Primary Care Networks: Clinic Setup for Encounter Reporting

Most physicians within B.C. submit fee-for-service (FFS) claims to the Medical Services Plan (MSP) through Teleplan. The same process is used to submit encounter records for family physicians (FPs), nurse practitioners (NPs), and nurses hired under a primary care network (PCN), urgent and primary care centre (UPCC), community health centre (CHC), or First Nations primary care centre (FNPCC). Before practitioners can submit encounter records, they will typically connect their MSP billing number to a clinic payee number. The following guide provides step-by-step instructions on how to do this.

First, practitioners will need to apply for an MSP billing number, if they don't already have one (Step 1). Next, practitioners will complete an **Assignment of Payment** form (FP) or an **Encounter Record Submission Authorization** form (NP/RN/licenced practical nurse (LPN)) for each of the primary care sites where they provide care. For detailed instructions about how to connect a practitioner's billing number to the clinic payee number, including a link to each of the forms above, please see Step 2.

Practitioners will generally assign their encounters through a shared payee number for the primary care site. Health authority primary care liaisons/contract managers are directed to contact their health authority's medical affairs team to request ministry-issued Y-status payee numbers for any site within where PCN-funded practitioners provide services. Ministry-issued Y-status payee numbers are required to encounter report only where no shared payee number currently exists. For specific instructions on the Y-status payee setup process, please see the document titled *Agency*[1] *Instructions for Creating Y-Status Payee Numbers,* included below in Appendix 1.

Physicians on the New to Practice (NTP) Contract can assign encounters to a Y-status payee but must bill any FFS work they undertake outside the contract to a separate payee.

Physicians on the Group Contract for Practicing Full Service Family Physician (PFP) require a shared M-status payee for their clinic work. Separate reporting instructions have been created for the PFP contract which should be referenced instead of this document. Please contact your health authority's medical affairs department for support.

STEP 1: REGISTER THE PRACTITIONER IN THE MEDICAL SERVICES PLAN

To register with the MSP, the practitioner requires a MSP billing number (also known as a *practitioner number)*. A billing number denotes the person providing the service and is required for an encounter record submission through the Teleplan system. FPs who have received an MSP billing number as part of the licensing process can skip this step.

[1] "Agency" means a Health Authority and any other public agency funded by the Government and, in the context of an Alternative Payment Arrangement where the Government is a party, includes the Government.

If the practitioner does not have an MSP billing number, they must complete the appropriate *Application for Billing Number* Form below.

Health provider	Form Description
Physicians	Application for MSP Billing Number (Form #2991) https://www2.gov.bc.ca/assets/gov/health/forms/2991fil.pdf
Nurse Practitioners, Registered Nurses and Licensed Practical Nurses	Application for Billing Number (Form #2997) http://www2.gov.bc.ca/assets/gov/health/forms/2997fil.pdf

STEP 2: CONNECT THE PRACTITIONER'S BILLING NUMBER TO THE CLINIC PAYEE NUMBER

To connect the MSP billing number to a shared clinic payee number, the physician must complete an **Assignment of Payment** form and NP/RN/LPNs must submit an **Encounter Record Submission Authorization Form**. The practitioner will then submit the form to their health authority primary care liaison, contract manager, or directly to HIBC.

Health authority and/or division PCN staff who are assisting practitioners with this process should ensure both forms are completed and processed successfully by HIBC before the practitioner begins submitting encounter records.

Health provider	Form Description
Physicians	Assignment of Payment (Form #2875) https://www2.gov.bc.ca/assets/gov/health/forms/2875fil.pdf
Nurse Practitioners, Registered Nurses and Licensed Practice Nurses	Encounter Record Submission Authorization (Form #2871) http://www2.gov.bc.ca/assets/gov/health/forms/2871fil.pdf

Note:

- If the site or clinic where the practitioner is providing services **already has** a shared clinic payee number, this number can be specified as the "assignee payment number" or "site payee" in the linked forms above.
- However, if the site or clinic **does not have** a shared clinic payee number, and no lead physician is available, health authority and/or division PCN staff should follow the process for requesting a new Y-status payee number outlined in *Appendix 1* below. Once this process is complete, practitioners should complete Step 2 as outlined above.
- If the practitioner provides care at multiple sites, they must complete and submit the applicable form for each site.
- For HIBC practitioner assistance and inquiries, contact 1-866-456-6950 or go to www.hibc.gov.bc.ca

TIPS FOR ENCOUNTER REPORTING

Note: this section is intended for medical office assistants (MOAs), billing agents, or other professionals who directly support billing/encounter record submission processes.

