Module 7: Submission Codes

7.1 Overage Claims – How to Bill

Pursuant to section 27(3) of the *Medicare Protection Act*, section 33 of the Medical and Health Care Services Regulation prescribes 90 days as the period of time within which a claim for payment must be submitted to the Medical Services Commission. Pursuant to section 27(5) of the *Medicare Protection Act*, the Commission may, in its discretion, pay claims submitted outside of the prescribed period. The following information provides an overview of the appropriate use of submission codes C, X, I, W and A when billing claims over the 90 day limit for claim submissions.

For more information contact:

Practitioner and Patient Claims Support
Phone: 1 866 456-6950 or
604 456-6950 (Vancouver)
Use billing prompts
Fax: 250 405-3593

Mailing Address
Medical Services Plan
PO Box 9480
STN PROV GOVT
Victoria, BC
V8N 9E7

SUBMISSION CODE C

The patient did not have active coverage at the time the service was rendered. The claim is now over 90 days old and the coverage has been reinstated.

- No need to write for prior approval
- Use Submission Code C
- Note record required: "coverage reinstated"

If you are having difficulty confirming coverage, there are a number of ways to obtain this information:

Obtain patient information prior to the visit

- When booking an appointment, ask the patient for their name and PHN (Personal Health Number) exactly as it appears on their CareCard.
- Remind each patient to bring their CareCard with them to the appointment.
- Enquire whether the patient has made any changes to their name or coverage since their last visit.

Confirm patient coverage prior to the visit

- Teleplan's Batch Eligibility function provides overnight verification of patient eligibility. There is no limit to the number of verification requests and the information will be made available to you the following morning.

Confirm patient information at the time of the visit

- Teleplan's Immediate Online Eligibility function provides coverage information while the patient is at your office. Up to 40 requests can be processed at one time.

Automated Coverage Enquiry Line

Our automated service handles coverage enquiries using an Interactive Voice Response (IVR) system. The patient's Personal Health Number (PHN) must be provided. This service can also provide information on a patient's surname and initials.

Victoria	250 383-1226
Vancouver	604 669-6667
Other areas of BC (toll-free)	1-800 742-6165

If the PHN is unknown you may fax the request on a coverage research form to 250 405-3592.

SUBMISSION CODE X

The claim is over 90 days old but you disagree with the adjudication of the claim:

- No need to write for prior approval
- Use Submission Code X
- Include a note record and any additional information required to re-adjudicate the claim
- Resubmit claim within 90 days from the remittance date of the original claim

SUBMISSION CODE I

The claim is over 90 days old but since originally submitted, has been either refused or accepted by ICBC:

- No need to write for prior approval
- Use Submission Code I
- Claims must be submitted within 90 days of being advised of ICBC decision

SUBMISSION CODE W

The claim is over 90 days old but since originally submitted, has been either refused or accepted by WorkSafe BC (WSBC):

- No need to write for prior approval
- Use Submission Code W
- Claims must be submitted within 90 days of being advised of WSBC decision

SUBMISSION CODE A

Submission Code A is to be used only when a claim does not meet the criteria for the other submission codes (C, X, I and W).

- Written request is required
- Requests must include detailed explanation for late submission
- Requests must include the date range of the claims, number of claims, value of claims and the fee items involved.
- **Administrative issues such as staffing problems, clerical errors, lost or forgotten claims, system or service bureau problems do not qualify for exemption.**

Note: When a written application is approved for retroactive billing, the maximum retroactive period will be six months from the date of approval. Only in very exceptional circumstances will claims be approved beyond six months. In those exceptional circumstances due to system restrictions the maximum retroactive period granted will be 18 months.

Approved Claims

The approval applies only to the exemption to the 90-day submission limit and does not guarantee payment. All claims billed are subject to the usual processing and adjudication rules and regulations.

7.2 Submission Code D

Duplicate or Multiple Services

A duplicate claim is one for the same patient, service date, and fee item as that identified in another claim. It may be for two or more visits on one day, or for multiple services performed at the same time under the same fee item.

