

## CHAPTER 2

### INBOUND RECORDS TO MSP

#### 2.1 TELEPLAN INBOUND RECORDS OVERVIEW

This chapter identifies the (ASCII) Teleplan record structure needed for medical office software to supply data that is to be transmitted to MSP using the Teleplan system. The section called Outbound Records defines the data that is available for Teleplan users from MSP.

##### 2.1.1 Inbound Record Types

There are four Inbound Record types which allow the sending of medical claims fees for services rendered, notations, and eligibility coverage requests.

###### 1. Batch Eligibility Request (B04)

Records data to determine if a subscriber's coverage is active – any number of requests can be sent with replies supplied overnight.

###### 2. MSP Claims Record (C02)

Records data that supports a Fee for Service or Encounter for Population Based Funding (PBF) sites, Alternative Payment Program (APP) and Nurse Practitioners.

###### 3. MSP Note Record (N01)

Records comments that support a claim being submitted (as required), by a structured PBF or Work Safe BC (WSBC) record.

###### 4. Vendor Submission Control Record (VS1)

Records data for MSP and vendors about the billing software being used to submit claims. This record is mandatory for all submissions to MSP of any Inbound Record type. It must be the first record of each submission. Any other VS1 records submitted at the time of submission will be ignored.

##### 2.1.2 Online Eligibility Requests

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

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

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

## 2.2 INBOUND RECORDS DESIGN WARNING!

The following items are crucial to the design and understanding of the records required for Teleplan processing.

### 2.2.1 Vendor Submission Control Record (VS1) – MANDATORY

This record is to be **the first record** in any submission to MSP. It identifies for MSP and vendors what sites are using valid versions of software and will allow proactive support by MSP and vendors to Teleplan sites. To accommodate high-volume sites, we have allowed for multiple VS1 records to be submitted within the same submission but only the first VS1 record is edited and captured per transmission.

Each time this record is submitted, the backend system will collect the information and update statistical reports.

**Note:**

Vendors, on request to Teleplan Support, can obtain a list of all data centres using their specific software. Teleplan support staff can provide the Data Centre Number, name, vendor name and number, last claims submitted date, and the vendor header information from the VS1 record.

### 2.2.2 Data Centre Sequence Number Rationale

The 'Data-Centre-Seqnum' is the primary link between Teleplan users and MSP. This field provides a unique key for MSP processes, should a subsequent file search be required. The 'Data-Centre-Seqnum' is to be sequentially assigned by the Data Centre's medical office software (incremented by 1) on each record in the submission, regardless of record type. In MSP's view, a unique record key is the combination of the Data Centre and Data Centre Sequence Number fields. See Sequence Number Failure section for detail rules.

There are seven digits in the Data Centre Sequence Number. Once the number reached 9999999, it can be continue with the sequence number 0000001 on the next submission record, and continue to increment by one for each subsequent record.

### 2.2.3 Office Folio Claim Number

MSP has provided an optional ability for a Data Centre to record their office (Folio) claim number as a memo item on each claim. This field will be returned on the outbound records for all claim and batch eligibility details. Currently, if the number is submitted as zeros, then MSP fills this field with the submitted data centre sequence number.

### 2.2.4 Maximum Transmission Volumes

The MSP Teleplan system has been designed to restrict Teleplan sites to a current maximum transmission of nine thousand (9,000) records at any one time. This does not prevent a site from transmitting numerous times a day. Except for large service bureaus, the majority of sites transmit under 500 claims a day.

**Note:**

This is to accommodate a system-wide database failure recovery, if it was to occur.

**Note:**

During an actual transmission, each record is edited for major failures. Normally no problems are detected and the contents of the submission are saved for processing.

**2.2.5 How to Indicate End of a Teleplan Record (CR & LF)**

**!!!!!! IMPORTANT !!!!!**

All Teleplan records are FIXED LENGTH and REQUIRE the CR (CARRIAGE RETURN) and LF (LINE FEED) values inserted after the end of each record. Although most Windows software programs do this automatically, please ensure your office billing software does this insertion.

**Example:** a full claim detail record including Reciprocal data is 424 characters but is 426 in actual length. Failure to provide the CR and LF values normally results in an aborted transmission with a failed transfer.

**Note:**

- PC Hexadecimal value of CR is 'OD' when viewed in a Windows Text Editor; it looks like a musical note.
- PC Hexadecimal value of LF is 'OA' when viewed in a Windows Text Editor; it looks like a small circle.

