| IB | 00012/90000 is not payable when performed with other blood work. |
| IC | Multiple injections are paid to a maximum of three per sitting. |
| ID | Claims for 00081 must be supported with details of the bedside/resuscitative services. Please provide break down on a per 1/2 hour basis. |
| IE | The tariff committee has not recommended approval for this tray service. Patient may be charged for costs. |
| IF | A visit fee is not payable with subsequent injections. |
| IG | Fee is not applicable unless the physician is called from another site to render the emergency service. Resubmit with details of where you were called from. |
| IH | The consult or visit constitutes the first half hour of care. |
| II | Misc fees must be supported with details of the service provided. |
| IJ | 00083 cannot be billed alone. Your claim has been adjusted to the appropriate visit fee. |
| IK | Duration of visit is required for this service. |
| IL | 00081 includes any minor procedures performed at the same time. |
| IM | This service charge is not applicable for the time/date and/or the item billed. |

| Code | Description |
|-------------|--|
| IN | 01210-01212 are not payable with diagnostic procedures. |
| IO | Paid according to the time and/or duration stated. |
| IP | Counselling and visit fees related to substance abuse disorder within 6 days of fee item 00039 - management of opioid agonist treatment (OAT) are not payable. |
| IQ | Refractory period is 30 minutes for non- operative continuing care surcharges unless for CCFPP care. |
| IR | Minor tray fee not applicable. |
| IS | Major tray fee not applicable. |
| IT | Tray fee not applicable with fee item billed/paid. |
| IU | Tray fee not applicable when service performed in a ministry funded facility. |
| IV | Tray fee not payable to hospitals or extended care facilities, etc. |
| IW | The Tariff Committee has recommended approval for the addition of this tray service. |
| IX | The Tariff Committee has not recommended approval for the addition of this tray service. Included in overhead. |
| IY | Tray fee to be billed by physician performing procedure. |
| IZ | Mini tray fee not applicable. |
| I0 | ICBC has refused responsibility of this claim, therefore MSP has accepted responsibility the insurer code has been changed. |
| I1 | Please resubmit with details of the emergency call out. |
| I2 | 01210 - 01212 are not billable with non-emergency procedures. |
| I3 | 01200-01202, 01205-01207 and 01215-01217 only apply when the physician is specially called to render emergency or non-elective services. |
| I4 | Please resubmit the remainder of this claim under the applicable fee for continuing care, according to the time indicated. |
| I5 | Emergency visits/surcharges are not paid for routine call backs. Please resubmit with details of the medical necessity for additional emergency services. |
| I6 | Claims for 00082 must be supported by details of the care provided to critically ill patient. Please provide breakdown on a per 1/2 hour basis. |
| I7 | Only one tray fee is applicable when multiple procedures are performed |
| I8 | Another physician has claimed 00039 - management of opioid agonist treatment (OAT) during the same time period. rebill with additional information. |
| I9 | ICBC has refused responsibility of this claim. |
| JA | Multiple diagnostic procedures are paid at 100% for the larger fee and 50% for the lesser. |
| JB | If a diagnostic procedure takes place on a subsequent visit within 30 days, only the diagnostic procedure is paid. |

| Code | Description |
|-------------|--|
| JC | The annual limit has been reached. |
| JD | Fee items 00931-00936, 00942, 00943 are paid at 100 percent when billed together. |
| JE | Payment has been made at the appropriate per diem rate based on the date(s) and sequence of associated claims. |
| JF | When the patient acuity level changes up or down, the appropriate second day rate applies (01521 01522 or 01523). |
| JG | Services for pain control/acute pain control are included in critical care fees for ventilatory support and/or comprehensive care. |
| JH | A claim for critical care has been received from another practitioner. If you are not part of the critical care team please rebill with details. |
| JI | There is insufficient medical necessity to process this claim. Resubmit explaining the need for services outside the critical care team, if applicable. |
| JJ | Written support for medical necessity is required to pay critical care fees within the post-op period. Resubmit with additional information, if applicable. |
| JK | Information provided does not meet the criteria for the critical care fee item billed. Please resubmit with additional information, if applicable. |
| JL | Subsequent non inclusive surgical procedures rendered by a member of the critical care team are paid at 75%. |
| JM | Day 1 rates have been paid to you or another physician. Please rebill and provide details if patient transferred from a different city/hospital. |
| JN | Critical care schedule fee items are not payable within the duration of a general anesthetic. |
| JO | To be considered for payment claims for fee items 00081/00082 in lieu of critical care fees must be accompanied by a written explanation of medical necessity. |
| JP | Critical care ventilatory support (01412 - 01442) has been paid to another physician. Your claim has been paid/refused according to the section preamble. |
| JQ | Day 2 rates for critical care apply when patient is re-admitted for the same condition. |
| JR | Critical care (01411-01441) has been paid to another physician. Your claim has been paid/refused according to the section preamble. |
| JS | Day 2 rates for critical care apply when the service is preceded by a consultation. |
| JT | Claims for percutaneous transluminal coronary angioplasty/additional vessel (00840-00842) are payable at 75% when billed by a team member. |
| JU | Comprehensive care (01413-01443) has been paid to another physician. Therefore, we are unable to process your claim for payment. |
| JV | When a patient is admitted to NICU after 48 hours, second day rates will apply again (01521, 01522, 01523). |
| JW | 01200-01202, 01205-01207 and 01215-01217 are not payable in addition to adult and paediatric critical care fees (01411-0 1441, 01412-1442 and 01413-01443). |
| JX | When a patient is readmitted to NICU within 48 hours, billing continues at the same rate as if there were no break, unless there is a change in acuity level. |

