

New Web Site for Alternative Payment Programs & Rural Practice Programs

A new Web site was launched April 2005 at:

<http://www.healthservices.gov.bc.ca/pcb/index.html>.

This Web site contains information about Alternate Payment Programs (APP), Rural Practice Programs and the Medical On-Call Availability Program (MOCAP). The Rural Practice Programs section links to information that outlines programs under the Subsidiary Agreement for Physicians in Rural Practice (RSA) and the Specialist Locum Program.

Information about rural programs, other than those that assist with physician supply can be found at: <http://www.healthservices.gov.bc.ca/rural/index.html>. This site includes information on the Travel Assistance Program (TAP) for patients.

Announcing the new Isolation Allowance Fund

During the 2004 negotiations between the Government and the British Columbia Medical Association, a new Isolation Allowance Fund was established under the Rural Subsidiary Agreement for Physicians in Rural Practice (RSA). It provides a stipend for physicians practicing in RSA communities with fewer than four physicians, no hospital and do not receive Medical On-Call Availability Program (MOCAP), Call Back or Doctor of the Day payments.

The Joint Standing Committee on Rural Issues (JSC) has now set the policy and is implementing the Program. The amount of the stipend payable per physician is established by using a weighted point value based upon the number of physicians available in the community and the relative degree isolation of the community as determined by the annual Rural Retention Program (RRP) confirmation process. The annual stipend, which is not an on-call payment, will range from approximately \$6,000 to approximately \$50,000. The amounts payable to each physician are calculated at the end of each calendar year.

The health authorities will disburse the applicable amounts to physicians who have resided and practiced in an eligible community for at least 9 months of the calendar year. Funding for physicians who reside and practice for 9 to 12 months will be prorated based on the number of months the physician has practiced. This funding will be released to the health authorities annually in the last quarter of the fiscal year and will be paid to the physicians in a lump sum payment.

Information on the Isolation Allowance Fund is available on the Web site: www.healthservices.gov.bc.ca/pcb/rpp.html.

Full Service Family Practice Incentive Program - Obstetrical Premium

The General Practice Services Committee (GPSC) is pleased to announce an improvement to the Obstetrical Care Incentive Payment through the Full Service Family Practice Incentive Program, first introduced in September 2003.

The Full Service Family Practice Incentive Program, Obstetrical Care Incentive Payment was designed to encourage and support low to moderate volume delivery practice.

The Obstetrical Care Incentive Payment is now entitled *Obstetrical Premium* and is modified to allow payment of the Obstetrical Delivery Bonus for the first delivery of the day.

The premium fee code remains as 14000 and may be billed retroactively to April 1, 2005. The Obstetrical Premium payment for fee code 14104 is \$258.33 and for 14109 is \$215.17.

The limit of 25 cases per calendar year is still applicable.

For more information on the Full Service Family Practice Incentive Program visit:
<http://www.healthservices.gov.bc.ca/cdm/practitioners/fullservice.html>

Announcing Weekend Coverage under the Rural GP Locum Program

Effective April 1, 2005, the Joint Standing Committee on Rural Issues (JSC), a joint committee of the Ministry of Health Services and the British Columbia Medical Association (BCMA), is pleased to announce the expansion of the Rural GP Locum Program (RGPLP) to include weekend locum coverage for physicians in eligible Subsidiary Agreement for Physicians in Rural Practice (RSA) communities.

The objective of the weekend locum coverage is intended to free up physicians on weekends in RSA communities with seven or less physicians. The purpose is to enable this group of physicians to make use of this time to attend family matters, attend professional conferences, etc.

Weekend locum coverage will commence on Fridays at 18:00 and will conclude at 08:00 on Monday (or 08:00 Tuesday if a statutory

holiday is part of the weekend). RGPLP locums are entitled to (i) travel reimbursement, (ii) an honoraria for travel time and (iii) a rate of \$2,000 for Friday to Monday coverage (or \$2,750 for Friday to Tuesday if a statutory holiday is part of the weekend).

Both urban and rural practicing physicians may be eligible to provide locums in RSA communities, provided they have up to date training in ACLS or ATLS. For those requiring upgrades please refer to the Urban Skills Enhancement Program (USEP) that makes funding available for urban physicians to upgrade their skills in ACLS, ATLS or other training necessary for rural practice.

Further information on the Rural GP Locum Program, including the weekend coverage component, and the Urban Skills Enhancement Program is available on our Web site at www.healthservices.gov.bc.ca/pcb/index.html, or by contacting the Rural Practice Programs at 250 952-1104.

Gamma Knife Stereotactic Radiosurgery

Effective immediately, the Ministry of Health Services will insure the use of gamma knife stereotactic radiosurgery in Canada for facial tic and movement disorders.

For other diagnoses, including but not limited to acoustic neuroma, meningiomas, arterio-venous malformations, and brain tumours, pre-authorization must be sought by an appropriate BC specialist through:

Out of Province Claims,
6th Floor, 1515 Blanshard St.,
Victoria, BC V8W 3C8
Fax: 250 952-1940

“An appropriate” BC specialist means a medical professional actively involved in the beneficiary’s care with expert knowledge in the proposed service and/or specialty that will deliver the out of province service.

Additionally, funding for out of province stereotactic radiotherapy/ radiosurgery by gamma knife for brain tumours will be approved only if recommended by the BC Cancer Agency (BCCA). The beneficiary’s medical specialist is responsible for providing the Ministry of Health Services with a written recommendation from the medical director of the radiation oncology division of the BCCA regarding the medical necessity for gamma knife treatment.

Fee items 00108, 00114 & P12148 – Reminder

Fee item 00108 applies only to the care of patients in acute care hospitals, including those in discharge planning units, holding units, and patients in acute care wards who are waiting to be transferred to non-acute care facilities.

Fee item 00114 applies to the normal care of patients in extended, intermediate, personal, rehabilitation, chronic and convalescent care facilities or any other non-acute care facility whether or not the facility is geographically associated with an acute care hospital.

Fee item P12148

- i) Payable only when provided to patients who have had an acute medical or surgical episode and have been transferred from an acute care facility to a sub-acute care facility.
- ii) Payable 2 times per week per patient. In higher acuity situations, a note record explaining the medical necessity is required if additional visits are necessary.
- iii) Not payable with 00108, 13108, 00128, 13128, 00127, 13127, 13148, 00112, 00109, 00114, 13114, or 00115.

RURAL GP LOCUM PROGRAM (RGPLP)

The Ministry of Health Services and the British Columbia Medical Association Joint Standing Committee on Rural Issues (JSC) oversees the Rural GP Locum Program (RGPLP), which is negotiated as part of the Subsidiary Agreement for Physicians in Rural Practice (RSA). The RGPLP is recognized as very successful and is considered a win-win program by both host physicians and locums alike. The JSC is pleased to share the following article that appeared in the *Tumbler Ridge News* regarding the RGPLP.

When Dr. Szelag left Tumbler Ridge for Ontario at the end of July 2004, no long term replacement physician was available until at least December 2004. The community was then placed in the difficult position of having potentially only one physician for the interim four months, at a time

when the patient load in the Tumbler Ridge Medical Clinic was steadily increasing. The provincial Joint Standing Committee on Rural Health officially only supports locum tenens for 28 days a year for this kind of vacancy, through its Rural Locum Program, and there is no guarantee that this position gets filled.

Faced with this situation, the Medical Clinic applied twice through Dianne Hiley of the Rural Locum Program to have this period extended, given the unprecedented nature of the problem. Both times this request was granted by the Joint Standing Committee, and coverage for the entire four month period was approved if locums could be found.

Dianne Hiley and her staff worked wonders and managed to find no less than five locums, who between

them managed to fill the vacancy for all but three weeks out of seventeen. Drs. Mathews, Halenar, Klapstein, Wiseman and Williams successively helped Tumbler Ridge out during this time of need. Rural British Columbians can take comfort that a good rural locum system not only exists, but was flexible enough to accommodate our unique situation.

Good news is that Dr. Chrisman Louw plans to assume a permanent position in the Tumbler Ridge Medical Clinic in December. He brings with him a wealth of experience in Family Medicine, both in his native South Africa, and in Saskatchewan where he has worked for the past four years.

Tumbler Ridge Medical Clinic thanks all those who have helped in this time of transition, and bids a warm welcome to Dr. Louw.

Plaster Casts and Associated Tray Fees

During an audit a family physician was found to be incorrectly billing orthopedic cast fee items and the associated tray fee for application of a commercial air splint. The following is clarification on billing cast fees and the associated tray fees.

Cast fee items 51016 to 51025 are only payable for application of custom-made plaster or fiberglass casts. These are normally used as treatment for a fracture or tendon repair. Fee item 00090 - major tray fee is payable only when the associated supply costs are incurred by the physician.

Casting procedure fee items and the associated tray fees are not payable for 'back slabs', 'gutter splints' or other lesser plaster appliances which do not represent a definitive full circumference cast. Similarly, cast fee items and tray fees do not apply to fitting and dispensing commercial splints, braces and inflatable 'air boots' that are used to treat soft tissue injuries.

New and Amended Explanatory Codes

The following explanatory codes have been amended:

GH Consult/visit is included in the fee for the procedure

LQ Visit fees are not payable at the time anaesthetic services are rendered.

