Module 1: Claims Processing

1.1 Claims Processing System
1.2 Interpreting Remittance Statements

1.1 Claims Processing System

Teleplan

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

Introduction to Teleplan

MSP's Teleplan Web Access, (version 4.2.6), provides a means for you to send and receive your claims-related files securely across the Internet. MSP's Teleplan Web Access application assists practitioners to send their claims to MSP's mainframe (host) computer in a machine-readable format. MSP's Teleplan Web Access v4.2.6. does not replace the billing software supplied by your vendor.

Teleplan Claims Submission and Processing

Teleplan is a telecommunications system which allows practitioners to securely submit claims, notes, retrieve remittance information and check patient eligibility over an encrypted Internet connection from MSP. The system is built to industry standards for secure Internet communications (like that used for online banking transactions). Teleplan receives and processes over 8 million claims monthly. Approximately 98.9% of all claims are processed within 30 days, with the majority being paid within 14 days. Processing times depend on the timing of the submissions and the complexity of the claims. Payments are made at the middle and end of each month, either by electronic funds transfer or by cheque.

Teleplan Support Centre

The Teleplan Support Centre handles questions about Teleplan, the Claims Processing System and Teleplan Specifications including:

- electronic billing problems
- electronic remittance statements and refusals
- MSP-practitioner-vendor liaison
- "zapping" claims submitted with incorrect data
- resetting revoked passwords, and
- hardware and software problems.

Zapping Erroneous Submissions

If you discover that your Teleplan submission contains incorrect billings, you can arrange to have the submission returned to you for correction before it is processed if you notify the Teleplan Support Centre by 4:30 pm on the same business day that you made the submission.

The entire submission will be "zapped" and returned the next day with the explanatory code **FC**. You can correct and re-submit the claims immediately.

If you discover an incorrect submission after the transmission day but before MSP closes off a claims period to process payments, you may still contact the Teleplan Support Centre for assistance.

You will be asked to identify the specific claims by Data Centre, Payee Number, and Sequence Number. These records will then be rejected, but will not be returned until after MSP has issued your next remittance statement. Again, the explanatory code **FC** will be used for the returned claims.

Teleplan Support Centre

Vancouver:	**604 456-6950**
Toll-free:	**1 866 456-6950**

Claims Processing System

The Claims Processing System processes approximately 98.9% of all claims within 30 days, with the majority being paid within 14 days. Processing times depend on the timing of the submissions and the complexity of the claims.

Payments are made at the middle and end of each month, either by electronic funds transfer or by cheque.

Claims processing involves four major sequential components.

Step 1: Pre-Edit

This component, which runs nightly against electronic claims, performs the following tasks for each claim:

- Verifies the billing number to ensure that it is approved for that site.
- Checks all fields to ensure that values have been submitted in the correct format and with valid codes (*e.g.*, valid PHN, valid fee items).
- Checks mandatory fields to ensure that they contain data.
- Refuses the claim if it does not meet these data requirements.
- Codes the refused claim to indicate the refusal reason and returns it to the submitter electronically.

Step 2: Eligibility Edit

This component, which runs nightly against claims, performs the following tasks for each claim:

- Verifies the match between the PHN and the patient name.
- Verifies that the amount billed is consistent with the fee item.
- Verifies that the physician is authorized to bill for the service.
- Refuses the claim if it does not meet these data requirements.
- Returns erroneous electronic claims to the submitter for re-submission.

Step 3: Adjudication

This component, which runs twice monthly, uses approximately 2,700 automated payment rules in assessing claims:

- Verifies billings of physicians that are dependent on other physician claims (*e.g.*, surgical billing matches for anesthetic and/or surgical assistant claims).
- Provides electronic explanatory codes for downgraded or refused claims.

Fewer than 1.1% of claims are adjudicated manually.

Step 4: Payment and Remittance

This component, which runs twice monthly, performs the following tasks with each run:

- Processes over 4 million claims from 12,000 practitioners.
- Processes all third-party and audit-recovery items.
- Handles adjustments that may be applied to gross payments, including retroactive payments, interest, and HST charges.
- Approximately four days prior to remittance date, sends electronic remittance statements to submitters, advising of payments to be made on the remittance date.

This component also contains the Broadcast Message program.

1.2 Interpreting Remittance Statements

The remittance statement is a record of a physician's paid claims and adjustments for a given payment period. Payment and remittance statements are issued at the middle and end of each month.

