PREAMBLE TO THE PAYMENT SCHEDULE

DEFINITIONS

In this document:

“**emergency room physician**” means either a medical practitioner who is a specialist in emergency medicine or another medical practitioner who is physically and continuously present in the Emergency Department or its environs for an arranged, designated period of time;

“general practitioner” means a medical practitioner who is registered with the College of Physicians and Surgeons of British Columbia as a General Practitioner;

“**health care practitioner**” means the following persons entitled to practice under an enactment:

a) a chiropractor;
b) a dentist;
c) an optometrist;
d) a podiatrist;
e) a midwife;
f) a nurse practitioner;
g) a physical therapist;
h) a massage therapist, or;
i) a naturopathic physician.

“**medical practitioner**” means a medical practitioner as entitled to practice under Section 34 of the *Medical Practitioners Act;*

“**practitioner**” means

a) a medical practitioner, as defined above, or
b) a health care practitioner who is registered with the Medical Services Plan;

“**specialist**” means a medical practitioner who is:
a Certificant or a Fellow of the Royal College of Physicians and Surgeons of Canada; and/or be so recognized by the College of Physicians and Surgeons of British Columbia in that particular specialty.

A. ADMINISTRATION

1. Fees Payable by the Medical Services Plan (MSP)

A Payment Schedule for medical practitioners is established under Section 26 of the *Medicare Protection Act* and is referred to in the Second Master Agreement between the Government of the Province of British Columbia and the Medical Services Commission (MSC) and the British Columbia Medical Association (BCMA). The fees listed are the amounts payable by the Medical Services Plan (MSP) of British Columbia for listed benefits. “Benefits” under the Act are limited to services which are medically required for the diagnosis and/or treatment of a patient, which are not excluded by legislation or regulation, and which are rendered personally by medical practitioners or by others delegated to perform them in accordance with the Commission’s policies on delegated services. Services requested or required by a “third party” for other than medical requirements are not insured under MSP. Services such as consultations, laboratory investigations, anesthesiology, surgical assistance, etc., rendered solely in association with other services which are not benefits also are not considered benefits under MSP, **except in special circumstances as approved by the Medical Services Commission (e.g.: Dental Anesthesia Policy).**

2. MSP Billing Number

A billing number consists of two numbers - a practitioner number and a payment number. The practitioner number identifies the practitioner performing and taking responsibility for the service. The payment number identifies the person or party to whom payment will be directed by the Medical Services Plan (MSP). Each claim submitted must include both a practitioner number and payment number.

3. Assignment of Payment

An “Assignment of Payment” is a legal agreement by which an attending practitioner designates payment for his/her services to another party. In this circumstance, the designated party may use the attending practitioner’s practitioner number in combination with its own payment number when submitting claims to MSP. To authorize MSP to make payment to a designated party, the attending practitioner must complete and file an “Assignment of Payment” form. However, even though the payment has been assigned, the responsibility for the clinical service and its appropriate billing remains with the practitioner whose practitioner number is used.

4. Reciprocal Claims

All Provinces, and Territories, except Quebec, have entered an agreement to pay for insured services provided to residents of other provinces when a patient presents with a valid Provincial Health Registration Card. Claims can be submitted electronically or by card and details of this process may be obtained by contacting MSP. However, the services listed below are exempt from this agreement and should be billed directly to the non-resident patient.

Medical Practitioner Services Excluded under the Inter-Provincial Agreements for the Reciprocal Processing of Out-of-Province Medical Claims

1. Surgery for alteration of appearance (cosmetic surgery)
2. Gender-reassignment surgery
3. Surgery for reversal of sterilization
4. Therapeutic abortions
5. Routine periodic health examinations including routine eye examinations
6. In-vitro fertilization, artificial insemination
7. Acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy
8. Services to persons covered by other agencies; RCMP, Armed Forces, Workers' Compensation Board, Department of Veterans Affairs, Correctional Services of Canada (Federal Penitentiaries)
9. Services requested by a "Third Party"
10. Team conference(s)
11. Genetic screening and other genetic investigation, including DNA probes
12. Procedures still in the experimental/developmental phase
13. Anesthetic services and surgical assistant services associated with all of the foregoing.

The services on this list may or may not be reimbursed by the home province. The patient should make enquires of that home province after direct payment to the BC medical practitioner.

5. Setting of Fees - General Considerations

This Section refers to internal BCMA policy and, therefore, is not included in the MSC Payment Schedule.

6. Modifications to the MSC Payment Schedule

Under the Master Agreement between the MSC and the BCMA, additions, deletions, fee changes or other modifications to the MSC Payment Schedule are made by the Medical Services Commission, upon advice from the BCMA. Services not listed in the MSC Payment Schedule must not be billed to MSP under other listings. Medical Practitioners who wish to have modifications to the Schedule considered should submit their proposals to the BCMA Tariff Committee through the appropriate Section. On recommendation of the BCMA Tariff Committee, interim listings may be designated by the Commission for new procedures or other services for a limited period of time to allow definitive listings to be established, if appropriate.

7. Miscellaneous Services

For unusually complex procedures, for established but infrequently performed procedures which are not listed in the MSC Payment Schedule, for unlisted "team" procedures, or for any medically required service for which the medical practitioner desires independent consideration to be given by MSP, a claim should be submitted under one of the "miscellaneous" fee codes. A complete list of the miscellaneous fee codes is outlined below. When submitting claims under a miscellaneous fee code, an estimate of an appropriate fee should be included, with details of the calculation of that fee and sufficient documentation of the services (such as the operative report) to substantiate the claim. Claims made under the miscellaneous codes will be adjudicated in equity with services of similar responsibility, skill and duration.

Miscellaneous (...99) Fee Items

00099 General Services
00199 General Practice
00299 Dermatology
00399 General Internal Medicine
00499 Neurology
00599 Pediatrics
00699 Psychiatry
00999 Diagnostic Procedures
01799 Physical Medicine
01999 Anesthesia
02599 Otolaryngology
02999 Ophthalmology
03999 Neurosurgery
04999 Obstetrics & Gynecology
06999 Plastic Surgery
07999 General Surgery/Cardiac Surgery
08699 X-ray
08899 Miscellaneous Diagnostic Ultrasound
08999 Urology
09899 Nuclear Medicine
30999 Clinical Immunology and Allergy
31999 Rheumatology
32999 Respirology
33199 Cardiology
33299 Endocrinology and Metabolism
33399 Gastroenterology
33499 Geriatric Medicine
33599 Hematology and Oncology
33699 Infectious Diseases
33899 Nephrology
59999 Orthopaedics
77799 Vascular Surgery
79199 Thoracic Surgery
94999 Laboratory Medicine

8. Inclusive Fees

If it is not medically necessary for a patient to be personally reassessed prior to prescription renewal, specialty referral, release of laboratory results, etc., claims for these services must not be made to MSP regardless of whether or not a medical practitioner chooses to see his/her patients personally or speak with them via the telephone.

Some services listed in the MSC Payment Schedule have fees which are specifically intended to cover multiple services over extended time periods. (Examples are most surgical procedures, the critical care per diem listings and some obstetrical listings.)

When, because of serious complications or coincidental non-related illness, additional care is required beyond that which would normally be recognized as included in the listed service, MSP will give independent consideration to claims for this additional care, when submitted with adequate explanation.

9. Medical Research

Costs of medical services (such as examinations by medical practitioners, laboratory procedures, other diagnostic procedures) which are provided solely for the purposes of research or experimentation are not the responsibility of the patient or MSP. However, it is recognized that

medical research may involve what is generally considered to be accepted therapies or procedures, and the fact that a therapy or procedure is performed as part of a research study or protocol does not preclude it from being a service insured by MSP. In the situation where therapies or procedures are part of a research study, only those reasonable costs customarily related to routine and accepted care of a patient's problem are considered to be insured by MSP; additional services carried out specifically for the purposes of the research are not the responsibility of MSP.

Experimental Medicine

Costs of medical services which are provided for the purpose of what is considered to be experimental medicine are not the responsibility of the patient or MSP.