*Vendor software is tested using the Teleplan test system. New vendor software must be tested and verified by Teleplan. Only certified vendor software will be allowed to have production service providers as clients.*

**2.2.5.1 Quick way to view CR/LF Records**

Record codes like 'C02' for a claim detail having CR/LF values are displayed in the first three (3) positions of a screen line for each new record, not randomly across the screen.

Example: using Windows Notepad application software.

```
VS1.....record one.....>
C02..... record two .....>
.....
C02.....record three.....>
.....
```

But the following lines are wrong:

```
VS1.....>
... C02.....>
..... C02 .....> C02.....
```

**2.2.5.2 Detailed Data Elements List**

Sections 2.3, 2.4, and 2.5 describe in detail all field rules, conditions, and layout of each record's data element submitted to MSP.

### 2.3 BATCH ELIGIBILITY REQUEST RECORD LAYOUT (B04)

SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
P00	REC-CODE-IN	3	X(3)	<p>This field is to identify specific types of records inbound to the MSP System.</p> <p>'B04' is reserved for a Batch Eligibility Request Inbound Record for Registered Subscribers and their Dependents.</p>
P02	DATA-CENTRE-NUM	5	X(5)	<p>Unique Identifier of a submitting location (authorized Data Centre) for security and control. This could be a practitioner's office or a service bureau. Value is assigned by MSP – example: A1234 – 'A' represents an alpha character.</p>
P04	DATA-CENTRE-SEQNUM	7	9(7)	<p>A unique sequential number assigned (by each Data Centre) to each record before transmission to the MSP Host site. (Any record that is not sequentially higher than the last by 1 will cause transmission failure.) This number is the prime system Record Key between a Data Centre and MSP systems.</p> <ul style="list-style-type: none"> <li>- Numeric field</li> </ul>
P06	PAYEE-NUM	5	X(5)	<p>Valid MSP payee number.</p> <ul style="list-style-type: none"> <li>- Numeric or alphanumeric field</li> </ul>
P08	MSP-REGISTRATION :MSP PHN :MSP Identity (restricted use)	10	9(10)	<p>Personal Health Number uses a modulus 11 check digit. It is 10 digits long and starts with '9'.</p> <p>or</p> <p>MSP ID is 8 or 9 digits or less.</p> <ul style="list-style-type: none"> <li>- Leading positions must be left zero filled</li> <li>- Must be right justified</li> <li>- Modulus 10 check digit</li> </ul>
P10	DEPENDENT-NUM	2	9(2)	<p>Valid value required (00)</p> <ul style="list-style-type: none"> <li>- Always zeros if PHN is used</li> <li>- Dep 66 (Newborn) not valid for this eligibility request record</li> </ul>
	continued next page →			

2.3 (B04) continued →				
SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
P12	NAME-VERIFY	4	X(4)	First initial of the first name followed by first initial of second name (or blank), then followed by the first 2 characters of patient's surname.
P14	BIRTH-DATE	8	9(8)	<p>Patient's Birth date CCYYMMDD – example: December 25, 2004 is 20041225.</p> <ul style="list-style-type: none"> <li>- Supply zeros for DD if day is not known</li> <li>- Default is zeros only when patient's birth date is not known (00000000)</li> <li>- Numeric field</li> </ul>
P16	DATE-OF-SERVICE	8	9(8)	<p>This field sets the start date of a coverage request (format: CCYYMMDD - March 31, 2004 is 20040331). Patient's date of service normally current or a prior DOS.</p> <ul style="list-style-type: none"> <li>- Numeric field</li> <li>- Default is current date</li> </ul> <p><b>Note:</b></p> <ol style="list-style-type: none"> <li>1. Current DOS requests for active coverages will be set to a maximum of current plus 7 days' honour period. The actual claim ('C02' record) must be received by MSP within a 7-day period of the last SERVICE-VALID-DATE.</li> <li>2. DOS request for active coverages prior to current date are set to only that DOS. Claim must be received by MSP within 7 days after request date.</li> </ol>
P18	SEX	1	X(1)	<p>Patient's sex:</p> <ul style="list-style-type: none"> <li>- 'F' = Female</li> <li>- 'M' = Male</li> <li>- Default is blank</li> </ul>
continued next page →				

SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
2.3	<b>(B04) continued →</b>			
P20	PATIENT-STATUS-REQUEST	1	X(1)	Request to MSP for confirmation of additional patient coverage information. Current Codes: 'A' = MSP Covered Service 'E' = Request last Eye Exam Paid by MSP  - Default is a BLANK - Future codes will be announced in MSP newsletters and/or messages
P22	OFFICE-FOLIO-NUMBER	7	9(7)	Optional item to allow office to submit its own Folio (claim) number. MSP will return number as submitted. - Default is zeros - Numeric field  If zeros are submitted, returned value will be zero
P99	FILLER-B04-RCD	19	X(19)	Future - Default is blanks

