ISSN 0848-676X

Physician's newsletter

Published by the Medical Services Plan for Medical Practitioners

inside

Issue 2 Volume 24 Winter 2000

Primary Care Demonstration Project

September 2000 marks the one year anniversary of the British Columbia Ministry of Health/Health Canada Transition Fund sponsored Primary Care Demonstration Project (PCDP). This three-year pilot project is testing new and innovative models of primary health care delivery that include a multidisciplinary team-based approach to care involving nurses and other health care providers, a blended population-based funding method, advanced clinical information management technology, and integration of primary health care with existing community-based services. The PCDP provides the unique opportunity to learn first-hand about new ways of delivering primary care that benefit patients and practitioners.

Seven demonstration sites were launched in fall 2000, and we are pleased to announce that the Park Avenue Medical Centre (Terrace, B.C.) has recently joined the demonstration project. This fee-for-service site will contribute to the overall evaluation of the project, and thanks are extended to the BCMA/PCDP Liaison Committee for their assistance in site selection.

An external evaluation of the project is currently in progress with an interim report to the Health Transition Fund slated for completion March 2001. A final evaluation report will be completed in March 2002.

For more information please see the PCDP website at http://www.hlth.gov.bc.ca/care/primdemo/index.html

Enclosed with this newsletter is the Primary Care Demonstration Project Site Update (please see inserts).

General Practitioner – April 2000

It was discovered in an audit that a general practitioner was overservicing his patients, inadequately documenting his patients' charts and billing for complete physical exams that should have been billed as office visits. The doctor has now rectified these problems and this year a settlement was reached whereby the MSC was repaid $70,000. The agreement requires the doctor to comply with charting requirements associated with conducting complete physical examinations and only perform them where medically necessary. The doctor must keep adequate and legible records to support billings and provide rationale for treatment and follow-up of patients, and only bill for counselling when justified by medical necessity and in accordance with the MSC Payment Schedule.

General Practitioner – August 2000

The Medical Services Commission (MSC) and a medical practitioner have settled a claim under section 37 of the Medicare Protection Act. The Billing Integrity Program conducted an audit of claims made by the general practitioner from 1991 to 1996. The audit found claims for fee item 0110 (general practice consultation) in which the doctor did not personally see the patient, and therefore did not make a physical examination. According to the Payment Schedule a physical examination is required for all consultations whether performed by general practitioners or specialists. The MSC determined that in those cases where the doctor did not see the patient, MSP had been billed inappropriately. After the audit, the doctor amended the pattern of practice and now personally examines each patient when claiming fee item 0110. The doctor has repaid the Commission $40,000 for claims inappropriately billed to MSP.

General Practitioner – September 2000

Through a mediated settlement, Dr. Jane Pedlow has agreed to repay the MSC the sum of $75,000.00. Dr. Pedlow is a general practitioner who is retired from active practice due to an injury. Dr. Pedlow was audited as a result of a statistically extraordinary rate of utilization of office visits and complete examinations during the period 1988 through 1992. The MSC found no fault with her clinical competence and agree that Dr. Pedlow's motivation in the provision of service was in her patients' interest. However, the parties agreed to the repayment in recognition that physicians must set reasonable limits to the frequency of visits, in keeping with medical necessity.

General Practitioner – August 2000

An audit was conducted on the billings of a general practitioner that determined an inadequate level of justification for the medical necessity or frequency of office visits and counselling services billed to MSP. A settlement was reached, which constitutes a compromise of a disputed claim, whereby the practitioner agreed to repay $20,000 to the MSC and to work towards fostering patient independence and self-care through medical education. In addition, the practitioner agreed to adopt a pattern of practice that will ensure the frequency of the patients' visits is justified by medical necessity, adequate records are kept that have clear rationales for treatment and follow-up, and billing for counselling is only when medically necessary and in accordance with the MSC Payment Schedule.