PCN practitioners use the following encounter code sets:

- FP: New Simplified FP Encounter Code Set[2]
- NP: New Simplified NP Encounter Code Set[3]
- RN/LPN: RN/LPN Encounter Code Set

1. Encounter records must be submitted in the format approved for electronic submission through Teleplan. All encounter record submissions must include the following information, unless otherwise stated:

FP/NP	RN/LPN
• Payee number (clinic payee number) • MSP billing number (of the practitioner) • Patient's personal health number (PHN) • Date of service(s) • Encounter code(s) • International Classification of Disease (ICD)-9 diagnostic codes (1 mandatory, 3 max) • Location code • Note • Referring/referred practitioner number (if the FP/NP is referring patient to or receiving a referral from another practitioner)	• Payee number (clinic payee number) • MSP billing number (of the practitioner) • Patient's PHN • Date of service(s) • Encounter code(s) • Start time (counselling/education codes only) • End time (counselling/education codes only) • ICD-9 diagnostic codes • Location code

2. Pursuant to the Medicare Protection Act and the Medical and Health Care Services Regulation, encounters must be submitted within 90 days of the date of service.
3. For the list of ICD9 Codes please refer to: http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/physicians/diagnostic-code-descriptions-icd-9.

NOTIFICATION OF ENCOUNTER RECORD ACCEPTANCE RETURN (REMITTANCE STATEMENT) OR NOTIFICATION OF CLAIM ADJUSTMENT/RETURN

Every clinic that bills FFS, or submits encounter records, receives a remittance statement twice per month from HIBC. In FFS, the remittance statement shows what claims have been accepted and paid to the MSP payee number as well as what claims have been refused. Refusals can happen for a number of reasons, some of which are discussed below.

https://www.pcnbc.ca/en/pcn/permalink/pcn93

[3] https://www.pcnbc.ca/en/pcn/permalink/pcn117

For clinics that submit encounter records, the remittance statement documents accepted encounter records and refused encounter records (called returned records). If an encounter record has been returned, a code is provided to explain why a particular encounter record was refused. Reasons for encounter record refusal may include:

- a claim is submitted more than 90 days past the date-of-service;
- a claim duplicates or overlaps a previous claim for the same service;
- a claim is not accurate; for example, it contains an incorrect PHN or encounter code number;
- HIBC did not receive and/or process the form (Encounter Record Submission Authorization) to connect the nurse's billing number to the payment/payee number.

If, after reading the remittance statement Notification of Claim Adjustment/Return, a clinic is still uncertain why an encounter record has been refused or what is required before resubmitting it, contact HI**BC** by calling toll free: 1 866-456-6950 or from Vancouver: 405 456-6950.

LOCATION CODES AND DESCRIPTORS

A Service Location Code is a field within each encounter record or FFS claim which identifies the location a service was provided (such as the practitioner's office or the hospital). Effective April 1, 2021, the practitioner Service Location Code A (Practitioner's Office) was replaced with new codes. The new codes allow the Ministry of Health to collect data related to service locations in greater detail. The new location codes are:

(B) Community Health Centre

(J) First Nations Primary Health Care Clinic

(K) Hybrid Primary Care Practice (e.g., part-time longitudinal practice, part-time walk-in clinic)

(L) Longitudinal Primary Care Practice (e.g., GP family practice or PCN clinic)

(N) Health Care Practitioner Office (non-physician)

(Q) Specialist Physician Office

(U) Urgent and Primary Care Centre

(V) Virtual Care Clinic

(W) Walk-In Clinic

The change will be phased in over a six-month period, ending September 30, 2021. Practitioners using Service Location Code A are encouraged to use the new codes starting April 1, 2021; however, it will continue to be valid from April 1, 2021 to September 30, 2021. Claims submitted with Service Location Code A for services provided after September 30, 2021 will be refused.