'B04'	Element count: 13 Record size total: 80
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## 2.4 MSP CLAIM DETAIL RECORD LAYOUT (C02)

The following list contains the MSP Fee for Service detail claim record requirements. Medical office software must format data elements as indicated for providers to submit for processing claims to be paid by MSP. There are TWO parts of this claim record which make up a full record type 'C02'. First are the basic claim data fields, followed by a second part called Other Insurer for a continuation of additional data required to support claims for patients of other provinces (except Quebec), BC Institution patients, Pay Patient, Opted-Out submitters, and WSBC.

### 2.4.1 Basic portion of C02 - part 1 of 2

SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
P00	REC-CODE-IN	3	X(3)	This field identifies the specific type of Inbound record. - 'C02' for Claims
P02	DATA-CENTRE-NUM	5	X(5)	Unique identifier of submitting location (an authorized Data Centre) for security and control. This could be a practitioner's office, service bureau, Laboratory, Hospital, or Clinic. Value is assigned by MSP.
P04	DATA-CENTRE-SEQNUM	7	9(7)	A unique sequential number assigned to each record—regardless of record type—before transmission to the MSP Host site by each Data Centre. - Each Data Centre originally starts at 0000001 and then increments by 1 all records until they reach 9999999, at which time it must start again at 1. (Any record that is not sequentially higher by 1 than the last record will cause a transmission failure.) This number is the prime system Record Key match between a Data Centre and MSP Systems. - <u>Data Centre Number and Data Centre Sequence Number fields</u> together make a unique key for MSP.
P06	PAYEE-NUM	5	X(5)	Identifies the Payee for this claim.
P08	PRACTITIONER-NUM	5	X(5)	Identifies the Practitioner who has provided the service to the patient. - See PBF Appendix C1/C2 for specs to support more than 1 practitioner per claim
	continued next page →			

**2.4.1 Basic portion of C02 - part 1 of 2 cont...**

SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
P14	MSP-REGISTRATION :MSP PHN -Correctional ID	10	9(10)	<p>Key field to MSP Subscriber Registration Database (right justify). The PHN is issued for BC residents only.</p> <ul style="list-style-type: none"> <li>- PHN is 10 digits with a '9' always in first position (use Mod-11 Check Digit).</li> <li>- If the patient is MSP Correctional ID, enter the Correctional ID in this field.</li> </ul> <p><b>Note:</b> Override Rules when using Other Insurer Portion for these patients:</p> <ul style="list-style-type: none"> <li>- Always default to zeros for Other Insurers</li> <li>- If patient is a non-resident from a province with an Other Insurer agreement with MSP then insert zeros in this field</li> <li>- See Fields P100 - P122 at end of claim record.</li> <li>- If BC Institutional claim (00010000008), or</li> <li>- If BC Pay Patient Opted Out, or</li> <li>- If BC WSBC, then the same rules apply as reciprocal claims</li> </ul>
P16	NAME-VERIFY	4	X(4)	<p>2 initials or initial and space, followed by first 2 characters of patient's surname</p> <ul style="list-style-type: none"> <li>- Zeros if Other Insurer Claim, see P14</li> </ul>
P18	DEPENDENT-NUM	2	9(2)	<p>Valid value required; 00 or 66 for BC residents only</p> <ul style="list-style-type: none"> <li>- If PHN used in P14 field then Dependent number is zeros except for non-registered newborns where the value is '66'. Use Mother's PHN for claims (up to month of birth plus two months) until newborn is issued his/her own PHN.</li> <li>- Zeros if Other Insurer claim, see P14</li> </ul>
P20	BILLED-SRV-UNITS	3	9(3)	<p>Must be numeric, equal to or greater than 001</p>
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**2.4.1 Basic portion of C02 - part 1 of 2 cont...**

SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
P22	SERVICE CLARIFICATION CODE (SCC)	2	X(2)	<p>Fee Item Service Clarification Codes. As required, various SCC codes will be assigned by MSP to enhance claims processing:</p> <ul style="list-style-type: none"> <li>- Default is zeros or blanks</li> <li>- Used for Rural Retention Program Codes - contact MSP for list</li> </ul>
P23	MSP SERVICE ANATOMICAL AREA	2	X(2)	<p><b>FUTURE USE: TO BE ANNOUNCED</b></p> <p>Allows further identification to process or enhance Fee Item payment.</p> <ul style="list-style-type: none"> <li>- Default is zeros (00) or blanks ( ), otherwise left justify code as shown with 'BLANK' fill as needed.</li> </ul> <p>1) Examples of Anatomical Area Codes:</p> <ul style="list-style-type: none"> <li>'L' Left</li> <li>'R' Right</li> <li>'B' Bilateral</li> </ul>
P24	AFTER HOURS SERVICE INDICATOR	1	X(1)	<p>Extra to consultation or other visit, or to procedure if no consultation or other visit charged as per fee schedule. Codes are:</p> <ul style="list-style-type: none"> <li>'0' (<b>zero</b>) Default or blank ( )</li> <li>'E' Evening (call placed between 1800 and 2300 hours, service rendered between 1800 and 0800 hours)</li> <li>'N' Night (call placed and service rendered between 2300 and 0800 hours)</li> <li>'W' Saturday, Sunday, or Statutory Holiday (call placed between 0800 and 2300 hours)</li> </ul> <p><b>Note: Claim must state time called and time service rendered. MSP can issue new codes at any time.</b></p>
P25	NEW PROGRAM INDICATOR	2	X(2)	<p>MSP may issue new codes at any time. This field identifies new services such as Hep C.</p> <p>e.g.: 01 = Hepatitis C 02 = Screening Mammography</p> <p><b>Codes are: '00' (zeros) Default or blanks</b></p>
	continued next page →			

**2.4.1 Basic portion of C02 - part 1 of 2 cont...**

SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
P26	BILLED-FEE-ITEM	5	X(5)	Valid MSP Fee for Service item - Right justified with left zeros fill  <b>NOTE:</b> MSP may issue <b>alphanumeric</b> fee items codes in future.
P27	BILLED-AMOUNT	7	9(5)V99	Valid Fee for Service item Value from the MSP Fee Schedule multiplied by the BILLED-SRV_UNTS - Numeric field (\$234.67 is 0023467)
P28	PAYMENT-MODE	1	X(1)	MSP Alternative Payment Branch Options/ Population Based Funding, Nurse Practitioners <b>- '0' default for regular MSP Claims FFS Submission.</b> ===== <p>WARNING! USE 'E' VALUE ONLY WHEN THE PAYEE IS REGISTERED WITH MSP's ALTERNATIVE PAYMENT BRANCH, Population Based Funding (PBF), OR IS A NURSE PRACTITIONER FOR BILLING ENCOUNTER.</p> ===== - 'E' Payee submits service encounter record for recording by MSP with valid Fee Item code but a zero Billed Amount. MSP will process and return a payment amount of zero. All other normal edits apply.  Note: Under some situations the PBF system will convert 'E' claims to Paid as Fee for Service claims. Site then receives a paid amount > zero record on its remittance.
P30	SERVICE-DATE	8	9(8)	Date service was performed - Valid date less than or equal to submission date (CCYYMMDD)
P32	SERVICE-TO-DAY	2	9(2)	To identify the last day of hospital services in a month - Default is zeros

**2.4.1 Basic portion of C02 - part 1 of 2 cont...**

SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
P34	SUBMISSION-CODE	1	X(1)	<p>This code identifies type of submission for MSP Claims Processing purposes.</p> <p><b>Regular Codes</b> under 90 days:</p> <ul style="list-style-type: none"> <li>- '0' (zero) for normal submission</li> <li>- 'D' for Duplicate claim</li> <li>- 'E' for DEBIT REQUESTS</li> </ul> <p>A site may request MSP to debit a previously-submitted claim. The site need only submit the previous claim with a SUBMISSION code = 'E' and complete Field P64, Original-MSP-FILE-NUM.</p> <p><b>A Note record with reason must follow.</b></p> <ul style="list-style-type: none"> <li>- 'R' for Re-Submitted claim (optional)</li> </ul> <p><b>MANDATORY Codes for claims over MSP submission period of 90 days:</b>                      ALL MSP CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS. MSP recommends all submitters transmit current claims on a daily basis.</p> <ul style="list-style-type: none"> <li>- 'A': Requested Pre-approval claim in writing to MSP. This claim must match a pre-authorized record created by MSP claims staff.</li> <li>- 'C': Subscriber coverage problem; a Note record (N01) is required</li> <li>- 'I': ICBC claim—include ICBC Claim number if known and set MVA field indicator to 'Y'</li> <li>- 'W': Claim not accepted by Worker's Compensation Board</li> <li>- 'W': Claim determined to be WSBC's; you must submit as Insurer WC—see P100</li> <li>- 'X': Resubmitting of refused previous or partially-paid claim.</li> </ul>