General Practitioner – September 2000

Dr. Ernest Ledgerwood came to the attention of the Audit and Inspection Committee as a result of ongoing screening of practitioner profiles statistics and a Service Verification Audit. In 1999, the MSC audited Dr. Ledgerwood's 1994-1998 practice with particular attention to out-of-office hours services and surcharges (the 1200 series fee items). The audit revealed many instances where, contrary to the MSC Payment Schedule, Dr. Ledgerwood had billed MSP for out-of-office hours services and surcharges when his office was not officially closed, or where the nature of the clinical problem was not urgent. Dr. Ledgerwood has agreed to reimburse the MSC $65,000 in relation to these billing errors. In addition, he has agreed to abide by a pattern of practice order requiring him to utilize the 1200 series fee items only when his office is officially closed, and only when he is called to render emergency or non-elective services. The Commission acknowledges that the billing errors identified resulted from Dr. Ledgerwood's honest misunderstanding of the Payment Schedule and not from a deliberate attempt to inappropriately bill the Medical Services Plan.

Future Replacement Codes for Explanatory Code "AF"

AF – This patient does not have coverage for the DOS (date of service).

To clarify "AF" refusals, MSP will implement specific explanatory codes to assist medical offices with their billings.

*A Our records indicate patient deceased. Please contact MSP.
*B Patient's eligibility with MSP is in question. Please have patient contact MSP.
*C MSP is unable to locate patient. Please have patient contact MSP.
*D MSP has been unable to contact patient. Please have patient contact MSP.
*E Our records indicate patient has permanently moved out of BC. Please contact MSP.
*F Patient has opted out of MSP. Patient should be billed directly.
*G Our records indicate MSP is not the primary insurer for this patient.
*H Our records indicates the patient requested coverage to be cancelled.

Note : asterisk (*) is part of the explanatory code

2001 Close-off Dates

January 3, 2001
January 19, 2001
February 5, 2001
February 16, 2001
March 5, 2001
March 20, 2001
April 2, 2001
April 18, 2001
May 3, 2001
May 18, 2001
June 5, 2001
June 19, 2001
July 3, 2001
July 19, 2001
August 2, 2001
August 21, 2001
September 4, 2001
September 18, 2001
October 2, 2001
October 19, 2001
November 2, 2001
November 20, 2001
December 3, 2001
December 14, 2001

DISAGREE WITH HOW MSP HAS PAID YOUR CLAIM?

If you disagree with how MSP has paid a claim, the most effective way to have it reassessed is to resubmit with a note record. In the note record, indicate that you are requesting a re-assessment and include a brief explanation. For example, an office visit has been refused as part of the 42 day post operative period but the reason for the visit was unrelated to the surgery. As the diagnostic code itself does not always provide sufficient information, provide the reason for the unrelated visit in a note record with your resubmission.

If you have attempted to have a disputed claim resolved by resubmitting the claim and are still dissatisfied, please bring this matter to the attention of our Claims Billing Support Unit. This can be done by faxing all information to (250) 952-3222 or by phoning Victoria - (250) 952-2654 or Vancouver (604) 806-0234.

MSP adjudication staff are committed to ensuring timely and accurate payment of claims. However, due to the complexity and volume of claims unintentional errors may occur. Should you find that you have to routinely resubmit a certain type or combination of claims due to incorrect payment, we would like to hear from you.

Please write to
Sandy Prette, Administrator
Claims Adjudication
RBB 3-1
1515 Blanshard St.
Victoria, BC V8W 3C8

MEDICAL PRACTICE ACCESS TO PHARMANET – PILOT PROJECT UPDATE

HealthNet/BC, a division of the Ministry of Health's Information Management Group, is conducting a pilot project that will see up to 100 medical practices accessing PharmaNet on a routine basis to obtain accurate and complete records of medications dispensed to their patients. The project to bring PharmaNet access to physicians in medical practices is strongly supported by the College of Physicians and Surgeons of BC. Participation in the pilot is voluntary. This initiative is separate from the Ministry's MSP Claims and Teleplan programs.