| Code | Description |
|-------------|--|
| JY | When a patient is readmitted to ICU with in 48 hours with the same or similar problem, billing continues at the same rate as if there were no break. |
| JZ | When a patient is readmitted to ICU after 48 hours with the same or similar problem, day 2 rates apply. |
| J0 | (519) WorkSafeBC payee is not authorized to provide goods/services for more information contact corporate and health care purchasing. |
| J1 | (283) WorkSafeBC refused - report submission incomplete, required information missing, work location missing. |
| J2 | (568) WorkSafeBC HST not applicable for item. |
| J3 | (287) WorkSafeBC refused - report submission invalid, specific reference number invalid or missing. |
| J4 | (285) WorkSafeBC refused - report submission incomplete, required information missing clinical information missing. |
| J5 | (281) WorkSafeBC refused - report submission incomplete, required information missing, workers city and or work location missing. |
| J6 | WorkSafeBC refused - report submission incomplete, required information missing injury description missing. |
| J7 | (277) WorkSafeBC refused - report submission incomplete, required information missing patient duration missing. |
| J8 | (275) WorkSafeBC refused - report submission incomplete, required information missing, disabled from work flag missing. |
| J9 | (273) WorkSafeBC refused - report submission incomplete, required information missing rehab program not indicated. |
| KA | There is no indication that two separate visits were made. If two visits were performed, please provide times of each visit. |
| KB | Visits and minor procedures, same diagnosis - larger fee only is paid. Different diagnosis - lesser fee paid at 50%. |
| KC | Repeat complete physicals within 6 months require an explanation of medical necessity. |
| KD | This service does not meet criteria for fee item billed. |
| KE | This fee is applicable between 8 am and 6 pm. |
| KF | Patients annual limit for counselling has been reached. |
| KG | Counselling for two or more members of a family must indicate that they were seen individually. |
| KH | One 00114 is paid every two weeks for care provided in a long-term care institution (nursing home, intermediate care facility) unless supported by an explanation. |
| KI | Another physician has been paid for daily hospital care. |
| KJ | The total number of services exceeds the number of hospital days. |
| KK | This service is not a benefit of the plan when performed in a hospital. |

| Code | Description |
|-------------|--|
| KL | Daily care is payable up to 30 days only unless supported by additional information of the medical necessity. |
| KM | Supportive care visits are limited to on e visit for the first 10 days of hospitalization then one visit per 7 days per MSC Payment Schedule Preamble D.4.7. |
| KN | Out-of-hospital care was provided during this time. Please verify hospitalization dates. |
| KO | In-hospital care was provided during this time. Please verify the dates. |
| KP | Lab, x-ray and/or interpretation fees are not a benefit under the plan for a registered bed patient. |
| KQ | Our records indicate patient is located in a nursing home. Please verify and rebill with the appropriate fee item. |
| KR | Hospital visits are not payable in addition to the routine care of a newborn. |
| KS | Hospital visits have been paid during the period you have billed nursing home care. Please verify location of patient. |
| KT | Nursing home visits have been paid during the time you have billed hospital care. Please verify location of patient. |
| KU | Please resubmit the remainder of this claim, if applicable, under supportive or directive care. |
| KV | Emergency Medicine fees and minor procedures - the lesser fee is paid at 50%. |
| KW | Fee item billed does not meet the criteria for group counselling. The appropriate visit fee has been paid. |
| KX | Fee item billed is only applicable when service is provided in hospital emergency room. The appropriate visit fee has been paid. |
| KY | Visit fee includes examination/assessment of multiple diagnoses. |
| KZ | Fee item and diagnostic code/note comment do not correspond. |
| K0 | 92515/92516 not payable with 92510, 92520-92544 or 92546. |
| K1 | Processed according to the Preamble to the Medical Services Commission Payment Schedule. |
| K2 | Processed according to the Section Preamble to the Medical Services Commission Payment Schedule. |
| K3 | Processed according to the description of the fee item, or the note relating to the fee item, in the Medical Services Payment Schedule. |
| K4 | Please refer to the protocol for this fee item. |
| K5 | Your rebilling has been processed. In future, please ensure that the necessary information (e.g. "CCFPP") appears in the first line of your note record. |
| K6 | Primary base fee is not applicable. Your account has been paid under the appropriate split base fee. |