continued next page →

**2.4.1 Basic portion of C02 - part 1 of 2 cont...**

SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
				A Note record (N01) with optional Original MSP File Number field is required.
P35	EXTENDED SUBMISSION CODE	1	X(1)	<b>FUTURE USE</b> - to be announced e.g.: A=Aged, D=Duplicates - Default is blank
P36	DIAGNOSTIC-CODE - 1	5	X(5)	Mandatory field - CURRENT USE is ICD9 codes - ICD9: left justify code and BLANK fill remaining spaces. DO NOT OMIT leading zeros, e.g., 010 is '010' - MSP minimal ICD9 submission code requirement is for the first 3 ICD9 characters followed by 2 blanks <u>or</u> - 4-character ICD9 followed by 1 blank <u>or</u> - Full 5-character ICD9 code  <b>Note:</b> only alphanumeric characters per ICD9 Book or MSP files are valid. ICD9 special characters like '.', '/', and '-' are invalid (example: V10.4 is V104, 102.51 is 10251, 0100 is '0100').
P37	DIAGNOSTIC CODE – 2	5	X(5)	<b>FUTURE USE for MSP</b> - to be announced - Optional for PBF use - If more than one diagnostic applies to this service, fill in the second diagnostic code - Default is blanks
P38	DIAGNOSTIC CODE – 3	5	X(5)	<b>FUTURE USE for MSP</b> - to be announced - Optional for PBF use - If more than two diagnostics apply to this service, fill in the third diagnostic code - Default is blanks
P39	DIAGNOSTIC EXPANSION	15	X(15)	<b>FUTURE USE</b> - Default is blanks
	continued next page →			

**2.4.1 Basic portion of C02 - part 1 of 2 cont...**

SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
P40	SERVICE-LOCATION-CD	1	X(1)	<p>To identify location of service - Mandatory field</p> <p>Current codes are:</p> <p>A – Practitioner’s Office – In Community (only available until September 30, 2021)</p> <p>B – Community Health Centre</p> <p>C – Residential Care/Assisted Living Residence</p> <p>D – Diagnostic Facility</p> <p>E – Hospital Emergency Room (unscheduled patient)</p> <p>F – Private medical/surgical facility</p> <p>G – Hospital, Day Care (surgery)</p> <p>I – Hospital Inpatient</p> <p>J – First Nations Primary Health Care Clinic</p> <p>K – Hybrid Primary Care Practice</p> <p>L – Longitudinal Primary Care Practice(e.g. GP family practice or PCN clinic)</p> <p>M – Mental Health Centre</p> <p>N – Health Care Practitioner Office (non-physician)</p> <p>P – Hospital Outpatient</p> <p>Q – Specialist Physician Office</p> <p>R – Patient’s private home</p> <p>T – Practitioner’s office, in publicly administered facility</p> <p>U – Urgent and Primary Care Centre</p> <p>V – Exclusive Virtual Care Clinic</p> <p>W – Walk-In Clinic</p> <p>Z – Other, e.g., accident site or in an ambulance</p> <p>MSP can allocate more codes as needed.</p>
P41	REF-PRACT-1-CD	1	X(1)	<p>Indicator that patient was referred BY or TO another practitioner, identified by P42</p> <p>- Code is a 'B' or 'T'</p> <p>- Default is zero</p>

P42	REF-PRACT-1	5	X(5)	First practitioner that patient is referred BY or TO; relates to P41 - Zeros or valid practitioner number
P44	REF-PRACT-2-CD	1	(X)1	Indicator that patient is referred BY or TO another practitioner, identified by P46 (second referral) - Code is a 'B' or 'T' - Default is zero
P46	REF-PRACT-2  continued next page →	5	X(5)	Second Practitioner that a patient is referred BY or TO; relates to P44 - Zeros or valid practitioner number - Default is zeros

