

CMQ96-010

Change in Claims Submission Period

Effective October 1, 1996, the allowable time for claim submission following the provision of a service is changed from 180 days to 90 days. The following exceptions to the 90 day limit are permitted:

- (a) Claims determined to be the responsibility of the Worker's Compensation Board (WCB);
- (b) Claims refused by the WCB and to be resubmitted as a Medical Services Plan (MSP) or Insurance Corporation of British Columbia (ICBC) claim;
- (c) Claims determined to be the responsibility of the ICBC;
- (d) Cases where a beneficiary's coverage has been backdated. Claims must be submitted within 90 days of the date the coverage was reinstated;
- (e) Cases where a physician disagrees with MSP adjudication. Resubmission of the claim must be made within 30 days of the date of adjudication;
- (f) Cases that, on written application to MSP, are pre-approved for retroactive billing. Maximum retroactive period will be 6 months from the date of service or the start of the fiscal year, whichever is sooner;
- (g) Cases where the reason for late submission is related to the billing requirement, such as billing for palliative care;
- (h) Under extreme circumstances, exceptions will be considered on a case by case basis, subject to approval by the Executive Director, Operations, MSP and when supported by the Director of Professional Relations, BCMA.

Note: Requests involving administrative problems originating in a physicians' office, such as staffing and vendor/service bureau issues, **will not** qualify as exceptions.

CMQ96-011

Lab Requisition Requirements for PSA Testing

Further to Item 3 of the *Minute of Commission # 1117*, dated June 12, 1995, and published in the Physician's Newsletter (Summer 1995):

Regarding prostatic specific antigen (PSA) testing, (fee item 9347), unless the physician has indicated **prostate cancer** or **suspected prostate cancer**, or has checked the **not for screening** box on the standard outpatient laboratory requisition, the investigation is considered screening, and therefore, should not be billed to MSP. Facilities that refer out PSA tests should provide the required information to the reference facility if the service is to be billed to MSP.

In the case of an audit, any claims for fee item 9347 for which the required information cannot be provided to MSP will be recoverable pursuant to Section 25 of the *Medicare Protection Act*.

Members:

David S. Kelly (Chair)
Keith J. Bennett
Barbara R. Bluman
Dr. David Bolton
Dr. C. John Chacko
Patricia K. Kaatz
Kimberley L. McEwan
Deborah Shera
Dr. Brian Winsby

CMQ96-012

Standing Orders for Diagnostic Testing

* The use of standing orders for diagnostic tests pertaining to a **specific patient** over a specific period of time is **acceptable**. Unless stated otherwise by the referring physician, standing orders automatically expire after six months.

Standing orders pertaining to **routine diagnostic requests** by physicians, for all patients, are **not acceptable**. A physician cannot request to have a routine menu of laboratory tests performed or a routine set of additional views taken when X-rays are ordered. For example, weight-bearing views and patellar views cannot be performed routinely when a knee X-ray is requested.

In accordance with the above policy, the diagnostic facility is responsible for ensuring that documentation is consistent with and supports the claim(s) submitted. In the case of an audit, any claim for which the documentation cannot be provided to MSP will be recoverable pursuant to section 25 of the *Medicare Protection Act*.

CMQ96-013

Laminaria Tent and Sera for Allergy Injection

Further to CMQ96-001 (Vol. 1, No. 1) relating to permitted patient charges (*Minute of Commission #1147*):

Sera for allergy injection (for testing and desensitization) and laminaria tent are included as permitted patient charges. Sera for allergy injections is included under 1(a) -“therapeutic drugs”, and laminaria tent is included under 1(b) -“devices”.

CMQ96-014

Payment of Claims for Registered MSP Beneficiaries

* The Medical Services Plan will honour claims for service rendered as of **May 1, 1996**, on behalf of registered beneficiaries whose coverage has lapsed due to non-payment of premiums. The residency requirements established in the Medicare Protection Act remain in effect. Physicians should continue to check residency eligibility of beneficiaries.

Please direct claims coverage inquiries to:
383-1226 (Victoria)
669-6667 (Vancouver)
1-800-742-6165 (Other areas)