| Code | Description |
|-------------|---|
| K7 | Patient not registered. Payment for third and subsequent services will be reduced to 50%. (Primary Care). |
| K8 | Patient not registered – payment reduced to 50%. (Primary Care). |
| K9 | Our records indicate that fee item 00114/00115 is not applicable. Please verify the patient's location. |
| LA | Volume discount mechanism applied as per 2007 renewed lab agreement. |
| LB | This item is not a benefit of the plan unless performed in an MSC approved facility or as an outpatient service. |
| LC | Your claim for fee item 13075 was refused as MSP has not received an associated claim from you or an ICBC visit (must be for an unrelated condition). |
| LD | Nerve blocks/IV procedures are not paid with time units or procedures. |
| LE | Continuous care by a second anaesthetist is paid under times fees only. |
| LF | Anesthetic Procedural Fee Modifiers are not payable in addition to diagnostic or therapeutic anesthesia fees. |
| LG | Your claim for fee item 13070 was refused as the WSBC visit was claimed for the same or a related condition. |
| LH | Anesthetic procedural modifiers are only applicable to general, regional and monitored anesthesia. |
| LI | Your claim for fee item 13075 was refused as the ICBC visit was claimed for the same or a related condition. |
| LJ | Intensity/complexity fees are not applicable to the surgical/diagnostic procedure(s) billed. |
| LK | Your claim for fee item 13070/13075 was refused as a procedure was billed for the same or a related condition. |
| LL | 13052 is not applicable for a pre-operative examination. |
| LM | Insufficient medical necessity for two anaesthetists has been received. |
| LN | Please provide duration of continuous time spent with the patient during second and/or third stages of labour only. |
| LO | Your claim for fee item 13070 was refused as MSP has received a non WSBC visit claim from you. |
| LP | Fee items 01151 and 13052 are not applicable when performed in conjunction with other anesthetic services. |
| LQ | Visit fees are not payable at the time anesthetic services are rendered. |
| LR | This service is included in the annual complex care block fee. |
| LS | Age related annual complex care block fee items must be provided on the same date of service as complex care planning fee item 14033. |

| Code | Description |
|-------------|--|
| LT | This service is not payable on inpatients who reside in a care facility. |
| LU | Your claim has been refused due to an inadequate medical record. The MSC Payment Schedule Preamble C.10 describes the requirements of an adequate medical record. |
| LV | This service is limited to once per calendar year per patient and has been paid to another practitioner. |
| LW | This service is only payable if the patient is seen and a visit billed on the same date. Please resubmit for both services, if applicable. |
| LX | Fee item 33583 is for administering single parenteral chemotherapeutic agents and not for the injection of LHRH. Please resubmit using fee item 00010 if applicable. |
| LY | Claim for Fee Item 32308/32318 has been paid as fee item 00308 as care has exceeded the first 10 days of hospitalization. |
| LZ | Not payable when the service is provided at the location (location code) indicated on the claim, and/or related claims. |
| L0 | LFP time codes must be billed per calendar day. Please resubmit time codes as separate claims for each calendar day. |
| L1 | (510) WorkSafeBC practitioner not authorized for date of service. For more information contact corporate and health care purchasing. |
| L2 | (316) WorkSafeBC refused – duplicate form detected. |
| L3 | (517) WorkSafeBC invoiced units reduced to daily maximum for good/service. |
| L4 | (533) WorkSafeBC incentive applied for proof timeliness. Please refer to the contract for more information. |
| L5 | (539) WorkSafeBC interest applied. |
| L6 | LFP fees are not payable on reciprocal patients. Please rebill with the appropriate MSC Payment Schedule fee(s). |
| L7 | LFP interaction fees are limited to one per patient. If two separate interactions were performed, please provide a note record with the times of each visit. |
| L8 | This service is included in the LFP payment model. |
| L9 | (509) WorkSafeBC practitioner number is missing or not recognized. Please add or correct the information on the invoice and resubmit. |
| MA | Multiple exams performed on the same visit, the lesser exams are paid at 50%. |
| MB | A repeat refraction within a 6 month period requires medical necessity. |
| MC | Items 02010, 02015 and 02012 include certain individual eye exams. |
| MD | Exam and a minor procedure billed on the same day, the lesser fee is paid at 50%. |
| ME | Eye exams are not paid with office/hospital visits. |

| Code | Description |
|-------------|--|
| MF | Referring doctor provided is invalid for payment of consultation billed. |
| MG | These exams are paid to a maximum of three per day. |
| MH | 02012 is not payable within three days of emergency surgery. |
| MI | The appropriate fees for removal of foreign bodies from the surface of the eye are 13610, 13611 or 06063. |
| MJ | A fee item has been established for this service. Please resubmit under the approved code. |
| MK | Fee item 13005 is not payable when the patient is a registered bed patient in an acute care hospital. |
| ML | Fee item 13005 may only be billed once per day per physician per patient. |
| MN | Fee item 13005 is not payable in addition to services provided on the same day/same physician/same patient. |
| MO | A total fee has been paid to the same practitioner or payee. Professional and technical fees are included in the total fee so your claim has been refused. |
| MP | Fee item 00109/13109 is not payable when a patient is admitted for surgery/delivery. The appropriate visit fee has been paid, if applicable. |
| MQ | Fee item 00109/13109 is not applicable when a patient is referred for continuing care by a certified specialist. The appropriate visit fee has been paid. |
| MR | Fee item 00109/13109 is not applicable when preceded by a complete physical exam within 7 days by the same physician. The appropriate visit fee has been paid. |
| MS | Does not meet the criteria for billed services for hospitalized patients. |
| MT | Sub acute care has been paid during the period you have billed for acute/supportive care. Please verify the location of the patient. |
| MV | Acute/supportive care has been paid during the period you have billed for sub acute care. Please verify the location of the patient. |
| MW | This RoadSafetyBC form fee is not payable on the same date of service as another RoadSafetyBC form fee that you have billed. |
| MX | Driver's license number is not numeric, is missing or is not located in the first seven spaces of the note or comment field. |
| MY | A repeat RoadSafetyBC form fee is not payable to any practitioner within 3 months. |
| MZ | Insurer is invalid for this service. |
| M1 | (269) WorkSafeBC refused – report submission incomplete, required info, regular practitioner indicator missing or invalid. |
| M2 | (271) WorkSafeBC refused – report submission incomplete, required info, return to full duties indicator missing or invalid. |