### 2.4.1 Basic portion of C02 - part 1 of 2 cont...

SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
P47	TIME-CALL-RECVD-SRV	4	9(4)	<b>FUTURE USE</b> - Time a call was received by the service provider (HHMM, 24-hour
P48	SERVICE-TIME-START	4	9(4)	Required for emergency visits, called start time, or anaesthesia start time. MSP can require as policy demands (HHMM, 24-hour clock) - Default is zeros  <b>Note:</b> Provision of different times for identical claims can prevent refusal of these claims.
P50	SERVICE-TIME-FINISH	4	9(4)	Rendered/Finish service time (HHMM, 24-hour clock) - Default is zeros
P52	BIRTH-DATE	8	9(8)	Birth Date of unregistered NEWBORNS is mandatory (CCYYMMDD), optional for other patients - Default is zeros
P54	OFFICE-FOLIO-NUMBER	7	9(7)	Office Claim (Folio) number from Data Centre - Optional field - Default is zeros
P56	CORRESPONDENCE-CODE	1	X(1)	Indicates correspondence supports this claim - 'C' = paper correspondence following - 'N' = Note Record following this claim record (Ref. Record type N01) - 'B' = both - Default is zero  This code is not related to P58.
P58	CLAIM-SHORT-COMMENT	20	X(20)	For short explanatory comment - alternative is to use the Note (Record type N01) submission method which allows up to 400 characters to support narrative communication to MSP. <b>Use only this field or the Note record, not both.</b> - Default is blanks
	continued next page →			

**2.4.1 Basic portion of C02 - part 1 of 2 cont...**

SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
P60	MVA-CLAIM-CODE	1	X(1)	<p>Required to indicate if treatment was for an injury as a result of a motor vehicle accident (MVA)</p> <ul style="list-style-type: none"> <li>- 'Y' = Yes for MVA claim</li> <li>- Default is 'N' = Not MVA claim</li> </ul> <p><b>Note:</b> a zero is assumed to be an 'N'.</p>
P62	ICBC-CLAIM-NUM	8	X(8)	<p>Required for all ICBC MSP claims - See MOD-7 check digit section</p> <ul style="list-style-type: none"> <li>- Default is zeros <b>or</b></li> <li>- ICBC number (Xnnnnnnn)</li> </ul>
P64	ORIGINAL-MSP-FILE-NUM (DCN/DCS/DRM)	20	X(20)	<p>Used when this claim relates to a previously submitted claim for information or for MSP'S DEBIT REQUEST RECORD system's computer search of a previous submission to debit. This is a group data element and must contain the following three data elements:</p> <ul style="list-style-type: none"> <li>&gt; First is the DATA-CENTRE-NUM, i.e., of record to be Debited (example: A1234 – 'A' represents an alpha character)</li> <li>&gt; Second is the DATA-CENTRE-SEQNUM, i.e., of record to be Debited (example: 1234567)</li> <li>&gt; Third is the DATE-RECEIVED-MSP, i.e., of record to be Debited - date (CCYYMMDD) sent to MSP, zeros, or an approximate date (example: 20070628)</li> </ul> <ul style="list-style-type: none"> <li>- Default is zeros for non-use</li> </ul>
P70	FACILITY-NUM	5	X(5)	<p>Facility Number per MSP rules or PBF</p> <ul style="list-style-type: none"> <li>- Default is zeros</li> </ul>
P72	FACILITY-SUB-NUM	5	X(5)	<p>Referring Facility Number per MSP rules, optional for PBF</p> <ul style="list-style-type: none"> <li>- Default is zeros</li> </ul>
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**2.4.1 Basic portion of C02 - part 1 of 2 cont...**

SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
P80	FILLER-CLAIM-C02-RCD	58	X(58)	<p><b>Future use.</b> - Default is blanks</p> <p>This is the last field of the regular claim data record, part 1 of 2.</p>

**IMPORTANT!!! Please read the following.**

MSP recommends you submit a full record if you are unsure as to when to include or exclude the Other Insurer portion of the full claim record. The 'C02' Claim Record continues on the next page with additional required fields for the Other Insurer portion, part 2 of 2 of an MSP claim.

**NOTE:**

You can either BLANK FILL the remaining fields P100-P122 (next page) of the C02 claim record (data for the Other Insurer MSP Claims portion—Other Insurer Patients using BC practitioners) and write the record to the PC file OR write the record after the above field (P80).

SEE END OF 'C02' CLAIM RECORD PART 2 of 2 FOR FINAL RECORD LENGTH.

**2.4.2 Other Insurer Portion of Claim (C02) 2 of 2**

This Extended Portion of the MSP claim record is designed for Other Insurer Carriers as the patients are normally not on the MSP Registration databases or extra data is required to allow these services.

MSP Fee for Service Claims for patients from provinces having an Other Insurer agreement with BC (excluding Quebec) must be submitted using these fields in addition to the appropriate regular claim fields previously created.

This portion is also used to bill the Insurer type called BC Institutional Claims and—as approved by MSP—Pay Patient Opted Out and WSBC claims.

