

MEDICAL SERVICES PLAN

Explanatory Codes

JULY 2008

ABBREVIATIONS

ASSOC	Association
DEP	Dependent
DOS	Date of Service
ICBC	Insurance Corporation of BC
IV	Intravenous
MSP	Medical Services Plan
MVA	Motor Vehicle Accident
NOI	Nature of Injury
OP	Operative
OSMV	Office of the Superintendent of Motor Vehicles
PHN	Personal Health Number
PVC	Patient Visit Charge
RCP	Reciprocal
WCB	Workers Compensation Board
WSBC	Work Safe B.C.

- *A** Our records indicate patient deceased. Please contact MSP.
- *B** Patient's eligibility with MSP is in question. Please have patient contact MSP.
- *C** MSP is unable to locate patient. Please have patient contact MSP.
- *D** MSP has been unable to contact patient. Please have patient contact MSP.
- *E** Our records indicate patient has permanently moved out of BC. Please have patient re-apply for coverage if applicable.
- *F** Patient has opted out of MSP. Patient should be billed directly.
- *G** Our records indicate MSP is not the primary insurer for this patient.
- *H** Our records indicate the patient requested coverage to be cancelled.
- *I** Date of service is prior to coverage effective date.
- AA** PHN is missing or invalid.
- AB** PHN is not on our records.
- AC** This is not a valid PHN for MSP.
- AD** This is an incorrect PHN for this patient.
- AE** This claim is the responsibility of the interim Federal Health Program.
- AF** This patient does not have coverage for the DOS.
- AG** This service billed as "A Donor" coverage.
- AH** Dependent number is missing or invalid.
- AI** Dependent is not registered.
- AJ** This is an incorrect dependent number.
- AK** Coverage for this dependent has been cancelled.

- AL** This dependent is not eligible for coverage with MSP.
- AM** Dependent number and/or initial(s) do not match our records.
- AO** First name or initial(s) does not match our records.
- AP** Initials and/or surname are missing or invalid.
- AQ** Surname does not match our records.
- AR** Birthdate missing or invalid.
- AS** Baby not registered.
- AU** A claim for this service has been paid on the mother's PHN, under dependent 66.
- AV** Technical difficulties with coverage check. Contact Teleplan support.
- AW** Claim must be submitted with PHN.
- AX** Province contacted, name and health number not matching.
- AY** Provincial/insurer or institution code missing or invalid or fee item not valid
- A1** Patient signature required on pay patient account.
- A2** Patient address required on pay patient account.
- A5** Referred to or by doctor number is not valid for DOS.
- A6** Child is over-age for dependent 66.
- A7** Dependent 66 - PHN submitted is registered to male. Please resubmit using mother's PHN and dependent 66.
- A9** PHN not approved for ICBC claim number. Please contact ICBC.
- BA** Initials and/or surname changed to match CareCard. Please confirm correct initials and surname with patient
- BB** PHN changed to match CareCard.
- BC** Surname/initials and PHN changed to match CareCard.

- BD** Child not registered. Processed under dependent 66.
- BE** PHN changed to newborn's PHN.
- BF** Claim is held for future processing.
- BG** Amount adjusted to the rate effective for this DOS.
- BH** This claim will be processed on a future remittance statement. Please do not rebill.
- BI** Fee item and diagnosis do not correspond.
- BJ** Fee item and amount billed do not correspond.
- BK** Your claim submission is being held pending WCB notice of approval.
- BL** Massage therapy discounted.
- BN** The maximum number of additional areas has been paid for this date of service.
- BP** Birthdate submitted does not match our records.
- BR** Please clarify the date of service.
- BU** Claim was received prior to date of service.
- BV** Service date exceeds allowable claim submission period.
- BW** Hospital visits must be submitted with each month on a separate line.
- BX** Claim is being held pending ICBC notice of approval.
- BZ** MSP has consolidated two PHNs held by this person. Please update your records to the PHN indicated.
- B2** Previous PHN has been replaced with PHN indicated. Please update your records.
- B3** In future, please bill multiple services of the same fee item on one line (eg. 13621 X 3; 09921 X 3)

- B4** Patient now has BC coverage. Please contact patient and rebill under the correct PHN.
- B5** Child is over-age for billing under mother's identity number under the reciprocal agreement.
- CA** Fee item and time stated do not correspond.
- CB** Number of services and time stated do not correspond.
- CC** Please state time anaesthetic commenced.
- CD** Date of service and fee item billed do not correspond.
- CE** DOS was not a Saturday, Sunday or statutory holiday.
- CF** Time called or time service was rendered is missing or invalid.
- CG** Each service must be on a separate line.
- CH** Please clarify billing; writing is illegible.
- CI** Number of services and amount billed do not correspond.
- CJ** Date of service and amount billed do not correspond.
- CK** Practitioner number is invalid for this payment number and date of service.
- CL** Payment number is invalid for this date of service.
- CM** Specialty is invalid for this date of service.
- CN** Practitioner is not registered with the College of Physicians and Surgeons or not active with MSP for this date of service.
- CP** Practitioner status invalid for date of service and type of submission.
- CQ** Practitioner is not licensed to bill for this service.
- CR** WCB refused claim. Service not paid with tray fee. Contact WCB Health Care Benefits Department.
- CS** WCB adjusted payment. Form received outside time limit. If clarification required, contact WCB Health Care Services.

- CT** WCB adjusted payment. ECCR did not meet standards. Contact WCB claims adjudicator.
- CU** We are unable to process this account as this is an invalid referral.
- CV** Claim submission changed to the appropriate MSP consultation rate plus the amount for fee item 19908. If clarification required contact WCB Health Care Services.
- CW** Telephone advice fees may not be charged when another service was provided on the same day.
- CX** WCB adjusted payment. Fee not paid with tray. Contact WCB Health Care Services.
- CY** WCB adjusted payment to fee schedule. If clarification required, contact WCB Health Care Services.
- CZ** WCB refused claim. No referral noted. Rebill correct MSP fee item or contact WCB Health Care Services.
- C1** Contact with invalid
- C2** Special program name invalid
- C3** Assessment diagnostic invalid
- C4** Treatment plan prescription missing or invalid – please specify
- C5** Primary disposition missing or invalid.
- C6** WCB fee item can only be billed by a hospital.
- C7** Emergency per diem is greater than three days from the date of injury. Please bill WCB directly.
- C8** Fee item and/or amount has been changed. If clarification required, contact WCB Health Care Services.
- C9** WCB adjusted payment - premium only paid for electronically submitted forms.
- DJ** This claim is the responsibility of ICBC.
- DR** Debit adjustment. See secondary explanatory code(s).