New procedures and therapies not performed elsewhere and which involve a radical departure from the customary approaches to a medical problem, are considered to be experimental medicine. Services related to such experimental medicine are not chargeable to MSP.

New therapies and procedures which have been described elsewhere may or may not be deemed to be experimental medicine for the purposes of determining eligibility for payment by MSP.

Where such a new therapy or procedure is being introduced into British Columbia and the medical practitioners performing the new therapy or procedure wish to have a new fee item inserted in to the fee schedule to cover the new therapy or procedure, the process to be used is as follows:

An application for a new fee item related to the new therapy or procedure will be submitted by the appropriate section(s) of the BCMA to the BCMA Tariff Committee for consideration, with documentation supporting the introduction of this item into the payment schedule. The BCMA Tariff Committee will advise the Medical Services Commission whether or not this new therapy constitutes experimental medicine. If the Tariff Committee considers that the item is experimental, it will not be considered an insured service and will not be introduced into the fee schedule. If the Medical Services Commission, on the advice of Tariff Committee, determines that the new therapy or procedure is not experimental medicine, the fee item application will be handled in the usual manner for a new fee.

When a new therapy or procedure is being performed outside British Columbia, a patient or patient advocate may request that the services associated with this new therapy or procedure be considered insured services by MSP. The situation will be reviewed by the Medical Services Commission utilizing information obtained from various sources, such as medical practitioners, the BCMA or evidence based research. If it is determined that the new therapy or procedure is experimental, then the cost of medical services provided for this type of medical care will not be the responsibility of MSP. If it is considered that the therapy or procedure is not experimental, the cost of medical services associated with this treatment will be in part or in whole the responsibility of MSP.

If procedures are accepted as no longer being experimental, they will be accepted into the fee guide on an interim basis and will be reviewed again within five years.

10. Missed Appointments

Claims for missed appointments must not be submitted to MSP. Billing the patient directly for such missed appointments would not be considered to be extra billing.

11. Group Practice/Partnerships/Locums

Each medical practitioner will charge for his/her own services. For MSP and WCB billings this requires the use of the individual's personal practitioner number. This includes members of Group Practices, Partnerships and Locums. Exceptions to this rule are the Laboratory Medicine Facilities and where specifically allowed by the MSC.

12. Disputed Payments

Remittance statements issued by MSP should be reviewed carefully to reconcile all claims and payments made. Claims may have been adjusted in adjudication and explanatory codes should designate the reason(s) for any adjustments. If a medical practitioner is unable to agree with an adjustment, the account should be resubmitted to MSP together with additional information for reassessment. Further disagreement with the payment should be referred to the BCMA Reference Committee for review and subsequent recommendation to the Commission.

13. Patient Agreement to Physician Restrictions

A very few patients occasionally develop a pattern of repeatedly visiting many different general practitioners. When this occurs without sufficient medical necessity, these patients may be requested by MSP to sign an "Agreement of Limitation" form. This is a legal agreement which limits the responsibility of MSP for payment to one general practitioner. If care is provided by another general practitioner, then the patient has agreed to accept responsibility for direct payment for that care. General practitioners will be notified when these restrictions are applied by MSP.

14. Extra Billing

"Extra Billing" means billing an amount over the amount payable for an insured service (a "benefit") by MSP. Extra billing is not allowed under the *Medicare Protection Act* except for services rendered by medical practitioners who are not "enrolled" with MSP (i.e. no services are covered by MSP) and then only for those services which are rendered outside of hospitals and community care facilities.

15. Differential Billing for Non-Referred Patients

If a specialist attends a patient without referral from another practitioner authorized by the Medical Services Commission to make such referral, the specialist may submit a claim to MSP for the appropriate general practitioner visit fee and in addition may charge the patient a differential fee. This is not considered "extra billing."

The maximum amount billable as a differential fee is calculated as the difference between the amount payable under the Payment Schedule to a general practitioner for the service rendered, and the amount payable under the Payment Schedule to the specialist had the patient been referred.

16. Balance Billing

Balance billing denotes the practice of medical practitioners who are opted in under MSP billing MSP for the MSP fee and the patient for the amount of the difference between the payment made by MSP for an insured service and the fee for that service listed in the BCMA Guide to Fees, under the heading "BCMA Fee." Except as defined by differential billing for non-referred patients above, balance billing is not presently permitted under the *Medicare Protection Act*.

17. Specialist/General Practitioner Payment

To be paid by MSP or WCB for specialist consultations, visit items and/or other specialty-restricted fee items listed in the specialty sections of the Payment Schedule, one must be a Certificant or a Fellow of the Royal College of Physicians and Surgeons of Canada and/or be so recognized by the College of Physicians and Surgeons of British Columbia in that particular specialty. A specialist recognized in more than one specialty by the College of Physicians and Surgeons of British Columbia should bill consultation and referred items under the specialty most appropriate for the condition being diagnosed and/or treated for that referral/treatment period.

18. MVA Billing Guidelines

1. All cases directly relating to an MVA which ICBC Insurance coverage applies should be identified as such by a "yes" code in the Teleplan MVA field.
2. All such cases should be coded "MVA" regardless of whether seen in an office visit, emergency, lab or x-ray facility. Surgery or procedures performed in regard to these cases should also be identified.
3. Where possible, please attach an ICBC claim number to each coded MVA in your Teleplan billing.
4. In cases where a visit or procedure was occasioned by more than one condition, the dominant purpose must be related to an MVA to code it as such.
5. If the patient is from another province, use the normal out-of-province billing process.
6. In those instances in which the patient has no MSP coverage, the medical practitioner should bill the patient or ICBC directly. Medical practitioners have the choice of either billing the uninsured patient directly at the BCMA recommended rate and having the patient recover the costs from ICBC, or billing ICBC for the MSP amount.
7. If the MVA is work-related, WCB should be billed under their procedures.
8. Medical Practitioners are accountable for proper MVA identification and are subject to audit.

19. Services to Family and/or Household Members

1. Services are not benefits of MSP if they are provided by a medical practitioner to the following members of the medical practitioner's family:

    a) a spouse,
    b) a son or daughter,
    c) a step-son or step-daughter,
    d) a parent or step-parent,
    e) a mother-in-law or a father-in-law,
    f) a grandparent,
    g) a grandchild,
    h) a brother or sister, or
    i) a spouse of a person referred to in paragraph (b) to (h).

2. Services are not benefits of MSP if they are provided by a medical practitioner to a member of the same household as the medical practitioner.

B. TERMS AND DEFINITIONS

1.a. General

All benefits listed in the MSC Payment Schedule, except where specific exceptions are identified, must include the following as inherent in the service being claimed and payment for these inherent components is included in the listed fees:

i) Direct face-to-face encounter with the patient by the medical practitioner or delegate, appropriate physical examination when pertinent to the service and on-going monitoring of the patient's condition during the encounter, where indicated. (Refer to Section B.1.b. Telehealth Services; Section 5 Delegated Procedures).

ii) Any enquiry of the patient or other source, including review of medical records, necessary to arrive at an opinion as to the nature and/or history of the patient's condition.

iii) Appropriate care for the patient's condition, as specifically listed in the Schedule for the service and as traditionally and/or historically expected for the service rendered.

iv) Arranging for any related assessments, procedures and/or therapy as may be appropriate, and interpreting the results, except where separate listings are applicable to these adjunctive services. (Note: This does not preclude medical practitioners rendering referred "diagnostic facility" services from billing for interpretation of diagnostic test results).

v) Arranging for any follow-up care which may be appropriate.

vi) Discussion with and providing advice and information to the patient or the patient's representative(s) regarding the patient's condition and recommended therapy, including advice as to the results of any related assessments, procedures and/or therapy which may have been arranged. No additional claims may be made to the Plan for such advice and discussion, nor for the provision of prescriptions and/or laboratory requisitions, unless the patient's medical condition indicates that the patient should be seen and assessed again by the medical practitioner in order to receive such advice.

vii) Making and maintaining an adequate medical record of the encounter which appropriately supports the service being claimed. A service for which an adequate medical record has not been recorded and retained is considered not to be complete and is not a benefit under the Plan.