**2.4.3 'C02' part 2 of 2 (cont'd)**

SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
P100	OIN-INSURER-CODE	2	X(2)	<p>The Insurer with which a patient has medical coverage while receiving service from a BC practitioner in BC—the Province/Location of health provider of patient</p> <ul style="list-style-type: none"> <li>- Reciprocal Other Insurer Provincial Plan</li> </ul> <p>Valid Canadian Province codes are: <b>AB, SK, MB, ON, NB, NS, PE, NF/NL, NT, YT and NU</b></p> <ul style="list-style-type: none"> <li>- 'IN' = BC Institutional claim - <b>MSP can set limits for claims</b></li> <li>- 'PP' = <b>BC Pay Patient Opted Out</b>, Physician, Naturopath, Chiropractor, Massage Therapist, Podiatrist, Physiotherapist, Optometrist, Acupuncturist</li> </ul> <p><b>Note: Opted Out cannot bill for Institutional or Incarcerated claims.</b></p> <ul style="list-style-type: none"> <li>- 'WC' = Work Safe BC (WSBC) including BC Opted Out Pay Patient</li> </ul>

SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
	continued →			
P102	OIN-REGISTRATION- NUM	12	X(12)	<p><b>DESCRIPTION</b></p> <p>Registration number of patient</p> <ul style="list-style-type: none"> <li>- Right justified as each insurer has various lengths</li> <li>- Left zero filled, example: 000012345678</li> </ul> <p><b>Warning!!</b></p> <ol style="list-style-type: none"> <li>1. PROVINCIAL INSURER CODES:                             <ul style="list-style-type: none"> <li>- Must have 12 digits</li> </ul> </li> <li>2. BC PAY PATIENTS and WSBC CLAIMS:                             <ul style="list-style-type: none"> <li>- Must use the BC CareCard PHN number: '9nnnnnnnnn' in positions 1-10</li> <li>- Use zeros in positions 11-12 or '66' when mother's PHN is used for a newborn in Pay Patient claims</li> </ul> </li> <li>3. BC INSTITUTIONAL CLAIMS:                             <ul style="list-style-type: none"> <li>- Use a value '0010000008' in positions 1-10 of OIN number or zeros followed by the BC Institution number 'nn' itself</li> </ul> </li> </ol>
P104	OIN-BIRTHDATE	8	9(8)	<p>Birth date of patient receiving service</p> <ul style="list-style-type: none"> <li>- Mandatory numeric field (CCYYMMDD)</li> </ul> <p><b>Note: DD can be zeros if not known.</b></p>
P106	OIN-FIRST-NAME	12	X(12)	Full patient first name
P108	OIN-SECOND-NAME- INITIAL	1	X(1)	Second name, initial only or blank
P110	OIN-SURNAME	18	X(18)	Full patient surname
P112	OIN-SEX-CODE	1	X(1)	'M' or 'F'
P114	OIN-ADDRESS-1	25	X(25)	<p>Patient's home/legal address</p> <ol style="list-style-type: none"> <li>1. Mandatory for OIN insurer type patient, i.e., Reciprocal Provinces, Pay Patients, BC Institution patients</li> <li>2. For 'PP' Pay Patient claims, must be the LEGAL address for cheque to be sent to; ensure it starts on Address Line 1</li> </ol> <p><b>Note: Pay Patient Address-1 must be more than 5 (five) characters.</b></p>
	continued →			

SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
	<u>or</u> WSBC Date of Injury (8)			3. WSBC's Claims: Date of Injury field - Format is CCYYMMDD followed by blanks
P116	OIN-ADDRESS-2	25	X(25)	Patient's home address, line 2, or continuation of legal *address
	<u>or</u> WSBC Area of Injury (5) & Anatomical-Position (2)			WSBC provides table values - Area of Injury code is 'XXXXX', then Anatomical Position Code 'XX', followed by 'blanks'— example: '00110RP'
P118	OIN-ADDRESS-3	25	X(25)	Patient's home address, line 3, or continuation of legal * address
	<u>or</u> WSBC Nature of Injury (5)			WSBC provides table values - Nature of Injury code 'XXXXX' followed by blanks—example: '00200'
P120	OIN-ADDRESS-4	25	X(25)	Patient's home address, line 4 or continuation of legal * address
	<u>or</u> WSBC Claim Number (8)			WSBC Claim Number - Normally 'NNNNNNNN', no check digit - Provide as known, WSBC edits - Blanks fill remainder
P122	OIN-POSTAL-CODE	6	X(6)	Address' Canadian Postal Code - Format of 'ANANAN', example: 'V8W3C8' - Default is 'blanks' - Mandatory for Insurer Code 'PP' (Pay Patients) to complete address submitted - Blank fill if address not used, postal code not known for claims with an address, or not a Canadian address