- DS** Account debited to agree with fee item paid to surgeon. Please rebill for payment.
- DV** Item 00012 is not payable with laboratory blood work or visit fee charges to the same or an associated physician on the same date.
- DW** Debit adjustment of MSP claim as WCB hospital emergency per diem rate billed for same date of service.
- 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 per debit request record.
- D4** Unable to perform debit request at this time. Claim is currently in process. Please review account when processed.
- D8** Debit adjustment of account paid at GP rates.
- D9** Original claim is at WCB and your debit request has been forwarded to WCB
- EA** 00101, 13101, 13201, 13301 are not payable to emergency room physicians.
- EB** Standby time is not payable by the Plan.
- EC** Services provided by the Canadian Blood Service are not a benefit of the Plan.
- ED** There is insufficient medical necessity to process this claim.
- EE** This service is not an insured benefit of the Plan.
- EF** Not a benefit under the Reciprocal Agreement.
- EG** This service is the responsibility of WCB.
- EH** Mileage is not a benefit except for unusual emergencies.
- EI** Service not listed in the Payment Schedule. Please contact your

Association.

- EJ** Services at the request of a third party are not an insured benefit of the Plan.
- EK** WCB refused payment - the RTW plan session was not pre-authorized or did not satisfy all conditions as per fee schedule.
- EL** WCB refused payment - fee item cannot be billed with payment of pre-arranged telephone consultation.
- EM** Service unrelated to MVA injury. Please contact ICBC.
- EN** WCB refused payment - fee item cannot be billed with payment of RTW plan.
- EO** WCB refused payment - fee item cannot be billed with payment of job site visit.
- EP** WCB refused payment - fee item cannot be billed with payment of RTW plan. Phase 2.
- EQ** WCB refused payment - exceeds the maximum number of RTW plans.
- ER** WCB refused payment - claim information had not been received. Fax the patient's address, PHN, phone number and the name of patient's employer to WCB. Refer to WCB/BCMA agreement education package.
- ES** WCB refused payment - the claim had been established before the original invoices were rejected.
- ET** WCB refused payment - fee item limit exceeded.
- EU** WCB refused payment - fee item cannot be billed with payment of requested copies.
- EV** WCB refused payment - fee item cannot be billed with payment of requested existing reports or chart notes.

- EW** WCB adjustment – “E-commerce fee” is paid on a per diem/visit basis.
- EX** This claim has been paid as a WCB account.
- EY** WCB refusal. Area of injury not accepted on claim.
- EZ** These fees are not a benefit when used for overtime compensation.
- E1** This service appears to be performed during your APP contracted hours – therefore it is not billable to MSP.
- E2** WCB limit of one form 8 per claim exceeded. Adjusted to appropriate form 11 rate.
- E3** WCB fee item previously paid under separate fee schedule/fee code.
- E4** Work Safe BC refused – ward rate, differential was not authorized.
- E6** Work Safe BC Refused Claim. Medical imaging not authorized.
- E7** Work Safe BC refused – hospital service is not authorized.
- E8** Work Safe BC refused – billed acute care per diem rate not correct for payee.
- E9** Work Safe BC refused – hospital service is not related to an accepted Work Safe BC claim.
- FA** Previous claim incorrectly refused/adjusted by the Plan.
- FB** This is a duplicate claim. An identical claim is being processed.
- FC** This account has been paid or refused in accordance with previous correspondence, phone call or note record.
- FE** Payment adjusted per information received.
- FF** Payment for the full fee has been paid to another physician; we do not split the fees.
- FG** Age of patient does not correspond with the fee item billed.
- FH** Service by definition is bilateral or multiple.

- FI** Services rendered to a physician's own family member are not payable.
- FJ** 00112, 01200-01202 only applies to the first patient treated.
- FK** This account was billed under the wrong PHN or dependent number.
- FL** Professional/technical fee paid to another facility. Total fee not payable.
- FM** Repeat graded exercise tests require an explanation of the medical necessity.
- FN** Previously paid service(s) considered to be included, have been deducted.
- FO** The sex of the patient does not correspond with the fee item/diagnostic code.
- FP** This patient's care is restricted to another physician. Please refer to the MSP bulletin.
- FQ** Adjustment made because of additional information received.
- FR** See explanatory letter.
- FS** Service is refused or adjusted. Information requested has not been received.
- FT** Additional information was not received.
- FV** This service is included in a previously paid item.
- FW** Rebilling submitted to change insurer responsibility.
- FX** This is a reciprocal claim.
- FY** This claim normally requires manual processing. It has been computer paid and is subject to review at a later date.
- FZ** This claim normally requires manual processing but has been computer adjusted or refused. If you disagree please resubmit with details in the claim comment/note field.
- F1** Included in WCB hospital emergency per diem rate.

- F2** Time/date does not correspond with related claims.
- F3** Your rebilling is being processed.
- F4** Operative/procedural report does not substantiate the fee item billed.
- F5** Group therapy is not paid for more than one member of a family per session.
- F6** Please check patient identification. This card has been reported lost or stolen.
- F7** Payment records show that this patient is seeing multiple general practitioners.
- F8** An adjustment is in process for the remainder of this claim.
- F9** Payment/refusal of the original claim cannot be reviewed until receipt of a rebilling plus additional details and/or operative/pathology report, if applicable.
- GB** A referral had not been received at the time of processing.
- GC** A major consultation is not payable if the patient has been seen within 6 months for the same condition.
- GF** As there is no indication of medical necessity for a new consultation, your account has been adjusted to the appropriate visit fee.
- GG** This fee is included in the consultation or visit fee.
- GH** Consultation/visit is included in the fee for the procedure.
- GJ** Our records indicate this is a referred case.
- GK** Referral now received.
- GL** A consultation is not payable to the family physician.
- GQ** Referral now received. Computer generated code.
- GR** Directive care is payable at 2 visits per week.
- GS** Directive care is payable after surgery unless the patient is seen for a different condition.

- GT** WCB refused – Electronic report submission. Incomplete form transmission.
- GU** WCB refused – Payee number closed by WCB vendor administrator. For more information contact WCB vendor administrator.
- GV** WCB refused – Treatment with start date more than 8 weeks after injury date. Not authorized by WCB claims manager.
- GW** WCB refused – Commencement of second treatment period not authorized by WCB claims manager.
- G1** WCB refused – Electronic report submission included an invalid date format.
- G2** WCB refused – Electronic report submission incomplete. Required information missing, employer’s name.
- G3** WCB refused – Electronic report submission incomplete. Required information missing, employer’s address.
- G4** WCB refused - Electronic report submission incomplete. Required information missing, employee’s address.
- G5** WCB refused - Electronic report submission incomplete. Required information missing, estimated time off work.
- G6** WCB refused - Electronic report submission incomplete. Required information, work restrictions.
- G7** WCB refused – Electronic report submission. Invalid anatomical position.
- G8** WCB refused – Electronic report submission. Invalid body part code.
- G9** WCB refused – Electronic report submission. Invalid nature of injury code.
- HA** This claim has been paid to you.
- HB** This claim has been paid to you. Please note the change in name/PHN.

