BRITISH COLUMBIA | Ministry of Health

British Columbia
Professional and Software Conformance Standards

Application Requirements - Population Based Funding (PBF)

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Security Classification: Low Sensitivity

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1.0 Introduction

Note: This is a companion document which has been developed to provide additional context to the Teleplan appendices.

Medical claims are submitted for payment electronically by practitioners through the Medical Services Plan (MSP) Teleplan system.

The Population Based Funding (PBF) model has some additional requirements for Electronic Medical Record (EMR) or billing software applications beyond what is required for submitting Fee-for-Service (FFS) claims.

The revisions to the Teleplan specifications[1] which support the PBF model are detailed in the following appendices:

- Appendix C1: Technical Summary of Required Changes for Population-Based Funding (aka Primary Health Care)

  https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/appendix_c1.pdf

- Appendix C2: Population-Based Funding, Special Record Formats

  https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/appendix_c2.pdf

There are some PBF specific changes in field usage, record format for claims, and the capability to submit up to three diagnoses per claim must be provided. The most significant PBF specific requirements, however, are related to handling the patient register.

Note: The following application rules do not apply to healthNetBC Web Services (HNWeb). The intent is to use the Teleplan channel for information exchange – independently from HNWeb.

[1] Teleplan Electronic Medical Claims System: Inbound and Outbound Record Specifications, Version 4.4, August 2016 (https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/claim-submission-payment/teleplan)

1.1 Key to Document Terminology

The conformance standards in this document use a consistent language convention:

- Standards or rules using the words "must", "will", "minimum", or "mandatory" are a compulsory function or requirement. Conformance testing, service on-boarding activities and/or application testing will confirm that this standard is correctly implemented.

- Acronyms and abbreviations are used for repetitions of some system and organization names. The first time an acronym or abbreviation appears in the document it is accompanied by the full name.

1.2 Contact

For more information about these conformance standards, contact the Ministry of Health (MOH) Conformance and Integration Services at:

- HLTH.CISSupport@gov.bc.ca

1.3 Audience

This document is primarily intended for software vendors and organizations developing an interface to Teleplan for PBF purposes.

2.0 Population Based Funding - Application Requirements

The PBF funding model is dependent on four aspects:

1. Clinic is registered for PBF;
2. Physician is registered for PBF;
3. Patient is registered for PBF; and
4. Service is within the core/extended lists for PBF.

Payee Number

The Ministry will coordinate with Health Insurance BC (HIBC) to assign a new or existing payee number to each clinic using the PBF funding model (PBF clinic) and establish the payment authority for each practitioner with the PBF clinic.

PBF payee numbers will become effective as of the agreed date of transition for the clinic to begin submitting Teleplan data under the PBF model.

Ideally, all Teleplan records should be submitted with this new payee number for all patients seen by these practitioners. Although, there may be circumstances where a different payee number could be used (e.g., for patients not receiving primary care services).

Note: If utilizing an existing payee number for a PBF clinic, it will need to be changed by HIBC to payee status 'F'.

Payee Status

All claims include a payee status which determines how the claim will be processed[2]. Payee status 'F' is a designation for the PBF model only and allows for a patient register to be held at HIBC, and submission of $0 services.

Each PBF clinic will have one PBF payee designation of status 'F' for which the submission and register handling rules described below apply. The EMR may also be used to submit claims under other payees (such as personal payee numbers of individual practitioners). Claims under any other payees (usually designated payee status 'M') must be submitted as FFS (whether the patient is registered or not) in the same way as if the claims had been sent from a EMR not enabled for PBF. The PBF rules only apply to the primary (status 'F') payee of the clinic.

[2] This is internal to HIBC and not part of the claim submission.

2.1 General Requirements

Table 1 General Population Based Funding Requirements

Rule #	Rule Description
PBF1.1	**PBF Payee Number** All Teleplan claims for primary care services provided by PBF practitioners should be submitted with the clinic's payee number. *Note: A new clinic payee number may be assigned if it is not possible to switch from an existing payee number.*

2.2 Patient Register

The PBF local patient register, held in the EMR in parallel with the PBF HIBC patient register[3], is integral to the PBF payment model and claims processing. The register is an actively managed list of the patients for whom providers at the clinic are responsible (providing most of the primary care) and for whom the clinic receives remuneration under PBF. Physicians at the clinic are able to provide services to other patients (i.e., patients not on the register) on a FFS basis.