1.b. Telehealth Services

"Telehealth Service" is defined as a medical practitioner delivered health service provided to a patient at a Health Authority approved, publicly-funded telehealth program, and live image transmission of those images to a receiving medical practitioner at another approved site, through the use of video technology. "Video technology" means the recording, reproducing and broadcasting of live visual images utilizing a direct interactive video link with a patient. In order for payment to be made, the patient must be in attendance at the sending site at the time of the video capture. Only those services which are designated as telehealth services are payable by MSP. Other services/procedures require face-to-face encounters. Telehealth services do not include teleradiology or tele-ultrasound, which are regulated by their specific Sectional Preambles.

Telehealth services are payable only when provided as defined under the specific Preamble pertaining to the service rendered (e.g.: telehealth consultation - see Preamble B.3) to a patient with valid medical coverage. Patients must be informed and given opportunity to agree to services rendered using this modality, without prejudice.

Notwithstanding the above, "telehealth examination" means an examination of a patient by the consultant at the receiving site using "telehealth services" as defined above, but does not include the "face-to-face encounter" requirements referred to under Preamble B.1.a.

In those cases where a specialist service requires a general practitioner at the patient's site to assist with the essential physical assessment, without which the specialist service would be ineffective, the specialist must indicate in the "Referred by" field that a request was made for a General Practice assisted assessment.

Where a receiving medical practitioner, after having provided a telehealth consultation service to a patient, decides s/he must examine the patient in person, the medical practitioner should claim the subsequent visit as a limited consultation, unless more than 6 months has passed since the telehealth consultation.

Where a telehealth service is interrupted for technical failure, and is not able to be resumed within a reasonable period of time, and therefore is unable to be completed, the receiving medical practitioner should submit a claim under the appropriate miscellaneous code for independent consideration with appropriate substantiating information.

Video technology services are generally payable once per patient/per day/per medical practitioner. Any exceptions to this policy must comply with all Payment Schedule criteria for multiple visits. Information regarding the medical necessity and times of service should accompany claims.

Compensation for travel, scheduling and other logistics is the responsibility of the Regional Health Authority. Rural Retention fee-for-service premiums are applicable to telehealth services and are payable based on the location of the receiving medical practitioner in eligible RSA communities.

The College of Physicians and Surgeons of British Columbia have confirmed that in this province, licensure is defined by the location of the medical practitioner. However, other jurisdictions may have other definitions. BC medical practitioners providing care via telehealth to patients outside the province must abide by the regulations set in the patient's home province.

See the appropriate Section for specific fee items and further criteria.

2. Adequate Medical Records of a Benefit under MSP

Except for referred "diagnostic facility" services, a medical record is not considered adequate unless it contains all information which may be designated or implied in the MSC Payment Schedule for the service and unless another medical practitioner of the same specialty, who is unfamiliar with both the patient and the attending medical practitioner, would be able to readily determine the following from that record and/or the patient's medical records from previous encounters:

a. Date and location of the service.
b. Identification of the patient and the attending medical practitioner.
c. Presenting complaint(s) and presenting symptoms and signs, including their history.
d. All pertinent previous history including pertinent family history.
e. The relevant results, both negative and positive, of a systematic enquiry pertinent to the patient's problem(s).
f. Identification of the extent of the physical examination including pertinent positive and negative findings.
g. Results of any investigations carried out during the encounter.
h. Summation of the problem and plan of management.

For referred "diagnostic facility" services, an adequate medical record must include:

a. Date and location of patient encounter or specimen obtained.
b. Identification of the patient and the referring practitioner.
c. Problem and/or diagnosis giving rise to the referral where appropriate.
d. Identification of the specific services requested by the referring practitioner.
e. Identification of specific services performed but not specifically requested by the referring practitioner, and identification of the medical practitioner who authorized the additional services.
f. Original requisition or a copy or electronic reproduction of the requisition, in which the method for copying or producing an electronic reproduction must be approved by the Commission, the nature of the copy or electronic reproduction must comply with the intent relative to the form and content of the standard laboratory requisition, and must be auditable to the original source document.
g. Where a requisition is submitted electronically, the electronic ordering methods must be approved by the Commission employing guidelines established jointly by MSP and BCMA.
h. Where a written requisition was never submitted by the referring practitioner, the laboratory staff person who recorded the verbal requisition must be identified. The requisitions must be retained for 3 years.
i. Results of all services rendered, and interpretation where appropriate. These data must be retained for 3 years.

3. Consultation

a. General

A consultation applies when a medical practitioner, or a health care practitioner (chiropractor, for orthopaedic consultations; midwife, for obstetrical or neonatal related consultations; nurse practitioner; optometrist, for ophthalmology consultations; oral/dental surgeon, for diseases of mastication), in the light of his/her professional knowledge of the patient and because of the complexity, obscurity or seriousness of the case, requests the opinion of a medical practitioner competent to give advice in this field. The service includes the initial services of a consultant necessary to enable him/her to prepare and render a written report, including his/her findings, opinions and recommendations, to the referring practitioner. A consultation must not be claimed unless it was specifically requested by the attending practitioner and unless the written report is rendered (refer to Preamble A.15). It is generally agreed that a written report will be generated by the medical practitioner providing the consultation within 2 weeks of the date-of-service. In exceptional circumstances, when beyond the consultant's control, a delay of up to a maximum of 90 days is acceptable.

b. Continuing Care by Consultant

Once a consultation has been rendered and the written report submitted to the referring practitioner, this aspect of the care of the patient normally is returned to the referring practitioner. However, if by mutual agreement between the consultant and the referring practitioner, the complexities of the case are felt to be such that its management should remain for a time in the hands of the consultant, the consultant should claim for continuing care according to the MSC Payment Schedule pertaining to the pertinent specialty.

Where the care of this aspect of the case has been transferred, except for a patient in hospital, the referring practitioner generally should not charge for this aspect of the patient's care unless and until the full responsibility is returned to him/her. For hospitalized patients, supportive care may apply.

Continuing care by a specialist (following consultation) normally is paid at the pertinent specialist rates. However, continuing care requires that a written update of the patient's condition and care be appropriately reported to the referring practitioner at least every six months, until the responsibility for this aspect of the patient's care is returned to the Primary Care practitioner.

c. Limited Consultation

A limited consultation requires all of the components expected of a full consultation for that specialty but is less demanding and normally requires substantially less of the medical practitioner's time than a full consultation.

d. Special Consultations

Specific additional conditions may apply to specific types of consultation, as designated in the Preamble to the pertinent section of the MSC Payment Schedule and/or the notes to the specific listings.

e. Limitations

i) A consultation for the same diagnosis is not normally payable as a full consultation unless an interval of at least six months has passed since the consultant has last billed a visit for the patient. A limited consultation may be payable within the six month interval, if applicable.

ii) For consultations and/or other specialty limited services to be paid by MSP, the medical practitioner rendering the service must be certified by or be a Fellow of the Royal College of Physicians and Surgeons of Canada, and be so recognized by the College of Physicians and Surgeons of British Columbia. No other specialist qualifications will be recognized by MSP and payments for visits and examinations rendered by licensed physicians not so qualified will be made on the basis of fees listed in the General Practice Section of this MSC Payment Schedule.

Exceptions to this limitation will only be made in cases of geographic need, as recommended by the College of Physicians and Surgeons of BC.