- HC** This claim has been paid under the indicated fee item.
- HD** This claim has been paid to an associated doctor or alternate payment number.
- HE** A retro adjustment has been applied to this paid claim.
- HF** This account has been paid to the physician providing LOCUM services.
- HG** Your account has been refused or debited as the patient was out of province on this/these dates.
- HI** Referral has now been received. Payment will remain at specialist rates.
- HJ** This fee has been paid to another physician or facility.
- HK** Credit Adjustment
- See secondary code for explanation.
- HL** This claim has been paid for a different date of service.
- HM** This claim does not meet the over-aged submission requirements.
- HN** The information provided does not correspond with our records on file.
- HO** This claim was paid as an ICBC account.
- HP** Your note comment/correspondence has been considered, however, we are unable to alter our previous decision.
- HQ** Computer-generated credit.
- HR** This procedure is normally performed once in a life time. Please resubmit with an explanation for the repeat procedure.
- HS** A credit adjustment has been processed for this claim.
- HT** This account has been overpaid in error.
- HU** Previously paid amounts for individually billed services exceed per diem rate.

- HV** A claim for this service has previously been processed
- HW** WCB refused your claim submission. Invoice already paid by WCB. If clarification required contact WCB Health Care Services.
- HX** This claim has been paid to you. Computer refusal.
- HY** Balance payment. Amount previously paid for individually billed services deducted from per diem rate.
- HZ** Payment for this account was previously withdrawn per your debit request record. If requesting payment, please resubmit with an explanation in your note record.
- H1** Daily volume limit exceeded. Payment discounted by 100%.
- H2** Referral not received.
- H4** Referral not received.
- H5** Daily volume limit exceeded. Payment adjusted.
- H6** Referral not received.
- H7** Referral not received.
- IA** "B" prefixed or asterisk items are included in visit/procedure fee.
- IB** 00012 is not payable when performed with other blood work.
- IC** Multiple injections are paid to a maximum of three per sitting.
- ID** Claims for 00081 must be supported with details of bedside/resuscitative services. Please provide break down on a per ½ hour basis.
- IE** The Tariff Committee has not recommended approval for this tray service. Patient may be charged for costs.
- IF** A visit fee is not payable with subsequent injections.
- IG** Fee is not applicable unless the physician is called from another site to render the emergency service. Resubmit with details of where you were called from.
- IH** The consult or visit constitutes the first half hour of care.

- II** Misc fees must be supported with details of the service provided.
- IJ** 00083 cannot be billed alone. Your claim has been adjusted to the appropriate visit fee.
- IK** Duration of visit is required for this service.
- IL** 00081 includes any minor procedures performed at the same time.
- IM** This service charge is not applicable for the time/date and/or the item billed.
- IN** 01210 - 01212 are not payable with diagnostic procedures.
- IO** Paid according to the time and/or duration stated.
- IP** 00039 is the only fee payable for any visit associated with methadone maintenance
- IQ** Refractory period is 30 minutes for non-operative continuing care surcharges unless for CCFPP care.
- IR** Minor tray fee not applicable.
- IS** Major tray fee not applicable.
- IT** Tray fee not applicable with fee item billed/paid.
- IU** Tray fee not applicable when service performed in a Ministry funded facility.
- IV** Tray fee not payable to hospitals or extended care facilities, etc.
- IW** The Tariff Committee has recommended approval for the addition of this tray service.
- IX** The Tariff Committee has not recommended approval for the addition of this tray service. Included in overhead.
- IY** Tray fee to be billed by physician performing procedure.
- IZ** Mini tray fee not applicable.
- I0** ICBC has refused responsibility for this claim, therefore, MSP has accepted responsibility. The insurer code has been changed.

- I1** Please resubmit with details of the emergency call-out.
- I2** 01210 - 01212 are not billable with non-emergency procedures.
- I3** 01200-01202 and 01205-01207 and 01215-01217 only apply when the physician is specially called to render emergency or non-elective services.
- I4** Please resubmit the remainder of this claim under the applicable fee for continuing care, according to the time indicated.
- I5** Emergency visits/surcharges are not paid for routine call backs. Please resubmit with details of the medical necessity for additional emergency services.
- I6** Claims for 00082 must be supported by details of the care provided to critically ill patient. Please provide breakdown on a per ½ hour basis.
- I7** Only one tray fee is applicable when multiple procedures are performed.
- I8** Our records indicate that another physician is responsible for care under the methadone maintenance program during the same time period. Rebill with additional information if necessary.
- I9** ICBC has refused responsibility of this claim.
- JA** Multiple diagnostic procedures are paid at 100% for the larger fee and 50% for the lesser.
- JB** If a diagnostic procedure takes place on a subsequent visit within 30 days, only the diagnostic procedure is paid.
- JC** The annual limit has been reached.
- JD** Fee items 00931 - 00936, 00942 , 00943 are paid at 100 percent when billed together.
- JE** Payment has been made at the appropriate per diem rate based on date(s) and sequence of associated claims.
- JF** When the patient acuity level changes up or down, the appropriate second day rate applies (01521 01522 or 01523).
- JG** Services for pain control/acute pain control are included in Critical

Care fees for ventilatory support and/or comprehensive care.

- JH** This service is included in the payment for critical care.
- JI** There is insufficient medical necessity to process this claim. Resubmit explaining the need for services outside the critical care team, if applicable.
- JJ** Written support for medical necessity is required to pay critical care fees within the post-op period. Resubmit with additional information if applicable.
- JK** Information provided does not meet the criteria for the critical care fee item billed. Please resubmit with additional information, if applicable.
- JL** Subsequent non-inclusive surgical procedures rendered by a member of the critical care team are paid at 75%.
- JM** The fee for the first day of critical care has already been paid to you or another physician.
- JN** Critical Care schedule fee items are not payable within the duration of a general anaesthetic.
- JO** To be considered for payment, claims for fee items 00081/00082 in lieu of critical care fees must be accompanied by a written explanation of medical necessity.
- JP** Critical Care ventilatory support (01412-01442) has been paid to another physician. Your claim has been paid/refused according to the Section Preamble.
- JQ** Day 2 rates for Critical Care apply when patient is re-admitted for the same condition.