TJ Invalid PHN/fee item combination:

- 9824870522 only valid for fee 14010
- 9825238602 only valid for fee items 36061, 36062, 36063, 36064, 36065

New explanatory code:

NP Fee item 14000 is payable for the first delivery the GP attends on the date billed, to a maximum of 25 bonuses per calendar year.

SO WCB treatment/service was not requested.

Proton Pump Inhibitors (PPIs) - Independent Academic Review Completed

In 2003, PharmaCare introduced the preferential Proton Pump Inhibitor (PPI) policy. The policy was aimed at shifting prescribing to the preferred and less costly PPI, rabeprazole. When the policy was introduced, we advised that an independent academic review of the policy would be conducted. That review is now completed.

The report by a joint team of researchers from Harvard Medical School comes to a positive conclusion. The main findings are:

- Almost half of all elderly PPI users switched to rabeprazole.
- There was no increase in the rate of discontinuation of PPI therapy, indicating that routine care was not interrupted.
- There was no increase in the rate of GI bleed or severe peptic ulcer disease leading to hospitalization, indicating that the policy is clinically safe.
- There was a 9% increase in visits to physicians coded as GERD-related three months after the policy change, possibly due to increased follow-up of patients. The total rate of visits to physicians was unchanged.
- The policy produced substantial savings of at least \$2.9 million in patients 65 years or older in the first six months of the policy.

Below is the abstract published in the Journal of the American Society of Clinical Pharmacology and Therapeutics, "Clinical Pharmacology and Therapeutics." The full report has been submitted for publication and is being peer reviewed.

Clinical and Economic Consequences of Formulary Restrictions for Three Leading Proton Pump Inhibitors

S. Schneeweiss, MD, ScD, M. Maclure, ScD, C. Dormuth, MA; MS, R. J. Glynn, PhD, ScD, C. Canning; MS, J. Avorn, MD, Brigham & Women's Hospital, Harvard Medical School, Boston, MA; University of Victoria, BC.

AIMS: We evaluated the clinical and economic consequences of a sharp formulary restriction for three leading proton pump inhibitors (PPIs) in a large-scale natural experiment of all British Columbia seniors.

METHODS: All BC residents 65+ were eligible for publicly funded health care, including drug benefits. The Ministry of Health holds linkable data on all prescription drug dispensings independent of payer, physician services, and hospitalizations. We selected a cohort of all patients who were 66 years or older and used one of the PPIs subject to restriction in the time period 6 months before the policy start (38,426).

RESULTS: The mean age was 76 years and 63% were women. Utilization for the restricted omeprazole and pantoprazole declined sharply after the policy (-9000 daily doses per month per 10,000 and -5700; $p < 0.0001$). The covered rabeprazole increased (+16,000; $p < 0.0001$). There was no increased switching to H-2 blockers or stopping all gastro-protective drugs. 45% of all PPI users switched to the covered rabeprazole. Lower income status and higher price of the PPI were associated with this switching (OR = 1.09 and 1.23). There was no increase in the excess rate of GI bleeds following the PPI restriction ($p = 0.97$).

There was a delayed increase in GERD-related visit rates (+3 per 10,000). Health plan savings were about \$2.9M over the first 6 months of the policy.

CONCLUSIONS: A formulary restriction of 3 leading PPIs led to substantial utilization changes and savings without negatively affecting GI bleed rates.

Clinical Pharmacology and Therapeutics, February 2005, Volume 77, Number 2, page P1

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Electronic Storage of Requisitions

In accordance with Sections 5(e), (j) and (l) and 27, of the Medicare Protection Act, the following outlines the circumstances under which claims for diagnostic services associated with requisitions which are stored electronically will be payable by the Medical Services Plan (MSP).

1. The original paper requisitions must be retained and available for audit when electronic storage is used. Upon application from the diagnostic facility, the Medical Services Commission (MSC) may consider removing this requirement six months after the start-up date of the electronic document storage system provided the facility can demonstrate to MSC that copies of requisitions can be readily retrieved and printed. Diagnostic facilities must obtain pre-approval to destroy paper requisitions and may apply six months after the start-up date.
2. Any payee using electronic storage must ensure that the system complies with the Canadian General Standards Board requirements for Microfilm and Electronic Images as Documentary Evidence as updated from time to time.
3. Failure to comply with MSC requirements described herein will result in recovery of part or all of the payments associated with requisitions stored in a manner that contravenes the foregoing MSC requirements.

Technical Requirements:

- a) Requisitions must be readily retrievable and easily printed in the presence of an auditor or inspector, by date and name or Personal Health Number.
- b) In the event of a disaster, a backup copy of the electronic images must be available and securely maintained off-site.
- c) The system must be secure and tamper proof. The image must be stored using WORM (write once, read many) technology.
- d) File Format – single page Tagged Image File Format (TIFF). Files will need to be monitored to ensure they remain accessible.
- e) For electronic images to be considered as documentary evidence the following are required.
 - i) documentation of business rules
 - ii) documentation of scanning policy and procedures, including access restrictions and security of the original scanned documents
 - iii) documentation of built-in audit and quality assurance processes
 - iv) records retention and disposition schedules must be developed, approved and implemented
- f) Compression: Image compression must be lossless.
- g) DPI: Minimum standard for routine black and white documents, 400 DPI, coloured documents may require higher DPI for clarity and sharpness.
- h) Indexing: Diagnostic Facilities need to establish acceptable metadata requirements for searching and speeding information retrieval times, with established business rules and controlled vocabulary.
- i) Diagnostic Facilities need to develop and document proper disposition procedures for electronic media.

MSP BULLETIN

SUMMER 2005

The Medical Services Plan's Bulletin is provided to help physicians identify patients whose MSP benefits have payment restrictions. This Bulletin provides important billing information for physicians only. Thank you for respecting the confidential nature of this information.

The Bulletin is an updated listing of restricted MSP enrollment numbers for clients who have signed a legal Agreement of Limitation form which limits MSP payment responsibilities to one primary care physician. If care is provided by other physicians, the charges must be made directly to the clients. MSP will not accept payment responsibility unless special circumstances are clearly stated. An example of this would be medical care that has been provided by an emergency physician in the hospital emergency room.

MSP is concerned about the potential misuse of CareCards and strongly recommends a complete check of CareCard information at all first appointments. If you suspect any unusual use of a CareCard, please request a second piece of picture identification in order to verify that the CareCard is being presented by the person named on the card.

PHN	Birthdate (MM/YY)	Sex M/F	Physician Number
9013676868	12/54	M	06541
9023967395	02/54	F	03023
9025293026	12/58	M	24287
9029287062	06/52	F	06061
9029596344	09/55	M	00792
9030165823	12/54	F	05334
9030205973	05/54	M	26411
9030780581	05/29	F	08241
9030861738	10/45	M	01604
9032398914	08/56	M	09760
9032842679	05/59	F	01229
9034248181	10/59	F	07834
9034793801	06/59	F	06468
9035294522	07/58	M	23759
9041726364	07/56	F	03733
9071584167	06/48	M	09604
9104870848	04/67	F	09443
9107346403	08/54	M	08365

Payment of Bone Mineral Densitometry

Effective May 1, 2005, the guideline for Bone Density Measurement in Women replaces the previous protocol for Bone Density Measurement that was effective November 1, 1999.

Copies of the guideline can be obtained by contacting the Utilization Management Branch, Ministry of Health Services at 250 952-1347 or fax to 250 952-1417.

Guidelines and Protocols are also posted on the MSP web site at <http://www.healthservices.gov.bc.ca/msp/protoguides/index.html>

1. Payment of multiple areas:

Additional areas are paid to a maximum of one, except for unusual circumstances, which must be accompanied by written explanation: Examples when exceptions might be made are when there are values on the initial scan which involve falsely elevated density readings (i.e.: unexpected increase in degenerative changes, or to rule out possible undiagnosed fracture).

2. Payment of BMD listings with other x-rays:

- a) If x-rays are billed for anatomical areas other than the lumbar spine and femur, they are payable as billed without a note record.
- b) X-rays of lumbar spine and femur are considered included unless a note record is provided explaining that the x-rays were performed for an unrelated diagnosis such as pain.

3. Payment of BMD listings – single/multiple and whole body:

Both whole body & single/second area DEXA are payable if the note record indicates one of the following:

- i) Post menopausal women with pelvic malignancy who are undergoing radiotherapy to the pelvis.
- ii) In patients whose spine only or spine/ femur measurements have been made but the central DEXA measurements are falsely elevated then either peripheral and/or whole body DEXA could be performed.
- iii) Patients with malabsorption/eating disorders in whom both central & whole body measurements can be used to monitor therapy.
- iv) Also central and whole body DEXA may be useful in selected pediatric cases.

4. Repeat BMD scans within 2 years of original scan may be paid if:

- i) Patients receiving high dose corticosteroids may require repeat scans approximately six months after a previous examination.
- ii) Patients receiving drug therapy may have follow-up bone density measurements performed annually for three consecutive years. If bone mass has stabilized after three years, repeat measurements may be performed every two years. (Note: drug therapy is considered to apply only when the patient is receiving prescription drug therapy).
- iii) Pediatric age group to assist in determination of body composition and nutritional status (i.e.: malnourishment/anorexia/eating disorders).
- iv) In adults when BMD of central sites (spine and femur) are suspected to yield falsely elevated values.