4. Visits and Examinations

In addition to the general requirements contained in Section B. 1., the following definitions apply. As well, please note when services are provided for simple education alone, including group education sessions (e.g.: asthma, cardiac rehabilitation and diabetic education) such services are not appropriately claimed under fee-for-service listings.

a. Complete Examination

i) A complete physical examination shall include a complete detailed history and physical examination of all parts and systems with special attention to local examination where clinically indicated, adequate record of findings and, if necessary, discussion with patient. The above should include complaints, history of present and past illness, family history, personal history, functional inquiry physical examination, differential diagnosis and provisional diagnosis.

ii) Routine or periodic complete physical examination (check up) is not a benefit under MSP. This includes any associated diagnostic or laboratory procedures unless significant pathology is found. The physician should advise the laboratory of patient's responsibility for payment.

b. Partial/Regional Examination

A visit for any condition(s) requiring partial/regional examination or history includes both initial and subsequent examination for same or related condition(s). A partial or regional examination includes a history of the presenting complaint(s), appropriate enquiry and examination of the affected part(s), region(s) and/or system(s) as medically required to make a diagnosis, exclude disease and/or assess function.

c. Counselling

Counselling is defined as the discussion with the patient, caregiver, spouse or relative about a medical condition which is recognized as difficult by the medical profession or over which the patient is having significant emotional distress. Counselling, to be claimed as such, must not be delegated and must last at least 20 minutes. Counselling is not to be claimed for advice that is a normal component of any visit or as a substitute for the usual patient examination fee, whether or not the visit is prolonged. For example, the counselling codes must not be used simply because the assessment and/or treatment may take 20 minutes or longer, such as in the case of multiple complaints. The counselling codes are also not intended for activities related to attempting to persuade a patient to alter diet or other lifestyle behavioural patterns. Nor are the counselling codes generally applicable to the explanation of the results of diagnostic tests.

Not only must the condition be recognized as difficult by the medical profession, but the medical practitioner's intervention must of necessity be over and above the advice which would normally be appropriate for that condition. For example, a medical practitioner may have to use considerable professional skill counselling a patient (or a patient's parent) who has been newly diagnosed as having juvenile diabetes, in order for the family to understand, accept and cope with the implications and emotional problems of this disease and its treatment. In contrast, if simple education alone including group educational sessions (e.g.: asthma, cardiac rehabilitation and diabetic education) is required, such service could not appropriately be claimed under the counselling listings even though the duration of the service was 20 minutes or longer. It would be appropriate to apply for sessional payments for group educational sessions. Unless the patient is having significant difficulty coping, the counselling listings normally would not be applicable to subsequent visits in the treatment of this disease.

Other examples of appropriate claims under the counselling listings are Psychiatric Care, the counselling that may be necessary to treat a significant grief reaction, and conjoint therapy and/or family therapy for significant behavioural problems.

MSP payment of counselling under the counselling listings is limited to four sessions per year per patient unless otherwise specified. Subsequent counselling is payable under the other visit listings. Counselling by telephone is not a benefit under MSP.

d. Psychiatric Care

For Preamble rules pertaining to Psychiatric Care, please refer to the Psychiatric Sectional Preamble.

e. Hospital/Institutional Visits

i) Hospital Admission Examination

An in-hospital admission examination may be claimed when a patient is admitted to an acute care hospital for medical care rendered by a general practitioner. The service also may be applicable when a medical practitioner is required to perform an admission examination prior to a hospital service being delivered by a health care practitioner (e.g.: a dental surgeon). The hospital admission examination listing is not applicable when a patient has been admitted for surgery or when a patient is admitted for care (other than directive care) rendered by a specialist. This service is applicable only once per patient per hospitalization and is in lieu of a “hospital visit” on the day it is rendered. This item is intended to apply in lieu of fee item 00108 on the first in-patient day. However, if extra visits are medically required because of the nature of the problem, 00108 may be billed in addition. An explanation of the reasons for the additional charges should accompany the claim.

This service includes all of the components of a complete examination and may not be claimed if either of these two services has been claimed by this medical practitioner, within the week preceding the patient’s admission to hospital. If the MSC Payment Schedule listing for a hospital admission examination is not applicable, the service encompassed by this listing is included, when rendered, under the “hospital visit” listings.

ii) Subsequent Hospital Visit

A subsequent hospital visit is the routine monitoring and/or examination(s) which is medically required following a patient’s admission to an acute care hospital. Payments for subsequent hospital visits are usually limited to one per patient per day for a period up to 30 days. However, it is not the intent of the MSC Payment Schedule that subsequent visit fees be claimed for every day a patient is in hospital unless the visits are medically required and unless a medical practitioner visits the patient each day. If it is medically required for a patient to be visited more than once per day at any time, or daily beyond the initial 30 day period (e.g.: if the patient is in one of the Intensive Care wards), an explanation should be submitted with the claim and independent consideration will be given.

iii) Surgery by a Visiting Doctor

If a surgeon operates outside of his/her geographical area, (for example as part of an outreach program or other such circumstances), and because of this, s/he is unable to render the usual post-operative care, the medical practitioner who performs this service for the patient may claim for necessary hospital visits at the usual frequency, as described under Preamble B.4.e.ii. Claims for such post-operative care should be accompanied by a written explanation or an electronic note record. No such claims, however, should be made if the hospital at which the post-operative care is being rendered is within the same metropolitan area or within 32 km of the surgeon’s home or office.

iv) Long-Stay Hospitalization

For long stays in an acute care hospital including discharge planning and holding units because of serious illness extending beyond 30 days, claims for subsequent hospital visits are limited to two visits per patient per week. However, for acute concurrent illnesses or exacerbation of original illness requiring a greater frequency of subsequent hospital visits, claims for additional visits should include an explanation and will be given independent consideration.

v) Directive Care/Concurrent Care/Supportive Care

Directive care refers to those subsequent hospital visits rendered by a consultant in cases in which the responsibility for the case remains in the hands of the attending practitioner but for which a consultant is requested to give directive care in hospital during the acute phase. Payments for directive care are limited to two visits per patient per week for each consultant requested to render directive care by the referring practitioner.

For those medical cases where the medical indications are of such complexity that the concurrent services of more than one medical practitioner are required for the adequate care of a patient, subsequent visits should be claimed by each medical practitioner as required for that care. To facilitate payment, claims should be accompanied by a written explanation or an electronic note record, and independent consideration will be given. For patients in I.C.U. or C.C.U. this information in itself, is sufficient.

Where a case has been referred and the referring medical practitioner no longer is in charge of the patient's care but for which continued liaison with the family and/or reassurance of the patient is necessary while the patient is hospitalized, supportive care may be claimed by the referring medical practitioner. Payments for supportive care are limited to one visit for every day of hospitalization for the first ten days and, thereafter, one supportive care visit for every seven days of hospitalization.

vi) Newborn Care in Hospital

Newborn care in hospital is the routine care of a well baby up to 10 days of age and includes an initial complete assessment and examination and all subsequent visits as may be appropriate, including instructions to the parent(s) and/or the patient's representative(s) regarding health care. Newborn well baby care in hospital normally is not payable to more than one medical practitioner for the same patient. However, when a well baby is transferred to another hospital (because of the mother's state of health), separate claims for newborn care when rendered by a different medical practitoner at each hospital may be made.

vii) Long-Term-Care Institution Visits

When visits are required to patients in long-term-care institutions (such as nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities and personal care facilities, whether or not any of these facilities are situated on the campus of an acute care facility) claims may be made to a maximum of one visit every two weeks. It is not sufficient, however, for the medical practitioner simply to review the patient's chart. A face-to-face patient/medical practitioner encounter must be made. For acute concurrent illnesses or exacerbation of original illness requiring institutional visits beyond the foregoing limitations, additional institutional visits may be claimed with accompanying written explanation.

viii) Palliative Care

The Palliative Care listings are applicable to the visits for palliative care rendered to terminally ill patients suffering from malignant disease or AIDS, or end-stage respiratory, cardiac, liver and renal disease and end-stage dementia with life expectancy of up to 6 months. These listings only apply where aggressive treatment of the underlying disease process is no longer taking place and care is directed instead to maintaining the comfort of the patient until death occurs. Claims for these listings should be billed continuously from time of determination of patient's palliative status, for a period not to exceed 180 days prior to death. Under extenuating circumstances palliative listings billed beyond 180 days will be given independent consideration upon receipt of an explanatory note record. The listings are applicable to patients in acute care hospitals, hospice facilities or other institutions whether or not the patient is in a designated palliative care unit. The palliative care listings do not apply when unexpected death occurs after long hospitalization for a diagnosis unrelated to the cause of death.