| Code | Description |
|-------------|---|
| M3 | GPSC conference fee items 14015, 14016 or 14017 have been paid to you on the same date of service. Therefore, this GPSC fee item is not applicable. |
| M4 | GPSC conference fee items 14015, 14016 or 14017 have been paid to a different GP on the same date of service so this GPSC fee is not applicable. |
| M5 | Specific GPSC fee items have been paid to you on the same or prior date of service so GPSC fee items 14015, 14016, 14017 and 14033 are not applicable. |
| M6 | Specific GPSC fee items have been paid to another GP on the same or prior date of service so GPSC fee items 14015, 14016, 14017 and 14033 are not applicable. |
| M7 | The GP daily volume limit was previously reached for this date of service. Please resubmit with explanation if you withdrew paid visits for this date. |
| NA | Payable at 50% when billed with delivery fees. |
| NB | Fee item 14094 is payable once within 6 weeks following a C-section or vaginal delivery but not to the physician who performed the C-section. |
| NC | 04116 is only applicable in the immediate post-partum phase. |
| ND | Pre-natal visit fees are not payable within the post-natal period. |
| NE | Included in the fee for delivery, caesarean section or post-natal care. |
| NF | Please resubmit with an explanatory note record per the direction provided in the note(s) listed under the fee item. |
| NG | Additional prenatal visits must be supported by medical necessity. |
| NH | Included in fee items 04025, 04050, 04052, 14108 and 14109. |
| NI | Only one prenatal complete examination (00101/14090) is payable per physician per pregnancy. |
| NJ | Multiple call backs are not normally paid with delivery. Provide details of serious complication(s) requiring additional emergency care. |
| NK | Timing for fee item 14199 begins after two hours of continuous care during second stage of labour. |
| NL | This claim has been paid to the obstetrician. |
| NM | The incentive for full service GP obstetrical bonus is only applicable when fee item 14104, 14108 or 14109 is paid to the same physician/same day. |
| NO | Item 14000 is only payable when the physician attends one delivery on the date billed to a maximum of 25 bonuses per calendar year. |
| NP | Fee item 14000 is payable for the first delivery the GP attends on the date billed, to a maximum of 25 bonuses per calendar year. |
| NQ | The incentive for full service GP obstetrical delivery bonus is payable for the first delivery the GP attends on the date billed. |

| Code | Description |
|-------------|--|
| NR | The incentive for full service GP obstetrical delivery bonus is payable to a maximum of 25 bonuses per calendar year. |
| NS | You have reached or exceeded the practitioner calendar year limit for this service. |
| NT | The monthly limit has been exceeded. |
| NU | The BCP daily limit has been reached resulting in a partial or zero BCP premium being applied to this claim. |
| NV | This fee item is only payable to the physician who has provided the majority of the longitudinal general practice care to the patient over the preceding year. |
| NW | This fee item is not payable for services provided by physician who are working under a salaried, sessional or service contract arrangement. |
| NX | Invalid PHN/fee item combination for payment model. |
| NY | LFP daily time units limit exceeded. |
| NZ | LFP daily interaction limit exceeded. |
| N0 | LFP consult has been refused as you have billed a consult within the last 6 months for the same/related condition. Please rebill as a visit/patient interaction. |
| N1 | (546) WorkSafeBC debit request from payee. |
| N2 | (544) WorkSafeBC invoices received date and time cannot be in future. |
| N3 | (555) WorkSafeBC invoices original amount cannot be negative. |
| N4 | (556) WorkSafeBC invoice must be a debit. |
| N5 | (557) WorkSafeBC invoice items created date and time cannot be in future. |
| N6 | (558) WorkSafeBC invoice items created date and time cannot be on or before received date and time. |
| N7 | (559) WorkSafeBC invoice total amount cannot be negative. |
| N8 | (560) WorkSafeBC invoice items unit amount cannot be negative. |
| N9 | WorkSafeBC refused – call out charges not payable for service(s) billed. |
| OA | Primary and secondary wound management fees are only applicable with fees from the Orthopaedic Section. |
| OB | Consult/visit is included in the paid claim on the same date of service by the same practitioner or payee for RoadSafetyBC fee item 96226 or 96227. |
| OC | Eye exam is included in the paid claim on the same date of service by the same practitioner or payee for RoadSafetyBC fee item 96226 or 96227. |
| OD | Visual field test 02041, 02042, 02043 is included in the paid claim on the same date of service by the same practitioner or payee for fee item 96226, 96228. |
| OH | Adjusted to the appropriate fee/amount for an open reduction and/or compound fracture. |