The first pilot site connected to PharmaNet in March 2000. Seventy-eight sites are now connected with more sites in various stages of implementation. Access rates vary and range from several per week to ten per day. Participants will be surveyed about their experience this fall and an evaluation report will be published early in the New Year.

Medical Practice Access to PharmaNet represents a key component of the Ministry's vision for electronic sharing of health information. This initiative is being leveraged on the highly successful and well-received project, which brought PharmaNet access to hospital emergency departments.

HealthNet/BC Education Website

HealthNet/BC is preparing to launch a new interactive education and training website "HNEd". HNEd is comprised of education material, quizzes, a visitor feedback form and links to related websites of interest. The introductory version of HNEd will be used to provide training and education on the privacy requirements of Medical Practice Access to PharmaNet. HNEd has been designed to accommodate any text based training material and provides self-paced learning and evaluation tools. Future versions of HNEd will address other HealthNet/BC standards and potentially education and training materials developed by other organizations for their employees.

A preview of the education material for Medical Practice Access to PharmaNet is available at a static website today; just connect to http://healthnet.hnet.bc.ca and click on the "Education" link displayed at the top of the page. When HNEd is fully implemented, first time visitors will be asked to register. This is a quick and easy process which allows HNEd to support self-paced learning. HNEd will be fully supported by the PharmaNet Help Desk.

Lab Test Standard

The HealthNet/BC Lab Test Standard (LTS) embodies the professional, business and technical standards for transmitting lab test orders and lab test result reports between any number of participating physicians and labs.

List of Inserts

1) Update to the Payment Schedule
2) MSP Bulletin (list of patients restricted to one physician)
3) Caring for Lesbian Health (article from Women's Programs)
4) Medical Forensic Evidence Collection and Storage (BC Women's Health)
5) Primary Care Demonstration Project – Project Site Updates
6) Adhesive label to Correct error in Guideline/Protocol: *Office and Laboratory Management of Genital Specimens* Appendix
7) Consumer Alert – Nonoxynol -9 (N-9)

Electronic distribution of lab test information is a top priority for physicians and labs. Concerns about privacy and the cost of maintaining multiple proprietary interfaces have limited the number of electronic exchanges actually implemented.

The LTS was developed by a task group with representatives from the Ministry, HealthNet/BC, the CPSBC, the BCMA, MSP, physicians in private practice, public and private labs. The LTS specifies privacy safeguards, uses state of the art security technology to ensure the secure transmission of information across the Internet and provides a single standard for the electronic exchange of lab test information.

Since it was first published in April of 1999 interest in the LTS has been growing. The BCCDC has declared its plans to move all its existing proprietary interfaces to the LTS and began this process with the implementation of the LTS to transfer lab test results from BCCDC to the Public Health Information System (PHIS) in June, 2000. Multiple symposiums, with attendees from around the province, have been held to provide a forum for education and discussion about implementation of the LTS. Several Health Authorities and their partners have submitted proposals encompassing the implementation of the LTS, to the federal Canadian Health Information Partnership Program (CHIPP) which provides grants for innovation in health information technology. The BCCA has identified the LTS as its preferred option for the electronic exchange of lab test information.

The LTS has been adopted by the Western Health Information Collaborative (WHIC), an initiative of the four western provinces and the territories to advance the sharing of health information technology knowledge and products.

Saskatoon District Health has indicated their intention to adopt the LTS in future initiatives. There is interest and support from the Canadian Institute for Health Information (CIHI) for moving the LTS forward as a national standard.

The LTS is a key component of the Ministry's vision for electronic sharing of health information and integral to the national initiative for the development of the Electronic Health Record.