EMR software supporting the PBF model must implement a local patient register. In order to keep the local patient register and the HIBC patient register in sync, register changes that originate with the EMR must be communicated to HIBC using the registration and de-registration fee items. Also, changes to the register that originate at the MOH and are sent via HIBC remittance records must be reflected in the local patient register, unless overridden by the user.

Changes to the patient registry that originate at the MOH follow a monthly process schedule. On the 5th of each month, a set of pending registration action records will arrive within the daily HIBC remittance records.

Proposed patient registrations and de-registrations from the MOH are based on a review of patient visits (occurring both inside and outside the practice), patient eligibility, and address information.

Any proposed registrations and de-registrations (in the monthly list) will be applied to the HIBC patient register at the end of a 10-day review period, at end of day on the 15th of the month[4]. However, during the 10-day review period, any overrides by users at the clinic are applied to a pending register table at HIBC.

[3] Stored by HIBC and owned by the MOH.
[4] Changes take effect on the 16th of the month.

Table 2 Patient Register Requirements

Rule #	Rule Description
PBF2.1	**Local Patient Register** The EMR supporting the PBF model must implement a local patient register identifying patients for whom providers at the clinic receive remuneration under the PBF model.
PBF2.2	**Patient Register Discrepancy** If there is a discrepancy between the HIBC patient register and the local patient register, the HIBC patient register takes precedence. The local patient register must be updated to stay in sync (as closely as possible) with the HIBC patient register.
PBF2.3	**User Changes to Patient Register** When a user revises patient data in the local patient register, the revisions must be sent to the MOH using the registration and de-registration fee items (96090 and 96091 respectively) accompanied by structured N01 note records. *Note: If a user changes PBF patient registration information directly via HNWeb, the user also needs to update the local patient register to reflect* the *change.*
PBF2.4	**MOH Proposed Changes to Patient Register** Proposed changes to the register that originate at the MOH (and are not overridden by the user) must be reflected in the local patient register. *Note: These will come via specially formatted "PCO#R1" M01 remittance records.*
PBF2.5	**Patient Register Export** The EMR must have the ability to export/extract the current local patient register into an electronic file. *Note(s):* *1) The export facilitates comparison/reconciliation between the register information in the local EMR and at HIBC.* *2) The user will send this exported file to the MOH via a secure file transfer mechanism established with the MOH outside of the EMR.*

Rule #	Rule Description
PBF2.6	**Patient Register Export File Fields** At minimum, the exported patient register file must include: • patient PHN, • patient name, • patient sex, • patient birthdate, • patient registration date, • patient de-registration date (empty if currently registered), and • responsible provider practitioner number. *Note:* Registration *and de-registration date may not be required if the export file contains a snapshot of patients currently registered on a given date.*
PBF2.7	**Patient Registration and De-Registration** The user must have the ability to register a currently non-registered patient and de-register a registered patient. When a patient is: • registered by the user, the EMR must submit a special purpose registration claim record using the billed fee item 96090 and include the structured N01 note record. • de-registered by the user, the EMR must submit a de-registration claim record using the billed fee item 96091 and include the structured N01 note record. *Note(s):* *1) The special purpose claims are described in Teleplan specifications (Appendix C1 – 3.2 and 3.3).* *2) Submission of these special-purpose fee items keep the HIBC patient register in sync with the EMR.* a) *Changes to the patient register can be performed by the user at any time.*
PBF2.8	**User Override** The EMR must present proposed registrations and de-registrations originating from HIBC to the user and allow the option to override selected proposed registrations or de-registrations. *Note(s):* *1) A set of pending registration action records are sent to the EMR within the daily remittance records (via PCO#R1 M01 remittance records) on the 5th of each month.* *2) Proposed patient registrations and de-registrations from the MOH are based on a review of patient visits both inside and outside the practice, patient eligibility, and address information.*