| Code | Description |
|-------------|--|
| OI | External fixation is not payable with an open reduction fee. |
| OJ | Remanipulation is not payable to the same physician within five days of the initial procedure. |
| OL | Primary wound care management fees are not stand-alone items. Please rebill with the appropriate fracture fee if applicable. |
| OM | 51037/51038 is only paid with applicable orthopaedic section items. |
| PA | 00622 has been paid for another dependent. This fee includes parental assessment. |
| PB | Consultations for two family members or more require individual referrals and must be seen separately. |
| PC | Psychotherapy sessions extending beyond one hour per day must be supported by an explanation of need. |
| PD | Family therapy is only payable on one member's PHN. |
| PE | Invalid service clarification code for psychiatry fee item. |
| PF | Invalid service clarification code for Rural Retention Premium. |
| PG | Specialty invalid for Rural Retention Premium. |
| PH | PCO Registration submitted for a PHN that is currently registered to an associated primary care organization. |
| PI | Adjustment due to PHN registration change. |
| PJ | PHN not registered on service date. Claim for a non physician and/or billed fee item does not meet conversion to fee for service criteria. |
| PK | Adjustment due to PHC registration change E-debit only, no matching credit created. |
| PL | Rural retention is not applicable to the geographic location where the service was provided. |
| PM | Subsequent LFP interactions on the same day/same patient require a note with the clinical reason. |
| PN | Only one time code can be paid for the same 15 minutes. |
| PO | Beneficiary reimbursement for services. |
| PS | This LFP Procedure is not payable in addition to an in-person interaction on the same day. |
| PT | Only one procedure code is payable per patient per day, except for 98022/98052. |
| PW | Resubmit as extended services code (960xx) or MSP fee code with an explanatory note. |
| PZ | Please resubmit with child's PHN. Consider registering PHN with the primary care organization. |
| P0 | Claim for a non-physician and/or billed fee item does not meet conversion to fee for service criteria. |

| Code | Description |
|-------------|---|
| P1 | Related claims have been paid by ICBC. Please check your records and rebill using MVA indicator "Y", if necessary. |
| P2 | Partial payment from ICBC for one service. |
| P3 | Related claims have been paid by WorkSafeBC. Please check your records and rebill using insurer code "WC", if necessary. |
| P5 | Not approved for service. |
| P6 | PHN not registered to primary care organization. |
| P7 | Invalid/missing date in note record. |
| P8 | PCO invalid registration cancel date/cancel reason code. |
| P9 | Registration not eligible for PCO site. |
| QA | An Operative Report is required to assess this claim. |
| QB | An Operative Report and the medical necessity is required to assess this claim. |
| QC | The medical necessity is required to assess this claim. |
| QD | Written support for two assistants is required from the surgeon. |
| QE | Service is within the pre or post-operative period. |
| QF | Pre and/or post-operative services have been deducted from this claim. |
| QG | Service is included in the composite surgical/procedural fee. |
| QH | Independent procedures are not payable with other services. |
| QI | 13612 is per laceration. If resubmitting, bill each laceration separately, and state length of any over 5 cm. |
| QJ | Adjusted to agree with the surgical/assist fee item paid for this date of service. |
| QK | Assistance at surgery/diagnostic procedures usually performed by one physician is not payable. |
| QL | Assists and visits are not paid together unless distinct unrelated times are provided. |
| QM | Multiple procedures at the same time, the lesser fee(s) paid at 50%. |
| QN | Fee item requires pre-authorization. Please resubmit with the operative/procedural report and provide details regarding the medical necessity. |
| QO | A claim for surgical fee item G04705, G04707 or G04709 has not been received. Therefore, this gynaecological certified assist fee item is not applicable. |
| QP | Repeat/staged procedures are not paid within designated time limit. |
| QQ | 77043 is not applicable according to the information provided. |
| QR | A surgical surcharge is not applicable as the procedure billed is not considered a surgical item. |

| Code | Description |
|-------------|---|
| QS | 07019/70019/70020 requires confirmation of medical necessity from surgeon. |
| QT | Payment at 75% is not applicable. |
| QU | Unassociated multiple procedures at the same time, the lesser fee is paid at 75%. |
| QV | A claim for surgical fee item G04709 has not been received therefore, G04713 second surgical assist in not applicable. |
| QW | Pre-approval is required for this fee item. Please resubmit upon approval. |
| QX | A new authorization is required after two years per Preamble D.9.1.1. Please rebill after a new authorization is received, if applicable. |
| QY | ICBC refusal. No refusal reason code. |
| QZ | 77043 is only paid with applicable vascular surgery items. |
| Q1 | Long-term care institution visits have been paid during the time you are billing for home visits. Please verify location of service. |
| Q2 | Home visits have been paid during the time you are billing for long-term care institution visits. Please verify location of service. |
| Q3 | The first visit of the day bonus has been refused or debited as the corresponding visit has also been refused or debited. |
| Q4 | Non-osteopathy fee item already paid on same DOS. |
| RA | Claim has been paid under the composite fee 08547 which includes 08530, 08537, 08544 and 08545. |
| RB | X-rays billed by non-certified radiologists are paid at 75%. |
| RC | Your rebilling has been refused. A retroactive adjustment will be made on a future remittance statement. |
| RD | Payment has been reduced as this fee item is paid on a "per case basis". |
| RE | Encounter received. |
| RF | Encounter required – patient registered to primary care organization. |
| RG | Encounter record converted to fee for service. |
| RH | Amount greater than \$0 billed on an encounter record. |
| RI | RGP fee for service. Claims are not valid for dates of service greater than June 30, 1995. |
| RJ | Registration must be submitted by a medical doctor. |
| RK | Fee for service record converted to an encounter record. |
| RL | Payable only for approved procedures. |
| RM | The miscellaneous fee item billed has been changed to this established fee item. |