For more information about these initiatives, please consult the HealthNet/BC extranet at http://healthnet.hnet.bc.ca and follow the "Products" link, or
Contact the HealthNet/BC office:
Chris Schrader, Project Manager, at (250) 952-2906 or chris.schrader@moh.hnet.bc.ca
Liz Carter, Business Liaison Consultant, at (604) 879-3313 or liz_carter@bc.sympatico.ca

HealthNet/BC is a prime contributor to the development of information technology standards for health care in BC.

BLUEBOOK AVAILABLE ON THE MSP WEBSITE

The 99/00 Medical Services Commission Financial Statement (Bluebook) can be accessed through the Ministry of Health's MSP Website at http://www.hlth.gov.bc.ca/msp, it is listed under both "Fact and Statistics" and "Publications" on the menu bar. The Statement contains an alphabetical listing of payments made to practitioners, groups, clinics, hospitals, health authorities and diagnostic facilities for the past fiscal year.

Re-introduction of MSP's Multi-doctoring Program

The Framework Memorandum commits Government and the BCMA to a number of utilization management initiatives. One initiative is directed at reducing potential over utilization resulting from patients obtaining services from multiple general practitioners. It is recognized that multi-doctoring is not just a cost concern but a quality of care concern and this program requires the support of the medical profession to be successful.

The Medical Services Plan (MSP) first implemented a similar program in 1978 which was aimed at detecting, educating and deterring multi-doctoring by its beneficiaries. However, the pursuit of new cases was suspended in 1994, awaiting the passing of legislation enabling the Medical Services Commission (the Commission) to deal with those individuals who continue to multi-doctor, after they have been contacted regarding this issue.

MSP is pleased to announce the introduction of a revised multi-doctoring program. This initiative should not be compared to the educational initiative undertaken in 1997, as many improvements have been made to the selection process. Based on past experience, it is anticipated that this program will impact a very small group of beneficiaries.

Based on utilization statistics and specific selection criteria, current and historical records of beneficiaries suspected of multi-doctoring will undergo a careful review by experienced MSP staff. Only those individuals whose MSP records confirm a trend of multi-doctoring with no apparent justification will be advised by letter of the benefits of limiting their care to one primary care physician or clinic. At that time, the beneficiaries will be invited to provide additional information regarding their need to seek care from multiple physicians. If, after monitoring, no change is seen in the beneficiaries' pattern of utilization (for those beneficiaries who have not provided a medical and/or practical need for their pattern of care), a second letter will be sent requesting they choose a single family physician or clinic for their medical care. If there remains no change after 90 days, a third letter will be sent asking the beneficiary to sign an "Agreement of Limitation of Physician Services." Should the beneficiary choose not to sign the agreement form, they will be advised of their opportunity to request a hearing before a panel of the Commission. A hearing may result in the panel ruling that payment of primary care services be limited to one physician or clinic.

If a beneficiary voluntarily signs an "Agreement of Limitation of Physician Services", the payment of any non-emergent care by a general practitioner other than the physician named on the agreement form becomes the responsibility of the individual. As in the past, those individuals restricted to a single physician or clinic will be identified in the "MSP Bulletin" published in each Physicians' Newsletter. Offices can also verify if a patient is restricted to one physician or clinic by using Teleplan's online eligibility system or by calling MSP's automatic coverage line at (250) 952-3102. Between printings of the newsletter, updates to the MSP bulletin will be provided via a broadcast message on your remittance statement. We strongly recommend that offices confirm by checking the Bulletin or automated coverage services before treating any new patient.

Inquiries about the multi-doctoring program may be directed to the Administrator of the newly created Utilization Management Operational Support team at: (250) 952-2697.

BONE DENSITY TESTING APPROVAL

On recommendation from the Advisory Committee on Diagnostic Facilities (ACDF), effective September 13, 2000, the Medical Services Commission extended approval for Bone Density Testing to all Category IV Diagnostic Radiology facilities upon written application.

