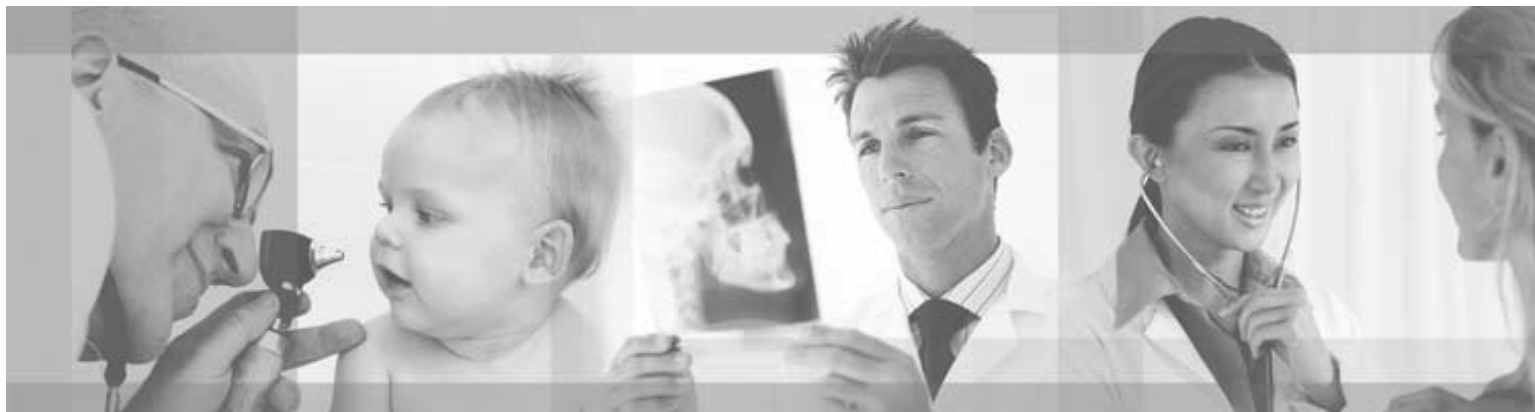


Physicians' Newsletter

PUBLISHED BY THE MEDICAL SERVICES PLAN FOR MEDICAL PRACTITIONERS

Summer 2009



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Inserts Featured in this Newsletter:

- General Practice Visits
- GPSC Fee Updates
- Submission of Claims over 90 Days
- Payment Schedule Update

We've Gone Green!



Welcome to our first web only edition of the Physicians' Newsletter. We will no longer be printing and mailing paper copies of the Newsletter. Future editions of the Physicians' Newsletter will be posted to this website and you will be notified when a new edition is available via our broadcast messaging system. Please keep us bookmarked under your favourites for ease in locating future editions of the newsletter.

⇒ www.health.gov.bc.ca/msp/infoprac/physnews

We also offer an email notification service if you wish to be advised when new MSP publications are posted to our site. It only takes a moment to register and can be easily done by visiting our site at:

⇒ www.health.gov.bc.ca/msp/listserv/index.html

This change has been made in keeping with Government's commitment to reduce our carbon footprint and paper consumption. Your support is appreciated.

Child Health B.C.

Child Health B.C., an initiative of B.C. Children's Hospital, is a network of the province's five regional health authorities, the Provincial Services Health Authority, health professionals, and health care facilities (including B.C. Children's Hospital and Sunny Hill Health Centre for Children), dedicated to excellence in the care of infants, children and youth in British Columbia.

The Child Health B.C. website offers a wealth of information to assist care providers in the delivery of optimal health services to infants, children and youth in the province. Their website has recently been updated to include information and links to resources available to assist physicians providing health services to children and youth in foster care. In their position statement issued in 2008 titled "Special considerations for the health supervision of children and youth in foster care", the Canadian Paediatric Society recognized that children and youth in foster care have a higher incidence of special needs including chronic medical conditions, mental health disorders, and developmental and academic delays. The information available via the Child Health B.C. website is provided to inform health care professionals of the resources available to assist them in providing optimal care to these children and youth and is in keeping with the recommendations put forward by the Canadian Paediatric Society for medical care for children in foster care. Please take a moment to visit the Child Health B.C. website by linking to:

⇒ www.childhealthbc.ca

The Canadian Paediatric Society position statement may be viewed by visiting the following link:

⇒ www.cps.ca



MSP Website



Visit the MSP website – we are adding enhancements to the site all the time.