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f. Emergency Department Examinations

i) Emergency Medicine Consultation

An emergency medicine consultation in the emergency department must fulfil all of the requirements designated for consultations in general and, in addition, it applies only when a patient is referred by another practitioner (other than an emergency physician at the same institution) who has seen and examined the patient and, because of the complexity, obscurity or seriousness of the problem, the referring practitioner has requested the consultation. An emergency medicine consultation cannot be charged for the routine transfer of care to the emergency medicine physician or for the provision of treatment for a stable medical condition. Neither does it apply to cases of self-referral by patients who present themselves to the emergency department or who are brought by persons acting on their behalf.

ii) On-Site/On-Duty Emergency Department Physicians

The emergency department listings which designate various intensity levels of emergency department care apply only to those circumstances wherein either specialists in emergency medicine or other medical practitioners are physically and continuously present in the Emergency Department or its environs for an arranged designated period of time. In addition to applying to full or part-time emergency room physicians who work pre-arranged shifts, these listings also apply to the services rendered by medical practitioners who provide on-call emergency room coverage for designated periods of time and limit the services they provide predominantly to emergency room coverage. The applicable levels of care are defined as follows:

LEVEL I A level of service pertaining to the evaluation and treatment of a single condition requiring only an abbreviated history, examination and treatment. It shall include the review of appropriate laboratory tests and/or x-rays. This level of service shall also pertain to those patients who do not meet the criteria for Level II or III care.

LEVEL II Pertains to the evaluation of a new or existing medical condition that necessitates a detailed medical history, and necessary physical examination of three or more regions. It will also include a review of laboratory tests and x-rays where required, and the initiation of appropriate therapy. This level of service shall also pertain to those patients whose illness/injury require prolonged observation, continuous therapy, and multiple reassessments.

LEVEL III **a)** Pertains to evaluation of patients with serious multiple and/or complex medical problem(s) which often can be obscure and where the emergency condition necessitates a detailed history and complete physical examination by the emergency room physician. This shall include the chief complaint(s), history of past and present illness, relevant personal and family history, functional enquiry, and complete physical examination with special attention to local examination where indicated. It shall include the review and interpretation of appropriate laboratory, x-ray and ECG studies, full recording of the findings, and discussion with the patient and/or family and/or the general practitioner, as well as the initiation of appropriate therapy.

b) This level of care shall also pertain to the management of a life threatening illness/injury which requires immediate evaluation and emergent treatment by the emergency room physician. It shall include the review and interpretation of appropriate laboratory, x-ray and ECG studies, full recording of the findings, and discussion with the patient and/or family and/or general practitioner.

g. House Calls

i) A house call is considered necessary and may be billed only when the patient cannot practically attend a physician's office due to a significant medical or physical disability or debility and the patient's complaint indicates a serious or potentially serious medical problem that requires a medical practitioner's attendance in order to determine appropriate management;

ii) A house call may be initiated by the patient, the patient's advocate, or by the physician when planned proactive care is determined to be medically necessary to manage the patient's condition;

iii) If a house call is determined to be necessary and is rendered any day of the week between 0800 and 2300 hours, the house call should be billed as a home visit (use 00103);

iv) If a necessary house call is initiated and rendered between 2300 and 0800 hours, the visit may be billed as an out-of-office visit with the night call-out charge (01201).

v) A house call provided for patient convenience should be billed as an out-of-office visit (12200, 13200, P15200, 16200, 17200 or 18200) without a service charge;

vi) The above also applies to house calls rendered by medical practitioners taking call for other medical practitioners;

vii) As practicality dictates, the necessity and detail and the time of the call should be documented in the patient's clinical record.

5. Delegated Procedures

Procedures which are generally and traditionally accepted as those which may be carried out by a nurse, nurse practitioner or a medical assistant in the employ of a medical practitioner may, when so performed, only be billed to MSP by the medical practitioner when the performance of the procedure is under the "direct supervision" of the medical practitioner or a designated alternate medical practitioner with equivalent qualifications. Direct supervision requires that during the procedure, the medical practitioner be physically present in the office or clinic at which the service is rendered. While this does not preclude the medical practitioner from being otherwise occupied, s/he must be in personal attendance to ensure that procedures are being performed competently and s/he must at all times be available immediately to improve, modify or otherwise intervene in a procedure as required in the best interest of the patient. Billing for these procedures also implies that the medical practitioner is taking full responsibility for their medical necessity and for their quality. Any exceptions to this rule are subject to the written approval of MSP.

"Procedures" in this context do not include such "visit" type services as examinations/ assessments, consultations, psycho-therapy, counselling, telehealth services, etc., which may not be delegated.

The foregoing limitations do not apply to approved procedures rendered in approved "diagnostic facilities", as defined under the *Medicare Protection Act* and Regulations and which are subject to accreditation under the Diagnostic Accreditation Program.

6. Diagnostic Facility Services

Diagnostic Facility Services are defined under the *Medicare Protection Act* as follows:

> “Medically required services performed in accordance with protocols agreed to by the Commission, or on order of the referring practitioner, who is a member of a prescribed category of practitioner, in an approved diagnostic facility by, or under the supervision of, a medical practitioner who has been enrolled, unless the services are determined by the Commission not to be benefits.”

The Medical Services Commission designates, from time to time, certain diagnostic procedures as “diagnostic facility” services under the MSC Payment Schedule. Currently, the following services are considered “diagnostic facility” services for purposes of the MSC Payment Schedule:

a. the services, studies, or procedures of laboratory medicine, diagnostic radiology, diagnostic ultrasound, nuclear medicine scanning, pulmonary function, computerized axial tomography technical fee (CT, CAT), magnetic resonance imaging (MRI), positron emission tomography (PET), and electro diagnosis (including electrocardiography, electroencephalography, and polysomnography), or

b. the taking or collecting of specimens in an approved diagnostic facility for the purpose of diagnosis, treatment or prevention of a human ailment. Such services are not payable by MSP for services rendered to hospital in-patients, “day surgery” patients, or emergency department patients.

The venepuncture and dispatch listings in the Payment Schedule (00012 and 90000) apply only to those situations where this sole service is provided by a facility or person unassociated with any other bloodwork services provided to that patient. Fee items 00012 and 90000 cannot be billed or paid to a medical practitioner or a laboratory if any other bloodwork assays are performed or if the specimen is sent to an associated facility.

7. Referral/Transferral

a. A referral is defined as a request from one practitioner to another practitioner render a service with respect to a specific patient. Such service usually would be a consultation, a laboratory procedure or other diagnostic test, or specific surgical/medical treatment.

   When the medical practitioner to whom a patient has been referred makes further referrals to other medical practitioners, it is the usual practice that the original referring medical practitioner be informed of these further referrals.

b. A transferral, as distinguished from a referral, involves the transfer of responsibility for the care of the patient temporarily or permanently. Thus, when one medical practitioner is going off call or leaving on holidays and is unable to continue to treat his/her cases, medical practitioners who are substituting for that medical practitioner should consider that the patients have been temporarily transferred (not referred) to their care.

   The medical practitioner to whom a patient has been transferred normally should not bill a consultation for that patient. However, when the complexity or severity of the illness requires that the medical practitioner accepting the transfer reviews the records of the patient and examines the patient, a limited or full consultation may be billed when specifically requested by the transferring medical practitioner.

8. Appliances/Prostheses/Orthotics

The costs of prostheses, orthotics and other appliances are not covered under MSP. Such devices, where insertion in hospital is medically/surgically required and where the devices are embedded entirely within tissue, may be covered under an institutional budget.

9. Surgery

a. General

The fees for surgery, unless otherwise specifically indicated, include the usual pre-operative preparation of up to one month's duration, the surgical procedure itself and post-operative follow-up, including removal of sutures and care of the operative wound by the surgeon or associate. Unless otherwise specifically indicated, the normal post-operative period included in the surgical fee is 42 days and the surgery fees include all concomitant services necessary to perform the listed service (including preparation of the operative site, incision, exploration, review of the results of diagnostic services rendered during the surgery, closure, and pre and post-operative discussion with the patient and/or patient's family).