Note: Fee items covered by this approval include only existing radiography items (DEXA) and do not include nuclear medicine or ultrasound. Existing policy states that bone densitometry for screening purposes is not a benefit. This policy is not changed by this decision. Please refer to the Protocol for Bone Density Measurement, adopted by the Commission, effective May 1999.

Enhancements to Claims Automated Phone System

Victoria	952-2654
Vancouver	806-0234
Toll Free	1-800-563-5556

We are enhancing the Claims automated phone system – the expected date of implementation is November 27, 2000. The telephone numbers are not changing – but some of the prompts are. Listen carefully for your first few calls to ensure that you are making the correct prompt selection so that your call is directed correctly.

New Prompts!

First Menu:
- General Public calling about Benefits or Coverage **press 1**
- All others (Medical Community) **press 2**

Second Menu:
- Benefit Services **press 1**
- Claims Billing Support **press 2**
- Provider Programs- **press 3**
- Out of Country **press 4**
- Info by Fax **press 5**

Fee Items 09868 and 09855

In order for fee items 09868 and 09855 to be performed and billed for the same time, the accompanying note for medical need must state "pulmonary embolism". If the note is not attached, the billing will be refused with explanatory code F9.

Fee Items 00960 and 00961

Some facilities are billing fee items for ear oximetry when the appropriate fee item is P00910 or P00911 (overnight home oximetry). Please note: fee items P00910 and P00911 are limited to Category III pulmonary laboratories with the established personnel qualifications for such laboratories.

Fee Item 00043

The Section of General Practice and the Tariff Committee have agreed that fee item 00043 – Anticoagulation therapy by phone – may be billed on the same date as a hospital visit provided that the visit and the 00043 occur at two different times. When billing, please indicate times of services or provide a note record.

Fee Item 00116

Fee item 00116 – Special in-hospital consultation – is not the appropriate fee item to bill for patients seen in the Emergency Room. The correct fee item to use is 00110 – Consultation (in or out of office).

Fee Item 00112 – Time Required

At the request of the BCMA the following note was added to fee item 00112 – "Claim must state time service rendered". Since that time many claims for fee item 00112 have continued to be submitted without time being stated. To address this issue, effective January 1, 2001 a start time will be required for all billings of fee item 00112. To avoid refusal of your accounts please include a start time each time you bill fee item 00112.

Billing Fee Items 00370 & 00371

When fee items 00370 and 00371 are billed with items 00706, 00707 or 00709 for diagnostic purposes, fee item 00370 is paid for the first procedure only. For subsequent procedures only the larger fee is paid. Fee item 00371 is paid with 00709, only if the note record or the procedural report justifies the need for both. This has been confirmed by the BCMA Tariff Committee.

Correction to Winter 1999 Newsletter article – Fee item 04026

There was an error in the Winter 1999 Newsletter article "Complicated Obstetrical Surgery" (page 10). It should read - Fee item 04026 is paid at 50% of the fee item when billed in conjunction with fee item 14104 and/or complicated delivery fee items.

Reminder - Billing two services on one date

When billing two services for the same date, please be explicit with the ICD9 codes or include a note stating the two separate conditions. ICD9 code 780 (general symptoms) is not specific enough to expedite payments. Your claim may be refused as included in the previous paid fee item for that date of service.