⇒ www.health.gov.bc.ca/msp/infoprac

You can find information including:

- MSC Payment Schedule
- Diagnostic Codes
- Explanatory Codes
- Forms for Physicians
- Teleplan Information and Specifications
- Physicians' Newsletter
- MSP Statutory Holidays and Close-off Dates
- Guidelines and Protocols

The MSP website is there to help you and your medical office assistant find valuable information quickly and easily.

Practitioner Claims Support Line

1 866 456-6950 (Toll free in B.C.)
604 456-6950 (Vancouver)

It is important to us to provide the best service we can. Please assist us by being prepared when you are calling the Practitioner Claims Support Line for assistance with a claim. It will enable us to readily access your claim and respond to your questions quickly if you have the following information available:

- Data Centre Number (T1234 or TTUT1234)
- Sequence Number
- Personal Health Number (PHN)

We appreciate your assistance.



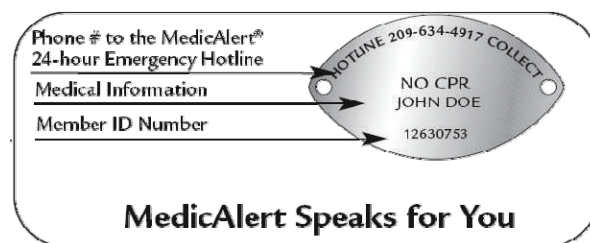
No Cardiopulmonary Resuscitation (No CPR) Form and Free MedicAlert Bracelet

The British Columbia Ambulance Service, in partnership with the British Columbia Medical Association, MedicAlert Canada and the Ministry of Health Services have updated and improved access to the No CPR form which has recently become available online.

The No CPR form provides physicians and their patients with a medico-legal option to order that CPR not be provided by health care providers and first responders (paramedics and fire fighters in British Columbia) when the physician and patient have signed the form together.

Physicians are encouraged to discuss the purpose and potential use of this form with those patients who may be at the end of their natural lives or who may be suffering with life-limiting or life-threatening illnesses, to confirm and record their informed consent to refuse CPR if that is the person's wish.

When an individual has a No CPR form that is visible and signed by themselves and their doctor, or if they are wearing a No CPR MedicAlert bracelet or necklet, they can be assured that CPR will not be given to them by first responders or health care providers.



The B.C. Ambulance Service recommends that a No CPR MedicAlert bracelet or necklet be worn to enable quick verification of a No CPR order. The bracelets and necklets are available free of charge to B.C. residents from MedicAlert by calling 1-800-668-1507 or visit:

⇒ www.medicalert.ca/nocpr

To get copies of the fill and print form, go to:

⇒ <http://www.bcas.ca/EN/main/news/servicesArchive/9995/no-cpr-form.html>

General Practice Visits Reference Guide

Included with this newsletter is an insert titled “General Practice Visits”. This reference guide has been developed to assist you in identifying the correct fee items for billing in-office visits, out of office visits, emergency visits, facility/hospital visits and on-call/on-site emergent hospital visits.

Electronic Debit Request Record

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

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

- Submission date of the debit request record must be within 12 months of the payment date of the original claim.
- Submission code must be **E**.
- The field known as Original, MSP File Number must contain:
 - Original Data Centre Number of submitted claim to be withdrawn;
 - Original Data Centre Sequence Number of claim to be withdrawn;
 - Date or approximate date when the claim was submitted or paid (zeroes are accepted when the date is unknown).
- A note record or claim comment is mandatory to explain the reason for the withdrawal of the claim. Statements such as "Incorrect date of service" or "Incorrect practitioner number" are sufficient.

Debit request records can be submitted on a daily basis. Submissions that do not pass the edit checks are refused and returned as normal refusal records (C11) with explanatory code **D1**. Accepted records are processed for the next payment period.

When re-billing claims for service dates outside the 90-day limit, use submission code **X** and indicate "Re-submission with matching Debit Request Record" in the note record or claim comment field.

Notes	1) Opted-out physicians cannot debit claims electronically unless they have been granted power of attorney by their patient.
	2) Do not use the debit request record if you disagree with MSP's adjudication of a claim. Rather, submit a new claim with additional information in a note record, and the claim will be reassessed.

Debit Request Record Remittance Statements

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

- A matched record is determined by the Original Data Centre and Sequence Number identified on the debit request record. A matched request record is returned as a remittance payment (S02) with explanatory code **D0**.
- If MSP cannot match the debit request record to an in-process or paid claim, the request record is returned as a remittance refusal (S03) with explanatory code **D2**.

