PREAMBLE

To the Laboratory Services Outpatient

PAYMENT SCHEDULE

Fee-For-Service Outpatient Laboratory Services in

British Columbia

Issued: October 1, 2015

Revised as of March 5, 2021

BRITISH COLUMBIA | Ministry of Health

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To the Laboratory Services Outpatient

PAYMENT SCHEDULE

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INTRODUCTION

Purpose of the Laboratory Services Outpatient Payment Schedule

The Laboratory Services Outpatient Payment Schedule (Payment Schedule) is issued by the Minister of Health (Minister) under the authority of the *Laboratory Services Act* (*Act*) for use by operators of approved laboratory facilities in British Columbia (B.C.). Both the Payment Schedule and the Preamble to the Payment Schedule were issued on October 1, 2015 and are revised as necessary.

The Payment Schedule applies to the provision of insured outpatient services in approved laboratory facilities receiving payment on a Fee-for-Service (FFS) basis. The Payment Schedule contains billing and payment detail for laboratory operators, a schedule of laboratory medicine fees, as well as limits and conditions on laboratory benefits approved for referring medical and health care practitioners.

Components of the Laboratory Services Outpatient Payment Schedule

The Preamble includes:

- An Introduction for operators of approved laboratory facilities;
- A facility operations and administration chapter with billing and payment procedures, record keeping requirements, and service provisions;
- An introduction for operators to Laboratory Services and Fees;
- Information regarding Referring Medical and Health Care Practitioners, including limits and conditions on certain laboratory tests and services; and
- A Glossary of Terms.

The Schedule of Fees consists of the following sections by sub-discipline, and includes the respective fee item numbers (codes), test description, limits and conditions (Notes), and fee item value:

Section One: Hematology and Blood Bank Fee Items
Section Two: Microbiology Fee Items
Section Three: Chemistry Fee Items
Section Four: Cytogenetics Fee Items
Section Five: Virology Fee Items
Section Six: Anatomic Pathology Fee Items
Section Seven: Other Fee Items

The Preamble within the Payment Schedule complements the Schedule of Fees (Sections One through Seven), including Notes found within each Section by sub-discipline. The intention is that, together, the Preamble and Notes will assist operators in billing for insured outpatient laboratory services. If there is an inadvertent conflict between a fee item description in the Schedule of Fees and information in the Preamble, the interpretation of the fee item description in the Schedule of Fees shall prevail.

The Schedule of Fees and associated fee item values are approved by the Minister and are payable to operators of approved laboratory facilities on a FFS basis for insured outpatient laboratory medical services provided to beneficiaries enrolled with the Medical Services Plan (MSP).

Legislation and Policy

The *Act* empowers the Minister as being responsible for the administration and provision of benefits under the Act. The *Act* replaces the provisions for laboratory services as benefits administered under the *Hospital Insurance Act* and the *Medicare Protection Act.*

The *Act* establishes a relationship between the Minister and providers (operators) for the provision of laboratory services in B.C. In addition, the statute provides the Minister with the authority to set outpatient laboratory fees and to determine the amount of all fees.

The Payment Schedule functions as the primary claim processing and payment policy document for insured FFS outpatient laboratory services in B.C. The Payment Schedule will be reviewed and updated as required based on best evidence and consultation with stakeholders.

Chapter 2	Laboratory Operators	Issued: October 1, 2015 Revised as of March 5, 2021

LABORATORY OPERATORS

Introduction for Laboratory Operators

The *Act* provides a single legislative framework governing the provision of laboratory services as benefits in B.C. Under the *Act*, a laboratory facility "operator" means:

- the owner;
- the person having responsibility for the daily operation of the laboratory facility;
- a regional health board or prescribed agency.

Note: The Laboratory Services Regulation (Regulation) defines the following bodies as prescribed agencies:

- *BC Cancer Agency;*
- *BC Centre for Disease Control and Prevention Society;*
- *Children's & Women's Health Centre of BC;*
- *Provincial Health Services Authority (PHSA)*

The person having responsibility for the daily operation of an approved laboratory facility could be the Medical Director or other person as designated by the operator. This Payment Schedule only applies to an "approved laboratory facility" as defined under the *Act*.

Fees Payable by the Minister

The Schedule of Fees for laboratory operators is established by the Minister under the authority of the *Act*. The fees listed are the amounts payable by the Minister for insured outpatient laboratory medicine benefits provided in approved laboratory facilities.

Under section 4 (1) of the *Act*, a laboratory service is a benefit if it is a medically required service provided through an approved laboratory facility, and by or under the supervision of a laboratory medicine physician (typically the Medical Director) or a prescribed person who is acting:

- at the request of a referring practitioner or a prescribed person *(see Chapter 5)*, and
- in accordance with all applicable protocols approved by the Minister.