- JR** Critical care (01411-01441) has been paid to another physician. Your claim has been paid/refused according to the Section Preamble.
- JS** Day 2 rates for critical care apply when the service is preceded by a consultation (after 2200 hours) by a team member
- JT** Claims for percutaneous transluminal coronary angioplasty/additional vessel (0084040-00842) are payable at 75% when billed by a team member.
- JU** Comprehensive care (01413-01443) has been paid to another physician. Therefore, we are unable to process your claim for payment.
- JV** When a patient is admitted to NICU after 48 hours, second day rates will apply again (01521, 01522, 01523).
- JW** 01200-01202 and 01205-01207 and 01215-01217 are not payable in addition to adult and pediatric critical care fees (01411-01441, 01412-01442 and 01413-01443).
- JX** When a patient is readmitted to NICU within 48 hours, billing continues at the same rate as if there were no break, unless there is a change in acuity level.
- JY** When a patient is readmitted to ICU within 48 hours with the same or similar problem, billing continues at the same rate as if there were no break.
- JZ** When a patient is readmitted to ICU after 48 hours with the same or similar problem, day 2 rates apply.
- J0** WCB refused – report submission incomplete, required information missing, worker's occupation missing.
- J1** WCB refused – report submission incomplete, required information missing, clinic information (clinic name, area code or phone number) missing.
- J2** WCB refused – report submission incomplete, required information missing, report date missing.

- J3** WCB refused – report submission invalid, required information missing, specific reference number missing or invalid.
- J4** WCB refused – report submission incomplete, required information missing, clinical information missing.
- J5** WCB refused – report submission incomplete, required information missing, worker’s city and/or work location missing.
- J6** WCB refused – report submission incomplete, required information missing, injury description missing.
- J7** WCB refused – report submission incomplete, required information missing, patient duration missing.
- J8** WCB refused – report submission incomplete, required information missing, disabled from work flag missing.
- J9** WCB refused – report submission incomplete, required information missing, rehab program not indicated.
- KA** There is no indication that two separate visits were made. If two visits were performed, please provide times of each visit.
- KB** Visits and minor procedures, same diagnosis - larger fee only is paid. Different diagnosis - lesser fee paid at 50%.
- KC** Repeat complete physicals within 6 months require an explanation of medical necessity.
- KD** This service does not meet the criteria for fee item billed.
- KE** This fee is applicable between 8 am and 6 pm.
- KF** Patient's annual limit for counselling has been reached.
- KG** Counselling for two or more members of a family must indicate that they were seen individually.
- KH** One 00114 is paid every two weeks for care provided in a long-term care institution (eg. nursing home, intermediate care facility) unless supported by an explanation.
- KI** Another physician has been paid for daily hospital care.
- KJ** The total number of services exceeds the number of hospital days.

- KK** This service is not a benefit of the Plan when performed in a hospital.
- KL** Daily care is payable up to 30 days only unless supported by additional information of the medical necessity.
- KM** Paid according to the supportive care formula stated in Preamble B.4.e.v) of the MSC Payment Schedule for the date of service of claim.
- KN** Out-of-hospital care was provided during this time. Please verify hospitalization dates.
- KO** In-hospital care was provided during this time. Please verify the dates.
- KP** Lab, x-ray and/or interpretation fees are not a benefit under the Plan for a registered bed patient.
- KQ** Our records indicate patient is located in a nursing home. Please verify and rebill with the appropriate fee item.
- KR** Hospital visits are not payable in addition to the routine care of a newborn.
- KS** Hospital visits have been paid during the period you have billed nursing home care. Please verify location of patient.
- KT** Nursing home visits have been paid during the time you have billed hospital care. Please verify location of patient.
- KU** Please resubmit the remainder of this claim, if applicable, under supportive or directive care.
- KV** Emergency Medicine fees and minor procedures - the lesser fee is paid at 50%.
- KW** Fee item billed does not meet the criteria for group counselling. The appropriate visit fee has been paid.
- KX** Fee item billed is only applicable when service is provided in hospital emergency room. The appropriate visit fee has been paid.
- KY** Visit fee includes examination/assessment of multiple diagnoses.
- KZ** Fee item and note comment do not correspond.

- K0** 92515/92516 not payable with 92510, 92520-92544 or 92546.
- K1** Processed according to the Preamble to the Medical Services Commission Payment Schedule.
- K2** Processed according to the Section Preamble to the Medical Services Commission Payment Schedule.
- K3** Processed according to the description of the fee item, or the note relating to the fee item, in the Payment Schedule.
- K4** Please refer to the protocol for this fee item.
- K5** Your rebilling has been processed. In future, please ensure that the necessary information (eg. "CCFPP" appears in the first line of your note record).
- K6** Primary base fee is not applicable. Your account has been paid under the appropriate split base fee.
- K7** Patient not registered. Payment for third and subsequent services will be reduced to 50%. (Primary Care).
- K8** Patient not registered – payment reduced to 50%. (Primary Care).
- K9** Our records indicate that fee item 00114/00115 is not applicable. Please verify the patient's location.
- LA** Volume discount mechanism applied as per 2007 renewed lab agreement.
- LB** This item is not a benefit of the plan unless performed in an MSC approved facility or as an outpatient service.
- LD** Nerve blocks/IV procedures are not paid with time units or procedures.
- LE** Continuous care by a second anaesthetist is paid under time fees only.
- LF** Anaesthetic Procedural Fee Modifiers are not payable in addition to diagnostic or therapeutic anaesthesia fees.
- LH** Anesthetic procedural modifies are only applicable to general, regional and monitored anesthesia.
- LJ** Intensity/complexity fees are not applicable to the

surgical/diagnostic procedure(s) billed.

- LL** 13052 is not applicable for a pre-operative examination.
- LM** Insufficient medical necessity for two anaesthetists has been received.
- LN** Please provide duration of continuous time spent with the patient during second and/or third stage s of labour only.
- LP** Fee items 01151 and 13052 are not applicable when performed in conjunction with other anaesthetic services.
- LQ** Visit fees are not payable at the time anaesthetic services are rendered.
- LR** This service is included in the annual complex care block fee.
- LS** Age related annual complex care block fee items must be provided on the same date of service as complex care planning fee item 14033.
- LT** This service is not payable on inpatients who reside in a care facility.
- LV** This service is limited to once per calendar year per patient and has been paid to another practitioner.
- LW** This service is only payable if the patient is seen and a visit billed on the same date. Please resubmit for both services, if applicable.
- L0** Work Safe BC refused – change of cast not noted.
- L1** WCB refused payment – practitioner not covered by a WCB service contract for this date of service. If clarification required contact WCB contract services.
- L2** WCB refused – duplicate form detected.
- L3** WCB refused – report submission incomplete, required information missing, functional abilities.