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

- If the original claim has not yet been paid but has passed the pre-edit checks, it is returned as a remittance refusal (S03) with explanatory code **XH**. It contains the Original Sequence and Claim Number.
- If the original claim has already been paid, it is returned as a remittance payment (S02) with a negative dollar value and explanatory code **D3**. It contains the Original Sequence and Claim Number.

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



Guidelines and Protocols Advisory Committee (GPAC)

(a joint committee of the B.C. Medical Association and the Ministry of Health Services)

GPAC NOTICE BOARD

The following new or revised clinical practice guidelines were recently posted on the GPAC web site

➡ www.BCGuidelines.ca:

- Hematuria - Microscopic Hematuria (Persistent) - (Revised)
- Osteoarthritis in Peripheral Joints – Diagnosis and Treatment (New Guideline)
- Infectious Diarrhea – Guideline for Ordering Stool Specimens (New Guideline)
- Acute Chest Pain - Evaluation and Triage (Revised)
- Gastroesophageal Reflux Disease (GERD) – Clinical Approach in Adults (Revised)
- Ankle Injury – X-Ray for Acute Injury of the Ankle or Mid-Foot (Revised)
- Urinalysis and the Investigation of Urinary Tract Infections (Revised)

New or updated guidelines currently under review include:

- Stroke and TIA – Management and Prevention (New Guideline)
- Febrile Seizures (New Guideline)
- Oral Rehydration Therapy (ORT) (New Guideline)
- Anxiety and Depression in Children and Youth (New Guideline)
- Palliative Care Approach to the Patient with Incurable Cancer (New Guideline)
- Chronic Obstructive Pulmonary Disease (COPD)
- Dyspepsia With or Without H. pylori Infection
- Otitis Media – Acute Otitis Media (AOM) and Otitis Media with Effusion (OME)

GPAC guidelines are also available to physicians on your Windows Mobile (pocketPC) and Palm devices in Personal Digital Assistant (PDA) format through the web site:

➡ www.clinipearls.ca/BCGuidelines

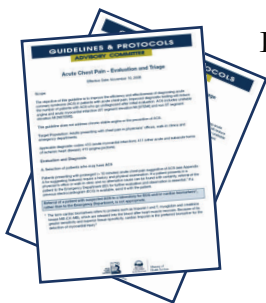
Information on *Continuing Medical Education (CME)* credits for physicians is also posted on the GPAC web site

➡ www.BCGuidelines.ca/gpac/cme_education.html

Look for the GPAC booth at the following upcoming conferences and events:

B.C. Conference of Family Physicians, October 3-4, 2009;

The St. Paul's Hospital CME Conference, November 17-20, 2009



Audit Reports

The MSP Resource Manual mentioned in a number of the following reports is available at:

➡ www.health.gov.bc.ca/msp/infoprac/physbilling/s6-billing.pdf

Dr. A. – General Practice

A General Practitioner came to the attention of the Billing Integrity Program as the result of the practitioner's use of emergency fee items. The physician was member of a group of general practitioners whose office was located in close proximity to an emergency department. Patients were seen in the office or the emergency department depending upon circumstances. However, the Payment Schedule is clear regarding the criteria that are required in order to bill for emergency visits.

Pre-booked appointments or pre-arranged emergency department visits for patients with non-urgent conditions must be billed as regular office visits regardless of where the service is provided. Further investigation, including an on-site audit of the physician's office, confirmed emergency visit claims had been inappropriately billed.

As a result of a negotiated settlement, the practitioner agreed to repay the Commission \$3,000, inclusive of costs and abide by a pattern of practice order in which claims will be submitted in accordance with the MSC Payment Schedule, with specific attention to emergency visits and the MSP Billing Guidelines published in the MSP Resource Manual for Physicians.

Dr. B. – Obstetrician/Gynaecologist

An Obstetrician/Gynaecologist came to the attention of the Billing Integrity Program as a result of service verification audits where a number of beneficiaries responded that they had not been a patient of the practitioner. Further investigation revealed that the practitioner had been submitting billings to MSP for family members who had accompanied the patient who had been referred for specialist services. The family members accompanying the referred patient had not been referred by the attending family physician for specialist care and a peer medical inspector found no records to support that any medically required insured services had been rendered to these family members.

As a result of a negotiated settlement, the practitioner agreed to repay the Commission \$11,900, inclusive of costs and abide by a pattern of practice order in which adequate medical records will be maintained and claims will be submitted in accordance with the MSC Payment Schedule, with specific attention to Preamble Clauses B.1.a and B.4.c regarding persons accompanying patients under the practitioner's care.