The remittance statement displays the total gross and net amounts billed and paid for each payment, and shows adjustments such as interest payments and the Rural Retention Premium.

If you bill **electronically**, your remittance statement is transmitted to you electronically. The statement layout varies, depending on the billing software you use. If you wish to receive printed copies of your remittance statements on an on-going basis, you can arrange to have Provider Accounts mail them to you for 4 cents per service line.

Billing by Forms

Practitioners who submit claims for fewer than 2,400 services per year and earn less than $72,000 annually in fee-for-service payments (who do not submit to MSP via TelePlan) may now submit claims online free of charge with the Pay Practitioner and Pay Patient Claim forms available at: www.hibc.gov.bc.ca.

After September 30, 2012 Claim Cards or Claim Forms submitted by mail will no longer be processed except for the claim types listed below.

The following claim types are permitted exemptions and claims may be submitted by mail using the downloadable "Fill, Print and Mail" format:

- Pay patient claims for opted-out practitioners
- Correctional facilities claims
- Dental claims
- Reciprocal claims
- Claims for patients covered under the Critical Care Coverage Program

If a practitioner can demonstrate that they reside in a community without Internet access or that obtaining Internet access will cause significant financial hardship, they can submit their claims via mail using a Claim Form. Practitioners must request an exemption in writing demonstrating that obtaining Internet access will cause significant hardship. Requests for an exemption should be sent to Health Insurance BC.

1. Online Submission Form:

To submit medical and health care service claims.

Link to Pay Practitioner Claim Form:
https://www.health.gov.bc.ca/msp/forms/hlth1915/intro.health

2. Fill, Print and Mail Forms:

To submit medical and health care service claims. After September 30, 2012, this Claim Form will no longer be processed if submitted by mail.

Link to Pay Practitioner Claim Form:

https://www.health.gov.bc.ca/exforms/mspprac/1915fil.pdf

Re-Submitting Claim for Reassessment of Payment

If you disagree with how MSP has paid a claim, the most effective way to have the claim reassessed is to re-submit the claim with a note record indicating that you are requesting a reassessment and including a brief explanation.

Example:

Fee Item (FI) 13611 billed at 100% for laceration on arm and 00100 is billed at 50% with diagnostic code 780 (general symptoms) - patient was seen for migraine headache.

The 13611 is paid and the 00100 is refused with explanatory code "KB" in accordance with Preamble D. 8. d. Diagnostic code 780 is too vague to determine if there are two unrelated medical conditions.

FI 00100 at 50% is rebilled with diagnostic code 346 (migraine). This is paid because now it is clear that there are two unrelated conditions.

If you are still dissatisfied with the outcome after re-submitting the claim, advise Practitioner and Patient Claims Support by phone or fax.

MSP is committed to ensuring timely and accurate payment of claims, although inadvertent errors do occur from time to time because of the volume and complexity of claims submitted. If you are routinely re-submitting a certain type or combination of claims because of incorrect payment, advise the Practitioner and Patient Claims Support Supervisor.

Payment Dispute Process

1. If a physician disagrees with payment of a claim by MSP, **the physician re-submits the claim to MSP** with a note record explaining the details (as indicated above) and additional information as appropriate.

   If paper correspondence related to the re-submission is being submitted, "correspondence sent" should be indicated in the claim comment field.

   The claim is then reviewed by one or more of MSP's medical or surgical advisors.

   If the claim is >90 days from the date of service, use submission code "X"

   Submission code X should be used anytime there is a payment dispute.

2. If a physician disagrees with the payment recommended by the medical or surgical advisors, **the physician requests a review directly to the**

Reference Committee.

BCMA's Reference Committee meets approximately three times a year to review disagreements between physicians and MSP regarding payments made by MSP for specific services, and recommends resolutions to these disputes. The physician submits details of the service and claim to the Committee, and MSP submits details of its adjudication and adjustment or refusal of payment.

3. **The Reference Committee submits its recommendations** to MSP.

4. Although the Committee's recommendations are not binding, MSP tries to follow them as closely as possible when making its decision. MSP may refer Payment Schedule interpretation issues to the Tariff Committee for comment, and may refer significant controversy to the Medical Services Commission for a final decision.

For additional info about the payment dispute process, contact:

Reference Committee
British Columbia Medical Association
115 - 1665 West Broadway
Vancouver, BC V6J 5A4

Phone: 604 736-5551

Fax: 604 736-4566