Invoicing and Reporting FAQ

JULY 2019

Q. How do we handle obtaining patient consent and sharing reports with ICBC?

A. The *Insurance (Vehicle) Act* requires health care practitioners to provide ICBC, upon request, with reports containing medical information, to the extent that the information is known by the health care practitioner. At the end of the report template, there is a check box to indicate that the report is being shared with consent.
While it is always preferred to receive information with client consent, ICBC notes that there is a provision in PIPA, s. 18(1)(o), that allows disclosure of information without consent if the disclosure is required or authorized by law. Therefore, it is ICBC's position that provision of the information is required by law, and PIPA allows disclosure of medical information for the purposes set out in the *Insurance (Vehicle) Act.*

ICBC has been made aware that some stakeholder groups have received circulating information citing restrictions for health care providers providing patient information to ICBC representatives. Please be aware it is ICBC's position that the Personal Information Protection Act (PIPA) does not override the *Insurance (Vehicle) Act* or its *Regulation*.

Providing the best possible care for your patient remains our top priority. As such, a patient consent considerations document has been created to outline some of the consent considerations that may arise related to ICBC reports in your practice. For further support, we encourage you to refer to your regulatory college or association.

Q. Is tax applied for invoicing?

A. The posted regulated fees do not include taxes. The HCPIR web application applies tax when applicable.

If you are unsure of your tax status you should consult a tax professional.

Additional notes on taxes and invoicing:

- Please ensure your vendor number is updated to identify whether your business is a small supplier or includes their GST number.
- You may submit taxable and non-taxable services in the same invoice submission if those services are attached to your vendor number.
- To update a vendor number, fill out the e-form on ICBC's Business Partners Health Services site.

Q: How will I know when invoices have been paid?

A. If an invoice is approved by ICBC within seven days from the date of submission, then payment will be issued at the seven-day mark, measured as seven days from the date of submission to ICBC. If the seven-day mark falls on a Saturday or Sunday, payment will be issued on the Monday.

If it is your first time submitting an invoice through the HCPIR application, you may experience a slight delay in receiving the payment due to the transition to a new payment cycle.

In some instances, the claims representative will be required to review invoices for approval. Occasionally, this process may lead to the invoice being approved after the seven-day window has lapsed (e.g. submission dated April 1 and payment is approved on April 9, then payment will be issued

on April 10). When this occurs, payment will be issued the day after the invoice has been approved. If the day after approval falls on a Saturday or Sunday, payment will be issued on the Monday.

The health care provider can review their statement to confirm which invoices have been paid. A unique reference number from the HCPIR prints onto your statement, so this should assist with payment reconciliation.

Note: Invoices submitted relating to single-alpha claim numbers (e.g. A000000-0) will not be approved for payment within the 7-day time frame. Single-alpha claim numbers are managed in a separate claims software solution which requires Claims Representatives to review all invoices for approval.

Q: Are progress reports required by ICBC? If so, when do they need to be submitted? What is the fee?

A. Progress reports (more commonly referred to as reassessment reports) are only required to be submitted to ICBC *upon request* from the Claims Specialist. A reassessment report may be requested when a patient has not returned to function and there continues to be significant barriers in returning to function or activities of daily living. Reassessment reports may also be required to support funding for treatment extension requests.

   Fees for these reports are listed on your specific health care provider page on ICBC's Business Partners Health Services site.

Q: Is there a separate invoicing fee for completing extension requests?

A. There is no fee associated with a treatment extension request. The extension request is not a report, but does require that information be provided to support ongoing treatment, such as outstanding functional goals and how further treatment will be directed at achieving said goals.

Q: Does every initial assessment require a report across health care providers?

A. Assessment report templates have been developed for chiropractors, counsellors, kinesiologists, occupational therapists, psychologists, physiotherapists, and physicians, and are requested to be submitted to ICBC when a customer consents to sharing their information, or upon receipt of a request letter from ICBC for the information.

   Registered massage therapists and acupuncturists will not be requested to submit reports to ICBC. A Claims Specialist may request clinical records or chart notes from any of the above health care providers, which can be provided to ICBC with patient consent.

Q: How quickly does the initial assessment report need to be submitted to ICBC? How do we bill if it takes multiple treatments to complete the initial assessment?

A. We request that you submit the assessment report within seven to 10 days of the assessment visit(s), or as early as possible.

We heard in consultations with health care providers that when a patient presents with several injuries, the initial report may require more than one or two sessions to complete.