When unusual circumstances require that additional medical services are provided either in the one month prior to an operative procedure over and above the usual pre-operative preparation, or in the 42 days following a surgical procedure over and above the concomitant services necessary to perform the operative procedure, the additional services performed are not part of the inclusive fee for the surgical procedure and may be billed separately. A written explanation is required.

b. Referred Surgical Cases

If a patient is referred for an opinion and this is followed by surgery, a consultation normally would be applicable. However, if a patient is referred specifically for the procedure, a limited, rather than a full consultation would normally be claimed.

c. Non-referred Surgical Cases

Where an examination determines that a surgical procedure should be performed on a non-referred patient and the surgical procedure is performed by the same medical practitioner, the examination(s) giving rise to that surgery is included in the surgical fee. Supportive and/or convalescent care by other medical practitioners also will not be applicable in such non-referred cases.

d. Operation Only

For listings designated "operation only" the pre-operative and post-operative visits may be claimed in addition to the surgical procedure, with the exception of the visit(s) made on the day of the procedure.

e. Multiple Surgery

i) When two or more similar procedures (including bilateral procedures) are performed under the same anesthetic, or when two or more procedures are performed in the same general area, whether through the same incision, an extension of that incision or through separate incisions, the procedure with the greater listed fee may be claimed in full and the fees for the additional procedure are reduced to 50 percent, unless otherwise indicated by the Schedule. However, additional incidental surgery performed en passant (i.e. surgery which would not have been performed in the absence of the primary procedure, such as an appendectomy during abdominal surgery, or incidental cystectomy during gynaecological surgery) is considered to be included in the fee for the planned procedure and may not be charged.

ii) When two or more different procedures are performed through separate incisions under the same anesthetic, and repositioning or redraping of the patient or more than one separately draped surgical operating field is medically/surgically required (because of the nature of the procedure and/or the safety of the patient), the procedure with the

greater listed fee may be claimed in full and the fees for the additional such procedures are reduced to 75 percent, unless otherwise indicated by the Payment Schedule.

iii) Procedures which are listed as “extra” in the Payment Schedule may be claimed at the full listed fee even when performed with other surgical procedures, unless otherwise indicated in the Payment Schedule.

iv) When two procedures are performed under the same anesthetic by two surgeons and both procedures are or should be within the competence of either one of the operators within the specialty or specialities, the total surgical fee claimed should be no more than that which would be payable if both procedures had been performed by one surgeon, plus one assistant’s fee.

v) Except where team fees are specifically listed in the Payment Schedule or where a team fee reasonably could be expected to apply, when two procedures are performed under the same anesthetic by two surgeons whose different specialty skills are required to perform both procedures, each surgeon may claim his/her specific services as if they were performed in isolation from the other surgeon. These surgeons are not eligible for assistant fees for assisting each other, however, unless each of the surgical procedures takes place consecutively instead of concurrently.

vi) Where a surgical procedure is performed in stages under separate anesthetics and where there is no specific staged procedure listing in the Payment Schedule, the maximum fee applicable to the complete procedure is 150 percent of the listed fee. However, for emergency surgery followed by a definitive surgical procedure for the same problem (e.g.: cholecystostomy followed by cholecystectomy at a later date) each procedure may be claimed at the full listed fee.

vii) Surgical procedures which are abandoned before completion will be given independent consideration and paid in accordance with the services performed.

viii) Additional surgery performed to correct an intra-operative injury(ies) which result from the complicated nature of the disease or significant pathology may be billed at 50%. When submitting a claim for a repair of an intra-operative injury, it must be supported by an explanation in a note record or an operative report. If the repair is performed by another surgeon, it may be billed at 100%.

f. Surgical Assistance

i) Time, for the purposes of fee codes 00193, 00198, 07920, T70019 and T70020 is calculated at the earliest, from the time of medical practitioner/patient contact in the operating suite.

ii) Where a medical practitioner renders surgical assistance at two operations under the same anesthetic but for which repositioning or redraping of the patient or more than one separately draped surgical operating field is medically/surgically required, separate assistants’ fees may be claimed for each operation, except for bilateral procedures, procedures within the same body cavity, or procedures on the same limb.

iii) If, in the interest of the patient, the referring medical practitioner is requested by the patient or the surgeon to attend but does not assist at the procedure, attendance at surgery may be claimed as a subsequent hospital visit.

iv) The specialist’s assistant listings apply only to surgical procedures having unusual technical difficulties such that the services of a certified surgical assistant are necessary. The general assistant listings are applicable to all other situations where surgical assistance is necessary. (Also see paragraph 14 - Prefixes to Fee Codes).

v) Where surgery is abandoned, independent consideration will be given to the fee applicable to the assistant, to a maximum of 50 percent of the listed assistant fee for the intended procedure.

g. Microsurgery

Microsurgery is defined as surgery for which a significant portion of the procedure is done using an operating microscope. Magnification by other than an operating microscope is not microsurgery.

h. Cosmetic Surgery

The guidelines for MSP coverage of surgery for alteration of appearance are listed under Preamble Rule B16. For cosmetic surgery not covered by MSP, the anesthetic and assistants' fees also are not covered. In addition, hospitalization charges are not insured for cosmetic surgical procedures not covered by MSP.

10. Fractures and Other Trauma

a. When multiple procedures for multiple fractures and/or soft tissue injuries are done by the same surgeon, through different incisions, the largest fee should be charged at 100% and all subsequent fees at 75%. In cases of dissociated injuries for which the presence of one impedes the progress of another, or in the case of multiple major fractures (e.g.: a fractured femur and tibia in the same limb), a full fee for each (to a maximum of 3) may be charged provided that adequate clinical evidence to support this charge is rendered with the account.

b. Open (compound) fractures: Primary wound management fee(s) may be charged in addition to the fracture fee and will be paid at the same percentage as applies to the fracture fees. These wound management fee items are exempt from the 42 day rule (9(a)). Secondary wound management fees may also be charged and are exempt from the 42 day rule (9(a)). These Primary and Secondary Wound Management fees are only applicable where fee items have been designated in a section's schedule of fees for specific open fractures or specified primary or secondary wound management of fractures.

c. Open reduction of fracture or dislocation when necessary - 50% extra may be charged except when a special fee is listed.

d. All casts may be charged in full in addition to the procedure and visit fees, except that cast applied at the time of the initial procedure. In the minority of cases where a cast application or alteration only is the sole purpose of a visit, a visit fee is not chargeable. Fees for application of casts are payable only when performed by the medical practitioner.

e. Open reduction of old malunited fracture - May be billed at an additional 25% of the listed fee unless a specific fee item exists.

f. External Skeletal Fixation with closed reduction - may be billed at an additional 25% of the listed fee unless a specific fee item exists.

11. Diagnostic and Selected Therapeutic Procedures

a. The listings under the “Diagnostic Procedures and Selected Therapeutic Procedures” section of the Payment Schedule may be claimed in addition to a consultation or other assessment/visit, when performed during that visit. If, however, the procedure takes place on a subsequent visit arranged to perform the procedure, then that visit may not be claimed in addition to the procedure unless the fee code for the latter is prefixed by the letter “Y” and the Payment Schedule does not preclude such claim. A subsequent visit fee will be paid in addition to the procedure if more than thirty days has elapsed between the initial visit and the diagnostic procedure.

b. Diagnostic procedures may be claimed in addition to surgical procedures, when applicable.

c. For multiple diagnostic procedures performed at the same sitting, the procedure having the largest fee may be claimed in full and the remaining procedure(s) at 50 percent of the listed fee(s), unless otherwise specifically indicated in the Payment Schedule.

d. When two diagnostic/therapeutic procedures are performed by separate medical practitioners at the same sitting and both procedures are or should be within the competence of either medical practitioner, the total fee claimed should be no greater than that which would be payable if both procedures had been performed by one medical practitioner, plus one assistant’s fee (if applicable).

e. When a medical practitioner performs a diagnostic procedure, s/he must be allowed to appropriately perform a full or limited consultation for which s/he charges and is paid, regardless of what consultations and procedures have been performed by other specialists or sub-specialists. The consultation would require a written report in addition to the report of the diagnostic procedure.