| Code | Description |
|-------------|---|
| RN | Dental/oral surgery with extractions – the higher gross fee item(s) are paid at 100% and extractions in the same quadrant paid as “each additional tooth”. |
| RO | Multiple dental/oral surgeries are paid as the larger fee at 100%; the lesser fee at 50% unless otherwise stated in the MSP Dental Schedule. |
| RQ | This fee item is payable once per jaw. |
| RS | A claim for this service has been paid within the previous 12 months. |
| RT | A claim for this service has been paid within the previous 12 months to another practitioner. |
| RU | Amounts greater than \$0 are not billable under this personal health number. |
| RV | This patient has not been seen face-to-face at least twice in the preceding 12 months. (This visit requirement excludes procedures, laboratory and x-rays). |
| RW | This item is not applicable unless continuous time is spent with the patient. |
| RX | Critical care fees are not applicable when the service starts after 2200 hours. |
| RY | The maximum rate paid for these multiple laparoscopic operations is the rate payable for fee item 04229. This service exceeds the maximum. |
| RZ | A visit is not payable in addition to a RoadSafetyBC or MSDSI form fee when the patient is seen for the same diagnosis. |
| R1 | (567) WorkSafeBC payment amount reduced to BC rates. |
| R2 | (154) WorkSafeBC refused your claim submission. Transmitted record had a date of service prior to the date of birth. |
| R3 | (536) WorkSafeBC penalty applied for service timeliness. Please refer to contract for more information. |
| R4 | (569) WorkSafeBC claim cannot be matched at this time. Please contact payment services at 604-276-3085 or 1-800-422-2228. |
| R5 | (535) WorkSafeBC invoiced amount was adjusted to the contract rate. |
| SB | WorkSafeBC refused your claim submission - concurrent treatment not authorized. If clarification required contact WSBC adjudicator. |
| SD | (522) WorkSafeBC claim decision is pending. Please resubmit when claim status is accepted. |
| SE | (523) WorkSafeBC service is not allowed with another service already entitled on this claim. Please refer to contract for contract terms. |
| SF | (526) WorkSafeBC invoice date is greater than 90 days from date of service. |
| SJ | (518) WorkSafeBC the supporting (proof) document was not received, or its service date does not match the service date for this item. Refer to your contract. |
| SM | Your claim has been refused. Please resubmit with WorkSafeBC fee item for WorkSafeBC services. |

| Code | Description |
|-------------|--|
| SN | This service is the responsibility of WorkSafeBC. Please resubmit with "WC" insurer code. |
| SO | Initial consult not performed in the past 12 weeks, or repeat consult already performed in the past 12 weeks |
| SR | Invalid fee item for WorkSafeBC claim. Please resubmit using the appropriate MSP WorkSafeBC fee item. |
| SX | (551) WorkSafeBC payee not contracted to provide service. |
| SZ | (147) WorkSafeBC refused claim. Invalid body part code. Please resubmit with amended information. |
| S1 | (146) WorkSafeBC refused claim. Invalid nature of injury code. Please resubmit with amended information. |
| S2 | (148) WorkSafeBC refused claim. Invalid side of body code. Please resubmit with amended information. |
| S3 | (542) WorkSafeBC payee could not be matched. |
| S7 | (155) WorkSafeBC refused you claim submission. Transmitted record had a date of injury prior to the date of birth. |
| TA | Patient's annual limit for this benefit has been reached. |
| TB | This fee is paid only once per patient, per year. |
| TC | Balance owing on previously paid account. |
| TD | Less than 3 months have elapsed since the last visit for this condition. |
| TE | Less than 21 days have elapsed since the last visit for this condition. |
| TF | Less than 3 months have elapsed since the last paid treatment. |
| TG | As no authorization has been received, your account has been refused. |
| TH | Fee item 02897 is included in fee items 02888, 02889, 02898 and 02899. |
| TJ | Invalid PHN/fee item combination: 9824870522 only valid for fee 14010. 982523860 2 only valid for fee items 36061, 36062, 36063, 36064, 36065. |
| TK | This item is not applicable until the MSP age appropriate counselling fee item (00120, etc) calendar year limit (4) has been utilized. |
| TL | ICBC approved claim with referring doctor number 99990. |
| TM | ICBC approved claim with referring doctor number 99995. |
| TO | This claim is the responsibility of ICBC. |
| TP | Previous visit within 6 months for same condition. |
| TR | ICBC claim is outside of approved treatment dates. |

| Code | Description |
|-------------|--|
| TS | Payment has been made in accordance with the information provided by the referring physician. |
| TT | Authorized payment amount has been reached. |
| TU | Details required for frequency of servicing. Please resubmit with explanation in note record. |
| TV | Service included in initial examination. |
| TW | Payment has recently been made to other optometrist for this service. |
| TX | ICD9 code does not match published list. |
| TZ | Retroactive adjustment. |
| T0 | Fee item 02888, 02889, 02898 and 02899 are included in fee items 02894 and 02895. |
| T1 | Extractions in conjunction with osteotomies/fractures – bill extractions as “each additional tooth per quadrant” regardless of the number of quadrants involved. |
| T2 | Please resubmit with the location of each of the extractions, lesions, etc. |
| T3 | A1234565 is not an acceptable ICBC claim number. |
| T4 | ICBC refused. This may be a WorkSafeBC claim. |
| T5 | Services exceed ICBC coverage limit. |
| T6 | ICBC refused responsibility. Please contact adjuster. |
| T7 | Therapy treatment discontinued by medical practitioner. Please contact ICBC. |
| T8 | Claimant has private plan for therapy. Please contact ICBC. |
| T9 | ICBC customer unknown - please contact ICBC. |
| UA | This claim was assessed by the Plan's Medical and Surgical Advisors. |
| UB | Claim has been paid/refused pending review by our Medical Advisors. You will be notified of any changes. |
| UC | If you disagree with the payment made, please refer to the appropriate committee of the DOCTORSOFBC (BCMA). |
| UD | Paid according to Reference Committee recommendations. |
| UE | Computer processed in accordance with Medical Services Commission Payment Schedule. |
| UF | Invalid MVA - no injury claim. |
| UG | Breach of ICBC coverage. |
| UH | MVA prior to April 1, 1994. Contact ICBC if necessary. |
| UI | Duplicate KOL 35 - contact ICBC if necessary. |
| UJ | No ICBC claim for PHN - use ICBC number. Contact ICBC if necessary. |