Rule #	Rule Description
PBF2.9	**Override a Proposed Registration or De-registration** When the user chooses to override a proposed: • registration, the EMR must submit a registration override record with the special-purpose fee item 96092 and include the structured N01 note record. • de-registration, the EMR must submit a de-registration override record with the special-purpose fee item 96093 and include the structured N01 note record.
PBF2.10	**Apply Proposed Changes** The EMR must apply any proposed registrations and de-registrations to the local patient register that have not been overridden by the user on the 15th of the month (i.e., 10 days after receiving the proposed registration actions on the 5th of the month).
PBF2.11	**Apply User Initiated Changes** The EMR must apply all user-initiated registrations and de-registrations to the patient register on the day the action is performed whether or not it is within the 10 day pending register window.
PBF2.12	**Patient PBF Registration History** The EMR must maintain a history of PBF patient registration periods for each patient. The user must be able to view the PBF registration history for a patient and see the date range(s) of each time period for which the person was registered.
PBF2.13	**Override Usage** Registration override and de-registration override functionality must only be used within the 10-day window (5th to 15th of each month) in response to proposed registration changes (registrations and de-registrations) originating from HIBC. Overrides will apply as soon as they are entered by the user.
PBF2.14	**Patient Registration Refusals** When a refusal has been received within the daily remittance records for fee items 96090, 96091, 96092, or 96093 (i.e., registrations, de-registrations, registration overrides, and de-registration overrides to the patient register), the EMR must undo the action associated with the refused fee item in the local patient register. *Note: For example, if a user submits a registration for a patient and the EMR receives a refusal the next day within the daily remittance records, the EMR needs to keep the history of both the registration submission and the refusal from HIBC.*

Rule #	Rule Description
PBF2.15	**Change to PBF Provider for Registered Patients** Patients are registered to a clinic with a most responsible provider assigned. If it is necessary to change the most responsible provider for a patient, there are two options: <u>Option 1</u>: (preferred) • Send registration to new practitioner which generates both a registration and de-registration. <u>Option 2</u>: • Send both a de-registration and registration. • The effective date of the registration should be the date immediately following the date of de-registration.
PBF2.16	**Batch Registration Check Process Functionality** The POS application must provide the ability to check patient registration status using the Batch Eligibility Request Record (B04) which will generate the Batch Eligibility Request Reply (B14). In addition to the MSP eligibility status, the B14 will include PBF registration status which must be presented to the PBF clinic for review. *Note(s):* *1) This process will be completed nightly before any other claims submitted on the same day.* *2) This process checks the registration status on the date of service (which can be up to six months in the past, but not the future).* *3) MSP eligibility status is represented by three blanks if eligible.* *4) Other MSP eligibility status response codes can be found in the Teleplan manual.* *5) PBF registration status codes include:* *a) Blank = Patient Not Eligible (Note: PBF registration status will not be returned.)* *b) Y = Registered on the Date of Service* *c) N = Not Registered on the Date of Service* *d) O = Registered at Another Clinic* *e) R = Currently Not Registered and Pending Registration to the Clinic* *f) D = Currently Registered and Pending De-Registration from the Clinic*

2.3 Fee Items

There are two types of service fee items included in the PBF funding model:

1) core fee items, and
2) extended ($0) service items.

Core fee items are a subset of regular FFS fee items and may be submitted as FFS or as $0 items.

Extended ($0) service items are:

- additional and can only be submitted as $0 encounters;
- available for:
  - non-physician providers in the practice (except nurse practitioners[5]); and
  - physicians to record services for registered patients, particularly if those services are not represented within the normal FFS fee schedule.

Patient registration, de-registration, and overrides of proposed registrations and de-registrations are communicated via extended ($0) service items 96090, 96091, 96092, and 96093.

Note: Lists of these items are supplied by the MOH.

[5] Nurse practitioners have their own schedule of $0 encounter items.

Table 3 Fee Item Requirements

Rule #	Rule Description
PBF3.1	**Core Fee Items and Extended ($0) Service Items** The EMR must store and utilise the list of both core fee items and extended ($0) service items supplied by the MOH. The core fee item list and the patient register must be used during claims submission to determine whether claims are submitted as FFS or $0 encounter.
PBF3.2	**Update Lists** When updates to the core fee items and extended ($0) service items are received from the MOH, the stored lists must be updated to reflect the changes.
PBF3.3	**Historical Fee and Services** Updates to the stored lists of core fee list and extended ($0) service items must not change historical claim records.