- L4** WCB refused – report submission incomplete, required information missing, injury status and objective findings.
- L5** WCB refused – report submission incomplete, required information missing, report type missing.
- L6** WCB refused – report submission incomplete, required information missing, recommendations missing.
- L7** WCB refused – report submission incomplete, required information missing, initial visit date missing.
- L8** WCB refused – report submission incomplete, required information missing, number of visits missing.
- L9** WCB refused – report submission incomplete, required information missing, physician’s surname and/or given name missing.
- MA** Multiple exams performed on the same visit, the lesser exams are paid at 50%.
- MB** A repeat refraction within a 6 month period requires medical necessity.
- MC** Items 02010, 02015 and 02012 include certain individual eye exams.
- MD** Exam and a minor procedure billed on the same day, the lesser fee is paid at 50%.
- ME** Eye exams are not paid with office/hospital visits.
- MF** Referring doctor provided is invalid for payment of consultation billed.
- MG** These exams are paid to a maximum of three per day.
- MH** 02012 is not payable within three days of emergency surgery.
- MI** The appropriate fees for removal of foreign bodies from the surface of the eye are 13610, 13611 or 06063
- MJ** A fee item has been established for this service. Please resubmit under the approved code.
- MK** Fee item 13005 is not payable when the patient is a registered bed

patient in an acute care hospital.

- ML** Fee item 13005 may only be billed once per day per physician per patient.
- MN** Fee item 13005 is not payable in addition to services provided on the same day/same physician/same patient.
- MP** Fee item 00109 is not applicable when a patient is admitted for surgery. The appropriate visit fee has been paid.
- MQ** Fee item 00109 is not applicable when a patient is referred for continuing care by a certified specialist. The appropriate visit fee has been paid.
- MR** Fee item 00109 is not applicable when preceded by a complete physical exam within 7 days by the same physician. The appropriate visit fee has been paid.
- MS** Does not meet the criteria for billed services for hospitalized patients.
- MT** Sub acute care has been paid during the period you have billed for acute/supportive care. Please verify the location of the patient.
- MV** Acute/supportive care has been paid during the period you have billed for sub acute care. Please verify the location of the patient.
- MW** This OSMV form fee is not payable on the same date of service as another OSMV form fee that you have billed.
- MX** Driver's licence number is not numeric, is missing or is not located in the first seven spaces of the note or comment field.
- MY** A repeat OSMV form fee is not payable to any practitioner within 3 months.
- MZ** Insurer is invalid for this service.
- M1** WCB refused – report submission incomplete, required info, regular practitioner indicator missing or invalid.
- M2** WCB refused – report submission incomplete, required info, return to full duties indicator missing or invalid.
- M3** Work Safe BC refused – service unrelated to Work Safe BC claim.

- M4** Work Safe BC refused your claim submission. Unable to locate employer for this claim/patient. Please clarify with patient. Resubmit with revised information if Work Safe BC claim.
- M5** Work Safe BC refused your claim submission the physio stream was not authorized. If clarification required contact WSBC Adjudicator.
- M6** Work Safe BC refused your claim submission. The fee item is not appropriate for the Work Safe BC claim decision.
- M7** Work Safe BC refused claim. Semi-private room was not billed with per diem.
- M8** Work Safe BC refused claim. Physiotherapy home visit travel only paid with visit.
- M9** Work Safe BC refused your claim submission – submitted fee item does not fall under physio treatment stream on file.
- NA** Payable at 50% when billed with delivery fees.
- NB** Fee item 14094 is only payable following a vaginal delivery.
- NC** 04116 is only applicable in the immediate post-partum phase.
- ND** Pre-natal visit fees are not payable within the post-natal period.
- NE** Included in the fee for delivery, caesarean section or post-natal care.
- NG** Additional prenatal visits must be supported by medical necessity.
- NH** Included in fee items 04025, 04050, 04052, 14108 and 14109.
- NI** Only one prenatal complete examination (00101/14090) is payable per physician per pregnancy.
- NJ** Multiple call backs are not normally paid with delivery. Provide details of serious complication(s) requiring additional emergency care.
- NK** Timing for fee item 14199 begins after two hours of continuous care during second stage of labour.
- NL** This claim has been paid to the obstetrician.

- NM** The incentive for full service GP obstetrical bonus is only applicable when fee item 14104, 14108 or 14109 is paid to the same physician/same day. .
- NO** Item 14000 is only payable when the physician attends one delivery on the date billed
- NP** Fee item 14000 is payable for the first delivery the GP attends on the date billed, to a maximum of 25 bonuses per calendar year.
- NQ** The incentive for full service GP obstetrical delivery bonus is payable for the first delivery the GP attends on the date billed.
- NR** The incentive for full service GP obstetrical delivery bonus is payable to a maximum of 25 bonuses per calendar year.
- NS** You have reached or exceeded the practitioner calendar year limit for this service.
- NV** This fee item is only payable to the physician who has provided the majority of the longitudinal general practice care to the patient over the preceding year.
- NW** This fee item is not payable for services provided by physician who are working under a salaried, sessional or service contract arrangement.
- N1** Work Safe BC refused – long term care not paid when an acute care per diem or an emergency visit has been paid.
- N2** Work Safe BC refused – case per diem unless it is the day of admission.
- N3** Work Safe BC refused – medical misc take away items must be billed on the same date as an emergency visit or day care surgery or on the day of acute care discharge.
- N4** Work Safe BC refused – billing submitted more than 90 days after service rendered.

- N5** Work Safe BC refused – hospital service not payable with already paid services.
- N6** Work Safe BC refused – dressing change – booked outpatient visit is not paid. With acute care per diem unless it is the day of admission.
- N7** Work Safe BC refused – sterile environment booked out patient visit is not paid with acute care per diem unless it is the day of admission.
- N8** Work Safe BC refused – ward rate – differential must be billed for same date of service as acute care per diem.
- N9** Work Safe BC refused – call out charges not payable for service(s) billed.
- OA** Primary and secondary wound management fees are only applicable with fees from the Orthopedic Section.
- OH** Adjusted to the appropriate fee/amount for an open reduction and/or compound fracture.
- OI** External fixation is not payable with an open reduction fee.
- OJ** Remanipulation is not payable to the same physician within five days of the initial procedure.
- OL** Primary wound care management fees are not stand alone items. Please rebill with the appropriate fracture fee if applicable.
- OM** 51037/51038 is only paid with applicable orthopaedic section items.
- 02** Work Safe BC refused – this service does not meet the criteria for fee item billed if clarification required contact Work Safe BC Payment Services Department.
- 03** Work Safe BC refused payment – expedited consult cancelled less than 24 hour notice or no show occurred. If clarification required contact WSBC Payment Services Department.
- PA** 00622 has been paid for another dependent. This fee includes parental assessment.