If you bill for multiple visits on the same day, the claims will be processed electronically if you provide the time for each service rendered. We recommend that you include a note record with all duplicate claim submissions.

Billing for a Duplicate Service

There are two ways of submitting valid duplicate claims:

1. Submit the original or first claim with submission code 0 (zero) as you would for any regular billing.

   Submit all duplicate claims with submission code D. Duplicate claims that do not use submission code D are automatically refused with explanatory code HA or HX.

   or;

2. Submit a single claim for multiple services, using a note record or claim comment to explain the multiple billings. This method of submission may be subject to manual adjudication or post-audit.

For duplicate services other than visits, use the following examples as a guideline:

Service	Fee Item	Amount	Submission Code	Time	Note
First	13610	Full	0		*Submission code D not required when billing amounts are not equal.*
Second	13610	50%	0		
First	15110	Full	0		
Second	15110	Full	D		Optional
First	90720	Full	0		
Second	90720	Full	D		Different sites

7.3 Electronic Debit Request Record

You can submit requests to debit claims billed in error, whether the claim is in process or has been paid, except for institutional claims with identity number 10000008. When you successfully submit a debit request record, MSP refuses the in-process claim or debits the paid claim.

The submission of a debit request record is actually a re-submission of the original claim but with submission code **E**. The following rules apply:

- Submission date of the debit request record must be within 12 months of the payment date of the original claim.
- Submission code must be **E**.
- The field known as Original, MSP File Number must contain:
  - Original Data Centre Number of submitted claim to be withdrawn;
  - Original Data Centre Sequence Number of claim to be withdrawn;
  - Date or approximate date when the claim was submitted or paid (zeroes are accepted when the date is unknown).
- A note record or claim comment is mandatory to explain the reason for the withdrawal of the claim. Statements such as "Incorrect date of service" or "Incorrect practitioner number" are sufficient.
- Debit request records can be submitted on a daily basis. Submissions that do not pass the edit checks are refused and returned as normal refusal records (C11) with explanatory code **D1**. Accepted records are processed for the next payment period.
- When re-billing claims for service dates outside the 90-day limit, use submission code **X** and indicate "Re-submission with matching Debit Request Record" in the note record or claim comment field.

Notes:

1. Opted-out physicians cannot debit claims electronically.
2. Do not use the debit request record if you disagree with MSP's adjudication of a claim. Rather, submit a new claim with additional information in a note record, and the claim will be reassessed.

Debit Request Record Remittance Statements

Remittance statements for **debit request records** have these characteristics:

- A matched record is determined by the Original Data Centre and Sequence Number identified on the debit request record. A matched request record is returned as a remittance payment (S02) with explanatory code **D0**.

- If MSP cannot match the debit request record to an in-process or paid claim, the request record is returned as a remittance refusal (S03) with explanatory code **D2**.

Remittance statements for **original claims** have these characteristics:

- If the original claim has not yet been paid but has passed the pre-edit checks, it is returned as a remittance refusal (S03) with explanatory code **XH**. It contains the Original Sequence and Claim Number.

- If the original claim has already been paid, it is returned as a remittance payment (S02) with a negative dollar value and explanatory code **D3**. It contains the Original Sequence and Claim Number

Debit Request Record Explanatory Codes

D0	Match found for Debit Request Record.
D1	Debit Request Record did not meet pre-edit or edit requirements.
D2	No match found for Debit Request Record.
D3	Payment withdrawn as indicated in Debit Request Record.
XH	Claim returned as indicated in Debit Request Record.

7.4 Note Records

MSP receives a large volume of correspondence that is not required, which leads to processing delays. To help MSP process your claims more quickly, please use your note record whenever possible instead of sending your paper correspondence.

For example, when billing a repeat complete physical within 6 months of a previous complete physical – provide a note explaining the medical necessity.

Another example, when billing repeat surgery (fee item 77043) please provide a note stating the approximate date and name of the original procedure or the approximate date and fee code of the original procedure.