Dr. C - General Practice

A General Practitioner came to the attention of the Billing Integrity Program as a result of complaint from a former employee. Further investigation, including an on-site audit of the physician's office, revealed a large number of MSP claims for which there were missing medical records as well as a number of claims that had been inappropriately billed, including injections that had been billed as office visits, and office visits that had been inappropriately billed as prolonged counselling or complete examinations without supporting documentation. During mediation discussions, it became apparent that many of the issues had resulted from poor office management practices and insufficient supervision of billing staff. Nonetheless, it was accepted that the physician is ultimately responsible for the maintenance of adequate medical records and for the proper submission of claims to MSP.

As a result of a negotiated settlement, the practitioner agreed to repay the Commission \$200,000, inclusive of costs and abide by a pattern of practice order in which adequate medical records will be maintained and claims will be submitted in accordance with the MSC Payment Schedule, with specific attention to Preamble Clause B.2 regarding adequate medical records and the MSP Billing Guidelines published in the MSP Resource Manual for Physicians.

Dr. D - General Practice

A General Practitioner came to the attention of the Billing Integrity Program as the result of a service verification audit that revealed a number of emergency visits had been billed for beneficiaries who reported that the service provided had been a routine pre-booked office visit. The physician was member of a group of general practitioners whose office was located in close proximity to an emergency department. Patients were seen in the office or the emergency department depending upon circumstances. However, the Payment Schedule is clear regarding the criteria that are required in order to bill for emergency visits. Pre-booked appointments or pre-arranged emergency department visits for patients with non-urgent conditions must be billed as regular office visits regardless of where the service is provided. Further investigation, including an on-site audit of the physician's office, confirmed that emergency visit claims had been inappropriately billed.

As a result of a negotiated settlement, the practitioner agreed to repay the Commission \$10,000, inclusive of costs and abide by a pattern of practice order in which adequate medical records will be maintained and claims will be submitted in accordance with the MSC Payment Schedule, with specific attention to emergency visits and Preamble Clause B.2 regarding adequate medical records and the MSP Billing Guidelines published in the MSP Resource Manual for Physicians.

Dr. E - General Practice

A general practitioner came to the attention of the Billing Integrity Program during the routine review of physicians whose MSP billings of the prolonged counselling visit fee items exceeded the statistical limits for general practitioners.

As a result of a negotiated settlement, the physician agreed to repay the Medical Services Commission \$10,000, inclusive of costs and surcharges, and to abide by an Order of the Commission requiring the correct submission of claims in accordance with the requirements of the MSC Payment Schedule.

Dr. F - General Practice

A General Practitioner came to the attention of the Billing Integrity Program as the result of a service verification audit that revealed a number of emergency visits had been billed for beneficiaries who reported that the service provided had been a routine pre-booked office visit. The physician was member of a group of general practitioners whose office was located in close proximity to an emergency department. Patients were seen in the office or the emergency department depending upon circumstances. However, the Payment Schedule is clear regarding the criteria that are required in order to bill for emergency visits.

Pre-booked appointments or pre-arranged emergency department visits for patients with non-urgent conditions must be billed as regular office visits regardless of where the service is provided. Further investigation, including an on-site audit of the physician's office, confirmed that emergency visit claims that had been inappropriately billed. The on-site audit also revealed that a small number of claims had been rendered by another doctor and should have been billed under the other doctor's practitioner number.

As a result of a negotiated settlement, the practitioner agreed to repay the Commission \$12,000, inclusive of costs and abide by a pattern of practice order in which adequate medical records will be maintained and claims will be submitted in accordance with the MSC Payment Schedule, with specific attention to emergency visits and Preamble Clause B.2 regarding adequate medical records and the MSP Billing Guidelines published in the MSP Resource Manual for Physicians. The pattern of practice order also included a requirement that MSP claims only be submitted under the practitioner number of the practitioner who personally renders the insured service(s) in accordance with Preamble Clauses A.1, A.2 and A.3 of the MSC Payment Schedule

Dr. G - General Practice

A GP came to the attention of the Billing Integrity Program as a result of the family constellation project, a project designed to review physicians who disproportionately bill for multiple members of the same family on the same date of service, and a routine review of practitioner billing profiles which revealed high costs per patient and high services per patient relative to the physician's peers. A peer medical inspector found missing and inadequate records for a number of cases. The medical inspector also found that many complete physical examinations were not supported by an adequate medical record.