Repeat scans within 2 years are not approved for:

- i) Compression fracture.
- ii) Diagnosis of "Osteoporosis" only.

5. Payment of whole body density:

Must be accompanied by a written explanation of need. Whole body BMD may be billed under the following circumstances:

- i) For pediatric age group to assist in determination of body composition and nutritional status. Example would include patients with malnourishment; anorexia; chronic diseases; endocrine abnormalities; or metabolic diseases.
- ii) Evaluation of the effects of a therapeutic regimen and/or drug on body compartments.
- iii) In adults when BMD of central sites (Spine and Femur) are suspected to yield falsely elevated values.

**GROUP VISITS FOR CHF
AND DIABETES**

The Medical Services Plan (MSP) recognizes that for certain chronic disease conditions (chronic heart failure and diabetes), group visits are proven to result in better patient outcomes. Physicians have asked if a visit may be billed to MSP for these group visits.

The Medical Services Commission Payment Schedule Preamble states that in order for a service to be payable, certain criteria must be met. It is understood that if during a group visit for the above mentioned conditions, the physician has a direct face-to-face encounter with the patient which is medically necessary, and the requirements for a visit (see Preamble B.1) are satisfied, then a visit may be billed to MSP for each patient seen.

This is not applicable, however, if the physician is receiving sessional or third party payment for the group visit, even if the patient is seen directly, as this would be considered included in that payment.

**Rescind MSCommuniqué
CMQ97-007**

The Medical Services Commission hereby rescinds Communiqué - CMQ97-007 that allowed for rota billing by diagnostic facilities.

Section 12(4) of the *Medicare Protection Act*, reads:

Payments for benefits in and approved diagnostic facility must be paid to the practitioner who was responsible for rendering the benefit.

Effective immediately, the use of one practitioner number or the rotating of practitioner numbers for the billing of diagnostic facility services is prohibited.

This does not affect the general use of assignments by practitioners where the physician renders a benefit and the diagnostic facility submits the claim for payment (in the practitioner's name) to MSP.

For information please contact Diagnostic Facilities Administration at 250 952-3190.

**Ambulatory Blood Pressure
Monitoring - 24 hour -
Reminder**

Ambulatory Blood Pressure Monitoring is not an insured benefit of MSP and may not be billed to MSP under any listing.

Audit Report

Dr. A Dermatology

A dermatologist was audited because patient responses to verification letters suggested that the physician was not present on-site when a nurse performed delegated services. Also, the dermatologist was certified in more than one specialty and submitted a significant number of claims for consultations using the alternate specialty fee items. In addition, the physician claimed removal of skin lesions using fee item 00190 from the General Practice listings and fee item 00100 GP visits, in lieu of using fee items 00217 and 00207, respectively, from the dermatology listings.

As the result of a negotiated settlement, the physician agreed to refund the MSC \$34,000, inclusive of costs and interest, and abide by a pattern of practice order in which the physician would:

- a) submit claims for removal of skin lesions using 00217, in lieu of 00190,
- b) use dermatology listings for consultations and special examinations involving predominantly diagnosis and treatment of skin disorders, including cutaneous manifestation of systemic disease,
- c) use continuing care fee items per Payment Schedule B.3.b. instead of 0100-series GP visit codes, for follow-up visits following a consultation and;
- d) prepare and maintain adequate medical records.

General Information on Audits

Why an Audit?

The process of being audited is a distressing event for physicians, whether the tax department, the Medical Services Plan (MSP), the College, or some other agency is doing it. Physicians must accept that payment agencies are mandated to ensure accountability for the funds they spend. The fee-for-service system requires a large element of trust that doctors will bill appropriately for their services. Random audits by MSP indicate that this trust is well founded. Very few doctors bill inappropriately, fewer yet, fraudulently.

The *Medicare Protection Act* provides the MSP with the legislated authority to audit physicians. The BCMA Patterns of Practice Committee (POPC), jointly funded by the BCMA and MSP, has no authority to audit but does have the mandate to provide peer review advice to the MSP, and to provide educational information to doctors regarding their pattern of practice. The POPC also provides advice to the MSP Audit Working committee regarding appropriate case-finding criteria for selecting audits, audit criteria, and process criteria to ensure physicians are treated fairly.

The committee tries to educate physicians about their pattern of practice through the production of the annual mini-profile. This profile is provided to all fee-for-service physicians, based on the claims data that you submit for payment to the MSP. The mini-profile is designed to be user-friendly (hopefully!) and to provide a good comparison of your practice with other colleagues in your comparison group.

Adjustments of the data have become increasingly more sophisticated such that comparisons not only involve age and gender distribution but also comparisons based on “disease burden” and continuity of care.

A practitioner may statistically flag on one or many fee items/services. This may simply reflect a certain element of uniqueness in your practice. Peer review by the POPC may sort that out. If not, the MSP may write to you for information and may eventually request an audit.

How does MSP Monitor Physicians?

The Billing Integrity Program (BIP) provides audit services to the MSP and Medical Services Commission (MSC). The MSC is authorized, and obligated, to monitor the billing and payment of claims in order to manage expenditures for medical care on behalf of MSP beneficiaries.

There are three main methods employed in monitoring payments for services rendered:

1. Random Service Verification Audits
Each year, 75,000 survey letters are sent to patients to confirm they received services which have been billed to MSP on their behalf. 1500 physicians are chosen annually (at random) and letters are sent to 50 of their patients who have received a service in the preceding 6 months.
2. Select Service Verification Audits
A select audit may be done because of findings from the random audit or because of complaints by the general public, other doctors, referrals by licensing bodies and professional associations, or by atypical practice profiles.

A letter will be sent by MSP to 200 of the selected practitioner's patients to confirm they received the services billed to MSP on their behalf.

3. Profile Reviews

Practitioner profiles are also used to monitor payments for services rendered. As mentioned above, the POPC produces a mini-profile that is provided to all practitioners. The mini-profile is based upon a more detailed profile that is maintained by MSP. MSP monitors the profile data to identify practitioners that appear to be statistically significantly different from their peers in their billing patterns.

How does MSP Audit Physicians?

If BIP considers there is reason to investigate the billings of a practitioner, they will forward their recommendations to the Audit and Inspection Committee (AIC). The AIC has been delegated by the MSC with the responsibility for determining which physicians will be referred for audit and, once an audit has been completed, which physicians will be referred for recovery action. The AIC consists of one physician representative from the BCMA, the College of Physicians and Surgeons, and the government, as well as one public representative.

A. Random Audits

MSP occasionally audits physicians chosen at random. Most random audits have very few material findings (usually none). Random audits serve as a type of control measure against which to compare audit cases that are selected for cause. However, because audit resources are limited, most audit cases are selected for a reason.

B. Audits for Cause

BIP analyzes all of the information derived from its monitoring activities and looks for statistically significant variation from an 'average' pattern of practice or billing, or other evidence of potentially unjustified billing practices. If such irregularities are encountered, BIP may undertake an audit, usually at the practitioner's office. The audits are conducted by a medical practitioner (inspector), who is a peer of the physician being audited and is jointly nominated by the BCMA and the College of Physicians and Surgeons. The inspector is responsible for looking at the medical records - an accountant provides assistance and is responsible for looking at the administrative and billing records.

The objectives of the audit are to determine by examination of charts the following:

1. Was a service actually rendered?
2. Was it a benefit of MSP (i.e., medically necessary)?
3. Was it billed correctly?
4. Was it properly documented?
5. Was it rendered by the practitioner making the claim and performed in such a way that there was no quality of care concerns?
6. Was the pattern of practice or billing pattern justifiable?

The audit report is submitted to the MSC. If a recovery of funds is being considered, the practitioner is given the opportunity to participate in a voluntary Alternative Dispute Resolution (ADR) process, which allows for reaching a negotiated settlement with or without help of a mediator. The choice to take part in an ADR process is at the physician's discretion.

If the practitioner elects to forego the ADR process, or an agreement

cannot be reached, the physician then has the opportunity to have a hearing before an Audit Hearing Panel, prior to any order for recovery being made. If potential quality-of-care issues are identified, these are referred to the College of Physicians and Surgeons.

The Audit Hearing Panel includes representatives of the Government, the profession and the public. It is a quasi-judicial body that has authority to make an order for recovery. Orders are filed with the B.C. Supreme Court. Physicians have access to support from the Canadian Medical Protective Association (CMPA) for legal assistance with the ADR and/or Audit Hearing Process.

How Can You Avoid an Audit?

We have a number of recommendations for you:

1. Ensure you read your mini-profile and see how your pattern of practice compares to your colleagues. If there are flagged statistical outliers, make sure you can justify these billings.
2. Read the Preamble to the MSC Payment Schedule and follow the Preamble recommendations as well as following any specific fee item guidelines. Remember, the POPC does not set policy on what you can and cannot bill; read the preamble.
3. Ensure you have an adequate record to prove the service was medically necessary and that the service you billed for was the one that was provided.