Correspondence should only be submitted in the following circumstances:

- A request for information has been made directly by MSP.
- Your account has been refused "F9" and you are providing additional information that cannot be sent in a note record (such as operative report) to support a rebilling.
- There is a requirement in the Payment Schedule to provide an operative report.
- You are billing a service not listed in the Payment Schedule under a miscellaneous item, and that service cannot be described in a note record.

7.5 Location Codes

The location codes are:

C	RESIDENTIAL CARE/ASSISTED LIVING RESIDENCE
D	DIAGNOSTIC FACILITY
E	HOSPITAL – EMERGENCY ROOM (UNSCHEDULED PATIENT)
I	HOSPITAL – INPATIENT
P	HOSPITAL OUTPATIENT
R	PATIENT'S PRIVATE HOME
Z	OTHER (E.G., ACCIDENT SITE OR AMBULANCE)
M	MENTAL HEALTH CENTRE
T	PRACTITIONER'S OFFICE – IN PUBLICLY ADMINISTERED FACILITY
G	HOSPITAL – DAY CARE (SURGERY)
F	PRIVATE MEDICAL/SURGICAL FACILITY
A	PRACTIONER'S OFFICE – IN COMMUNITY

Effective since October 1, 2006 claims that do not contain the above codes are refused and must be resubmitted with the correct code.

Details of changes to location codes may be found in the Memorandum to All Practitioners dated February 8, 2006. A copy of this memo is posted on the MSP Web site at: http://www.health.gov.bc.ca/msp/infoprac/index.html

In general, the key point to remember when choosing a location code is that it should reflect the actual place where the service is performed. Two specific questions that require clarification have emerged since the transition began:

Laboratory Specimens – Example: If a laboratory specimen is collected at a residential care facility then taken to a hospital laboratory for processing, the code to use is "P" (Hospital – Outpatient), because the diagnostic service is performed at the hospital for a non-admitted patient. A diagnostic facility that is privately owned, with a separate MSC Certificate of Approval should use code "D" when submitting claims for diagnostic services provided at that facility.

Mental Health Facilities – Example: Facilities that perform crisis stabilization services, where patients may be admitted for short periods, are not considered to be primarily residential in nature and should use code "M" (Mental Health Centre) when services are billed. Residential mental health facilities should use code "C".

Code	Descriptor	Definition
C	Residential Care/Assisted	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).
D	Diagnostic Facility	Service is provided in a facility that primarily/exclusively provides diagnostic testing and has been granted a MSC 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).
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).
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).
R	Patient's Private Home	Service is provided in a patient's own home (Note: Includes service provided in "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).
Z	Other (e.g., accident site or ambulance)	Service is provided in any other location such as a temporary community or school clinic, ambulance, accident site etc.
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 – Out-Patient).
F	Private Medical/Surgical Facility	Service is provided within a private medical/surgery facility accredited by the College of Physicians and Surgeons of BC.

A	Practitioner's Office – In Community	Service is provided in a practitioner's office (Note: Excludes practitioners' offices that are located within a publicly administered health care facility – see Practitioner's Office – In Publicly Administered Facility. Includes services provided by a physician, chiropractor, dentist, optometrist, podiatrist, physiotherapist, and massage therapist).
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).
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…).

7.6 Diagnostic Facilities Claims Submission - Facility & Sub-Facility Codes

In 1996, the Medical Services Commission (MSC), in accordance with Section 27(1) of the *Medicare Protection Act*, approved the requirement that Diagnostic Facilities submit claims for diagnostic services using a facility/site specific number. These fields are documented in the Teleplan Specifications Document – the document is on the Medical Services Plan (MSP) web site at:
http://www.health.gov.bc.ca/msp/infoprac/teleplanspecs/index.html

The Diagnostic Facility services to which this directive applies are:

Laboratory Medicine	Specimen Collection
Radiology	Ultrasound
Pulmonary Function Studies	EMG
EEG	Nuclear Medicine
Polysomnography	

This requirement does not apply to Laboratory Category 1 services performed in physician's offices.