| Code | Description |
|-------------|---|
| UL | (515) WorkSafeBC the maximum service units entitled have already been invoiced. Contact claim owner for more information. |
| UM | (513) WorkSafeBC service is not entitled on claim. |
| UP | Claim refused as ICBC responsibility. Please rebill ICBC directly or if patient qualifies for MSP therapy benefits, please bill MSP. ICBC claim # not required. |
| UQ | This claim has been paid on an independent consideration and without precedent basis after review by MSP's Medical and Surgical Advisors. |
| UR | Paid at the agreed fee amount. |
| U1 | Patient benefit limit reached - refractions are only payable once every 24 months for patients between the ages of 16 and 64. |
| U2 | A refraction has been previously paid to a different specialty - refractions are only payable once every 24 months for patients between the ages of 16 and 64. |
| U3 | Insufficient information has been provided to authorize a repeat refraction within 24 months. |
| U4 | Routine eye examinations are not a benefit of MSP. |
| U5 | Insufficient medical necessity provided for a repeat eye examination for the diagnosis indicated. |
| VA | Payment number is missing or invalid. |
| VB | Service is included in LFP time and/or interaction codes. |
| VC | Payment number not valid for this batch. |
| VD | Service is billable under the LFP Payment Model. Please resubmit the service as the appropriate LFP fee item(s). |
| VE | Amount billed is missing or invalid. |
| VF | Number of services is missing or invalid. |
| VG | Fee item is missing or invalid. |
| VH | Date of service is missing or invalid. |
| VI | Practitioner number is missing or invalid. |
| VJ | Invalid diagnostic code for referral by dentist/paediatric dentist or orthodontist. Diagnosis must relate to problems with mastication. |
| VK | Claim number is missing or invalid. |
| VL | Claim number is out of sequence. |
| VM | Referring practitioner number is missing or invalid. |
| VN | Diagnostic code missing or invalid. |
| VO | Anatomical position invalid or missing. |
| VP | Service to-date missing or invalid. |

| Code | Description |
|-------------|---|
| VQ | The number of services exceeds the maximum allowed. |
| VR | Critical care must be submitted on a claim form with a covering letter providing details to support the claim. |
| VS | The to/by indicator for the referring doctor is invalid. |
| VT | Claim has been paid/refused pending review. You will be notified of any changes. |
| VU | Nature of injury missing or invalid. |
| VV | Date of injury missing or invalid. |
| VW | WorkSafeBC claim number invalid or missing. |
| VX | Medical practitioner referral required by ICBC. Please contact ICBC. |
| VY | Area of injury missing or invalid. |
| VZ | ICBC claim number invalid for WorkSafeBC claim. |
| V0 | Invalid diagnostic code for referral to an otolaryngologist from a dentist or pediatric dentist. Diagnosis must relate to neoplasms of lip, oral cavity or pharynx. |
| V2 | Reserved for ICBC misc. adjustments where two bills are sent for one service. |
| V3 | Field(s) designated for future use contain(s) invalid data - refer to current Teleplan specs. |
| V4 | (533) WorkSafeBC invoiced amount paid. |
| V5 | Processed according to the description of the fee item, or the note relating to the fee item, in the LFP Payment Schedule. |
| V6 | Services for this fee do not require a to-date. If services provided on different dates, please submit as separate claims. |
| V7 | Services referred by de-enrolled practitioners are not a benefit of MSP. |
| V8 | Paid according to your MSP Orthodontia contract. |
| V9 | This patient is not user fee exempt for this date of service. |
| W\$ | WorkSafeBC claim submitted to WorkSafeBC on paper. |
| WA | Service not approved for this payment number or date of service prior to approval date. |
| WB | (541) WorkSafeBC claim could not be matched. |
| WC | Fee item not listed with Medical Services Plan. |
| WD | (511) WorkSafeBC claim rejected or disallowed. Do not rebill. |
| WE | Hospital payee claim submission refused. Bill WorkSafeBC directly. |
| WF | Fee item billed and doctor's specialty/practitioner number do not correspond. |
| WG | Fee items with letter prefix 'A' are not benefits of the Plan. |
| WH | We are unable to process a single claim for two different patients. |