As a result of a negotiated settlement, the physician agreed to repay the Commission \$75,000, inclusive of costs and abide by a pattern of practice order in which adequate medical records will be maintained and claims will be submitted in accordance with the MSC Payment Schedule

Dr. H - General Practice

A General Practitioner came to the attention of the Billing Integrity Program as the result of a service verification audit that revealed a number of emergency visits had been billed for beneficiaries who reported that the service provided had been a routine pre-booked office visit. The physician was member of a group of general practitioners whose office was located in close proximity to an emergency department. Patients were seen in the office or the emergency department depending upon circumstances. However, the Payment Schedule is clear regarding the criteria that are required in order to bill for emergency visits. Pre-booked appointments or pre-arranged emergency department visits for patients with non-urgent conditions must be billed as regular office visits regardless of where the service is provided. Further investigation, including an on-site audit of the physician's office, confirmed that emergency visit claims had been inappropriately billed.

As a result of a negotiated settlement, the practitioner agreed to repay the Commission \$5,000, inclusive of costs and abide by a pattern of practice order in which adequate medical records will be maintained and claims will be submitted in accordance with the MSC Payment Schedule, with specific attention to emergency visits and Preamble Clause B.2 regarding adequate medical records and the MSP Billing Guidelines published in the MSP Resource Manual for Physicians.

Dr. I. – Orthopaedic Surgeon

An orthopaedic surgeon came to the attention of the Billing Integrity Program regarding the incorrect billing of arthroscopic surgery fee items. The physician had exclusively billed fee item 56325 (arthroscopic meniscal repair, knee) to the exclusion of the other fee items relating to arthroscopic surgery of the knee.

As a result of a negotiated settlement, the physician agreed to repay the Medical Services Commission \$50,000, and to abide by an Order of the Commission requiring the correct submission of claims in accordance with the requirements of the MSC Payment Schedule.



PharmaCare Coverage of the Fluroquinolone Moxifloxacin (Avelox®)

Effective **January 15, 2009**, moxifloxacin 400 mg tablets became a regular benefit under PharmaCare. Several innovative approaches by the Ministry of Health Services resulted in patients being able to receive full coverage of moxifloxacin without the need for Special Authority. The overall goal of this initiative is to preserve the long-term effectiveness of moxifloxacin, the newest fluoroquinolone, while ensuring the timely availability of the drug for those who need it.

Prescribing criteria for moxifloxacin were developed in consultation with physicians, pharmacists and other professionals in public health, infectious diseases and medical microbiology. These criteria, listed below, will assist physicians in determining when other antibiotics should be used first and when moxifloxacin may have a role. The criteria also were designed to promote appropriate antibiotic stewardship, minimizing the future risk of resistance to moxifloxacin. A collaboration between the ministry and the manufacturer of moxifloxacin will focus on appropriate prescribing of moxifloxacin using educational, marketing and detailing tools. Utilization and resistance patterns will be monitored to ensure continued effectiveness and accessibility of moxifloxacin.

To further support optimal prescribing of anti-infectives in British Columbia, additional educational initiatives by ministry partners and stakeholders will follow.

Clinical Pearls: Limiting Fluoroquinolone Resistance^{1,2}

- **Do not use antibiotics when a viral etiology is suspected.**³
- **Do not use moxifloxacin to treat a urinary tract infection** (therapeutic concentrations in the urinary tract are not reached).^{3,4} 25 per cent of *Escherichia coli* isolates are resistant to quinolones in B.C.⁵
- **Do not prescribe two quinolones at the same time.**
- **Do not use fluoroquinolones if used in the last three months:** The risk of fluoroquinolone resistance increases with recent quinolone use; therefore, if a patient has received a quinolone (regardless of indication) in the last three months and requires antibiotic treatment, choose an antibiotic from a different class.³
- **Use fluoroquinolones appropriately:** Due to their broad spectrum and potential for resistance, reserve fluoroquinolones for select patients, who have no other treatment options and would benefit from therapy (e.g., patients who have failed previous antibiotic therapy or who have documented allergies to recommended therapies which precludes their use).³
- **Use according to prescribing criteria¹:** In general, use moxifloxacin only as third-line therapy for the treatment of acute bacterial sinusitis or acute exacerbation of chronic bronchitis, and only as second-line therapy for the treatment of community acquired pneumonia. Refer to the Recommended Prescribing Criteria for Moxifloxacin (below) for more details and exceptions.