2.4 Claim Submission

PBF clinics are paid FFS for services to all patients (registered or not) when the fee item is not included in the list of core services. FFS is paid for all services provided to non-registered patients. Core services provided to registered patients are not paid FFS and are processed as $0 encounters.

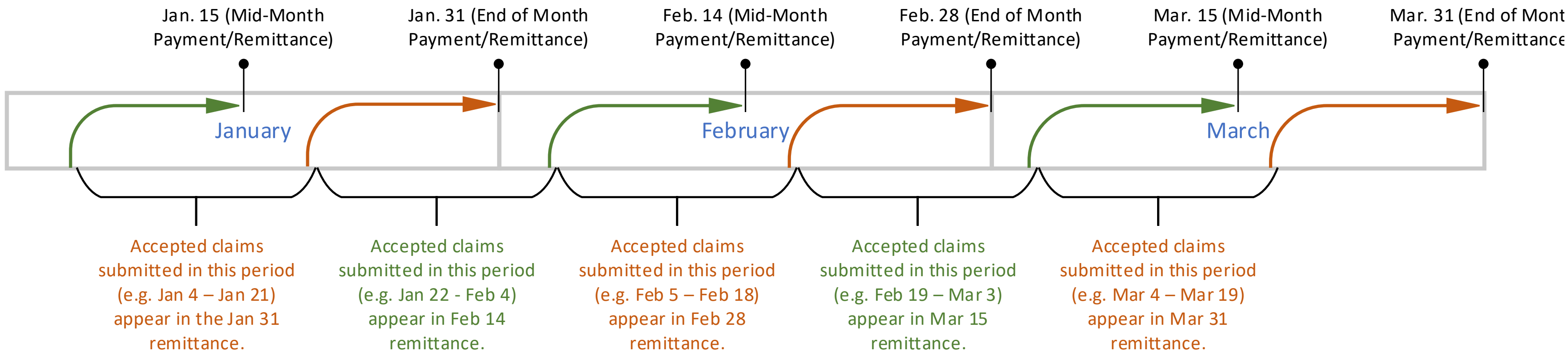
The patient register table and core fee item table at HIBC are used during claims processing to apply the above rules.

The EMR must also apply these rules when submitting claims, based on the list of core services and the HIBC patient register. HIBC will switch the claim between FFS and $0 encounter (or vice versa) if the patient register in the EMR does not match the HIBC patient register.

Between the 5th and 15th of the month, the pending register table is also referenced during HIBC overnight claims processing, and any proposed registrations that have not been overridden are considered as if they are in effect for the purpose of daily claims processing. That is, the claim will be converted from FFS to $0 encounter if there is a pending registration for the patient (that has not been overridden).

HIBC daily claims processing handles any submitted registrations, de-registrations, and registration and de-registration overrides (performed using fee items 96090, 96091, 96092, or 96093 respectively) prior to processing other claims submitted on the day. Thus, these actions can be considered as taking effect immediately.

Table 4 Claims Cycle and Timing of Remittance Records



Notes:

- *Accepted claims (including registrations, de-registrations, and overrides) will not appear in remittances until the next mid-month or end-of-month remittance batch. Subject to the “cut-off” dates for mid-month or end-of-month payment.*
- *Refused claims will be returned earlier within daily remittance records.*

Table 5 Claim Submission Requirements

Rule #	Rule Description
PBF4.1	**PBF Claims** The EMR must submit PBF claims to HIBC based on the patient's current registration status and type of core fee item or extended ($0) service item.
PBF4.2	**Registered Patient Non-Core Fee Items** Claims for non-core services (not in the core fee item list) provided to registered patients must be submitted as a FFS claim (i.e., payment mode = '0').
PBF4.3	**Registered Patient Core Fee Claims** Claims for core services provided to registered patients must be submitted as: • billed amount = $0, and • payment mode = 'E'.
PBF4.4	**Non-PBF Patients** Claims for services provided to non-registered patients must be submitted using a FFS claim (i.e., payment mode '0').
PBF4.5	**Extended Service Claims** Claims for extended ($0) service items (applicable to registered patients only) must be submitted as: • billed amount = $0, and • payment mode 'E'.
PBF4.6	**Fee-for-Service Claims** Claims submitted under any non-PBF payee must be submitted as FFS (whether the patient is registered or not).
PBF4.7	**Multiple Diagnoses Per Claim** The EMR must be able to submit up to three diagnoses per claim.
PBF4.8	**ICD9 and ICD9-CM Codes** The EMR must be able to submit any valid ICD9 and ICD9-CM codes.
PBF4.9	**Facility ID** The EMR must submit the Facility ID on all FFS and encounter claims from a PBF clinic. When more than one Facility ID exists for a PBF clinic, the user must be able to select the appropriate Facility for each record to be submitted. *Note: Facility ID(s) for each clinic are established by the MOH.*

