MSP PAYMENT SCHEDULE: PODIATRY SERVICES
Preamble and Payment Schedule

Tariff of Fees Approved and Prescribed as the Payment Schedule

The additional benefit for the payment of podiatrist services for insured persons is as follows:

PREAMBLE TO THE PAYMENT SCHEDULE

1. The Plan includes as insured services the services of podiatrists who are registered members in good standing of the College of Podiatric Surgeons 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 and #3 below.

2. Non-surgical podiatry services will be an insured benefit only for beneficiaries with Medical Services Plan (MSP) supplementary benefits status.

3. Surgical podiatry services will be an insured benefit for all beneficiaries of the MSP where such services are medically necessary.

4. The Plan does not pay a podiatrist for taking x-rays. A podiatrist taking x-rays must advise the patient beforehand in writing that x-ray services are not covered and include the visit cost of such x-ray in written notice. Such x-ray cost is the patient's responsibility. The Plan will pay for radiological (x-ray) services of a physician or surgeon on request or referral from a podiatrist.

5. The terms of this preamble emphasize the need for proper continuing close professional relationship between the patient's medical practitioners and the podiatrist.

6. a. Podiatrists who are opted-out of MSP are permitted to charge patients more for a service than is set out in the applicable Payment Schedule.

   Before providing services, practitioners must inform patient:

   - that the practitioner has opted out;
   - how much the patient will be reimbursed by MSP; and
   - how much, if any, the patient will be paying in addition to the MSP fee.

   b. For podiatrists who are not opted-out of MSP, the prescribed tariff is payment at 100 percent of the schedule fee for the professional service, and this shall be accepted as payment in full for the professional fee. Any billing direct to an insured person under the Plan would be for materials, drugs, appliances, or x- ray services given by the podiatrist and the patient must be made aware of that fact prior to the service.

7. The surgical fee for orthopaedic procedures (fractures and dislocations) includes the post-operative follow-up period normally considered to be 90 days for such procedures. The fee for other surgical procedures includes the post-operative follow-up care, including the removal of sutures and care of the operative wound. This period is normally considered to be 42 days.

8. Where a surgical procedure is performed by a podiatrist who administers a regional anaesthesia for that procedure, there shall be no additional charge for the administration over the procedural fee, except in rare or unusual cases or emergencies substantiated by a detailed letter. A net fee not in excess of $9.00 may be paid under the Plan if in the opinion of the Medical Advisor the circumstances of the specific case so warrant a fee for the regional anaesthesia in addition to the procedural fee.

9. If surgical services other than those specified are provided, or where because of serious complications or coincidental conditions additional services are required and the podiatrist wishes to claim extra remuneration, the podiatrist must describe the unusual circumstances that warranted the alternative or extra service and detail all services given provided with the podiatrist's suggested fee when submitting the podiatrist account. Such claims will be subject to individual adjudication by the Plan.

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

11. 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.

12. 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.

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PODIATRY PAYMENT SCHEDULE

The following pages list the tariff of fees for podiatrist services. These fees cannot be correctly interpreted without reference to the Preamble.

P00189 Podiatry Visit $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.

P01305 Hospital Consultation $94.32

In-depth evaluation of a podiatric problem seen on referral of a physician requiring a comprehensive history, review of x-rays and laboratory results, gait analysis study (where required), and a written report to the referring physician. Limited to in-patients in an acute care facility referred as high risk due to complex medical problems (for example, but not limited to, diabetes or vascular disease).

Notes:

i) Not billable within six months of fee item 00152 and 01309 when rendered for the same condition.

ii) If surgery is the recommended treatment and is being performed in hospital, bill under fee item 01309.

iii) If surgery is the recommended treatment and is being performed outside of hospital, bill under fee item 00152.

Special Surgical and Other Procedures

When two similar procedures are done at the same time, the charge for the second procedure should be 50 percent of the scheduled fee; when done separately at staged intervals, the full fee should be charged for each procedure.