Note: The Minister has adopted by reference, applicable laboratory protocols found in the Guidelines and Protocols Advisory Committee (GPAC) clinical practice guidelines and may also adopt guidelines or protocols established by any person or body.

GPAC is an advisory committee to the Medical Services Commission (MSC) and has representatives from both the Doctors of BC and the Ministry of Health.

A complete list of GPAC laboratory guidelines and protocols adopted by the Minister may be found on the MSC GPAC website.

Non-medically necessary laboratory services requested by a third party or a referring practitioner are not insured and are not to be billed under this Payment Schedule. Services such as consultations and laboratory investigations, rendered solely in association with other services that are not insured under the *Medicare Protection Act*, are not considered benefits under the *Act*, unless specified by the Minister.

A service is not a laboratory service if the person receiving the service is entitled to have the service paid for on their behalf, or be reimbursed for the cost of the service, under the:

- *Insurance (Vehicle) Act*;
- *Workers Compensation Act*; or
- any of the Acts of Canada listed in the Regulation (Part 4).

FFS claims for laboratory services rendered in approved laboratory facilities must be submitted by operators using the Teleplan web-based telecommunication system and supported by the Claims Processing System at Health Insurance BC (HIBC). The Minister will pay operator claims through approved remittance and payment processes, consistent with provisions of the *Act*, the Payment Schedule, or the payment provisions contained within a laboratory services agreement (Agreement) (as per section 12(1) of the LSA), if applicable.

Disputed Payments

Remittance statements issued by HIBC through the Teleplan telecommunications system should be reviewed carefully to reconcile all claims and payments made. Claims may have been adjusted in adjudication and explanatory codes should designate the reason(s) for any adjustments.

If an operator disagrees with an adjustment, the claim should be resubmitted to the Minister through HIBC together with additional information for reassessment, consistent with Teleplan Specifications.

If required, the resubmitted claim will be reviewed and a recommendation with supporting documentation will be provided to the Minister (or designate) for a final decision.

Payment Schedule Renewal Process

The Minister has the statutory authority to set the fees that are payable for insured, medically required outpatient laboratory services provided to beneficiaries enrolled with the MSP. A Schedule of Fees is contained within the Payment Schedule and lists the insured services (benefits) and fees paid to operators by the Minister. A subset of these Fees may be included as a schedule of tests within an Agreement.

Any additions, deletions or other changes to the Payment Schedule or to individual fees are approved by the Minister following a consultative process. If advances in technology, for example, result in the use of a different platform methodology for existing approved tests, an application for a new or amended fee item

must be submitted for review in accordance with Provincial Laboratory Medicine Services' (PLMS) test review process conducted by the PLMS's Test Review Committee.

Laboratory Services

Some services listed in the Schedule of Fees may have associated fees or tests that are specifically intended to cover multiple services or may include payment for add-ons (IgA quantitation, for example). Notes within the respective Schedule of Fees are explicit about the terms under which such add-ons are permitted.

Services not listed in the Schedule of Fees must not be billed to the Minister under other listings; Operators must use the correct fee item codes when submitting claims.

New fee items may be assigned a Provisional (P) status if approved on a provisional basis and awaiting further review. Prefixes to fee codes should not be submitted when billing.

Laboratory Medicine miscellaneous fee item 94999 has been added to the Schedule of Fees under Section Seven: Other Fee Items. This fee item relates to laboratory services not listed in the Payment Schedule that are:

- new medically necessary laboratory services generally considered to be accepted standards of care in the medical community currently and not considered experimental in nature, or
- for any medically required laboratory service for which the operator desires independent consideration to be given by the Minister.

Claims submitted under miscellaneous fee code 94999 may be accepted for adjudication only if the following are provided:

- a prior estimate of an appropriate fee, with rationale for the level of that fee, and
- sufficient documentation and pre-approval of the laboratory services to substantiate the claim.

The laboratory services must be pre-approved prior to fee item 94999 being submitted for adjudication.

The Minister, or designate, will review the fee estimate proposed and the supporting documentation, and by comparing the service provided with comparable laboratory services listed in the Payment Schedule, and other methods, will determine the level of compensation.

Medical Research and Experimental Medicine

Costs of laboratory procedures that are not benefits and are provided solely for the purposes of research or experimentation are not the responsibility of the Minister. In the situation where procedures are part of a research study, only those costs related to routine and accepted medically necessary care of a patient are considered to be insured; additional services carried out specifically for research are deemed uninsured and not the responsibility of the Minister.

New procedures and therapies not performed elsewhere and that involve a departure from the customary approaches to a medical problem are considered to be experimental medicine. Until new procedures, services and modalities are clinically validated by evidence based, peer reviewed studies and adopted by the medical community, they are experimental. Services related to such experimental medicine are not chargeable to the Minister.

