MSP PAYMENT SCHEDULE: MASSAGE THERAPY SERVICES
Preamble to the Payment Schedule

1. This includes as insured services the services of massage therapists who are registered members in good standing with the College of Massage Therapists of British Columbia, and licensed under the *Health Professions Act,* when rendered in the Province of British Columbia to insured persons as prescribed in #2 below.

2. Massage therapy services will be an insured benefit only for beneficiaries with Medical Services Plan (MSP) supplementary benefits status.

3. Payment for massage therapy services insured under MSP can be claimed as follows:

   09948 Massage Therapy Service.....$23.00

   Notes:

   i) This item is applicable only to patients who have MSP supplementary benefits status.
   ii) Subject to i) above, acupuncture, chiropractic, massage therapy, naturopathic, non-surgical podiatry, and physical therapy services are benefits up to a combined maximum of 10 visits per patient per calendar year.
   iii) Only payable if an adequate clinical record has been created and maintained for the service being claimed.

4. Extra-billing:

   The service provider must be enrolled with the MSP in order to be paid for these insured services. Those practitioners who are on “opted-out” status with MSP may charge patients more than the rate indicated.

5. Delegation or Assignment of Tasks:

   If the service is assigned or delegated in accordance with the applicable College Bylaws, it will only be considered an insured service if the claim is submitted by a massage therapist enrolled with MSP, and only if that practitioner was physically present to monitor and supervise the person to whom the task was delegated or assigned.

6. Personal Services:

   Section 29 of the Medical and Health Care Services Regulation specifies the nature of personal services which are not benefits.

   Personal Services

   29 *(1) Services are not benefits if they are provided by a health care practitioner to the following members of the health care practitioner's family*

   (a) a spouse,

   (b) a son or daughter,

   (c) a step-son or step-daughter,

   (d) a parent or step-parent,

   (e) a parent of a spouse,

   (f) a grandparent,

   (g) a grandchild,

   (h) a brother or sister, or

   (i) a spouse of a person referred to in paragraphs (b) to (h).

   (2) Services are not benefits if they are provided by a health care practitioner to a member of the same household as the health care practitioner.

7. Records:

   Section 16 of the Medical and Health Care Services Regulation lists requirements for an “adequate clinical record” – See Appendix A. For the purposes of Section 16, clinical records must be created and maintained in English.

Appendix A - Medical and Health Care Services Regulation (Part 4)

Services of Health Care Practitioners

Definition

16 *In this Part,* ***"adequate clinical record"*** *means a record of a health care practitioner, prepared in accordance with the applicable payment schedule, that contains sufficient information to allow another practitioner of the same profession, who is unfamiliar with both the beneficiary and the attending practitioner, to determine from that record, together with the beneficiary's clinical records from previous encounters, information about the service provided to the beneficiary including:*

(a) the date, time and location of the service;

(b) the identity of the beneficiary and the attending practitioner;

(c) if the service resulted from a referral, the identity of the referring practitioner and the instructions and requests of the referring practitioner;

(d) the presenting complaints, symptoms and signs, including their history;

(e) the pertinent previous history including family history;

(f) the positive and negative results of a systematic inquiry relevant to the beneficiary's problems;

(g) the identification of the extent of the physical examination and all relevant findings from that examination;

(h) the results of any investigations carried out during the encounter;

(i) the differential diagnosis, if appropriate;

(j) the provisional diagnosis;

(k) the summation of the beneficiary's problems and the plan for their management.