| Code | Description |
|-------------|---|
| WI | Billing is incomplete. Please resubmit with all required information. |
| WK | Please rebill with initial fee for the first service and the additional fee for each additional service performed. |
| WN | Pre-authorization number valid. |
| WO | Pre-authorization number invalid. |
| WP | Pre-authorization permits payment of this inactive coverage. |
| WR | Pre-authorized number invalid. |
| WS | (561) WorkSafeBC service prior to injury. |
| WT | Tray fee not applicable to procedure billed. Refer to the list of procedures eligible for a tray fee in the General Services Section of MSC Payment Schedule. |
| WU | Unknown reason for refusal or change to fee item and/or amount. Please contact WorkSafeBC. |
| W1 | Postal code missing or format invalid. |
| W2 | Data centre and payee number combination not on file. |
| W3 | Payee not active. |
| W4 | Use claims comment or note record. Please do not use both. |
| W5 | Note data type not equal to "A". |
| W6 | Note data line blank (no data). |
| W7 | Provincial institution not applicable for batch eligibility. |
| W8 | Dependent 66 not applicable for batch eligibility. |
| W9 | Greater than three errors for this claim. |
| X# | Invalid sub-facility for this service type. |
| XA | RCP claims - birthdate and sex code missing or invalid. |
| XB | Eligibility Request - invalid patient status request code used. |
| XC | Eligibility Request - invalid sex code. |
| XD | Invalid/insufficient information provided. (In note or claim comment field/description area.) |
| XE | Practitioner does not have approval for this service. |
| XF | Facility does not have approval for this service. |
| XG | Note comment does not correspond with submission code. |
| XH | This claim has been returned to you per your submission code E request record. |
| XJ | Please resubmit on the appropriate claim form. |
| XK | RCP/Registration Number is not numeric or is equal to zero. |

| Code | Description |
|-------------|---|
| XL | WorkSafeBC claim number has been added/updated. Please contact WorkSafeBC for correct claim number. |
| XM | PCO – ICBC has refused responsibility for this claim. |
| XN | PCO – encounter record created to replace fee for service claim refused by ICBC. |
| XP | ICBC refused – claim processed by MSP. |
| XQ | Practitioner not attached to BCP Facility. |
| XS | Your facility number was entered in the sub-facility field in error. |
| XT | BCP facility number is missing, please rebill with the approved BCP facility number. |
| XW | Expedited WorkSafeBC surgical premium applied. |
| XY | Vendor test record returned. |
| X0 | Facility – Prac or Payee not connected. |
| X1 | Original MSP file number invalid. |
| X2 | Facility number is missing or invalid. |
| X3 | Sub-facility number is missing or invalid. |
| X4 | RCP/Institution number missing, invalid, or not in correct format. |
| X5 | RCP/Institution birthdate missing or invalid. |
| X6 | RCP/Institution first name missing or invalid. |
| X7 | RCP/Institution second initial invalid. |
| X8 | RCP/Institution - patient sex code missing or invalid. |
| X9 | RCP address missing or not showing in line one. |
| YA | Note record missing or invalid for submission code C, E or X. |
| YB | This Teleplan record code is not operational. Please contact Teleplan Support. |
| YC | Claim number refused by ICBC. |
| YD | Insurer code does not match fee item billed. This fee item is only applicable for ICBC billings. |
| YF | Fee item valid for WorkSafeBC claim only. |
| YH | No payment owing. Insurer code adjusted. |
| YI | Provincial institution not valid for WorkSafeBC claim. |
| YK | Claim reprocessed at the request of WorkSafeBC. |
| YN | Newborns invalid for WorkSafeBC claim - Dep 66. |
| YP | WorkSafeBC claim must be submitted by PHN. |
| YR | Claim reprocessed/adjusted at the request of ICBC to change insurer responsibility. |

| Code | Description |
|-------------|--|
| YS | Specialty invalid for WorkSafeBC claim. |
| YT | WorkSafeBC claim must be Teleplan. |
| YU | ICBC refusal reason unknown - Please contact ICBC. |
| YV | Data Centre change. Record submitted by previous data centre being returned to new data centre. |
| YW | Insurer responsibility switched at the request of ICBC. |
| YX | Claim reprocessed at the request of ICBC. |
| YY | Pre-Edit System refusal. See second explanatory code(s). |
| YZ | Facilities edit refusal. |
| Y1 | Billed fee prefix invalid. |
| Y2 | Payment mode is invalid. |
| Y3 | Submission code invalid. |
| Y4 | Service location code missing or invalid. |
| Y5 | Referring practitioner code 1 missing or invalid. |
| Y6 | Referring practitioner code 2 missing or invalid. |
| Y7 | Correspondence code invalid. |
| Y8 | MVA claim code invalid. |
| Y9 | ICBC claim number invalid. |
| ZI | Note record is not preceded by correspondence code equal to "N" or "B" or practitioner number does not match C01/C02 record. |
| ZJ | PHN equals zero and province code equals zero or blanks. |
| ZK | A note record did not accompany correspondence code "N" or "B" or payee number does not match C02 record. |
| ZL | RCP province code is present and PHN not equal to zero. |
| ZM | Coverage good - batch eligibility. This code is used in Teleplan. |
| ZN | No coverage - batch eligibility. This code is used in Teleplan. |
| ZS | The referring doctor number has been changed to correspond with our records. |
| Z1 | Adjustment initiated by service verification audit. |
| Z8 | Unable to process IR1 or IR2 record, zero payments returned to ICBC. |
| Z9 | ICBC reversal request denied – MSP staff or data centre adjustment already created. |
| 0B | Provincial coverage limits payment to \$75 CDN for out-of-country MRI scans. |
| 1B | This fee item not valid for services provided in BC. Please resubmit with appropriate fee item. |

| Code | Description |
|-------------|--|
| 1W | WorkSafeBC claim submitted to WorkSafeBC on paper – WorkSafeBC adjusted keying fee deducted. |
| 2W | WorkSafeBC Claim - Invalid PHN |