00152 Surgical consultation to include review of x-rays, blood work, etc., consultation with patient, and written report to patient's referring physician $36.87

00155 Non-referred pre-operative assessment $27.11

Notes:

i) Billable only when non-referred case proceeds to podiatric surgery.

ii) Referred cases bill under fee item 00152.

iii) Cases not proceeding to podiatric surgery are the responsibility of the patient unless eligible for supplementary benefits and the annual limit has not been reached.

iv) Cases not proceeding to surgery where the patient is eligible for supplementary benefits, bill under fee item 00189.

MSP PAYMENT SCHEDULE: PODIATRY SERVICES
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In-hospital Special Surgical and Other Procedures

01309 In-hospital surgical consultation to include review of x-rays, blood work, etc., consultation with patient, and written report to patient's referring physician ... $143.55

01310 In-hospital incision and drainage superficial abscess (operation only) ... $39.14

Note:

i) Not billable within six months of fee item 00248 when rendered for the same condition.

01311 In-hospital Non-referred pre-operative assessment ... $94.32

Notes:

i) Not billable within six months of fee item 00155 when rendered for the same condition.
ii) Billable only when non-referred case proceeds to podiatric surgery.
iii) Referred cases bill under fee item 01309.
iv) Cases not proceeding to podiatric surgery are the responsibility of the patient unless eligible for supplementary benefits and the annual limit has not been reached.
v) Cases not proceeding to surgery where the patient is eligible for supplementary benefits, bill under fee item 00189.

Other Procedures

P01308 Post-podiatric surgery visit ... $14.66

Notes:

Billable only under the following circumstances:
i) When unexpected complications arise following the 42-day post-operative period; or
ii) When post-operative care is provided by a different podiatrist within 42-day post-operative period in a different community (more than 50km from where the surgical procedure was performed); and
iii) Only when the surgical procedure is a benefit of MSP.
iv) All claims for fee item P01308 must be substantiated by a note record indicating how the criteria in notes i) and ii) were met.

00187* Removal of foreign body requiring open exploration ... $85.96

00244* Osteotomy - cutting a transection of bone with realignment ... $207.77

00245* Remodeling - metatarsal head ... $183.78

00246* Remodeling - phalangeal head ... $133.05

00247 Primary fixation (internal) (in addition to 0245, 0246) ... $49.02

00251* Excision, removal of medium sized benign soft-tissue tumor where general anaesthetic or regional block is necessary ... $107.77

00252* Tenodesis ... $85.96

00253* Tendon lengthening ... $85.96

Repair of Deformities of Joints of Lesser Toes

00254*	Soft tissue only	$85.96
00255*	Arthroplasty (metatarso-phalangeal)	$122.15
00256*	Arthrodesis - interphalangeal with fixation	$183.78

Hallux Valgus

00257*	Simple	$218.14
00258*	Osteotomy and fixation	$244.86
00259*	Excision of neuroma	$124.88
00260*	Excision - surgical or plantar keratosis	$85.96
00261*	Sesamoidectomy and accessory bones	$92.71
00262*	Exostosis of tarsal bones	$61.18
00269	Surgical assistant fee - applicable to the total fee payable under the multiple surgery rule for fee items 00244, 00245, 00246, 00251, 00257, 00258. 00259 and 00262. Payable at 30 percent of surgical fee.	

* All items marked with an asterisk require a copy of the operative report and copy of the written report to patient's referring physician to accompany the claim to MSP.

Other Procedures

00171	Dislocations – toes	$36.87
00172	Dislocations - M.P. joints	$36.87
00173	Fractures – toes	$49.02
00174	Fractures- metatarsal	$73.41
00175	Excision granuloma	$61.18
00176	Clavus (helomata) surgical, includes redressing	$98.04
00179	Nails - permanent partial plate and matrix (includes redressing)	$98.04
00180	Nails - complete nail and matrix removal (includes redressing)	$122.15
00188	Nails - permanent partial matrixectomy of both borders of the same digit (includes redressing)	$130.00
00183	Verruca - Surgical excision	$98.04
00186	Removal of foreign body under local anaesthesia	$29.55

00240	Biopsy, skin (appropriate office visit additional)	$11.94
00242	Primary repair of soft-tissue wound	$36.87
00248	Incision and drainage superficial abscess (operation only)	$18.38
00289	Designated as a miscellaneous fee item, it can be billed up to a maximum of the amount indicated	$545.33

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.