For more detailed information please refer to the article on the government website: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/claim-submission-payment

(B) Community Health Centre
Inter-professional primary care that integrates services/programs in primary care, health promotion and community well-being including primary care services as well as a broader range of social supports.

(C) Residential Care/Assisted Living Residence
Service is provided to a patient in a licensed residential care facility or registered assisted living residence. (Note: Excludes small "group homes" where no professional health care support/care is available and includes extended care facility within a hospital.)

(E) Hospital – Emergency Room (Unscheduled Patient)
Service is provided in a hospital emergency department for a patient who presents for emergent or urgent treatment. (Note: Excludes hospital outpatients who receive services on a scheduled basis within an emergency department – see Hospital Outpatient)

(I) Hospital Inpatient
Service is provided for a patient who is an inpatient of a hospital. (Note: Excludes patients located within a designated "extended care unit" within a hospital – see Residential Care/Assisted Living Residence.)

(J) First Nations Primary Health Care Clinic
Provides inter-professional-based continuum of care that integrates health services, disease prevention and management, population health promotion, traditional and mental wellness, and social determinants of health, as well as embodies attributes of cultural safety and humility, trauma-informed care, and integration to first nations communities.

(K) Hybrid Primary Care Practice (part-time longitudinal practice, part-time walk-in clinic)
Part-time longitudinal primary care practice, part-time walk-in clinic (see definitions below).

(L) Longitudinal Primary Care Practice (e.g., GP family practice or PCN clinic)
A Family Physician, group of Family Physicians, or group of primary care providers (FPs and NPs), practicing in a private longitudinal primary care practice (e.g. Patient Medical Home).

(N) Health Care Practitioner Office (non-physician)
An office where Health Care Practitioners other than physicians, e.g. Nurse Practitioners, are providing primary care.

(P) Hospital – Outpatient
Service is provided in outpatient and/or ambulatory clinics where outpatients receive scheduled services including emergency department, or any other hospital setting where outpatients receive services. (Note: Excludes day care surgical patients)

(Q) Specialist Physician Office
A specialist physician office.

(G) Hospital – Day Care Surgery
Service is provided within a hospital to a patient who is a day care surgery patient. (Note: Includes all patients who are in hospital on a day care basis primarily to receive a "procedure". Excludes scheduled services - see Hospital – Outpatient)

(F) Private Medical / Surgical Facility
Service is provided within a private medical/surgical facility accredited by the College of Physicians and Surgeons of BC.

(R) Patient's Private Home
Service is provided in a patient's own home. (Note: Includes service provided in a "group homes" where on-site nursing or other health professional support care is not provided, but excludes assisted living residences and other residential facilities – see Residential Care/Assisted Living Residence)

(T) Practitioner's Office – In Publicly Administered Facility
Service is provided in a practitioner's office located within a publicly administered health care facility (e.g., Hospital, Primary Care Centre/Clinic, D&T Centre, etc.)

(U) Urgent and Primary Care Centre
Provides longitudinal full-service primary care and attachment in addition to meeting the episodic urgent primary care needs for both attached and unattached patients.

(V) Virtual Care Clinic
Exclusive method of delivering health care diagnosis and treatment services is via virtual care. Does not include other clinics or centers where virtual care is provided in addition to in-person care (e.g. a Longitudinal Primary Care Practice offering virtual care services would not use V).

(W) Walk-In Clinic
Provides same day, non-emergency Family Physician care without an appointment.

(D) Diagnostic Facility
Service is provided in a facility that primarily/exclusively provides diagnostic testing and has been granted a Medical Services Commission Certificate of Approval. (Note: Excludes diagnostic tests provided in practitioner's office. Also excludes diagnostic services provided in/by hospital and/or D&T centre facilities)

(M) Mental Health Centre
Service is provided in a publicly administered mental health centre to an outpatient. (Note: Excludes mental health facilities that are primarily residential in nature – see Residential Care/Assisted Living, includes CRESST Facilities.