   If the diagnostic procedure is done on an initial visit, and the initial visit is for the specific purpose of performing the diagnostic procedure, and this visit occurs on an out-patient basis in a procedure facility (including endoscopy suites and cardiac catheterization suites), then a limited consultation would normally be billed rather than a full consultation.

f. Procedures designated as “extra” will be paid at 100 percent for the first “extra” and 50 percent for any additional procedures. Should all procedures be designated as “extra” then the first procedure will be deemed a regular procedure and payment for the first subsequent “extra” will be at 100 percent and all others at 50 percent.

12. Minor Diagnostic/Therapeutic Procedures

a. Minor Diagnostic/Therapeutic Procedures are defined as procedures which have a fee value that is less than that of the General Practice office visit.

b. When minor diagnostic or therapeutic procedures are performed in conjunction with an assessment/visit (not a consultation) <u>either</u> the visit <u>or</u> the procedure may be claimed, but not both.

c. When the performance of a minor diagnostic or therapeutic procedure is the primary purpose of the visit (excluding home visits), the fee listed for the procedure includes the associated assessment.

d. If in the course of a visit for a specific complaint, one or more procedures are performed which are unrelated to the purpose of the visit (e.g.: URI and laceration repair), the service having the largest fee may be claimed in full and the remaining service(s) at 50 percent of the listed fee(s), unless otherwise specifically indicated in the Payment Schedule.

e. For two or more minor diagnostic/therapeutic procedures listed in the “General Services” section of the Payment Schedule and performed together at the same sitting, each applicable fee may be claimed in full.

13. Accompanying Patients

When it is medically essential that a medical practitioner accompany a patient to a distant hospital, MSP allows payment at the rates listed in the Payment Schedule for the travelling time spent with the patient only. Out-of-office hours premiums may also be applicable in accordance with the guidelines. Payment is not applicable to layover or return travel time. Claims should be submitted with details under fee code 00084. Claims for travel, board and lodging are not payable by MSP. Medical practitioners who accompany a patient who is being transferred will, upon application to the Health Authority, be reimbursed for expenses reasonably incurred during, and necessitated by, the transfer.

14. Prefixes to Fee Codes

B - designates services included in the visit fee.
C - designates fee items for which it is not required to indicate by letter the need for a certified surgeon to assist at surgery (see fee item T70019).
G - designates listings which are administered through the Claims payment system but are not funded through the medical practitioners’ Available Amount.
P - designates fee items approved on a provisional basis awaiting further review.
S - designates fee items for which a surgical assistant’s fee is not payable.
T - designates fee items approved on a temporary basis awaiting further information.
Y - designates office or hospital visit on the same day extra to procedure fee.
V - for General Surgery fee items P71007 and P71008 that can be billed for visits within the 30 day pre-operative and 42 day post-operative time period.

Note: *The above prefixes should not be submitted when billing, only the numeric code should be included.*

15. Age Categories

The Medical Services Commission Payment Schedule uses the following definitions:

Premature Baby	-	under 2.5 kilograms
Neonates	-	under 28 days
Infant	-	28 days up to and including 12 months
Child	-	1 year up to and including 15 years

16. Surgery for Alteration of Appearance

1. General

(1) Surgery to alleviate significant physical symptoms or to restore or improve function to any area altered by disease, trauma or congenital deformity normally is a benefit under MSP. Surgery solely to alter or restore appearance is not a benefit of MSP except under the circumstances listed in the following policy.

(2) In establishing this policy, it has been recognized that:
peer acceptance in our society often is influenced disproportionately by the facies, children are especially susceptible to emotional trauma caused by physical appearances,

some procedures traditionally have been accepted as benefits of Health Insurance Plans in spite of the obvious cosmetic nature of these procedures.

(3) Emotional, psychological or psychiatric grounds are not considered sufficient reason for MSP coverage of surgery for alteration of appearance except in children and under exceptional circumstances in adults. On request of the attending medical practitioner, exceptions may be made on an independent consideration basis if the proposed surgery is to alter a significant defect in appearance caused by disease, trauma or congenital deformity, and if the surgery is essential in order to obtain employment as documented by the attending physician and by an employer with regard to a specific job.

(4) Surgery to revise or remove features of physical appearance which are familial in nature is not a benefit of MSP.

(5) Within the context of this policy, the word "disease" does not include the normal sequelae of aging. Surgery to alter changes in appearance caused by aging is not a benefit of MSP.

(6) Within the context of this policy, the word "trauma" includes trauma due to treatment such as surgery, radiation, etc.

(7) The phrase "reasonable period of convalescence" admittedly is imprecise, but it does not seem reasonable to set a definite time interval of convalescence following each procedure. Independent consideration will be given to the questionable cases.

(8) Authorization from MSP is not required for all surgery to alter appearance. It is required only for those categories of procedures for which some cases may not be a benefit under MSP policy.

(9) Authorization where required and obtained remains valid for a period to be determined by MSP, after which a new authorization will be required.

(10) Where authorization has been denied or has not been obtained when required for a surgical procedure, the associated consultations, anesthesiology and surgical assistance also are not covered by MSP. Hospitalization costs also will remain the patient’s responsibility.

2. Surface Pathology

(1) Trauma Scars

(a) Neck or Face

Includes non-hair bearing areas of the scalp.

Repair of all significant and unsightly such scars, including acne scars, is a benefit of MSP.

Repair procedures will depend upon the lesion but may include excision, revision, dermabrasion, etc. Rhytidectomy procedures to remove scar prominence, however, are not a benefit of MSP.

Implantation of collagen, etc. to restore contour, or chemical abrasion to reduce hyperpigmentation are not benefits of MSP except in those rare cases where the pitting or the pigmentation is so severe that a generally acceptable result would not be possible without these procedures.

MSP authorization for repair of such scars is required to ensure that the most appropriate fee items are used.

(b) Scars in other Anatomical Areas

Repair of scars which interfere with function or which are significantly symptomatic (pain, local irritation, etc.) is a benefit of MSP.

Scars with no significant symptoms or functional interference:

(i) Repair is a benefit if such repair is carried out within a reasonable period of convalescence, or is part of a pre-planned post-traumatic (including post surgical) staged process. MSP notification must be included as part of the planning process in the latter case.

(ii) Other post-traumatic scar revision is not a benefit of MSP.

(iii) Revision of acne scars other than on the face or neck is not a benefit of MSP.

MSP authorization is required for all scar repair procedures.

(2) Keloids/Hypertrophic Scars

(a) Head or Neck

The repair of all significant and unsightly such keloids is a benefit of MSP. Repair procedures may include excision and/or injection.
Although no preauthorization is needed, claims for excision of keloids are assessed manually to ensure that the most appropriate fee item is used.

(b) Excision of keloids in other areas

Not a benefit of MSP unless significantly symptomatic or there is functional impairment.

(3) Tattoos

(a) Face and Neck

Excision or destruction of all significant and unsightly such tattoos is a benefit of MSP
Authorization is not required but adjudication of repair procedures will be identical to that for scars in these areas.

(b) Other Anatomical Areas

Normally not a benefit of MSP

(4) Benign Skin Lesions

Surgical, physical or chemical removal of benign lesions of the skin, including that done by dermabrasion or chemical peel, unless the diagnosis is specifically defined as an approved indication, in article 2(4)(a) is not a benefit of MSP.

Examples of benign lesions that are not insured include but are not limited to the following: benign naevi, seborrhoeic keratosis, common warts (verrucae), lipomata, uncomplicated benign dermal and/or epidermal cysts, telangiectasias and angiomata of the skin, skin tags, acrochordons, fibroepithelial polyps, papillomata, neurofibromata, dermatofibromata.

(a) Exceptions

Destructive therapies of benign skin lesions are insured services when the treatment is medically necessary. Examples of medical necessity include but are not limited to the following indications:

genital warts (condylomata acuminate)
plantar warts
viral induced cutaneous tumours in the immune compromised patient
inflamal dermal and epidermal cyst
dysplastic naevi
lentigo maligna
congenital naevi
actinic (solar) keratosis
atypical pigmented naevi

lesions which cause significant pathophysiologic dysfunction

(b) When a patient presents with a surface pathology, the initial visit and or consultation and/or pathologic examination of a tissue specimen, when one is submitted, is regarded as medically necessary to establish the diagnosis, and therefore, is an insured service.