The Patterns of Practice Committee (POPC) is pleased to receive comments from practitioners. Please write to the committee at:

BCMA/Department of Professional Relations
Graham E. White, MD, Chair, POPC
115 - 1665 W. Broadway
Vancouver, BC V6J 5A4

Update to the Medical Services Commission Payment Schedule

Preamble

Effective January 1, 2005 the following modifications have been made to the Payment Schedule:

Amendment:

The wording of Section A.17 of the Preamble to the Payment Schedule is modified as follows:

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:

- i) be a Certificant or 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 in that particular specialty or
- ii) be recognized as a specialist pursuant to the Health Professions Act and bylaws of the College of Physicians and Surgeons of British Columbia.

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.

Amendment:

Effective immediately, the following modifications to the Payment Schedule have been approved by the Medical Services Commission:

1. The following prefix is added under Preamble B.14 to identify those fee items for which a surgical assistant is not required:

“S” - designates fee items for which a surgical assistant's fee is not payable

2. This prefix is hereby added to the following fee items:

- a) All eye surgery listings
- b) The following Sectional fee items which have been identified as items for which a surgical assistant's fee is not payable:

00331	Closed drainage of chest - operation only
02323	Removal of nasal polypi bilateral
02365	Nasal fracture- reduction and splinting
03104	Percutaneous rhizotomy 5th nerve

03165 Insertion of intracranial pressure monitoring device – operation only

03167 Insertion of skull tongs (operation only)

03188 Ventriculostomy or insertion of external ventricular drain (operation only)

03196 Exploration, mobilization and transposition

03216 Puncture of ventricular shunt for CSF aspiration (operation only)

03217 Percutaneous ventricular puncture (operation only)

03240 Implantation of totally implantable ventricular access device (eg., Ommaya reservoir) - (operation only)

04001 Laparoscopy (operation only)

04500 Cervix dilation and curettage

04531 Cauterization of cervix - with dilation and curettage

06113 Abrasive surgery - between quarter and half-face

06114 Abrasive surgery - full face

06200 Tattooing Surgery - Facial area: Less than one-quarter of face

06201 Tattooing Surgery - Facial area: One-quarter to one half of face

06202 Tattooing Surgery - Facial area: Full face

06206 Tattooing Surgery - Nonfacial area - Less than 65 sq.cm

06207 Tattooing Surgery - Nonfacial area

06258 Exploration of peripheral nerve and neurolysis

07843 Implantation of endocardial pacemaker (ventricular)

07844 Implantation or replacement of pulse generator for cardiac pacing

07847 Endocardial pacemaker (atrial A-V sequential)

07924 Decompression of traumatic pneumothorax - operation only

07925 Artificial pneumothorax

07952 Electronic monitoring of pacing and pacemaker function

07953 Double lead endocardial pacemaker

T08123 Extra-corporeal shock wave lithotripsy (ESWL), operation only

08146 Uteroscopy and basket manipulation of ureteral calculus with or without lithopaxy (operation only)

08155 Insertion of internal ureteral stent to include C & P and ureteroscopy, (operation only)

08200 Bladder fulguration with cystoscopy

08202 Cystostomy by Trochar, isolated procedure

T08232 Periurethral collagen injections

08250 Transurethral resection of bladder or urethral tumour and adjacent muscle and electrocoagulation, as necessary

08251 Transurethral resection bladder neck, female

08254 Litholapaxy and removal of fragments

08256 Transurethral resection of external urinary sphincter

08257 Transurethral removal of foreign body (excluding ureteric stents)

08260 Urethrotomy, external or internal

08261 Urethroscopy

08262 Meatotomy and plastic repair

08264 Stricture of urethra - office dilation

08265 Stricture of urethra - dilation in hospital, isolated procedure, with or without anaesthesia

08269 TUR posterior urethral valves

08282 Excision prolapse of urethra or caruncle - includes cystoscopy

08301 Dorsal slit, isolated procedure

08312 Circumcision - excluding clamp or bell technique

08319 Balloon dilation of prostate (includes cystoscopy)

08323 Exploration of scrotal contents - unilateral

08325 Reduction of torsion of testis and spermatic cord repair bilateral

08327	Biopsy of testis
08329	Simple orchidectomy
08340	Abscess, incision, complete care
08341	Spermatocoele or hydrocoele excision
08343	Epididymovasostomy or re-anastomosis of vas - unilateral
08344	Vas cannulation, unilateral or bilateral
08345	Vasectomy - bilateral
52800	Manipulation: Shoulder Joint: Manipulation under GA
53800	Manipulation: Elbow Joint: Manipulation under GA
54800	Manipulation: Hand/Wrist Joint: Manipulation under GA
55800	Manipulation: Hip Joint: Manipulation under GA
56800	Manipulation: Knee Joint: Manipulation under GA
57800	Manipulation: Ankle/Foot: Manipulation, with GA

c) The “S” prefix is added to all diagnostic procedures with exception of the following:

11215	Arthrotomy shoulder joint or bursa
11245	Shoulder Girdle, Clavicle and Humerus - Biopsy, open
11315	Arthrotomy elbow joint
11345	Elbow, Proximal Radius and Ulna - Open biopsy
11415	Arthrotomy wrist joint
11416	Arthrotomy MP, PIP, DIP Joints
11445	Hand and Wrist - Open biopsy, hand or wrist
11515	Arthrotomy hip joint
11545	Arthrotomy and biopsy, hip
11546	Pelvis, Hip and Femur - Biopsy open, soft tissue or bone
11615	Arthrotomy knee joint
11645	Femur, Knee Joint, Tibia and Fibula - Biopsy, open
11715	Incision - Diagnostic, Open - Ankle joint
11716	Incision - Diagnostic, Open - Subtalar joint
11717	Incision - Diagnostic, Open - Midtarsal joint
11718	Incision - Diagnostic, Open - Tarsal-metatarsal, metatarsal-phalangeal, interphalangeal joint
11745	Tibial Metaphysis (Distal), Ankle & Foot - Open biopsy, under GA
11845	Vertebra, Facette and Spine - Biopsy, with GA

General Practice

Effective immediately, the following note is hereby added to the Surgical Assistance listings (00194 – 00198) and existing notes:

iii) Visit fees are not payable with surgical assistance listings on the same day, unless each service is performed at a distinct / separate time. In these instances, each claim must state time service was rendered.

The following notes are appended to the indicated fee item:

13610 Minor laceration or foreign body – not requiring anaesthesia – operation only

Notes:

- i) Intended for primary treatment of injury*
- ii) Not applicable for dressing changes or removal of sutures*
- iii) Applicable for steri-strips or glue to repair primary laceration*

Dermatology

Effective January 1, 2005 the cancellation date of the following provisional item has been extended. This extension will expire on December 31, 2005 or when replaced by a subsequent Minute, whichever occurs first:

P00228	Photo epilation of facial hair – per ¼ hour (or major portion thereof)	\$27.88
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Notes:

- i) Billable to a maximum of ½ hour per session*
- ii) Epilation of facial hair for familial hirsutism is not a benefit of the Plan*
- iii) Pre-authorization is required (see Preamble B.16.2(6))*

Ophthalmology

Effective January 1, 2005 the cancellation dates of the following provisional items have been extended. This extension will expire on June 30, 2005 or when replaced by a subsequent Minute, whichever occurs first.

P22067	Computerized retinal nerve fibre layer photography and neuro-retinal rim assessment (e.g.:Heidelberg, GDx)	\$63.92
P22068	- professional fee	\$12.28
P22069	- technical fee	\$51.64

Notes:

- i) Requires both qualitative and quantitative assessments*
- ii) Includes examination of both eyes whether at one time or two separate visits*
- iii) Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 180 days without written justification.*

Internal Medicine

Effective January 1, 2005 the cancellation date of the following provisional items have been extended. This extension will expire on December 31, 2005 or when replaced by a subsequent Minute whichever occurs first:

Patient Activated Cardiac Event Recorders

P00362	Event/unmonitored loop recorders (first strip) – Professional fee	\$35.62
P00369	- each additional strip (per strip)	\$17.76

Note: Additional strips are limited to two extra strips per patient, per two-week period.

P00392	Event/unmonitored loop recorder – Technical fee	\$42.68
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Notes:

- i) The following notes apply to fee items 00362, 00369, 00392*
- ii) These items are intended to cover a two-week period*
- iii) Consultation not paid in addition*
- iv) Provide note record when more than one recording billed per patient, per year.*
- v) Holter monitor not payable in addition*
- vi) An explanatory note is requires for second test, same patient.*

Clinical Immunology and Allergy

The payment rate of the following listing is modified as indicated. This increase is funded from the outstanding balance of new fee item funds identified in the fiscal year 2004/05:

30010	Clinical immunology and allergy consultation: To include a detailed history and physical examination with review of laboratory investigations, plus appropriate allergy and immunology management and additional visits necessary to render a written report	\$138.81
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Plastic Surgery

The following modifications were effective April 15, 2005:

Amendments:

1. The payment rate of the following fee item is hereby adjusted as indicated. The resulting savings will be used to fund several new items, as indicated. These items are to be monitored for the 12 month period following the implementation date. In the event that the cost of these changes over the 12 month period differ from the savings from 06010 for the period under review, adjustments will be made to 06010 on a retrospective basis and prospective basis to correct for this difference.