Updated list of available Guidelines and Protocols

TOPIC	GUIDELINE/PROTOCOL
Ankle injury	• X-ray for Acute Ankle Injury, Revised 2000
Bone density	• Bone Density Measurement
Bone scans in prostate cancer	• Investigation of Metastatic Bone Disease in Newly Diagnosed Prostate Cancer Using Nuclear Medicine Techniques, Reviewed and unchanged April 2000
Bone scans in suspected osteomyelitis	• Investigation of Suspected Osteomyelitis in Normal Bone Using Nuclear Medicine Techniques, Reviewed and unchanged April 2000
Cataracts	• Treatment of Cataract in Adults
Chest x-rays	• Chest X-rays in Asymptomatic Adults
Cholesterol	• Cholesterol Testing: Adults Under 69 Years
Colonoscopy after colorectal cancer	• Follow-up of Patients After Curative Resection of Colorectal Cancer
Diabetes, glucose and HbA1C	• Use of Glucose and HbA1C Tests in Diagnosis and Monitoring of Diabetes Mellitus
Diarrhea	• Investigation of Suspected Infectious Diarrhea
Dyspepsia	• Clinical Approach to Adult Patients with Dyspepsia
ECGs	• 24-Hour Ambulatory ECG (Holter Monitor) • Electrocardiograms, Revised 2000
ESR	• Erythrocyte Sedimentation Rate, Revised 2000
Gallstones	• Treatment of Gallstones in Adults
Gastroesophageal reflux disease	• Clinical Approach to Adult Patients with Gastroesophageal Reflux Disease
Genital specimens	• Office and Laboratory Management of Genital Specimens
Helicobacter pylori	• Detection and Treatment of Helicobacter pylori Infection in Adults
Hepatitis, viral testing	• Viral Hepatitis Testing
House calls	• House Calls, Reviewed and Unchanged April 2000
Iron	• Use of Serum Ferritin and Total Iron and Iron Binding Capacity
Mammography	• Use of Diagnostic Facilities for Mammography
Prenatal testing	• Prenatal Cytogenetic Testing, Revised 2000 • Prenatal Ultrasound
Pre-operative testing	• Routine Pre-Operative Testing, Revised 2000
Sleep disorders	• Assessment and Management of Obstructive Sleep Apnea in Adults, Revised 2000 • Primary Care Management of Sleep Complaints in Adults
Stool testing for ova and parasites	• Ova and Parasite Testing of Stool Samples
Throat, sore	• Diagnosis and Management of Sore Throat
Thyroid testing	• Use of Thyroid Function Tests in the Diagnosis and Monitoring of Patients with Thyroid Disease
Urinalysis	• Macroscopic and Microscopic Urinalysis and Investigation of Urinary Tract Infection

Correction to Appendix of Genital Specimens Protcol

A correction has been made to the appendix of the Office and Laboratory Management of Genital Specimens protocol. The incorrect text appears at the top of page 2 of the Appendix.

It should read:

Charcoal (black media) swabs collected for gonorrhea should never be refrigerated. Follow the instructions provided by your laboratory for transport and storage of Amies (clear) or Stuart's (clear) media).

A sticker has been provided (see inserts) to replace the text in error. To align, remove backing and place the vertical line on the sticker over the vertical line on the appendix.

Expanded Location Codes

In 1997 MSC approved the use of expanded location codes, that change was listed in the 1999 Teleplan Specifications sent to vendors. MSP has allowed a transition period and has not implemented edits to the system to allow a phase in period. Use of expanded location codes is required on all claim submissions. If you have any questions about the capability of your billing software to input these codes, please contact your software vendor. The following are the expanded location codes:

R	Patient's residence
O	Physician's office
C	Continuing Care facility
H	Hospital
I	Hospital Inpatient
E	Hospital Emergency Department or Diagnostic & Treatment Centre
P	Outpatient
D	Diagnostic Facility
S	Reserved for future use
Z	None of the above e.g. accident site or in an ambulance

Billing Guidelines for Ministry of Social Development and Economic Security Form Fees (96200, 96300)

The following billing guidelines apply to fee items 96200 (General Practitioner Completion of Part C only of MSDES Disability Benefits application form) and 96300 (Specialist Completion of Part C only of MSDES Disability Benefits application form):

If the sole purpose of the visit is the assessment of the patient in order to complete the application form, no additional visit fee may be billed to MSP. If, the patient is seen for other condition(s) unrelated to the patient's disability, the appropriate visit or consultative service may be billed in addition. Please provide details of the medical indication for the additional service in your note record. Claims submitted without supporting information will be refused.