(Z) Other (e.g., accident site, etc.)
Service is provided in any other location such as a temporary community or school clinic, ambulance, accident site etc.

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APPENDIX 1
Agency Instructions for Creating Y-Status Payee Numbers

Agencies that hire or contract health professionals to deliver services that require encounter reporting must report to Teleplan through a Y-Status Payee number. This document explains how Y-status payee numbers are provided to contracting agencies for encounter reporting purposes.

1. Contact the Compensation Analyst at the Alternative Payments Program (APP) in the Ministry of Health that is assigned to your agency.

To receive a Y-status payee number, contact the Alternative Payments Program compensation analyst at the Ministry of Health assigned to your agency. If you do not have this contact information, your agency's medical affairs department or equivalent will be able to provide you with it.

When contacting APP staff to set up a payee, please provide a description of:

- Which professions are being hired that require encounter reporting
- What services are being provided
- When the hired employee / contractor will begin delivering services
- Where the contracted services will be delivered

Requests for new Y-Status Payees should only be made by agency employees via APP. **Y-status payee requests should not be made directly to HIBC by agencies, care providers or billing agents**.

2. Agency receives payee information and associated forms from APP Compensation Analyst

Upon receiving a request for a new Y-Status Payee number, the APP compensation analyst assigned to your agency will compare your request to all existing Y-Status Payee numbers to determine if an existing payee can support encounter reporting at the site. If no suitable existing Y-Status Payee numbers are found, the analyst will contact HIBC and request that a new Y-Status Payee number be reserved for the agency. The analyst will then send this new number and a copy of each of the following forms to you, the agency:

- Form HLTH 2875 Assignment of Payment (for Physicians)
- Form HLTH 2871 Encounter Record Submission Authorization for Non-Physician Providers
- Form HLTH 2876 Application for Additional Payment Number

3. Agency works with care providers to complete forms

Once the health authority has received the new payee number and the required forms, they should then work with the care providers who will be assigning encounters to the new payee to ensure they complete the forms. Please refer to the following guidelines when completing the forms.

1. Form HLTH 2875 Assignment of Payment.
    a) Each physician who will be assigning encounters to the new payee must complete a copy of Form 2875.
    b) Each nurse practitioner, registered nurse, and licensed practical nurse who will be assigning encounters to the new payee must complete a copy of Form 2871.
    c) An assignment cannot be for a period of longer than five years.
2. Form HLTH 2876 Application for Additional Payment Number.
    a) For payees where the care providers will be submitting $0 encounters only and where no single provider under the payee can be considered the most responsible physician (MRP), Section E can be signed by the contract manager at the health authority.
    b) For Y-status payees where a payment is generated out of Teleplan (e.g. fee for service top-up) the MRP **must** be a care provider who is also assigned to that payee.

4. Health authority sends completed forms to HIBC

Once the forms are completed, the health authority collects the forms and scans and emails or faxes them to HIBC at: 250-405-3592 or provider.program@hibc.gov.bc.ca.

5. HIBC activates the new payee number

Upon receiving the forms, HIBC will activate the new Y-Status Payee in Teleplan and assign the signatory care providers. At this point the payee will become **Active** and can have billings and/or encounters submitted under it.

- Once a new payee is set up, a confirmation letter is sent by mail to the address on the application. If a site would like to confirm before the letter arrives, they can contact HIBC by phone.
- HIBC will contact the site if there is an issue with the Assignment of Payment (AOP). If the site would like to confirm that the AOP has been process, they can contact HIBC by phone two to three days after sending the AOP in and HIBC can give verbal confirmation.

6. (ONGOING) As contracted care providers enter / leave the program

When new care providers are hired to provide services for the program, they must sign an Assignment of Billing form (2875 or 2871) in order to submit encounter reporting under the program's Y-Status Payee number. The agency should provide the care provider a copy of form 2875 and ensure it is submitted to HIBC prior to their contract's start date.