# MSCommuniqué

Communicating the policy and directives of the Medical Services Commission of British Columbia

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**CMQ97-013**

**Revised MSC Payment Schedule**

*Minute of Commission #97-015*

**Approval of the Revised Medical Services Commission Payment Schedule**

The Medical Services Commission, in accordance with Section 21(3) of the *Medicare Protection Act*, adopts the attached* revised MSC Payment Schedule. The revised schedule is based on the restructured "British Columbia Medical Association Guide to Fees" and includes the attached list of administrative amendments. The revised Payment Schedule will be effective for dates of service beginning April 1, 1997.

*Payment Schedule distributed March 1997

Note: Copies of the *MSC Payment Schedule* are available from MSP Provider Programs at (250) **952-2654.**

**CMQ97-014**

**Revision of Standard Out-patient Laboratory Requisition Form**

The Medical Services Commission has approved the revision of the standard out-patient laboratory requisition form (see reverse). Please note the following:

The revised standard out-patient requisition form replaces previous forms used for all laboratories, irrespective of category approval.

The revised requisition form becomes mandatory as of January 1, 1998. MSC Audit Recovery Policy regarding non-compliance with laboratory requisitions will apply as of this date.

All laboratories are encouraged to introduce the revised requisition form and remove outdated versions from physicians' offices as soon as possible.

The Protocols/Guidelines section must not be altered. The form includes reference to existing protocols and guidelines and to new protocols and guidelines soon to be formally approved by the Commission.

The standard out-patient laboratory requisition may be revised as often as every six months to comply with requirements of newly implemented protocols and guidelines.

Note: Questions or concerns regarding the laboratory requisition form can be faxed to MSP Claims Branch at (250) **952-3101**.


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British Columbia — Ministry of Health and Ministry Responsible for Seniors

# STANDARD LABORATORY REQUISITION

| NAME OF PHYSICIAN | MSP PRACTITIONER NUMBER |
|---|---|
| ADDRESS | TELEPHONE |
| CITY/TOWN | POSTAL CODE |

| SURNAME OF PATIENT | FIRST NAME AND MIDDLE INITIAL | GENDER ☐M ☐F | DATE OF BIRTH DD MM YY |
|---|---|---|---|
| ADDRESS | | TELEPHONE | |
| CITY/TOWN | | POSTAL CODE | |

CURRENT MEDICATIONS

DATE OF SPECIMEN TIME: ☐AM ☐PM

HOURS SINCE LAST MEAL

CLINICAL PROBLEMS/DIAGNOSIS

INSURER CODE
- ☐ MSP
- ☐ ICBC
- ☐ WCB
- ☐ OTHER:

FOR LABORATORY USE ONLY

## HAEMATOLOGY

- ☐ WBC ☐ only
- ☐ HAEMOGLOBIN ☐ only
- ☐ DIFFERENTIAL COUNT
- ☐ HAEMATOLOGY PANEL (Hgb, Hct, WBC, RBC, Indices)

## CHEMISTRY

- ☐ GLUCOSE - FASTING
- ☐ 1 H POST 50 G (PREGNANCY)
- ☐ GTT 100 g (PREGNANCY)
- ☐ GTT 75 g (NON-PREG) HRS ____

PREGNANCY TEST
- ☐ Urine
- ☐ Serum

☐ DRUG ASSAY: Specify Drug(s)

## MICROBIOLOGY

TEST
- ☐ BACTERIAL CULTURE (sens &/or biochem ident. only if warranted)
- ☐ GRAM
- ☐ FUNGAL CULTURE

SITE
- ☐ NOSE
- ☐ SPUTUM
- ☐ THROAT
- ☐ VAGINAL
- ☐ CERVICAL
- ☐ URETHRA
- ☐ RECTAL
- ☐ STOOL
- ☐ OTHER:

## PROTOCOLS/GUIDELINES

Tests in this section should be ordered in compliance with the protocol or guideline.

- ☐ Serum Ferritin ☐ *Special case (if iron & binding capacity also requested)
- ☐ ESR (Written indications required)
- ☐ TSH ☐ *Special case (List additional tests)

PSA
- ☐ Screening (Not a benefit)
- ☐ Not for Screening

LIPIDS

Major Risk Factor(s)/CAD
- ☐ Yes
- ☐ No (Not a benefit)

- ☐ TOTAL CHOLESTEROL
- ☐ TRIGLYCERIDES
- ☐ HDL CHOLESTEROL
- ☐ LDL CHOLESTEROL (Calculated)

STOOL O & P
- ☐ Single Specimen
- ☐ High Risk (Times

URINALYSIS/URINE CULTURE
- ☐ MACROSCOPIC
- ☐ MICROSCOPIC
- ☐ MACROSCOPIC/MICROSCOPIC IF INDICATED
- ☐ MACROSCOPIC AND MICROSCOPIC - *Special Case
- ☐ MICROSCOPIC/URINE CULTURE IF INDICATED
- ☐ URINE CULTURE

## ADDITIONAL TESTS OR INSTRUCTIONS

*Special cases must be justified

## LABORATORY ADDRESS

Write or stamp on back of form if necessary

## SEND COPY OF RESULTS TO:

## INSTRUCTIONS TO PATIENTS

☐ MEDICATION: Omit taking:

____ ____ hours prior to test

☐ FASTING: ____ hours prior to test

| SIGNATURE OF REQUESTING PHYSICIAN | TELEPHONE REQUISITION TIME OF CALL: ____ ☐AM ☐PM | DATE: DD MM YY | INITIALS OF RECORDER |
|---|---|---|---|