A site-specific number was issued to all diagnostic facilities and is on the Diagnostic Facility and/or Specimen Collection Station Certificate of Approval. Effective April 1, 2003 MSP required the submission of valid facility numbers on all fee-for-service diagnostic facility claims completion of the sub-facility field is also required on all claims. Though it was mandatory for all private lab facilities to comply by April 1, 2003 the Health Authorities were given an extension until September 30, 2006.

Rules of Design:

- All diagnostic facility sites must have the ability to assign and submit facility and sub-facility values on their claims to the MSP.
- Both fields are Alpha/Numeric. Each field is five (5) characters in length, default is zeros.

If first accessioning and performance of a test occurs at the same facility, then the facility number should be entered in the facility field, and the sub-facility field should be defaulted to 00000. Where first accessioning occurs at a site other than the facility billing MSP for the service, the facility number at which first accessioning occurred should be submitted in the sub-facility field, and the number of the facility billing MSP should be submitted in the facility field.

Facility numbers are available from the Teleplan System through “Other Processing Options”.

Billing Examples:

Completion of Facility and Sub-Facility Fields on MSP Claims

Example One - Hematology Profile

i) Accessioning and test processing occur at Laboratory *B*, which bills MSP for fee item 90205.

Billing:
Claim for fee item 90205 is submitted by Laboratory *B*, which enters facility number *B* in the facility field and "00000" in the sub facility field.

ii) Accessioning for a haematology profile occurs at Specimen Collection Station (SCS) *A*, and is forwarded to Laboratory *B*, which processes the test and bills MSP for payment.

Billing:
Claim for fee item 90205 is submitted by Laboratory *B*, who enters the facility number *B* in the facility field, and the facility number of SCS *A* in the sub-facility field.

iii) Laboratory C collects specimens at a Long Term Care Facility, physician's office or patient's home, which are processed by Laboratory *B*.

Billing:
MSP has created a miscellaneous facility number B9998 for these types of collections. The claim for fee item 90205 is submitted by Laboratory C, who enters facility number C in the facility field, and the miscellaneous facility number B9998 in the sub-facility field.

Example Two - ECG

i) An ECG is performed at site *D*, other than the billing site and the results are forwarded to Laboratory *E* for interpretation and billing.

Billing:
Laboratory *E* bills fee item 93120 (technical fee) with facility number of Laboratory E in the facility field and the facility number of the site where the ECG was performed - site *D* - in the sub facility field. The professional fee (33018, 00117, 00529) is billed using the facility number of Laboratory *E* and "00000" is entered in the sub-facility field.

ii) An ECG is performed at Laboratory *E* where interpretation and billing to MSP occur.

Billing:
Laboratory *E* bills fee item 33016 (combined) with facility number *E* in the facility field and "00000" in the sub facility-field.

Example Three Fee Item restricted to Tertiary Facility

First accessioning occurs at SCS *F*, and is sent to Community Hospital *G* (e.g. Victoria General Hospital). Hospital *G* sends sample to tertiary facility *H,* (e.g. Children's Hospital) which is the only facility approved to do a specialized test such as fee item P91777. Tertiary facility *H* performs the test and bills MSP.

Billing:
Laboratory at hospital *H* bills fee item P91777, entering Laboratory *H* facility number in the facility field and SCS *F* facility number in the sub facility field. Community hospital *G* which routes the sample is not identified on the claim.

Example Four Specimens sent to an Alternatively Funded Facility

Accessioning occurs at SCS M and the specimen is sent to an alternatively funded facility (e.g. the Provincial Laboratory or BCCA) by billing Facility N.

Billing:
As there is no listing for collection of specimens, no billing can be made to MSP. The exception is fee item 00012 - if a blood specimen is collected and sent to an alternatively funded facility, then the claim should list facility number of the billing facility N in the facility field and the facility number of the SCS M in the sub facility field.

Example Five EMG Physicians

Approvals for diagnostic facility services list the address where the service must be provided in order for it to be considered a benefit of the MSP. EMG physicians providing services both at the hospital and in their private office have been issued Certificates for both sites. Claims should be submitted using the applicable facility number in the facility field to indicate the location of where the EMG service was performed.