06010	Consultation	\$60.73
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2. The following note is hereby appended to the indicated fee item:

06157 Nipple-areolar reconstruction
Note: This procedure is to result in a pigmented areolar complex using pigmented epithelium.

3. The following note is hereby appended subsequent to the listings for Tattooing Surgery non-facial area (fee items 06205-06207):

Note: Fee items 06205-06207 are not payable for nipple areolar tattooing.

New Fee Items:

1. The following new fee item is to be monitored for the 12 month period following the implementation date. In the event that the cost of these changes over the 12 month period differs from the savings from 06010 estimated for the period under review, adjustments will be made to fee item 06010 on a retrospective basis and prospective basis to correct for this difference.

CP06159	TRAM Flap reconstruction of mastectomy defect	\$1,000.00 Anaes Level 5
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Notes:

- i) *Includes preparation of site to be grafted, harvesting and insertion of the graft, closure of donor defect, with or without mesh.*
- ii) *Reconstruction of both breasts (bilateral) with two pedicled TRAM flaps is payable at 150%.*

2. The following new fee items are funded from the new fee money identified in the Letter of Agreement and will be monitored for the 12 month period following the implementation date.

P61166	Mastopexy, balancing unilateral (isolated procedure)	\$313.79 Anaes Level 3
P61167	Mastopexy, balancing - when performed at same time as contralateral breast surgery	\$235.34 Anaes Level 3

The following new fee items are effective May 1, 2005:

P61224	Open (compound) hand fractures – Primary Wound Management	\$40.10 Anaes Level 2
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Notes:

- i) Includes management of soft tissue component of open fracture, including wound excision, debridement, irrigation, and implementation of antibiotic beads.*
- ii) Payable in addition to 06224, 06225, P61223*
- iii) Payable at same percent as applies to fracture fee*
- iv) Payable only when procedure performed in operating room*

P61225	Open (compound) hand fractures – Secondary Wound Management	\$80.10 Anaes Level 2
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Notes:

- i) Repeat primary management of soft tissue component of open fracture, including wound excision, debridement, irrigation, implementation of antibiotic beads at a second sitting or return to the O.R. for delayed primary closure. Not payable in addition to closure with skin grafts and/or local skin flaps*
- ii) Includes removal of beads*
- iii) This listing is exempt from the 42-day rule (Preamble B.9.d)*
- iv) Payable only when procedure performed in operating room*

Effective April 15, 2005 the following fee items are to be monitored for the 12-month period following the implementation date. In the event that the cost of these changes over the 12-month period differs from the amount estimated for the period under review, adjustments will be made to fee item 06010 on a retrospective basis and prospective basis to correct for this difference.

New Fee Items

P61223	ORIF of phalangeal (middle or proximal) or metacarpal fracture	\$261.00 Anaes Level 2
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Note: Multiple fractures paid in accordance with Preamble B.10.a

P61222	CRIF of phalangeal (middle or proximal) or metacarpal fracture	\$191.35 Anaes Level 2
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Deleted Fee Items

The following fee items are deleted effective April 14, 2005:

06152	Abdominal lipectomy	\$230.38 Anaes Level 4
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06155	Abdominal lipectomy – with flap procedure, mobilization of umbilicus, and repair of umbilical hernia	\$461.46 Anaes Level 4
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New Fee Item

The following new fee item is effective April 15, 2005 and will be monitored for the 12-month period following implementation date:

P61152	Abdominal panniculectomy – where medically indicated, secondary to chronic subpanus intertrigo, which has been unresponsive to a reasonable period of medical treatment	\$292.68 Anaes Level 4
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Note: To include umbilicoplasty where medically indicated.

Deleted Fee Item

The following item is deleted effective April 14, 2005:

C06158	Myocutaneous flap involving major muscle rotated on its neurovascular pedicle	\$746.78 Anaes Level 5
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New Fee Items:

The following new fee items are effective April 15, 2005. Service volumes are to be monitored for a 6-month period following the implementation date and any savings will be allocated back to the Section at the end of the monitoring period.

PC61158	Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving major muscles	\$746.48 Anaes Level 5
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Note: The following muscle flaps are payable under this item:

- i) biceps femoris flap*
- ii) deltoid flap*
- iii) external oblique flap*
- iv) gastrocnemius flap*
- v) gluteus maximus flap*
- vi) gracilis flap*
- vii) latissimus dorsi flap*
- viii) pectoralis major flap*
- ix) rectus abdominus flap*
- x) rectus femoris flap*
- xi) soleus flap*
- xii) trapezius flap*
- xiii) temporalis flap*
- xiv) tensor fascia lata flap*
- xv) triceps flap*
- xvi) vastus lateralis flap*
- xvii) vastus medialis flap*

PC61157	Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving medium muscles	\$560.08 Anaes Level 5
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Note: The following muscle flaps are payable under this item:

- i) brachioradialis flap*
- ii) coracobrachialis flap*
- iii) pectoralis minor flap*
- iv) peroneus brevis flap*
- v) peroneus longus flap*
- vi) platysma flap*
- vii) sartorius flap*
- viii) serratus flap*
- ix) sternocleidomastoid flap*
- x) tibialis anterior flap*
- xi) tongue flap*

PC61156 Yocutaneous flap or fascia cutaneous flap rotated on its vascular or
neurovascular pedicle involving small muscles \$373.39
Anaes Level 5

Note: The following muscle flaps are payable under this item:

- i) abductor digiti minimi flap*
- ii) abductor hallucis flap*
- iii) abductor pollicis brevis flap*
- iv) anconeus flap*
- v) extensor digitorum communis flap*
- vi) extensor digitorum longus flap*
- vii) extensor hallucis longus flap*
- viii) first dorsal interosseous flap*
- ix) flexor carpi ulnaris flap*
- x) flexor digitorum brevis flap*
- xi) flexor digitorum longus flap*
- xii) flexor hallucis longus flap*
- xiii) orbicularis oculi flap*
- xiv) orbicularis oris flap*

General Surgery

Effective June 1, 2005 the following item has been approved on a provisional basis. This Minute will expire May 31, 2006, or when replaced by a subsequent Minute, whichever occurs first.

P07479 Sentinel lymph node biopsy (SLN) \$433.96
Anaes. Level 3

Notes:

- i) Payable only for the staging of malignant breast disease and malignant melanoma.*
- ii) Subsequent surgery (07474 or 07475) performed under same anaesthetic is payable at 50% of the applicable fee for the lesser item.*
- iii) Payable only to BCCA validated physicians.*
- iv) SLN component of the combined procedure not payable to surgeons during the training phase.*

Radiology

Effective June 1, 2005 the following item has been approved on a provisional basis, this Minute will expire on May 31, 2006 or when replaced by a subsequent Minute, whichever occurs first:

P10905	Cerebral intra-arterial thromboysis	\$1,168.24
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Notes:

- i) Payable once only, regardless of number of arterial territories treated.*
- ii) Includes all diagnostic and superselective angiograms performed during procedure and immediate post procedure CT scans.*
- iii) Interventional radiology consultation not payable in addition.*

Laboratory Medicine

Amendment

The **bolded** note is added after the following fee item as indicated:

90295	Immunophenotyping by flow cytometry peripheral blood and/or bone marrow and/or body fluids – each additional tube
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Notes:

- i) Do not count control(s) as separate tube(s)*
- ii) Fee items 90290 and 90295 not payable for CD4 counts in patients with HIV infection*

Effective January 1, 2005, the cancellation date of the following provisional item has been extended. This extension will expire on December 31, 2005 or when replaced by a subsequent Minute whichever occurs first:

P91719	Glucose – 2 hr, post-75 g	\$19.76
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Note: i) Restricted to Category IIC and Category III laboratories.

Effective January 1, 2005 the cancellation date of the following provisional item has been extended. This extension will expire on December 31, 2005 or when replaced by a subsequent Minute whichever occurs first:

P92227	Sirolimus	\$53.19
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The cancellation date of the following provisional items have been extended. This Minute will expire on December 31, 2005 or when replaced by a subsequent Minute, whichever occurs first:

P92355	Troponin	\$30.77
P92510	Methadone Metabolite	\$4.33
P92513	Methadone	\$4.33
P92515	Blood Methadone	\$56.73
P91760***	Helicobacter pylori Carbon 13 urea breath test	\$59.99

Nuclear Medicine

P95053	Thallium body imaging	\$374.11
	<i>Notes:</i>	
	<i>i) Not payable with 09806, 09817, 09854 or 09826</i>	
	<i>ii) 09877 payable in addition if the patient is brought back for additional imaging the same or next day</i>	

The following modification to the Payment Schedule is effective immediately:

Amendment

The following fee item is deleted:

Nuclear Medicine

P95012	Helicobacter pylori Carbon 14 urea breath test	\$104.14
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Effective January 1, 2005 the cancellation dates of the following provisional items have been extended. This Minute will expire on December 31, 2005 or when replaced by a subsequent Minute, whichever occurs first:

Haematology:

P90027***	Activated Protein C Resistance (APCR)	.....	\$51.88
P90036**	Antiphosphatidylserine (IgG)	.....	\$30.03
P90037**	Antiphosphatidylserine (IgM)	.....	\$30.03
	<i>Note: When both P90036 and P90037 performed on same specimen, second test is billable at \$22.38.</i>		
P90038***	Anti Saccharomyces Cerevisiae (ASCA) – IgA	.....	\$31.50
P90039***	Anti Saccharomyces Cerevisiae (ASCA) – IgG	.....	\$31.50
	<i>Note: When both P90038 and P90039 are performed on same specimen, second test is billable at \$25.11.</i>		
P90042***	Anti-Xa Heparin assay.....		\$115.01
P90045**	Bone marrow examination.....		\$265.97
	<i>Note: 90045 includes 90465, 90490, 90205, 90340 and 90210</i>		
P90055***	Circulating inhibitor screen - unincubated simple mixing study.....		\$37.32
P90065	Cold agglutinins – qualitative.....		\$17.69
P90072**	Collagen Binding assay.....		\$64.17
	<i>Note: Not billable with 90505.</i>		
P90073**	Dilute Russell Viper Venom Time.....		\$31.33
P90075**	Differential cell count on body fluids other than blood.....		\$12.72
P90080	Direct antiglobulin (Coombs ¹) test, polyspecific.....		\$30.36
P90095**	Erythropoietin (EPO) assay.....		\$36.08
P90127***	Factor V Leiden / PGM – 1 st gene.....		\$95.12
	<i>Notes:</i>		
	<i>i. Restricted to Royal Columbian, Vancouver and Victoria General Hospitals</i>		
	<i>ii. Not billable for screening purposes</i>		
	<i>iii. Applicable to patients with thrombophilia.</i>		

P90128***	Factor V Leiden / PGM – 2 nd gene	\$60.01
	<i>Notes:</i>	
	<i>i. Billable only when performed with P90127</i>	
	<i>ii. Restricted to Royal Columbian, Vancouver and Victoria General Hospitals</i>	
P90185	Glucose-6-phosphate dehydrogenase (G-6-PD) screening test.....	\$21.35
P90240**	Haemoglobin electrophoresis.....	\$38.60
P90290**	Immunophenotyping by flow cytometry - peripheral blood and/or tissue and/or bone marrow and/or body fluids - 5 tube panel	\$266.23
P90335**	Malaria and other parasites	\$23.20
P90340**	Marrow films for interpretation.....	\$195.16
P90357	Neutrophil Oxidative Burst Assay.....	\$137.83
P90360**	Nitro blue tetrazolium test.....	\$37.21
P90377**	Phospholipid Neutralization Test – for confirmation of Lupus Anticoagulant.....	\$52.25
P90390**	Platelet antibodies	\$42.11
P90400	Platelet estimation on film	\$5.67
P90427**	Protein S Activity (clot-based)	\$46.82
	<i>Note: Not billable with 90435 or 90430</i>	
P90440	Prothrombin time/INR	\$14.89
P90460+	RBC antibody detection, per tube (albumin, enzyme or other antibody enhancement, e.g. LISS additive)	\$8.44
P90465	RBC morphology including platelet estimation.....	\$8.44
P90470	Red cell folate.....	\$39.74
P90510+	Saline tubes (per tube)	\$9.28
P90525	Sickle cell identification.....	\$30.90
P90530***	Stypven prothrombin time	\$34.57
P90560***	Von Willebrand's multimer analysis by autoradiography.....	\$108.49
P91160**	Antimyeloperoxidase Ab.....	\$31.82
P91355	Cells, count - CSF and other fluids.....	\$36.01
Microbiology:		
P90605**	Anaerobic culture investigation	\$14.55
P90610***	Smear for inclusion bodies	\$40.23
P90615**	Antibiotic susceptibility test, semi-quantitative per organism	\$19.24
P90620	Biochemical identification of micro-organism- per organism.....	\$11.80
P90625**	Blood culture, using aerobic and/or anaerobic media	\$42.99
P90651	Chlamydia trachomatis using NAT – urine	\$32.99
P90652	Chlamydia trachomatis using NAT – urogenital swab.....	\$32.06
P90665**	Fungus culture.....	\$16.73
P90730	Smear for inclusion bodies	\$15.05
P90740	Stained smear	\$7.25
P90750	Biochemical identification of micro-organism in stool.....	\$14.21
P90780**	Throat or nose culture - each additional culture	\$6.18
P90785	Trichomonas and/or candida, direct examination	\$5.49
P90795	Examination for pinworm ova	\$5.76
P90815	Serological tests - 1 to 3 antigens	\$31.23
P90820	Serological tests - 4 or more antigens.....	\$46.41
	<i>Note: Not to be billed for any virology testing where specific listings exist (e.g.: Hepatitis).</i>	
P90825***	Smear or section for electron microscopy	\$33.98
P90830	Virus isolation	\$55.82

Chemistry:

P91023**	Acetyl CoA: a-glucosaminide-N-acetyl transferase, white blood cells	\$114.53
	<i>Note: Restricted to BC Children's Hospital.</i>	
P91027**	Acid Lipase, white blood cells	\$62.64
	<i>Note: Restricted to BC Children's Hospital.</i>	
P91036***	ACTH stimulation test.....	\$53.27
P91037**	Acylcarnitine profiling.....	\$50.45
	<i>Note: Restricted to BC Children's Hospital.</i>	
P91096**	Alpha-iduronidase, white blood cells	\$62.64
	<i>Note: Restricted to BC Children's Hospital</i>	
P91097**	Alpha-mannosidase, white blood cells	\$62.64
	<i>Note: Restricted to BC Children's Hospital.</i>	
P91120***	Amniotic fluid, bilirubin scan	\$64.89
P91142**	Anti-diuretic hormone (ADH), plasma.....	\$111.26
P91155*	Antiglomerular basement membrane antibody	\$31.82
P91162	Anti-tissue transglutaminase antibodies (anti-TTG), IgA.....	\$29.90
	<i>Note: Not billable with 91800.</i>	
P91180***	Apoprotein E genotyping	\$75.55
P91231**	Beta-glucuronidase, white blood cells	\$62.64
	<i>Note: Restricted to BC Children's Hospital.</i>	
P91232**	Beta-mannosidase, white blood cells	\$62.64
	<i>Note: Restricted to BC Children's Hospital.</i>	
P91330	Calculus analysis – urine.....	\$34.45
P91380**	Cholinesterase with dibucaine number	\$37.00
P91386***	Chromatography - keto acids	\$44.38
P91387***	Chromatography - reducing substances-urine	\$38.37
P91388***	Chromatography - thin layer (T.L.C.).....	\$39.91
P91395	Complement, total haemolytic (CH 100)	\$54.04
P91480	Acetazolamide	\$56.86
P91484	Amikacin	\$56.86
P91486	Amiodarone	\$56.86
P91490	Amoxapine.....	\$56.86
P91492	Chlorpromazine	\$56.86
P91496	Clobazam	\$60.89
P91498	Clomipramine	\$60.89
P91500	Clonazepam	\$56.86
P91508	Desmethyloclobazam	\$56.86
P91510*	Diazepam	\$56.86
P91512	Disopyramide.....	\$56.86
P91514	Doxepin	\$56.86
P91516	Fluoxetine	\$56.86
P91518	Flupenthixol	\$56.86
P91520	Fluphenazine	\$56.86
P91522	Fluvoxamine	\$56.86
P91526	Haloperidol	\$56.86
P91528	Imipramine.....	\$56.86

P91530	Lidocaine	\$54.66
P91532*	Lorazepam.....	\$56.86
P91534	Loxapine	\$56.86
P91536	Maprotiline	\$56.86
P91538	Methotrexate.....	\$56.25
P91540	Methotrimeprazine.....	\$56.86
P91542	Methylphenidate	\$56.86
P91544	N-Acetyl procainamide	\$56.86
P91546	Netilmicin	\$56.86
P91548	Nitrazepam	\$56.86
P91552	Paroxetine	\$56.86
P91554	Perphenazine	\$56.86
P91556	Procainamide.....	\$56.86
P91558	Propranolol	\$56.25
P91560*	Sertraline	\$56.86
P91562	Thioridazine	\$56.86
P91566	Trazodone	\$56.86
P91568	Trifluoperazine.....	\$56.86
P91570	Trimipramine.....	\$56.86
P91601**	Electrophoresis - protein, quantitative.....	\$33.25
P91602**	Electrophoresis - C.S.F	\$38.59
P91680	Gastric analysis, intubation	\$22.17
P91715***	Glucose quantitative, 2 to 5 hours.....	\$36.65
P91717**	Glucose quantitative – intravenous	\$47.54
P91730	Glutathione peroxidase.....	\$52.20
P91762**	Heparan sulfamidase, white blood cells.....	\$114.53
	<i>Note: Restricted to BC Children's Hospital.</i>	
P91777**	Hexosaminidase, white blood cells	\$114.53
	<i>Note: Restricted to BC Children's Hospital.</i>	
P91800	IgA Anti-gliadin antibodies.....	\$39.83
	<i>Note: Applicable only to TTG negative gluten sensitive enteropathy</i>	
P91820***	Immunofixation – CSF.....	\$124.04
P91850	Inclusion bodies - (cytomegalic) – urine	\$9.51
P91912	Lead - porphyrin screening test – urine.....	\$7.60
P91915***	Lecithin sphingomyelin ratio	\$273.52
P91920***	LHRH stimulation test - in addition to specific tests billed.....	\$56.48
P91940**	Lipoprotein electrophoresis	\$68.49
P91970	Metachromatic granules – urine	\$18.34
P91992	Mitochondrial preparation – muscle	\$110.67
	<i>Note: Restricted to BC Children's Hospital.</i>	
P91997**	N-acetyl-Galactosamine-6-sulfate sulfatase, white blood cells.....	\$114.53
	<i>Note: Restricted to BC Children's Hospital.</i>	
P92035	Pentagastrin test – gastric.....	\$82.50
P92075	Pigments, abnormal, (spectroscopic).....	\$17.18
P92090	Porphyrins - qualitative, urine.....	\$9.43
P92091	Porphyrins - quantitative with separation – urine	\$67.63
P92095**	Porphyrins - quantitative – blood.....	\$26.92
P92110	Pregnancy Test – Serum.....	\$10.14
P92146	Proteins - timed urine collection	\$10.96