ICBC/WCB - Billing Claims to the Appropriate Insurer

As you are aware, MSP acts as the processing agent for both ICBC and WCB claims. We would like to take this opportunity to again remind you of the importance of billing claims to the appropriate insurer, as MSP relies solely on how a claim is submitted in order to determine which insurer is responsible. For ICBC, the claim submission must include the MVA indicator, and the ICBC claim number when available. For WCB, the claim must be submitted using the claim submission format designed for WCB claims. If claims are not submitted using either of these methods, they are considered MSP's responsibility and are applied against the Available Amount.

It is recognized that at the time of service, the physician or facility may not be advised that the claim should be billed to ICBC or WCB. To address this issue, MSP introduced a new program in the spring of 1999 to alert physicians when claims that appear to be the responsibility of ICBC or WCB have been billed to MSP. Please see the Spring 1999 edition of the Physician's Newsletter for further details regarding this program.

Ensuring that the appropriate insurer is identified on your claims helps to protect the Available Amount.

SINGLE OPERATOR FEE ITEMS

The British Columbia Medical Association Tariff Committee and the Medical Services Plan have agreed the following surgical procedures do not require an assistant. Therefore, unless a note record is provided to indicate the extra-ordinary circumstances requiring a surgical assistant, the assistant fee items will be refused with the following procedures. Please refer to the payment schedule for the complete description of the fee item and applicable notes.

00331 - Closed drainage of chest
00866 - Dynamic cavernosometry and cavernosography
02323 - Removal of nasal polypi – bilateral
02365 - Nasal fracture-reduction and splinting
03104 - Percutaneous rhizotomy 5th nerve
03165 - Insertion intracranial pressure monitoring device
03167 - Insertion skull tongs
03188 - Ventriculostomy or insertion of external ventricular drain
03196 - Exploration, mobilization and transposition
03216 - Puncture of ventricular shunt
03217 - Percutaneous ventricular puncture
03240 - Implantation of totally implantable ventricular access device
04001 - Laparoscopy
04500 - Cervix dilatation and curettage
04531 - Cauterization of cervix
06113 - Abrasive surgery - between quarter and half-face
06114 - Abrasive surgery - full face
06200 - Tattooing surgery - facial area - less than one quarter of face
06201 - Tattooing surgery - facial area - one-quarter to one half face
06202 - Tattooing surgery - facial area - full face
06206 - Tattooing surgery - non-facial - less than 65 sq. cm.
06207 - Tattooing surgery - non-facial - less than 650 sq. cm.
06258 - Exploration peripheral nerve and neurolysis
07843 - Implantation of endocardial pacemaker
07844 - Implantation or replacement of pulse generator or cardiac pacing
07847 - Endocardial pacemaker
07924 - Decompression of traumatic pneumothorax
07925 - Artificial pneumothorax
07952 - Electronic monitoring of pacing and pacemaker function

Designated Statutory Holidays – Year 2001

January 1, 2001	New Year's Day	Monday
April 13, 2001	Good Friday	Friday
April 16, 2001	Easter Monday	Monday
May 21, 2001	Victoria Day	Monday
July 2, 2001	in lieu of Canada Day	Monday
August 6, 2001	B.C. Day	Monday
September 3, 2001	Labour Day	Monday
October 8, 2001	Thanksgiving Day	Monday
November 12, 2001	in lieu of Remembrance Day	Monday
December 25, 2001	Christmas Day	Tuesday
December 26, 2001	Boxing Day	Wednesday