Recommended Prescribing Criteria for Moxifloxacin

Acute Bacterial Sinusitis

Viruses cause the majority of sinusitis cases and antibiotic therapy is controversial.^{3,6}

Moxifloxacin is recommended only in the treatment of acute bacterial sinusitis when the following criteria are met:

1. patient has not received a quinolone in the past three months AND
 - A) failure of at least two complete courses of recommended therapy (amoxicillin, doxycycline, trimethoprim/sulfamethoxazole (TMP/SMX), amoxicillin-clavulanate, cefuroxime axetil, or clarithromycin), OR
 - B) prescription by an ENT specialist following culture and sensitivity reports of an appropriately collected sample showing bacterial resistance to recommended therapies and sensitivity to fluoroquinolones, OR
 - C) documented allergy to recommended therapies which precludes their use, OR
 - D) for completion of therapy initiated in the hospital setting for an indication where alternative antibiotics are not appropriate.

Acute Exacerbation of Chronic Bronchitis

Nearly 50 per cent of acute exacerbations of chronic bronchitis are caused by viruses. ^{3,7}

Moxifloxacin is recommended only in the treatment of acute exacerbation of chronic bronchitis when the following criteria are met:

1. patient has not received a quinolone in the past three months, AND
2. patient has a complicated exacerbation: i.e. COPD with increased sputum, increased purulence, increased shortness of breath and at least one risk factor* ⁷, AND
 - A) for this exacerbation, failure of two complete courses of recommended therapy (amoxicillin, doxycycline, TMP/SMX, cefuroxime axetil, amoxicillin-clavulanate, or clarithromycin), OR
 - B) documented allergy to recommended therapies which precludes their use, OR
 - C) for completion of therapy initiated in the hospital setting for an indication where alternative antibiotics are not appropriate.

* Risk factors include: \geq four exacerbations per year OR FEV1 < 50 per cent predicted OR ischemic heart disease OR use of home oxygen OR chronic oral corticosteroid use. ⁷

Community Acquired Pneumonia

Moxifloxacin is recommended only in the treatment of community acquired pneumonia when the following criteria are met:

1. patient has not received a quinolone in the past three months, AND
 - A) community care patient with clinical failure[†] of recommended therapy⁸ (no comorbid factors: doxycycline, clarithromycin, or erythromycin; or if comorbid factors[‡]: beta lactam + macrolide; beta lactam + doxycycline; beta lactam = amoxicillin [high dose] or amoxicillin-clavulanate or cefuroxime axetil), OR
 - B) residential care patient with clinical failure[†] of recommended therapy⁸ (amoxicillin +/- [macrolide or doxycycline]; cefuroxime +/- [macrolide or doxycycline]; or if aspiration pneumonia suspected amoxicillin-clavulanate +/- [macrolide +/- doxycycline]), OR
 - C) documented allergy to recommended therapies which precludes their use, OR
 - D) for completion of therapy initiated in the hospital setting for an indication where alternative antibiotics are not appropriate.

[†] Community Acquired Pneumonia – Clinical Failure of therapy defined as: hemodynamic compromise, no improvement in symptoms after completion of recommended therapy, clinical deterioration after 72 hours of antibiotic therapy ³

[‡] Community acquired pneumonia – Comorbid risk factors defined as: Chronic lung disease (asthma, smoking, COPD), diabetes, alcoholism, chronic renal or liver disease, congestive heart failure (CHF), malnutrition or acute weight loss (>5 per cent), hospitalization in past three months, lung cancer or other malignancies; immunosuppressing conditions like HIV/AIDS and asplenia or use of immunosuppressing drugs.) ^{3,8}

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7. O'Donnell DE, Hernandez P, et al. Canadian Thoracic Society recommendations for management of chronic obstructive pulmonary disease – 2008 update – highlights for primary care. Can Respir J. 2008;(15): S1A-7A.
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PharmaCare Frequency of Dispensing Policy

Dispensing fee reimbursements are a leading driver of PharmaCare expenditures. Although there was no change in the PharmaCare maximum dispensing fee between 2004 and 2007, dispensing fee expenditures grew by 33 per cent. Analysis showed that over half that growth resulted from an increase in dispensing frequency.

The incidence of circumstances that render frequent dispensing appropriate should be relatively stable over time. However, between 2004 and 2007, the average growth rate of frequent dispensing remained above 20 per cent¹.

The new Frequency of Dispensing policy - part of the Interim Agreement reached between the Ministry of Health Services and the B.C. Pharmacy Association - will reduce frequent dispensing in situations in which it does not offer an improved health outcome.

How it Works

Under the policy, when a **physician** orders frequent dispensing, dispensing fees are covered but subject to a maximum number of fees (see “Dispensing Fee Limits” below).