Associated costs for laboratory services related to complications of any treatment, including experimental medicine, are benefits under the Payment Schedule.

Applications to the Minister for the introduction of any new fee items arising from medical research or experimental medicine would follow the established Payment Schedule renewal process.

Operator – Laboratory Physician Relationship

Under the *Act*, the Minister approves public and private operators for the provision of insured outpatient services in approved laboratory facilities. The Minister in turn provides for payments to these operators for the provision of insured laboratory service benefits.

A laboratory medicine physician is defined in the *Act* as a medical practitioner registered with and authorized to practise in a prescribed specialty by the College of Physicians and Surgeons of British Columbia. Part 3(5) of the Regulation specifies that a laboratory medicine physician must be authorized to practice in one or more of the following specialities as recognized by the Royal College of Physicians and Surgeons of Canada:

- general, anatomical or hematological pathology;
- medical biochemistry;
- medical genetics;
- medical microbiology;
- neuropathology.

Operators may only make claims for specialty-restricted fee items listed in the Schedule of Fees, or listed in a schedule of tests contained within an Agreement, if the laboratory medicine physician providing clinical oversight for services provided is a Certificant or a Fellow of the Royal College of Physicians and Surgeons of Canada and recognized by the College of Physicians and Surgeons of British Columbia in that particular specialty.

Provisions of the *Health Professions Act* as well as standards of conduct enforceable by these Colleges applicable to a medical practitioner also apply to laboratory medicine physicians.

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Chapter 3	Facility Operations and Administration	Issued: October 1, 2015 Revised as of March 5, 2021

FACILITY OPERATIONS AND ADMINISTRATION

Laboratory Facilities and Services

The following are considered laboratory services:

- the taking or collecting, or the analysis, of specimens for the purposes of preventing, diagnosing or treating human injury, disease or illness; or
- prescribed services, studies, or procedures of laboratory medicine as detailed in the Laboratory Services Schedule of Fees or as prescribed in an Agreement.

An operator of an approved laboratory facility must ensure that all operational requirements set out in the Regulation are maintained in a manner deemed to be satisfactory by the Minister. It is only upon issuance of an Approval or an Agreement can a facility be defined as an 'approved laboratory facility' under the *Act*.

An approved laboratory facility must first be accredited to a standard satisfactory to the Minister for a facility to provide benefits and to bill a fee item. Performance standards established by the Diagnostic Accreditation Program (DAP) of the College of Physicians and Surgeons of BC have been adopted by the Minister for accreditation of approved laboratory facilities under the *Act*.

For the purposes of this Payment Schedule, a laboratory facility means:

a) that part of a hospital that provides outpatient laboratory services;
b) a facility that provides outpatient laboratory services; or
c) a specimen collection station associated with a hospital or facility.

Services rendered to hospital inpatients, "day surgery" patients, or emergency department patients are not payable by the Minister under this Payment Schedule.

All non-laboratory Diagnostic Facility services are defined by the *Medicare Protection Act* and described in greater detail in the MSC Payment Schedule. Services provided at non-laboratory diagnostic facilities are out of scope for the Laboratory Services Payment Schedule.

Operator Payment Administration

The *Act* provides for payment to facility operators, rather than to individual laboratory medicine physicians, for the provision of outpatient FFS insured laboratory services. To effect automated FFS payment to operators of approved laboratory facilities through the Teleplan telecommunications system, payment for services must first be assigned by a designated laboratory medicine physician (the *assignor*) to the respective facility or operator (the *assignee*).

All claims for laboratory services are submitted through Teleplan by the operator; claims are then adjudicated and payment amounts determined by the Claims Processing System at HIBC. All FFS claims originating from the same facility or operator are submitted using a MSP practitioner number (typically, the Medical Director's), in combination with the operator's MSP payee number.

An operator must keep the books, accounts and financial transactions of the approved laboratory facility in the form and manner required by the Minister.

Reciprocal Claims

All Provinces and Territories, except Quebec, have entered into an inter-provincial agreement to pay for insured services, including outpatient laboratory medicine services, provided to residents of other provinces when a patient presents with a valid provincial health registration card. Reciprocal claims can be submitted electronically; details of this process may be obtained by contacting HIBC.

Certain laboratory services listed below are exempt from this inter-provincial agreement, however, and are not benefits under the *Act*. Payment for these non-insured procedures should be billed directly to the non-resident patient:

- Services to persons covered by other agencies; Armed Forces, WorkSafeBC, Department of Veterans Affairs, Correctional Services of Canada (Federal Penitentiaries);
- Services requested by a "Third Party";
- Genetic screening and other genetic investigations, including DNA testing; and
- Procedures still in the experimental/developmental phase

Operators may refer to the MSC's Payment Schedule for additional information on medical services excluded under the inter-provincial agreements.