For example, if three sessions are needed to complete the assessment, please submit invoices via HCPIR for the first two sessions as standard treatments. Once the initial report is complete after the third session, this would be the time to invoice the initial assessment & visit via the HCPIR application. When a report is submitted using the HCPIR application, it will automatically apply both the assessment and report fee; these fees are indivisible under the new regulation fee schedule.

Q: Can the initial report be submitted separately from the invoice on the HCPIR application?

A. The initial report cannot be submitted separately from an invoice. The assessment visit and report is a combined fee, as stipulated in the regulation.

Q: Is it possible to submit multiple invoices at once through the HCPIR application? Can multiple treatment sessions, with different health care providers, be invoiced on the same day?

A. Invoicing through the HCPIR is by claim number. For example, if your patient received treatment for both counselling and physiotherapy in the same day, you may invoice for both types of treatment on the same submission on the same day. However, you cannot submit multiple invoices with different claim numbers in the same submission.

Q: Are discharge reports required for claims?

A. Only occupational therapists will be requested to submit a discharge report for patients who have been discharged from care following a motor vehicle accident. All other health care providers will be requested to submit a discharge notification via the HCPIR application.

Q: Can corrections be made through the HCPIR on submitted invoices?

A. No, corrections cannot be made through HCPIR once a submission has been completed. When required, the health care provider may contact the Claims Vendor Inquiry unit (claimsvendorinquiry@icbc.com) with payment inquiries.

Q: Can health care providers choose to invoice the ICBC customer directly, instead of direct billing ICBC? What is the required date for submitting receipts?

A. To avoid patients being out-of-pocket for expenses, we encourage all providers to direct bill ICBC.
If you opt not to directly bill ICBC for the regulated fees, you may invoice the ICBC customer. The ICBC customer must submit the receipt to ICBC for reimbursement, up to the regulated fee, within 60 days of the treatment date, unless they have a reasonable excuse for not doing so. Fees charged in excess of the regulated fee amount may be payable by a third party health benefits provider. These fees will not be recoverable from ICBC for claims with an accident date of April 1, 2019, or thereafter.

Invoicing & Reporting FAQ

Q: How does invoicing work for physiotherapist-led active rehabilitation?

A. You may continue to invoice as normal using invoices@icbc.com for all current programs authorized by the Claims Specialist. All active rehab programs provided by a physiotherapist require exception approval by the claims or recovery specialist

The approved rates for physiotherapy-administered treatments remains at a maximum of $85 per session. All physiotherapy specialities, including physio-administered AR, are currently under review. We will notify you when any policy changes come into effect. Please be aware that ICBC is moving away from authorizing physio-led AR in favour of more cost-effective approaches, except where access to treatment is limited or under other exceptional circumstances.

Q: How do I invoice for vestibular physiotherapy in the HCPIR?

A. Vestibular physiotherapy is included in the regulated rate for a standard treatment. Vestibular physiotherapy has always been billable via MSP Teleplan using *Prolonged Visit, CNS* code (9935) as per the MSP physiotherapy fee schedule. Since MSP Teleplan has been discontinued, and its associated fee schedule replaced by the regulated rate of $79 per treatment, these treatments are to be administered under the regulated amount and within the pre-authorized treatment amount. Should treatments be required beyond 12 weeks or 25 sessions (inclusive of any other physiotherapy sessions the patient is attending) a treatment extension request is required. This can be completed via the HCPIR invoicing and reporting application or directly to the claims or recovery specialist.

Q: Is there a need to confirm with ICBC that the claim is ready for invoicing for the initial pre-authorized 25 treatments?

A. No. The health care provider may begin treating a patient within the first 12 weeks following the crash without approval from the Claims Specialist, so long as the patient provides a valid claim number. In addition, treatments provided within this time frame do not require a written referral from the primary care provider.

Q: Do patients have to exhaust any extended health coverage for treatments prior to invoicing ICBC?

A. As of April 1, 2019, ICBC became the primary payer (first payer) for the types of health care services listed under Schedule 3.1 of the *Insurance (Vehicle) Regulations* in addition to occupational therapy services. Other types of medical services may require the customer to submit to their extended health insurance provider first. Further questions can be referred to the ICBC Claims Specialist.

Q: What are the other billable expenses and how do you invoice for them? Do they require pre-approval?

A. Related expenses such as equipment and travel that can be invoiced via the HCPIR are listed in the HCPIR drop down menu. These items require pre-approval.

Q: Is there a preferred or required frequency for invoicing?

A. No. The HCPIR application can be used by health care providers for submitting invoices at a frequency that works best for their business.