When frequent dispensing is initiated by a **pharmacist**, it is expected that the pharmacist will determine the patient's need for frequent dispensing using similar criteria to those normally used by physicians, that is, criteria based on the patient's health and safety. Therefore, dispensing fees (up to the maximum number of fees) are covered only if the pharmacist documents that a patient exhibits one or more of the following difficulties:

- Cognitive impairment
- History of abuse or poor compliance
- No support structure (to assist with administration of drug therapy)
- Risk of dependence
- Susceptible to theft or loss of belongings
- Complex medication regime
- Physical or mental disability
- Literacy issues
- Language issues
- Non-compliance or misuse is suspected



Dispensing Fee Limits

The new policy limits the number of dispensing fees that will be covered for dispensing frequencies of one to 27 days, as follows:

- For daily dispensing one dispensing fee per patient, per drug (DIN), per day, to a maximum of three dispensing fees per patient per day (methadone excluded).
Note that physicians must indicate the order for daily dispensing by hand-writing the order on the prescription.
- For dispensing a two to 27 day supply, one dispensing fee per patient, per drug (DIN), per prescribed supply, to a maximum of five dispensing fees per patient, per prescribed supply. For example, a patient on weekly dispensing would be covered for a maximum of five dispensing fees per week.

1. Pharmaceutical Services Division, PharmaNet/HNData, 2008.

Documentation Requirements for Pharmacist-Initiated Frequent Dispensing

As mentioned above, the policy requires pharmacists to complete a Frequent Dispensing Authorization form when dispensing a two to 27 day supply that has not been ordered by the prescriber. The form, signed by the patient, indicates why the patient needs frequent dispensing. Completed forms are faxed to the patient's primary health care practitioner.

- If the prescriber agrees with the frequency of dispensing, ***no action is necessary***.
Please do not fax the form to PharmaCare or to the pharmacy. In this case, the form is for your information only.
- If the prescriber does ***not*** agree with the dispensing frequency, the prescriber can fax the form back to the pharmacy and PharmaCare indicating their concern. Please note that health care practitioners are not required to register their disagreement with the frequency of dispensing.

What does this mean for my prescribing practices?

Health care practitioners can continue to prescribe and order frequent dispensing when they believe it to be appropriate.

For daily dispensing, the written prescription will be valid for a maximum of sixty days for the purposes of PharmaCare dispensing fee reimbursement. At the expiry of the sixty day period, the prescriber must re-authorize daily dispensing in hand-writing on a new prescription if the prescriber wants daily dispensing to continue and the patient needs PharmaCare coverage of dispensing fees.

We recommend that, as with orders for daily dispensing, prescribers specifically order all frequent dispensing by handwriting the order on the prescription. This removes the need for the pharmacist to have the patient sign an authorization form.

Are you faxing to the right place?

PharmaCare continues to receive faxes re-directed from other areas of the Ministry of Health Services. When faxing Special Authority requests, be sure you are sending them to one of the approved fax numbers:

From Victoria, fax to 250-952-1065

From elsewhere in B.C., fax toll-free to 1-800-609-4884

Applications for Psychiatric Medication Coverage

Applications for Psychiatric Medication Coverage (HL/TH3497) must be faxed **only to a Mental Health Services Centre**. Please verify that the fax number for the centre is correct and provide your own fax number. If you inadvertently send the fax to a wrong number, providing your fax number will allow the recipient to contact you and advise you of the error.

Faxing to any other number compromises patient's privacy and may result in coverage not being in place when needed.

CPSID Required on All Prescriptions

PharmaCare receives many calls, particularly on weekends, from pharmacists who discover that a prescription does not include the physician's CPSID.

Most commonly, the difficulty arises because the physician has:

- given their Medical Services Plan Billing Number instead of their CPSID, or
- used a generic pad (for a walk-in clinic, hospital emergency department, etc.) and failed to include their CPSID.

Please include your College of Physicians & Surgeons Identity Number CPSID on all prescriptions, as set out in the College of Physicians & Surgeons Resolution 00-54 of September 1, 2000. Accurate physician identification is an important as this information will be included in a patient's PharmaNet medication history.

Travel Assistance Program

Do you have patients who must travel to another community for medical care?

The Travel Assistance Program (TAP) is a partnership between the Ministry of Health Services and a number of private transportation partners who agree to offer discounted fares to eligible British Columbia residents when a completed and approved travel assistance form is presented. Referral must be to a medical specialist or specialty service in a hospital or clinic.