**This identifies entire MSP claim record including the Other Insurer portion.**

'C02'	Element Count: 54
	Record Size Total: 424

## 2.5 NOTE RECORD LAYOUT (N01)

This record must follow in sequence the MSP claim that it supports. Allows a data centre to submit an electronic note to clarify reason for claim being submitted. Submission of a note can delay payment of a claim dependent on adjudication requirements and time required to manually review. Data centres should only submit this record where it is a requirement by MSP or an explanation is felt needed to prevent refusal of the claim. An alternative for comments 20 characters or less is to use field P58 of the Claim Record 'C02' called 'Claim-Short-Comment'.

**NOTE: WSBC Claims use this record for their WSBC Electronic Forms and PBF for their records.**

SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
P01	NOTE-BASIC-IN	25	X(25)	The first 25 characters of this Note record are as outlined in the Claim Record (see C02 record, fields P00-P08). First - REC-CODE-IN (3) must be 'N01' Second - DATA-CENTRE-NUM (5) Third - DATA-CENTRE-SEQNUM (7) Fourth - PAYEE-NUM (5) Fifth - PRACTITIONER-NUM (5)
P20	NOTE-DATA-TYPE	1	X(1)	Classification of note types - 'A' = Regular note - 'W' = WSBC Electronic Form - 'P' = PBF Note Additional note codes to be assigned as required.
P22	NOTE-DATA-LINE  or WSBC-NOTE-DATA-LINE (400) or PBF-NOTE-DATA-LINE (400)  *** <b>Warning!</b> *** Ensure that the claim field called 'CORRESPONDENCE-CODE' (P56) is coded as an 'N' or 'B'	40	X(400)	To allow narrative comments related to the preceding claim record - Left justified - Ensure BLANKS are in the positions not used  See WSBC for specific definitions and Appendix-B  See PBF for specific definitions and Appendix-C1 / C2  The MSP system can accommodate a maximum of 400 characters submitted per claim.

'N01'	Element Count: 3
	Record Size Total: 426

## 2.6 VENDOR SUBMISSION IDENTIFICATION RECORD (VS1) MANDATORY RECORD

The Vendor Submission Identification Record (VS1) must be submitted as the first record of every submission to MSP in order to validate and maintain support among Teleplan, its vendors, and sites. MSP can then provide feedback of sites to specific vendors upon request. Teleplan will only keep the last submitted VS1 record on file.

SEQ	DATA ELEMENT NAME	SIZE	TYPE	DESCRIPTION
P01	RECORD-CODE	3	X(3)	Always 'VS1' Vendor Submission Identification Record - Mandatory field
P02	DATA-CENTRE-NUMBER	5	X(5)	Teleplan Data Centre Number - MSP assigned. - Mandatory, example: Annnn ('A' represents an alpha character) or Vnnnn if a vendor site
P03	DATA-CENTRE-SEQUENCE	7	9(7)	Data Centre Submission Seq #, Normal MSP rules Mandatory, example: 0012345
P04	VENDORS-MSP-DC-NUMBR	5	X(5)	Vendor's Assigned Data Centre Number by MSP - Mandatory, example: V0001 - Vendor must be registered and approved by MSP
P05	VENDORS-SOFTWARE-NAME	25	X(25)	Software Name - Mandatory
P06	VENDORS-SOFTWARE-VERSION	10	X(10)	Software Version Number/release - Mandatory, example: V400.B 01
P07	VENDORS-SOFTWARE-INSTALLED-DATE	8	9(8)	Date of Installation (CCYYMMDD) - Mandatory, example: 20040628
P08	VENDORS-COMPANY-NAME	40	X(40)	Company Name registered with MSP - Mandatory
P09	VENDOR-CONTACT	15	X(15)	Contact Phone Number - Mandatory, example: (250) 123-4567
P10	VENDOR-CONTACT-NAME	25	X(25)	Contact Name - Optional, blank fill
P100	FILLER	57	X(57)	<b>Future Use.</b> Blanks.

'VS1'	Element Count: 11
	Record Size Total: 200



**NOTE:**

Fields P02 and P04 can be the same value when a vendor is testing its own site software, e.g., V1234 (Excellent Billings Vendor Site) testing V1234 (Vendor Assigned). For Production, the VS1 record would be the A5678 ('A' represents an alpha character) billing site using the V1234 software.