Rule #	Rule Description
PBF4.10	**Third-Party Insured Claims** Claims insured by third-parties (e.g., ICBC, WorkSafeBC, Out-of-Province Patients) must be submitted as FFS (i.e., payment mode = '0') whether or not the patient is registered for PBF.

3.0 Use Cases

3.1 Claim Submission Use Cases

The following use cases related to claims for registered and non-registered patients using either the PBF payee number or personal payee number with either a core fee item or FFS item.

Table 6 Claim Submission Use Cases

Scenario	EMR Registration Status	HIBC Registration Status	Payee Number	Service Claim	Submitted Claim	Expected Response from HIBC	Subsequent User Action Required?
Claim 1	Registered	Registered	Clinic PBF	Core	$0 Encounter	Accepted	None
Claim 2	Registered	Registered	Clinic PBF	Non-Core	FFS	Accepted	None
Claim 3	Registered	Non-Registered	Clinic PBF	Core	$0 Encounter	Switched to FFS	Correct EMR or HIBC patient register
Claim 4	Registered	Non-Registered	Clinic PBF	Non-Core	FFS	Accepted	None
Claim 5	Non-Registered	Registered	Clinic PBF	Core	FFS	Switched to $0 Encounter	Correct EMR or HIBC patient register
Claim 6	Non-Registered	Registered	Clinic PBF	Non-Core	FFS	Accepted	None
Claim 7	Non-Registered	Non-Registered	Clinic PBF	Core	FFS	Accepted	None
Claim 8	Non-Registered	Non-Registered	Clinic PBF	Non-Core	FFS	Accepted	None

Scenario	EMR Registration Status	HIBC Registration Status	Payee Number	Service Claim	Submitted Claim	Expected Response from HIBC	Subsequent User Action Required?
Claim 9	Registered	Registered	Personal Payee	Core	FFS	Accepted	None
Claim 10	Registered	Registered	Personal Payee	Non-Core	FFS	Accepted	None
Claim 11	Registered	Non-Registered	Personal Payee	Core	FFS	Accepted	None
Claim 12	Registered	Non-Registered	Personal Payee	Non-Core	FFS	Accepted	None
Claim 13	Non-Registered	Registered	Personal Payee	Core	FFS	Accepted	None
Claim 14	Non-Registered	Registered	Personal Payee	Non-Core	FFS	Accepted	None
Claim 15	Non-Registered	Non-Registered	Personal Payee	Core	FFS	Accepted	None
Claim 16	Non-Registered	Non-Registered	Personal Payee	Non-Core	FFS	Accepted	None
Claim 17	Registered	Registered	Personal Payee	Core	$0 Encounter	Refused	Either resubmit as FFS or $0 Encounter under PBF clinic payee
Claim 18	Registered	Registered	Clinic PBF	Non-Core	$0 Encounter	Refused	Re-submit non-core fee item as FFS

3.2 Patient Registration Use Cases

The following use cases related to patient registration may occur at any time during the month.

Table 7 Patient Registration Use Cases

#	Scenario	EMR Registration Status	HIBC Registration Status	Payee Number	User Action	EMR Submission to HIBC	Expected Response from HIBC	Subsequent User Action Required?
1.	Patient was registered and the user wants to de-register the patient.	Registered	Registered	Clinic PBF	De-Register	De-Register	Accepted - Change to Non-Registered in the HIBC (and local) register.	None
2.	Patient was unregistered and the user wants to register the patient.	Non-Registered	Non-Registered	Clinic PBF	Register	Register	Accepted - Change to Registered in the HIBC (and local) register.	None
3.	Patient was registered in the EMR, but the patient is not registered in the HIBC patient register. The user wants to de-register the patient in the EMR.	Registered	Non-Registered	Clinic PBF	De-Register	De-Register	Refused - Change to Non-Registered in local register (HIBC patient register was already correct)[6].	None

[6] It is appropriate that this is refused at HIBC, since the HIBC register is already in the desired state.