(5) Hair Loss

(a) Scalp or Neck
(i) Post-traumatic:
Repair to the area of traumatic hair loss is a benefit of MSP only if carried out within a reasonable period of convalescence.
MSP authorization is required.
(ii) Other Etiology:
Not a benefit of MSP
(iii) Usual repair procedures may include skin shifts or flaps, skin grafts, or hair plugs.

(b) Other Anatomical Areas
Not a benefit of MSP

(6) Epilation of Hair

(a) Face
This procedure, when done for alteration of appearance, is a benefit of MSP when rendered by medical practitioners and only for those patients with documented endocrine abnormality, drug-induced hirsutism or from hair-bearing facial graft.
MSP authorization is required.

(b) Other Anatomical Areas
Not a benefit of MSP

(7) Redundant Skin

(a) Excision of redundant skin for elimination of wrinkles, etc. is not a benefit of MSP.

(b) Blepharoplasty is not a benefit of MSP unless there is documented evidence of medical necessity such as a visual field defect caused by the redundant eyelid skin and which meets the BCMA/MSC guidelines for significant defect.

(c) MSP authorization is required.

3. Sub-Surface Pathology

(1) Congenital deformities

(a) Face or neck
Repair is a benefit of MSP except for:
surgery to revise or remove features which are familial in nature;
surgery to correct ear abnormalities in patients who are sixteen years of age or over.
MSP authorization is required.

(b) Other Anatomical Areas
Normally not a benefit of MSP if surgery is for alteration of appearance only.

(2) Post-Traumatic Deformities

Reconstructive procedures are a benefit at the acute stage; within a reasonable period of convalescence; or if part of a pre-planned staged process of repair. Repair procedures may include bone revision, tissue shifts and grafts, prosthesis implantation, etc.
MSP authorization is required for repairs beyond the acute stage.

(3) Deformities resulting from local disease (such as loss or distortion of bone, muscle, connective tissue, adipose tissue, etc.).

(a) Head or Neck

Reconstructive procedures for significant abnormalities are a benefit at the acute stage; during a chronic disease process; within a reasonable period of convalescence, or if part of a planned staged process of repair initiated during one of these periods.
Repair procedures normally could include tissue grafts, flaps or shifts, bone revision, prosthesis insertion, etc.
Face lifts, modified face lifts, brow lifts, etc. are not a benefit of MSP if skin, only, is involved in the procedure. However, a repair such as ptosis repair or face lift with underlying slings is a benefit of MSP if the procedure is to correct significant deformity following stroke, cancer, VIIth nerve palsy, etc.
MSP authorization is required for repair of deformities resulting from local disease.

(b) Other Anatomical Areas

Not a benefit of MSP if the correction is for appearance, only.

(4) Breast Surgery

(a) Augmentation Mammoplasty

This procedure is a benefit of MSP unilaterally or bilaterally for a female patient with breast aplasia.
It is a MSP benefit unilaterally for a female patient with a severely hypoplastic breast when the other breast is not also hypoplastic.
A "balancing" augmentation mammoplasty may be allowed on an independent consideration basis for correction of unilateral hypoplasia when performed in association with approved contralateral reduction mammoplasty.
MSP authorization is required.

(b) Post-Mastectomy Reconstruction

Unilateral or bilateral breast reconstruction is a benefit of MSP when the procedure is subsequent to total or partial mastectomy or prophylactic mastectomy.
Authorization is not required but the reason for the reconstruction must accompany the claim.

(c) Reduction Mammoplasty

Reduction Mammoplasty is a benefit for female patients only, where there is significant associated symptomatology such as intertrigo, neck or back pain or shoulder grooving. Ptosis and/or size are not sufficient grounds for MSP coverage of reduction mammoplasty. Mastopexy is not normally covered by MSP.
Unilateral reduction mammoplasty may be a benefit of MSP if there is gross disproportion present, or in association with approved unilateral augmentation mammoplasty or post mastectomy reconstruction of the contralateral breast.
MSP authorization is required.

(d) Male Mastectomy
This procedure is a benefit of MSP.
Authorization is not required.

(e) Accessory breasts or accessory nipples
Excision of such accessory tissue is a benefit of MSP.
The appropriate fee item normally would be from the skin tumour excision listings.
Authorization is not required.

(5) Excision of excess fatty tissue

This is a benefit of MSP only if there is significant associated symptomatology such as intertrigo, pain or excoriations.
When performed for alteration of appearance, the removal of redundant skin and fat from the abdomen, extremities, etc. is not a benefit of MSP.
There must be clinical evidence of substantial hyperplasia of adenomatous breast tissue.
MSP authorization is required.

4. Gender-Reassignment Surgery

Prior approval is required for gender reassignment surgical procedures before they are deemed benefits of MSP. Approval requires that patients be assessed by two psychiatrists, with recognized and demonstratable expertise in the treatment of gender dyspohoria, regarding the appropriateness of surgery. In addition, each case undergoes individual consideration by the Gender Reassignment Surgical Review Committee based on strict protocols. Medical and surgical consultations, anesthesiology and surgical assistance are not benefits when performed in conjunction with non-approved gender-reassignment surgery.

5. Complication and/or Revisions

(1) The treatment of acute medical or surgical complications resulting from surgery for alteration of appearance and/or function is a benefit of MSP whether or not the original surgery was covered by MSP. This includes complications resulting from trans-sexual surgery (such as breakdown of the artificial vaginal wall). No authorization is required.

(2) Revision of surgery for alteration of appearance, because of undesirable results, is a benefit of MSP only if the original surgery was a benefit and if the revision either is part of a preplanned staged process or occurs within a reasonable period of convalescence. Correction of the effects on appearance which are due to complications is a benefit of MSP if it is carried out within a reasonable period of convalescence. MSP authorization is required.

17. Guidelines for Payment for Services by Residents and/or Interns

When patient care is rendered in a clinical teaching unit or other setting for clinical teaching by a health care team, the medical practitioner responsible shall be personally identified to the patient at the earliest possible moment. No fees may be charged in the name of the responsible staff physician for services rendered by an intern or resident prior to the identification taking place. Moreover, the responsible staff physician must be in the clinical teaching unit and/or immediately available to intervene (immediately available means on-site).

For a medical practitioner who supervises two or more procedures or other services concurrently through the use of residents, interns or other members of the team, total billings must not exceed the amount that a medical practitioner could bill in the same time period in the absence of the other team members. Thus, for example:

a) If an anesthesiologist is supervising two rooms simultaneously, the anesthetic intensity/complexity units should only be billed for one of the two cases.

b) If a surgeon is operating in one room while his/her resident is operating in a second room, charges should only be made for the case the surgeon performs.

c) In psychotherapy where direct supervision by the staff physician may distort the psychotherapeutic milieu, the staff physician may claim for psychotherapy when a record of the psychotherapeutic interview is carefully reviewed with the resident and the procedure thus supervised. However, the time charged by the staff physician should not exceed the lesser of the time spent by the resident in the psychotherapeutic interview or the staff physician in the supervision of that interview.

d) For hospital visits and consultations rendered by the resident in the name of the staff physician, the staff physician should only charge for services on the days when actual supervision of that patient's care takes place through a physical visit to the patient by the staff physician and/or a chart review is conducted with detailed discussion with the other members of the health team.

18. Salaried and Sessional Arrangements

Fee-for-Service items cannot be billed simultaneously with sessional or salary arrangements.

Other Agencies

With the exception of medical practitioners paid by the BC Transplant Society under an alternate payment plan, all medical practitioner services associated with cadaveric organ donor recovery (“organ donation”) are payable on a fee-for-service basis through the MSP. For the purpose of payment of these services, the donor’s PHN will remain valid after legal brain death until such time as the donor’s organs have been successfully harvested. A note record should accompany the account stating “organ donor”.