- PB** Consultations for two family members or more require individual referrals and must be seen separately.
- PC** Psychotherapy sessions extending beyond one hour per day must be supported by an explanation of need.
- PD** Family therapy is only payable on one member's PHN.
- PE** Invalid service clarification code for psychiatry fee item.
- PF** Invalid service clarification code for Rural Retention Premium.
- PG** Specialty invalid for Rural Retention Premium.
- PH** PCO Registration submitted for a PHN that is currently registered to an associated primary care organization.
- PI** Adjustment due to PHN registration change.
- PJ** PHN not registered on service date. Claim for a non physician and/or billed fee item does not meet conversion to fee for service criteria.
- PK** Adjustment due to PHC registration change E-debit only, no matching credit created.
- PL** Rural retention is not applicable to the geographic location where the service was provided.
- PO** Beneficiary reimbursement for services.
- PW** Resubmit as extended services code (960xx) or MSP fee code with an explanatory note.
- PZ** Please resubmit with child's PHN. Consider registering PHN with the primary care organization.
- P0** Claim for a non-physician and/or billed fee item does not meet conversion to fee for service criteria.
- P1** Related claims have been paid by ICBC. Please check your records and rebill using MVA indicator "Y", if necessary.
- P2** Partial payment from ICBC for one service.
- P3** Related claims have been paid by WCB. Please check your

records and rebill using insurer code "WC", if necessary.

- P5** Not approved for service.
- P6** PHN not registered to primary care organization.
- QA** An Operative Report is required to assess this claim.
- QB** An Operative Report and the medical necessity is required to assess this claim.
- QC** The medical necessity is required to assess this claim.
- QD** Written support for two assistants is required from the surgeon.
- QE** Service is within the pre or post-operative period.
- QF** Pre and/or post-operative services have been deducted from this claim.
- QG** Service is included in the composite surgical/procedural fee.
- QH** Independent procedures are not payable with other services.
- QI** 13612 is per laceration. If resubmitting, bill each laceration separately, and state length of any over 5 cm.
- QJ** Adjusted to agree with the surgical/assist fee item paid for this date of service.
- QK** Assistance at surgery/diagnostic procedures usually performed by one physician is not payable.
- QL** Assists and visits are not paid together unless distinct unrelated times are provided.
- QM** Multiple procedures at the same time, the lesser fee(s) paid at 50%.
- QP** Repeat/staged procedures are not paid within designated time limit.
- QQ** 07043 / 77043 is not applicable according to the information provided.
- QR** A surgical surcharge is not applicable as the procedure billed is not considered a surgical item.

- QS** 07019/70019/70020 requires confirmation of medical necessity from surgeon.
- QT** Payment at 75% is not applicable.
- QU** Unassociated multiple procedures at the same time, the lesser fee is paid at 75%.
- QV** 07043 is only paid with applicable general surgery items.
- QW** Pre-approval is required for this fee item. Please resubmit upon approval.
- QX** A new authorization is required after 12 months per Preamble B.16.1(9). Please rebill after a new authorization is received, if applicable.
- QY** ICBC refusal. No refusal reason code.
- QZ** 77043 is only paid with applicable vascular surgery items.
- Q1** Long-term care institution visits have been paid during the time you are billing for home visits. Please verify location of service.
- Q2** Home visits have been paid during the time you are billing for long-term care institution visits. Please verify location of service.
- RA** Claim has been paid under the composite fee 08547 which includes 08530, 08537, 08544 and 08545.
- RB** X-rays billed by non-certified radiologists are paid at 75%.
- RC** Your rebilling has been refused. A retroactive adjustment will be made on a future remittance statement.
- RD** Payment has been reduced as this fee item is paid on a “per case basis”.
- RE** Encounter received.
- RF** Encounter required – patient registered to primary care organization.
- RG** Encounter record converted to fee for service.
- RH** Amount greater than \$0 billed on an encounter record.

- RI** RGP fee for service. Claims are not valid for dates of service greater than June 30, 1995.
- RJ** Registration must be submitted by a medical doctor.
- RK** Fee for service record converted to an encounter record.
- RL** Payable only for approved procedures.
- RM** The miscellaneous fee item billed has been changed to this established fee item.
- RN** Dental/oral surgery with extractions – the higher gross fee item(s) are paid at 100% and extractions in the same quadrant paid as “each additional tooth”.
- RO** Multiple dental/oral surgeries are paid as the larger fee at 100%; the lesser fee at 50% unless otherwise stated in the MSP Dental Schedule.
- RQ** This fee item is payable once per jaw.
- RS** A claim for this service has been paid within the previous 12 months.
- RT** A claim for this service has been paid within the previous 12 months to another practitioner.
- RW** This item is not applicable unless continuous time is spent with the patient.
- RX** Critical care fees are not applicable when the service starts after 2200 hours.
- RY** The maximum rate paid for these multiple laparoscopic operations is the rate payable for fee item 042229. This service exceeds the maximum.
- RZ** A visit is not payable in addition to an OSMV or MHR form fee when the patient is seen for the same diagnosis.
- SA** WCB refused your claim submission. Only one course of treatment acceptable per day. If clarification required contact WCB Health Care Services.

- SB** WCB refused your claim submission. Concurrent treatment not authorized. If clarification required contact WCB Health Care Services.
- SC** WCB refused your claim submission. Additional area not authorized. If clarification required contact WCB Adjudicator.
- SD** WCB refused your claim submission. Date of injury does not match WCB records. Clarify and resubmit if WCB claim.
- SE** WCB refused your claim submission. Area of injury provided does not match WCB records. Clarify with patient and resubmit with revised information if WCB claim.
- SF** WCB refused your claim submission. Date of birth does not match WCB records. Clarify with patient. Resubmit with revised information if WCB claim. Have patient advise WCB correct date of birth.
- SG** WCB refused your claim submission. The WCB claim number not valid for this patient name. Please clarify and resubmit with revised information if WCB claim.
- SH** WCB refused your claim submission. PHN does not match WCB records. Clarify with patient and resubmit with revised information if WCB claim.
- SI** WCB refused your claim submission. Unable to locate WCB claim for this patient. Please clarify with patient. Resubmit with revised information if WCB.
- SJ** Unable to locate WCB form. Please verify payee number and date of service on invoice and resubmit with revised information.
- SK** Invalid WCB form type.
- SL** WCB has refused your claim. Fee item billed is invalid for form type.
- SM** Your claim has been refused. Please resubmit with WCB fee item for WCB services.
- SN** This service is the responsibility of WCB. Please resubmit with WC insurer code.
- SP** Fee item limit exceeded for this patient. If clarification required

contact WCB Health Services.