Current transportation partners include: B.C. Ferries, Angel Flight, Harbour Air, Hawk Air, Central Mountain Air, Pacific Coastal Airlines, North Pacific Seaplanes, Helijet, and Via Rail.

All British Columbia residents enrolled with the Medical Services Plan (MSP) are eligible for this program unless their medical travel is covered by a third-party insurance plan, such as employer plans, ICBC, Workers' Compensation, Department of Veterans' Affairs, Canadian Armed Forces or other federal government programs.

In order to complete their confirmation process, patients need their referring physician's office to complete Part One of the TAP form. Please ensure that the "Escort required" box is ticked only if (1) the patient requires an escort for medical reasons; or (2) the patient is 18 years of age and under. An escort is not considered required in order to drive a vehicle on behalf of a patient who does not fall under (1) or (2).

Need TAP forms?

Physicians can obtain TAP forms by calling HIBC Provider Services at 1-866-456-6950 toll free or 604 456-6950 for the Greater Vancouver area (please press option three to be transferred to Provider Services). You can also fax your request to HIBC Provider Services at 250 405-3592. Be sure to include your name, mailing address, and MSP Practitioner Number with your faxed request. Please note that TAP forms are individually numbered and cannot be faxed or copied.

For more information about the Travel Assistance Program, please call (250) 952-1587 or visit:

⇒ www.healthservices.gov.bc.ca/msp/mtapp/index.html



Reciprocal Billing Agreement

Residents of all the Canadian provinces and territories except Quebec are covered under the Reciprocal Agreement. The agreement does not apply to hospitals, for which there is a separate inter-hospital agreement regarding services provided to out-of-province patients. To be eligible to have a physician's services billed under the Reciprocal Agreement, an out-of-province patient must **present** a valid, non-expired health care identification card. It is not acceptable for the patient to cite a number without presenting a card. When checking the patient's card, ensure that the coverage has not expired. Some provinces issue renewable rather than lifetime registration numbers. In the spirit of the *Canada Health Act*, MSP encourages physicians to bill reciprocally when an out-of-province patient presents a valid health care card. If a patient does not present a valid health care card, the services are not eligible for reciprocal billing and must be billed to the patient. Patients who are billed directly are entitled to subsequently seek reimbursement from their home province medical plans. MSP does not accept reciprocal claims submitted after the expiry of the 90-day submission time limit.

Reciprocal Billing Tips:

Please note that the following service is exempt from this agreement and should be billed directly to the non-resident patient:

Fee item 14560 - Routine Pelvic Examination including papanicolaou is not a benefit on a reciprocal basis for patients from another province unless there is a medical requirement (also, not billable when done as a pre and post-natal service). This is in accordance with Preamble A.4 of the MSC Payment Schedule, which states "routine periodic health examinations" are excluded under the Reciprocal Agreement. If the service is performed for a medical reason other than screening, please include that information in a note record with your claim.

X4 refusals – if your claim has been refused X4, please check your original submission to ensure that the health number has 12 digits including zeroes at the front. *Example: Enter 987654321 (9 digits) as 000987654321 (12 digits).*

TB-Related X-Rays

This spring, the B.C. Centre for Disease Control (BCCDC) and the provincial Medical Services Plan (MSP) have implemented two significant improvements to the management of TB related x-rays.

- Effective March 24, 2009, BCCDC will be able to receive chest x-ray images electronically from radiology service providers, so images will no longer be required in CD or film format. This solution leverages the existing Picture Archiving and Communication Systems (PACS) that are currently used by Radiology departments across the province, by allowing them to electronically transmit images associated with TB cases to the Bcast Transfer Grid, to be retrieved by the TB Clinic in Vancouver.
- Effective April 1, 2009, all claims for payment for TB related x-rays may be submitted through Teleplan, using the standard MSP process. The x-rays will now be read by the on-site radiologist. If the x-ray has been requested by a BCCDC TB Clinic, only the report is required to be forwarded to the BCCDC if the x-ray is normal. For referrals where there is an abnormality on the x-ray, the referring physician will be required to send both the report and the images to BCCDC TB Control. These initiatives are expected to improve significantly the quality and timeliness of patient care

MSP is responsible for payment of all X-rays which are requested as follow-up to a positive tuberculin skin test, using the TB Screening Program requisition forms. If screening is requested by a third party as a condition of employment, payment for those x-rays is the responsibility of the employer or the patient.



Note: Please use referring practitioner number "99996" when submitting claims for the TB related x-rays referred by public health.