P92156**	Pyruvate Carboxylase, Fibroblasts_.....	\$114.53
	<i>Note: Restricted to BC Children's Hospital.</i>	
P92157**	Pyruvate Dehydrogenase, fibroblasts	\$114.53
	<i>Note: Restricted to BC Children's Hospital.</i>	
P92195**	Respiratory chain enzymes – muscle.....	\$335.53
	<i>Notes:</i>	
	<i>i) Includes Complex 1, Complex II, Complex IV, citrate synthase</i>	
	<i>ii) Restricted to BC Children's Hospital.</i>	
P92201	Salicylates, qualitative – gastric	\$3.54
P92202	Salicylates, qualitative – urine	\$3.67
P92320***	Thyroid Releasing Hormone (TRH) Stimulation Test.....	\$68.33
	<i>Note:Includes all time spent with patient, including injection and medication administered.</i>	
P92346**	Transferrin Isoelectric focusing (qualitative).....	\$110.59
	<i>Note: Restricted to BC Children's Hospital.</i>	
P92353**	13C Triolein Breath Test for malabsorption.....	\$82.97
	<i>Note:</i>	
	<i>i. Includes collection of "before" and "after" breath samples</i>	
	<i>ii. Not billable with 91636</i>	
	<i>Note: Restricted to BC Children's Hospital.</i>	
P92395	Urinalysis, microscopic.....	\$5.89
P92430*	Vitamin A	\$56.38
P92435*	Vitamin B1	\$66.36
P92440*	Vitamin B2	\$66.36
P92445*	Vitamin B6	\$66.36
P92465	Vitamin E	\$63.53
P92467	White blood cell preparation for lysosomal enzyme testing	\$51.76
P92470**	Xylose tolerance	\$129.72
Anatomical:		
P93010	Crystal identification, synovial fluid.....	\$41.11
P93070***	Chromosomal breakage studies.....	\$214.10
P93085	Cytologic preparation and examination of fine needle aspirate	\$112.30
P93090	Cytologic preparation and interpretation of pre-screened, non-gynaecological cytology	\$78.10
P93095	Cytologic preparation and interpretation of unscreened, non-gynaecological cytology	\$101.90
P93100*	Electron microscopy fee	\$458.06
Nuclear Medicine:		
P09817	Receptor Imaging - Isolated Procedure.....	\$235.77
P09826	Tumour imaging - isolated procedure.....	\$1265.13
P09870	Ocular tumour localization.....	\$164.92
P09871	Brain scan - regional cerebral blood flow (isolated procedure)	\$239.95
P09880	Treatment for hyperthyroidism or cardiac disease - charge per course of treatment (Iodine therapy)	\$205.41

P09881	Treatment for polycythaemia vera with P32 - charge per course of treatment.....	\$205.41
P09883	Treatment for prostate cancer - charge per course of treatment	\$414.88
P09884	Treatment for metastatic carcinoma of bone - charge per course of treatment.....	\$269.74
P09885	Treatment for ascites and/or pleural effusion, malignant	\$403.91
P09898	Coronary perfusion with radio particles, per radionuclide	\$175.74

Medical Microbiology:

P94005	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums)	\$104.76
P94010	Consultation: to consist of examination, review of history and laboratory findings with a written report.....	\$117.83
P94012	Repeat or limited consultation: where a consultation for same illness is repeated within six (6) months of the last visit by the consultant or where, in the judgement of the consultant, the consultative service does not warrant a full consultative fee	\$65.47
P94006	Directive care.....	\$26.19
P94007	Subsequent office visit.....	\$26.19
P94008	Subsequent hospital visit.....	\$26.19
P94009	Subsequent home visit	\$52.43

Telehealth Services

Amendment to the Medical Services Commission Payment Schedule

In accordance with Section 26(3) of the Medicare Protection Act, the following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective as indicated below:

Amendments:

The following amendments have been approved on a provisional basis, effective immediately. This Minute will expire one year from the effective date, or when replaced by a subsequent Minute, whichever occurs first:

The Preamble to the Payment Schedule is hereby amended as indicated:

- 1) Preamble B.1 is modified as follows:
The section is renumbered as B.1.a. and the wording is modified as indicated. In addition the notes included in B.1.a are converted from lower case alpha characters to lower case roman numerals:

B.1.a. Direct face-to-face encounter with the patient by the physician 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.)

- 2) Paragraph 2 of Preamble B.5 is modified as follows:

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

New:

The following has been approved on a provisional basis, effective immediately. This Minute will expire one year from the effective date, or when replaced by a subsequent Minute, whichever occurs first:

- 1) The following new Section is hereby added to the Preamble to the Payment Schedule:

Section B. 1. b Telehealth Services

"Telehealth Service" is defined as a physician 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 physician at another approved site, through the use of videotechnology. "Videotechnology" 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 Practice Assistant 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 physician, after having provided a telehealth consultation service to a patient, decides s/he must examine the patient in person, the physician 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 physician should submit a claim under the appropriate miscellaneous code for independent consideration with appropriate substantiating information.

Videotechnology services are generally payable once per patient/ per day/per physician. 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 physician 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 physician. However, other jurisdictions may have other definitions. BC physicians 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) The following new fee items and headings are hereby added as indicated:

i) Section of General Practice:

The following new heading and fee item are added subsequent to the "Miscellaneous Visits" section:

Telehealth Service with Direct Interactive Video Link with the Patient

P13020 Telehealth General Practitioner Assistant - Physical Assessment as requested by receiving specialist: - for each 15 minutes or major portion thereof 27.90

Notes:

- i) *Applicable only if general practitioner is required at the referring end to assist with essential physical assessment, without which the specialist service would be ineffective.*
- ii) *Applies only to period spent during consultation with specialist.*

ii) Section of Dermatology:

The following new heading and fee items are added to the "Referred Cases" section:

Telehealth Service with Direct Interactive Video Link with the Patient

P20210	Telehealth Consultation: To include history and dermatological examination, with review of any previous X-ray and laboratory findings and written report	52.95
P20214	Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee (laboratory test and biopsy when necessary, extra)	36.15
<i>Note: Punch and shave biopsies are included in consultation or visit fees.</i>		
P20207	Telehealth subsequent office visit	21.89
P20208	Telehealth subsequent hospital visit	20.87

iii) Section of Ophthalmology

The following new heading and fee items are added to the "Referred Cases" section:

Telehealth Service with Direct Interactive Video Link with the Patient

P22010	Telehealth Consultation: To include history, eye examination, review of x-rays and laboratory findings and any or all of measurement for refractive error, ophthalmoscopy, biomicroscopy, tonometry, eye-balance test, keratometry, where indicated and necessary to prepare a written report	71.37
P22011	Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit to the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	47.89
P22007	Telehealth subsequent office visit	27.58
P22008	Telehealth subsequent hospital visit	21.72

iv) Section of Paediatrics

The following new heading and fee items are added to the "Referred Cases" section:

Telehealth Service with Direct Interactive Video Link with the Patient

P50510	Telehealth Consultation: To consist of an examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	158.25
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P50511	Telehealth Consultation for complex behavioural, developmental or psychiatric condition in a child: To consist of a physical and neurological examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report	320.65
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Notes:

i) Not to be billed when no change in condition from previous assessment.

ii) Minimum time requirement for service is 1.5 hours.

iii) Developmental delays include, but are not limited to: non-verbal learning disability, developmental reading disability, developmental coordination, disability, developmental writing disability, dyscalculia, autistic spectrum disorders, fetal alcohol syndrome, mental retardation and other cognitive defects.

iv) Includes collection of data from collateral sources and formal screening, as appropriate.

P50512	Telehealth repeat or limited consultation: Where a formal consultation for the same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	76.75
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P50514	Telehealth prolonged visit for counselling	59.36
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Note:

The Plan will pay up to four such visits per year (see Clause B.4.c. of the Preamble).