#	Scenario	EMR Registration Status	HIBC Registration Status	Payee Number	User Action	EMR Submission to HIBC	Expected Response from HIBC	Subsequent User Action Required?
4.	Patient was registered in the EMR, but the patient is not registered in the HIBC patient register. The user wants to register the patient in the HIBC patient register.	Registered	Non-Registered	Clinic PBF	Register	Register	Accepted - Change to Registered in the HIBC patient register (local is already correct).	None
5.	Patient was not registered in the EMR, but the patient is registered in the HIBC patient register. The user wants to register the patient in the EMR.	Non-Registered	Registered	Clinic PBF	Register	Register	Refused - Change to Registered in local register (HIBC patient register was already correct)[6].	None

#	Scenario	EMR Registration Status	HIBC Registration Status	Payee Number	User Action	EMR Submission to HIBC	Expected Response from HIBC	Subsequent User Action Required?
6.	Patient was not registered in the EMR, but the patient is registered in the HIBC patient register. The user wants to de-register the patient in the HIBC patient register.	Non-Registered	Registered	Clinic PBF	De-Register	De-Register	Accepted - Change to Non-Registered in the HIBC patient register (local is already correct).	None
7.	Patient is already registered in the EMR and at HIBC. The user wants to change the provider on the register for this patient.	Registered	Registered	Clinic PBF	Register	Register[7]	Accepted – The patient is de-registered and re-registered on the following day under a different provider.	None

[7] The EMR can send a registration claim (96090) for a registered patient, which will result in both de-registration and re-registration of the patient (to the indicated provider). It is also possible to accomplish this by submitting both a de-registration (96091) and registration (96090).

3.3 Monthly MOH Originated Registration Use Cases

The following use cases will occur from the 5th to the 15th of the month, which forms the monthly MOH originated proposed registration period. If the MOH proposed action (register or de-register) is not desired, the user will need to override the proposed registration status. Overrides must only occur within this time period.

Table 8 Monthly MOH Originated Registration Use Cases

#	Scenario	EMR Registration Status	HIBC Registration Status	MOH Proposed Registration Status	User Action	Expected Action from the EMR	Expected Response from HIBC	Subsequent User Action Required?
1.	Patient was not registered in EMR; MOH proposed registration. The user accepts the registration.	Non-Registered	Non-Registered	Registered	Accept Registration (either explicitly or by not overriding)	Submit no Teleplan claim. Register patient in local EMR (when overrides are finalized)	Accepted - Change to Registered in the HIBC patient register[8].	None
2.	Patient was not registered in EMR; MOH proposed registration. The user overrides the registration.	Non-Registered	Non-Registered	Registered	Override Registration	EMR submits an override of registration, and does not add patient to EMR register.	Patient remains unregistered[9].	None

[8] The HIBC register will be updated after the 15th of the month. Through to the 15th, pending registrations are referenced during HIBC claim processing; non-overridden proposed registrations have the same effect in claims processing as if permanent.
[9] On the day the override is received, the proposed (pending) registration will be removed at HIBC, leaving the patient off the register.

#	Scenario	EMR Registration Status	HIBC Registration Status	MOH Proposed Registration Status	User Action	Expected Action from the EMR	Expected Response from HIBC	Subsequent User Action Required?
3.	Patient was unregistered in EMR; MOH proposed de-registration, but the user wants to register the patient and overrides the de-registration.	Non-Registered	Registered	De-Registered	Override De-Registration	EMR submits an override of the de-registration.	Accepted - Patient will not be de-registered at HIBC. Patient continues to be in discrepancy between EMR and HIBC.	Correct discrepancy (register patient in EMR to match HIBC)
4.	Patient was unregistered in EMR; MOH proposed de-registration, and the user does not override the de-registration.	Non-Registered	Registered	De-Registered	Accept De-Registration (either explicitly or by not overriding)	Submit no Teleplan claim. No action required.	De-Register the patient (after the 15th).	None
5.	Patient was registered in EMR; MOH proposed registration, but the user wants to de-register the patient and overrides the registration.	Registered	Non-Registered	Registered	Override Registration	EMR submits an override of the registration.	Accepted - patient will not be registered at HIBC. Patient continues to be in discrepancy between EMR and HIBC.	Correct discrepancy (de-register patient in EMR to match HIBC)
6.	Patient was registered in EMR; MOH proposed registration, and the user accepts the registration.	Registered	Non-Registered	Registered	Accept Registration	Submit no Teleplan claim. No action required.	Register the patient (after the 15th).	None