- SQ** Fee item daily limit exceeded for this patient. If clarification required contact WCB Health Care Services.
- SR** Invalid fee item for WCB claim. Please resubmit using the appropriate MSP/WCB fee item.
- SS** WCB refused claim. Treatment plan not received by WCB Adjudicator, contact WCB Claims Adjudicator.
- ST** WCB refused your claim submission. Service required WCB pre-authorization.
- SU** WCB refused your claim submission. Surgery was not accepted as WCB responsibility
- SV** WCB refused your claim submission. Services must be performed within the 42 day post operative period to qualify for payment.
- SW** WCB refused claim. Return to work education session must be completed in initial visit
- SX** WCB refused your claim. Worker appeal denied and medical-legal fee not payable by WCB.
- SY** WCB refused claim. Medical-legal fee adjusted to fee schedule. If clarification required contact WCB Health Care Services.
- SZ** WCB refused claim. Invalid body part code. Please resubmit with amended information.
- S0** Work Safe BC treatment/service was not requested.
- S1** Work Safe BC refused claim. Invalid nature of injury code. Please resubmit with amended information.
- S2** Work Safe BC refused claim. Invalid side of body code. Please resubmit with amended information.

- S3** Work Safe BC refused your claim submission. Transmitted record had an invalid NOI/body part combination.
- S4** Work Safe BC refused your claim submission. Transmitted record had an invalid body part/anatomical position combination.
- S5** Work Safe BC refused your claim submission. Transmitted record had an invalid NOI/anatomical position.
- S6** Work Safe BC refused your claim submission. Transmitted record had multiple invalid codes.
- S7** Work Safe BC refused your claim submission. Transmitted record had a date of injury prior to the date of birth.
- S8** Work Safe BC refused claim. Physio treatment prior to initial treatment.
- S9** Work Safe BC refused claim. Physio treatment plan must have same date of service as initial visit or assessment treatment visit.
- TA** Patient's annual limit for this benefit has been reached.
- TB** This fee is paid only once per patient, per year.
- TC** Balance owing on previously paid account.
- TD** Less than 3 months have elapsed since the last visit for this condition.
- TE** Less than 21 days have elapsed since the last visit for this condition.
- TF** Less than 3 months have elapsed since the last paid treatment.
- TG** As no authorization has been received, your account has been refused.
- TH** Fee item 02897 is included in fee 02899.
- TI** Two PVCs have been deducted as two services were rendered.
- TJ** 00159 is the only fee applicable for institutionalized patients.
- TK** This item is not applicable until the MSP age appropriate

counselling fee item (00120, etc) calendar year limit (4) has been utilized.

- TL** ICBC approved claim with referring doctor number 99990.
- TM** ICBC approved claim with referring doctor number 99995.
- TN** PVC has been deducted.
- TO** This claim is the responsibility of ICBC.
- TP** Previous visit within 6 months for same condition.
- TR** ICBC claim is outside of approved treatment dates.
- TS** Payment has been made in accordance with the information provided by the referring physician.
- TT** Authorized payment amount has been reached.
- TU** Details required for frequency of servicing. Please resubmit with explanation in note record.
- TV** Service included in initial examination.
- TW** Payment has recently been made to other optometrist for this service.
- TX** ICD9 code does not match published list.
- TZ** Retroactive adjustment.
- T0** Fee item 02898/02899 is included in fee 02894/02895.
- T1** Extractions in conjunction with osteotomies/fractures – bill extractions as “each additional tooth per quadrant” regardless of the number of quadrants involved.
- T2** Please resubmit with location of extraction, lesion, etc.
- T3** A1234565 is not an acceptable ICBC claim number.
- T4** ICBC refused. This may be a WCB claim. Please contact ICBC.
- T5** Services exceed ICBC coverage limit. Please contact ICBC.

- T6** ICBC refused responsibility. Please contact adjuster.
- T7** Therapy treatment discontinued by medical practitioner. Please contact ICBC.
- T8** Claimant has private plan for therapy. Please contact ICBC.
- T9** ICBC customer unknown - please contact ICBC.
- UA** This claim was assessed by the Plan's Medical and Surgical Advisors.
- UB** Claim has been paid/refused pending review by our Medical Advisors. You will be notified of any changes.
- UC** If you disagree with the payment made, please refer to appropriate committee of the BCMA.
- UD** Paid according to Reference Committee recommendations.
- UE** Computer processed in accordance with Medical Services Commission Payment Schedule.
- UF** Invalid MVA - no injury claim.
- UG** Breach of ICBC coverage.
- UH** MVA prior to April 1, 1994.
- UI** Duplicate KOL 35 - contact ICBC if necessary.
- UJ** No ICBC claim for PHN - use ICBC number.
- UL** WCB refused claim. The maximum number of services has been exceeded.
- UM** WCB refused claim. The physiotherapy treatment was not authorized for an extension. If clarification is required please contact the WCB office.
- UN** WCB refused claim. Physiotherapy plan/report for home visit must have the same date of service as the first home visit.

- UO** WCB refused claim. Physiotherapy plan/report for CNS disorder must have the same date of service as the first central nervous disorder visit.
- UP** Claim refused as ICBC responsibility. Please rebill ICBC directly or if patient qualifies for MSP therapy benefits, please bill MSP. ICBC claim # not required.
- U1** Patient benefit limit reached - refractions are only payable once every 24 months for patients between the ages of 16 and 64.
- U2** A refraction has been previously paid to a different specialty - refractions are only payable once every 24 months for patients between the ages of 16 and 64.
- U3** Insufficient information has been provided to authorize a repeat refraction within 24 months.
- U4** Routine eye examinations are not a benefit of MSP
- U5** Insufficient medical necessity provided for a repeat eye examination for the diagnosis indicated.
- VA** Payment number is missing or invalid.
- VB** Invalid payment number for tape or diskette submission.
- VC** Payment number not valid for this batch.
- VE** Amount billed is missing or invalid.
- VF** Number of services is missing or invalid.
- VG** Fee item is missing or invalid.
- VH** Date of service is missing or invalid.
- VI** Practitioner number is missing or invalid.
- VJ** Invalid diagnostic code for referral by oral/dental surgeon or orthodontist. Diagnosis must relate to problems with mouth or mastication.
- VK** Claim number is missing or invalid.
- VL** Claim number is out of sequence.

- VM** Referring practitioner number is missing or invalid.
- VN** Diagnostic code missing or invalid.
- VO** Anatomical position invalid.
- VP** Service to-date missing or invalid.
- VQ** The number of services exceeds the maximum allowed.
- VR** Critical care must be submitted on a claim card with a covering letter providing the details.
- VS** The to/by indicator for the referring doctor is invalid.
- VT** Claim has been paid/refused pending review. You will be notified of any changes.
- VU** Nature of injury missing or invalid.
- VV** Date of injury missing or invalid.
- VW** WCB claim number invalid.
- VX** Medical practitioner referral required by ICBC. Please contact ICBC.
- VY** Area of injury missing or invalid.
- VZ** ICBC claim number invalid for WCB claim.
- V2** Reserved for ICBC misc. adjustments where two bills are sent for one service.
- V3** Field(s) designated for future use contain(s) invalid data - refer to current Teleplan specs.
- V4** WCB refused claim. No initial physio visit Contact WCB Claims Adjudicator.
- V5** WCB refused claim. Physio requested report not received by WCB Adjudicator. Contact WCB Claims Adjudicator.
- V8** Paid according to your MSP orthodontia contract.
- V9** This patient is not user fee exempt for this date of service.