P50506	Telehealth directive care	38.23
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P50507	Telehealth subsequent office visit	48.86
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P50508	Telehealth subsequent hospital visit	38.64
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v) Section of Plastic Surgery

The following new heading and fee items are added to the “Referred Cases” section:

Telehealth Service with Direct Interactive Video Link with the Patient

P66010	Telehealth Major consultation: To include complete history and physical examination, review of X-ray and laboratory findings, if required, and a written report	64.73
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P66012	Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six (6) months of last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	35.58
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P66007	Telehealth subsequent office visit	21.45
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P66008	Telehealth subsequent hospital visit	18.28
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vi) Section of Psychiatry

The following new heading and fee items are added to the "Referred Cases" section:

Telehealth Service with Direct Interactive Video Link with the Patient

Full Telehealth Consultations:

P60610	Telehealth Individual full consultation: Diagnostic interview or examination, including history, mental status exam and treatment recommendation, with written report	185.95
P60613	Telehealth Geriatric consultation (patients 75 years or older)	256.46
P60622	Telehealth consultation - Emotionally disturbed child: Diagnostic interview or examination, including mental status and treatment recommendation, assessment of parents, guardian, or other relatives and written report	320.65

Repeat or Limited Telehealth Consultations

Where a formal consultation for the same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee.

P60625	Telehealth - Individual consultation	93.91
P60614	Telehealth - Geriatric consultation	128.21
P60626	Telehealth - Emotionally disturbed child	160.33

Telehealth Psychiatric Treatment

P60607	Telehealth office visit to include services such as chemotherapy management and/or minimal psychotherapy	39.75
P60608	Telehealth hospital in-patient visit	46.62

Individual Telehealth Psychiatric Treatment:

P60630 - per 1/2 hour	79.46
P60631 - per 3/4 hour	110.74
P60632 - per 1 hour	141.81

Family/Conjoint Telehealth Therapy (two or more family members):

P60633 - per 1/2 hour	84.68
P60635 - per 3/4 hour	118.01
P60636 - per 1 hour	151.19

Telehealth - Miscellaneous

P60624	Evaluation interview with family member without presence of patient – per 1/2 hour session	72.99
P60645	Patient Management Conference - meeting by specific appointment to discuss/plan patient management with third parties, which may include referring physicians or hospital staff (if an inpatient) or relatives and must include at least one professional or community agency representative - per 1/4 hour <i>Notes:</i> a) <i>Not to exceed a maximum of two hours per patient per psychiatrist, per calendar year.</i> b) <i>A written record of the meeting must be maintained and/or a report generated by the psychiatrist.</i> c) <i>If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.</i>	39.75

vii) Section of Rheumatology

The following new heading and fee items are added to the “Referred Cases” Section:

Telehealth Service with Direct Interactive Video Link with the Patient

P31110	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	144.34
P31112	Telehealth Repeat or Limited Consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant, the consultative services do not warrant a full consultative fee	72.62
P31106	Telehealth directive care	40.00
P31107	Telehealth subsequent office visit	44.99
P31108	Telehealth subsequent hospital visit	29.10

viii) Section of Thoracic (Chest) Surgery

The following new heading and fee items are added to the “Referred Cases” section:

Telehealth Service with Direct Interactive Video Link with the Patient

P79210	Telehealth Consultation: To include complete history and physical examination, review of x-ray and laboratory findings, and a written report	114.41
P79212	Telehealth Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	51.49
P79207	Telehealth subsequent office visit	22.83
P79208	Telehealth subsequent hospital visit	19.48

Emergency Medicine Fee Schedule

Questions – Answers and Guidelines

Fee Schedule

01810	Consultation	
01811	Level 1 – Day	08:00 – 18:00, weekdays
01821	Level 1 – Evening	18:00 – 23:00, weekdays
01831	Level 1 – Night	23:00 – 08:00
01841	Level 1 – Saturday, Sunday or stat holiday	08:00 – 23:00
01812	Level 2 – Day	08:00 – 18:00, weekdays
01822	Level 2 – Evening	18:00 – 23:00, weekdays
01832	Level 2 – Night	23:00 – 08:00
01842	Level 2 - Saturday, Sunday or stat holiday	08:00 – 23:00
01813	Level 3- Day	08:00 – 18:00, weekdays
01823	Level 3 – Evening	18:00 – 23:00, weekdays
01833	Level 3 – Night	23:00 – 08:00
01843	Level 3 - Saturday, Sunday or stat holiday	08:00 – 23:00

Who can bill the fee schedule?

- a) Any full time Emergency Physician (specialty code 28), or a CCFP Emergency Physician (with proof of qualification) while on duty and on-site in the hospitals emergency department.
 - A full time emergency Physician may not use the fee schedule when working outside of the Emergency Department

- b) Any other physician who is designated by the medical staff to be on duty and on site in the hospitals emergency department may use the fee schedule during his/her shift of work
 - The physician is required to remain on site for the entire shift to qualify for this fee guide. It is not designed to be used in an intermittent manner such as on a “call-in” basis. The Section of General Practice has fee items that apply to that type of emergency coverage.
 - 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 physicians who provide on-call emergency room coverage for designated periods of time and limit the services they provide predominantly to emergency room coverage.

- c) The exception is the consultation fee. Only Royal College certified emergency medicine physicians may bill fee code 01810.

How do you decide on the level of care?

It is imperative that great care and sense of responsibility are applied to your designation of levels. There is an expected percentage of distribution for each hospital that will form the basis of monitoring.

The levels have been defined below and a few examples have been provided to assist you in interpretation. It should be understood that these are examples only and that each individual case must be assessed on its own merits.

Level 1

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 2 or 3 care.

This level applies to most of the ambulatory emergency patients that are treated. Those patients that have a single complaint such as an ear ache, sore foot, injured back, sore throat or burn on hand. They do not require any extended physical examination but may require an x-ray or simple blood work.

Examples:

1. Acute sprain or soft tissue injury of single body area, including x-rays.
2. Child with ear ache or an upper respiratory infection (URI).
3. Person with obvious cystitis
4. Suspected shoulder strain
5. Assessment of uncomplicated URI symptoms
6. Evaluation of a patient with neck or back strain

Level 2

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 requires prolonged observation, continuous therapy and multiple reassessments.

This level applies to those patients with more vague or multiple complaints or with conditions that may demonstrate pathology in widespread regions. This history and physical examination will involve three or more regions.

For the purpose of this fee item the body regions are:

1. Head and neck
2. Chest
3. Abdomen
4. Back and pelvis
5. Upper limbs
6. Lower limbs

This level also applies to patients with a single problem but which will require prolonged observation and repeat assessment by the Emergency Physician.

Examples:

1. Evaluation of a child or adult who has sustained trauma, from a fall, assault or MVA and has complaints of pain or, by nature of the force suspected injury to more than two body regions.
2. Evaluation and management of acute asthma requiring Emergency Department treatment and reassessment
3. Evaluation of a patient with acute back or neck pain with positive radicular signs or with a complicated past history requiring emergency management and reassessments
4. Evaluation of a patient who has sustained an isolated closed head injury without loss of consciousness requiring a complete neurological examination.
5. Evaluation of a patient presenting with acute abdominal pain requiring emergency investigation and reassessments
6. Evaluation of a child or adult with fever without an obvious source.

Level 3

- A. Pertains to the evaluation of a patient with multiple complex and/or serious medical problems which often can be obscure where the emergency condition necessitates a detailed history and complete physical examination by the Emergency physician. This shall include the chief complaint(s), history of present and past illnesses, relevant personal and family history, functional inquiry and examination where indicated. It shall include the review and interpretation of appropriate laboratory, x-ray and ECG findings, full recording of the findings, discussion with the patient and/or family and personal physician as well as the initiation of the appropriate therapy.
- B. This level of care shall also pertain to the management of a patient with life-threatening illness or injury who requires immediate and emergent evaluation and treatment. It shall include the review and interpretation of appropriate laboratory x-ray and ECG findings, full recording of the findings, discussion with the patient and/or family and/or personal physician.

Examples:

1. Crush injury from a motor vehicle accident, semi-loss of consciousness and acute abdominal pain.
2. Myocardial infarction with respiratory distress

Consultation Fee:

The preamble is self-explanatory on the requirements for billing a consultation fee. The key aspect is that another physician must refer the case to you because of complexity, obscurity or seriousness of the problem. Be sure to insist that the referring physician records a referral to you when he or she bills their care.

It is not to be billed for transfer of care to you or referral to you for the performance of a procedure, such as application of a cast.

Transfer of Care:

The routine transfer of care between emergency physicians at the change of shift shall not generate a new visit fee. However, in the event of a significant deterioration in a patient's status that medically requires both a new examination and modification of the treatment plan then the appropriate visit fee may be claimed.

Additional Guidelines:

Fee item 01810

- Can only be billed by a physician certified in Emergency Medicine and referred by a physician other than a physician at the same institution.
- This fee follows the same adjudication rules as all other major consultations.
- Call out charges do not apply

Note: The condition of the patient must be complex, obscure or serious. An Emergency Department Chart does not constitute a consultation report.

Fee item 01811 – 01843

- These fees are not restricted to those certified in Emergency Medicine.
- These fees are applicable to those physicians that are scheduled for duty (a shift) in the Emergency Department of the hospital and remain on shift.
- Physicians working in the Emergency Department of hospitals on a call-in basis may not bill these fees. Billing should be made under the appropriate general practice section.
- These fees do not apply to physicians who choose to attend their patients in the Emergency Department. Billings should be made under the appropriate fees in the general practice section.
- Out of office service charges (01200 – 01207) are not billable in addition to these fees.
- If a minor procedure is performed during the visit, Preamble B.12 applies.