#	Scenario	EMR Registration Status	HIBC Registration Status	MOH Proposed Registration Status	User Action	Expected Action from the EMR	Expected Response from HIBC	Subsequent User Action Required?
7.	Patient was registered in EMR; MOH proposed de-registration, and user accepts de-registration.	Registered	Registered	De-Registered	Accept De-Registration (either explicitly or by not overriding)	Submit no Teleplan claim. De-register patient in local EMR (when overrides are finalized)	De-Register the patient (after the 15^{th}).	None
8.	Patient was registered in EMR; MOH proposed de-registration, and user overrides de-registration.	Registered	Registered	De-Registered	Override De-Registration	EMR submits an override of the De-Registration, and patient remains Registered at the EMR.	Patient remains Registered[10].	None

[10] On the date the override is received via Teleplan, the pending de-registration will be removed, leaving the patient in registered status.

4.0 Glossary

Table 9 Glossary

Term	Definition
Adjusted Clinical Group (ACG)	A series of mutually exclusive health status categories which are defined by morbidity, age and sex as defined by the Johns Hopkins University ACG classification system.
Core Fee Item	Specific fee items representing the majority of primary care services included in the PBF model funding. These services are claimed as $0 encounters for registered patients (and FFS for non-registered patients).
Electronic Medical Record (EMR)	A computer-based, electronic patient medical record used by authorized healthcare professionals to access patient information in order to deliver healthcare services. Also known as an electronic heatlh record (EHR).
Extended ($0) Service Item	The set of parallel extended ($0) service items that provide the opportunity to record activities that may not map directly to the regular MSP fee schedule. Both physicians and non-physicians can utilize these items. Must be billed as $0 encounters and only for registered patients.
Fee-for-Service (FFS)	A method of payment for physicians based on a fee schedule that itemizes each service and provides a fee for each service rendered.
healthNetBC Web Services (HNWeb)	Health Authorities and health care providers or organizations who deliver health services may request access to online services through the MOH secure website (https://healthregistry.moh.hnet.bc.ca). Access requires MOH approval including the completion of an information sharing agreement for system and data use. *Note: PBF functionality will be retired from this service in the future.*
Local Patient Register	An active list of patients (stored within the EMR) for whom providers at the clinic are responsible (providing the majority of primary care) and for whom the clinic receives remuneration under the PBF model.
Non-Core Fee Item	Fee items that are not identified as core fee items and for which services are billed solely on a FFS basis for both registered and non-registered patients.

Term	Definition
Non-Registered Patients	Patients who receive services from a PBF clinic, but are not "registered". Services are provided on a FFS basis.
Patient Register	The record of registered patients (stored by HIBC). *Note: Refer to 'Local Patient Register' above for register contained within the EMR.*
Payee Status	The payee status determines how a claim will be processed. *Note: Payee status 'F' is for PBF only and allows a patient register to be stored at HIBC and for $0 service submission.*
PBF Clinic	A clinic or associated facility funded using the PBF model. *Note: There could be one clinic with multiple sites.*
Personal Payee	A payee number that belongs to an individual health care provider at a PBF clinic. Should only be used for situations when dealing with patients that are not registered to a clinic (e.g., providing shifts of hospital care).
Population Based Funding (PBF)	A funding model that uses the expected expenditure for core services to registered patients in a given period; largely based on the illness burden of patients and not the reimbursement of individual services rendered to those patients. The province-wide PBF envelope for core services for registered patients of a given PBF clinic is calculated on the basis of the: • Adjusted Clinical Group (ACG) category of each registered patient in the practice; • daily rate ("ACG-based rate") for core services in each ACG category; and • number of days each patient is registered in the practice.
Registered Patient	A patient that is registered to, and receives the majority of medical care at, a PBF clinic. *Note: A patient may only be registered at one PBF clinic at a time and should live in the related catchment area for the clinic.*