- W\$** Work Safe BC claim submitted to Work Safe BC on paper.
- WA** Service not approved for this payment number or date of service prior to approval date.
- WB** WCB customer unknown. Please clarify with patient and resubmit with correct information if WCB.
- WC** Fee item not listed with Medical Services Plan.
- WD** WCB claim disallowed. If clarification required contact WCB Health Care Services.
- WE** Hospital payee claim submission refused. Bill WCB directly.
- WF** Fee item billed and doctor's specialty/practitioner number do not correspond.
- WG** Fee items with letter prefix 'A' are not benefits of the Plan.
- WH** We are unable to process a single claim for two different patients.
- WI** Billing is incomplete. Please resubmit with all required information.
- WJ** WCB refused responsibility. Please contact Criminal Injuries Compensation.
- WK** Please rebill with initial fee for the first service and the additional fee for each additional service performed.
- WL** Mailed submission. Fee \$0.00 per BCMA Agreement.
- WM** WCB refused your claim submission. Treatment limit exceeded. If clarification required contact WCB Adjudicator.
- WN** Pre-authorization number valid.
- WO** Pre-authorization number invalid.
- WP** Pre-authorization permits payment of this inactive coverage.

- WQ** WCB claim refused - approval outstanding - pending time exceeded. Please resubmit using submission code "W".
- WR** Pre-authorized number invalid.
- WS** Date of service prior to WCB injury. If clarification required please contact WCB.
- WT** Tray service payable only on same date of service as approved procedure.
- WU** WCB refusal reason unknown. Please contact WCB.
- WV** Unknown reason for refusal or change to fee item and/or amount. Please contact WCB.
- W0** Work Safe BC refused your claim submission. Report incomplete. If clarification required contact WCB Health Care Services.
- W1** Postal code missing or format invalid.
- W2** Data centre and payee number combination not on file.
- W3** Payee not active.
- W4** Use claims comment or note record. Please do not use both.
- W5** Note data type not equal to "A".
- W6** Note data line blank (no data).
- W7** Provincial institution not applicable for batch eligibility.
- W8** Dependent 66 not applicable for batch eligibility.
- W9** Greater than three errors for this claim.
- XA** RCP claims - birthdate and sex code missing or invalid.
- XB** Eligibility Request - invalid patient status request code used.
- XC** Eligibility Request - invalid sex code.
- XD** Invalid/insufficient information provided. (In note or claim

comment field/description area.)

- XE** PHN not 9128673459 for fee items 00158/00164.
- XF** Fee items 00158/00164 - patient name not P. Session.
- XG** Note comment does not correspond with submission code.
- XH** This claim has been returned to you per your submission code E request record.
- XJ** Please resubmit on the appropriate claim card.
- XK** RCP/Registration Number is not numeric or is equal to zero.
- XL** WCB claim number has been added/updated. Please contact WCB for correct claim number.
- XM** PCO – ICBC has refused responsibility for this claim.
- XN** PCO – encounter record created to replace fee for service claim refused by ICBC.
- XP** ICBC refused – claim processed by MSP.
- XQ** WCB claim - date of service prior to May 8, 1996
- XR** WCB claim - injured worker not covered under the WCB Act. If clarification required, please contact WCB adjudicator.
- XS** WCB claim refused - claim suspended pending further investigation. If clarification required, please contact WCB adjudicator.
- XT** Date of injury does not match WCB records. Please clarify with your patient - resubmit with revised information if WCB claim.
- XU** WCB refused claim. Report not required. Contact WCB Health Care Services.
- XV** WCB refused claim. Time limit for report submission exceeded. If clarification required, contact WCB Health Care Services.

- XW** WCB refused claim. WCB did not receive report. If clarification required, contact WCB Health Care Services.
- XO** Fac – Prac or Payee fac not connected
- X1** Original MSP file number invalid.
- X2** Facility number is missing or invalid.
- X3** Sub-facility number is missing or invalid.
- X4** RCP/Institution number missing, invalid, or not in correct format.
- X5** RCP/Institution birthdate missing or invalid.
- X6** RCP/Institution first name missing or invalid.
- X7** RCP/Institution second initial invalid.
- X8** RCP/Institution - patient sex code missing or invalid.
- X9** RCP address missing or not showing in line one.
- YA** Note record missing or invalid for submission code C, E or X.
- YB** This Teleplan record code is not operational. Please contact Teleplan Support.
- YC** Claim number refused by ICBC. Please contact ICBC.
- YD** Insurer code does not match fee item billed. This fee item is only applicable for ICBC billings.
- YF** Fee item valid for WCB claim only.
- YH** No payment owing. Insurer code adjusted.
- YI** Provincial institution not valid for WCB claim.
- YK** Claim reprocessed at the request of WCB.
- YN** Newborns invalid for WCB claim - Dep 66.
- YP** WCB claim must be submitted by PHN.

YR Claim reprocessed/adjusted at the request of ICBC to change insurer responsibility.

YS Specialty invalid for WCB claim.

YT WCB claim must be Teleplan for opted in practitioner.

YU ICBC refusal reason unknown - Please contact ICBC.

YV Data Centre change. Record submitted by previous data centre being returned to new data centre.

YW Insurer responsibility switched at the request of ICBC.

YX Claim reprocessed at the request of ICBC.

YY Pre-Edit System refusal. See second explanatory code(s).

YZ Facilities edit refusal.

Y1 Billed fee prefix invalid.

Y2 Pre-authorization code missing or invalid.

Y3 Submission code invalid.

Y4 Service location code missing or invalid.

Y5 Referring practitioner code 1 missing or invalid.

Y6 Referring practitioner code 2 missing or invalid.

Y7 Correspondence code invalid.

Y8 MVA claim code invalid.

Y9 ICBC claim number invalid.

ZI Note record is not preceded by correspondence code equal to "N" or "B" or practitioner number does not match C01/C02 record.

ZJ PHN equals zero and province code equals zero or blanks.

- ZK** A note record did not accompany correspondence code "N" or "B" or payee number does not match C02 record.
- ZL** RCP province code is present and PHN not equal to zero.
- ZM** Coverage good - batch eligibility. This code is used in Teleplan II.
- ZN** No coverage - batch eligibility. This code is used in Teleplan II.
- ZS** The referring doctor number has been changed to correspond with our records.
- 1B** This fee item not valid for services provided in BC. Please resubmit with appropriate fee item.
- 1W** Work Safe BC claim submitted to Work Safe BC on paper – Work Safe BC adjusted – keying fee deducted.
- 2W** Work Safe BC claim submitted to Work Safe BC on paper – refused by Work Safe BC.