07953 - Double lead endocardial pacemaker
08123 - ESWL
08146 - Ureteroscopy and basket manipulation of ureteral calculus
08155 - Insertion of internal urteral stent
08200 - Bladder fulguration with cystoscopy
08202 - Cystostomy by Trochar
08232 - Periurethral collagen injections
08250 - Transurethral resection of bladder or urethral tumour
08251 - Transurethral resection of bladder neck
08254 - Litholapaxy and removal of fragments
08256 - Transurethral resection of external urinary sphincter
08257 - Transurethral removal of foreign bodies
08260 - Urethrotomy
08261 - Urethrostomy
08262 - Meatotomy and plastic repair
08264 - Stricture of urethra - office
08265 - Stricture of urethra - dilation in hospital
08269 - TUR posterior urethral valves
08282 - Excision prolapse of urethra or caruncle
08301 - Dorsal slit
08312 - Circumcision
08319 - Balloon dilation of prostate
08323 - Exploration of scrotal contents
08325 - Reduction or torsion of testis and spermatic cord repair
08327 - Biopsy of testis
08329 - Simple orchidectomy
08340 - Abscess, incision
08341 - Spermatocoele or hydrocoele excision
08343 - Epididymovasostomy or re-anastomosis of vas
08344 - Vas cannulation
08345 - Vasectomy
08399 - Doppler evaluation of penile blood flow

For more information please call Claims Billing Support at Victoria (250) 952-2654
Vancouver & Lower Mainland (604) 806-0234 or the BCMA Tariff Committee.

Palliative Care Consultation
1-877-711-5757

A new after-hours and weekend service is available to BC physicians and homecare nurses who may require advice on managing symptoms of terminally ill patients.

The service started October 2, 2000 and is available from 5PM to 9AM weekdays. On week-ends, you will be connected with a palliative care physician who can assist in symptom management, advise you of resources in your area, and provide suggestions for case management.

This service is a pilot project of the BCMA Palliative Care Working Group and Vancouver Home Hospice in co-operation with the Ministry of Health. The phone line is funded by Aventis Pharma.

Contact Palliative Care Consultation 1-877-711-5757.

End-of-Life Care

A new resource guide provides valuable information about end-of-life services and care for the elderly.

Taking into consideration Canada's cultural mosaic, *A Guide to End-of-Life Care for Seniors* offers a range of discussions and provides a basis for national guidelines. Maintaining comfort and effective care delivery as well as the spiritual and cultural end-of-life needs of Canada's Aboriginal peoples is included.

The Guide is co-produced by The Universities of Toronto and Ottawa with funding from Health Canada.

For more information, or to download a free pdf copy of the Guide, visit the End-of-Life Project website at:

http://www.rgp.toronto.on.ca/iddg/eol.htm

Notification of ICBC Refused Claims is coming

In an effort to provide physician offices with current and correct information on which insurer is responsible for specific claims, MSP will begin to notify physicians early in 2001 if there is a change in responsibility for a claim from ICBC to MSP.

You will recall that in 1994, as a result of negotiations between BCMA and government, the method which ICBC reimbursed MSP for MVA-related claims changed from a formula payment basis to an incurred claims basis.

To keep the process seamless, claims billed with an MVA indicator are processed and paid as an ICBC responsibility. After payment, MSP forwards an electronic copy to ICBC of all claims paid on their behalf. ICBC then adjudicates each claim and decides whether or not it is their responsibility. If ICBC refuses responsibility for an account, MSP is notified, internal adjustments are made to MSP records and the claim is changed to MSP responsibility.

When a claim is billed and paid as ICBC's responsibility and later ICBC refuses responsibility for a paid claim, a debit adjustment will be initiated with an explanatory code DR (and another explicit refusal code). Simultaneously, a credit will be initiated to reflect MSP as the insurer with the explanatory code HK I0. (I0 - ICBC has refused responsibility of this claim, therefore MSP has accepted responsibility. The insurer code has been changed.) This requires no further action on your part unless you dispute ICBC's refusal of your claim. In this case, you must contact ICBC directly.

Further information on this change will be provided on future remittance statements as broadcast messages.

Unfortunately, this complicated process is required as the original ICBC claim has been paid and reconciled by your system. Please be assured that this is a revenue neutral process.