Out of Province/Out of Country (OOP/OOC)

Tests that are medically necessary for beneficiaries, but not available in BC can be referred to the OOP/OOC program at the PLMS for payment decision.

Duty to Verify Enrolment

Before providing benefits to a person, an operator must take reasonable steps to verify whether the person is or is not a beneficiary. The operator will require the person to provide:

- the person's BC Services Card
- the person's identity number, accompanied by one piece of identification showing the person's photograph and legal name, or two pieces of identification showing the person's legal name; or
- if the documentation referred to above is not available, information that is necessary to verify whether the person is or is not a beneficiary, including the person's legal name, date of birth, address or gender.

The operator must also disclose this information to the Minister and obtain confirmation if the person is or is not a beneficiary before providing benefits to the person. Patient eligibility checks may be conducted directly online through the Teleplan Web 'Check Eligibility' function.

An operator or employee of an approved laboratory facility, or a person who provides medical, scientific, technical or administrative services under contract to the facility, must report to the Minister if they have reason to believe that another person has misused an identify number in order to obtain benefits under the *Act*.

Payment Record Keeping Requirements

An operator of an approved laboratory facility must keep prescribed records in the form required by the Minister and produce those records on request of the Minister and within the time requested. A payment may be refused if the information submitted in support of a claim for payment is not adequate or the records an operator is required to keep are incomplete or otherwise inadequate.

An operator must keep in a readily retrievable manner the clinical and financial records referred to in Part 3 of the Regulation, as well as records of internal protocols and results of internal reviews in relation to quality assurance and adverse events. These records must be kept for at least six years, unless:

- the Minister agrees in writing to a shorter period, or
- an audit or investigation is in process at the end of the six-year period, in which case the records must be kept until the audit or investigation is complete.

> *Note: Operators may also be subject to other statutory or other requirements for retention periods of documents and records and adhere to whichever is longer.*

Third Party Payers

HIBC acts as a medical services claims processing agent for WorkSafeBC (WSBC) and the Insurance Corporation of British Columbia (ICBC). A referring practitioner must indicate on the Standard Outpatient Laboratory Requisition form that the laboratory services being requested are billable to WSBC or to ICBC, as appropriate.

To the extent the referring practitioner advises, laboratory service operators will subsequently submit claims through Teleplan to HIBC for these referring practitioner-identified WSBC and Motor Vehicle Accident (MVA) related laboratory services. Operators are accountable for proper identification of WSBC and ICBC claims, consistent with Teleplan Specifications and coding requirements, as these costs are not the responsibility of the Minister.

Audit and inspection provisions of the *Act* also apply to payments made by the Minister on behalf of WSBC, ICBC, and the Office of the Superintendent of Motor Vehicles (RoadSafetyBC) as if those services were benefits.

Delegated Procedures and Liability

Procedures that are generally and traditionally accepted as those that may be carried out by a laboratory technologist in the employ of an operator may, when so performed, only be billed to the Minister by the operator when the procedure is performed under the clinical supervision of the laboratory medicine physician or a designated medical practitioner with equivalent qualifications.

Clinical supervision requires that, during the procedure, the laboratory medicine physician or practitioner must be accessible at all times. Facilities must continue to abide by the accreditation requirements of the DAP.

Billing for these services requires that the operator take full responsibility for service quality. In addition, the operator must ensure that operational requirements set out in the Regulation are maintained to the satisfaction of the Minister.

Facility Approval Categories

For billing and payment purposes, prospective facility operators will identify in their Application for a New Approved Laboratory Facility what Facility Approval Category or level of FFS outpatient laboratory service a facility is resourced to provide.

The *Act* requires that the laboratory facility that is the subject of a proposed Approval or Agreement must be accredited to a standard satisfactory to the Minister. The DAP has been established as the accreditation standard by the Minister.

As part of the facility approval process, the Minister assigns one or more Category levels to each approved laboratory facility, reflecting the laboratory services (benefits) the facility is authorized to provide. These Categories are intended to correspond with the DAP accreditation disciplines.

For example, a “Category 1 facility” would only be approved to provide, and subsequently submit claims to the Minister for, laboratory services corresponding to the fee items (tests and procedures) listed under Category 1.

Operators may only submit claims for fee items listed under the Category approved for that facility. If the capability or capacity of an approved laboratory facility is changed, a new Facility Category may be assigned by the Minister.

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Chapter 4	Laboratory Services and Fees	Issued: October 1, 2015 Revised as of March 5, 2021

LABORATORY SERVICES AND FEES

Introduction for Laboratory Operators

The Laboratory Services Schedule of Fees is issued under the authority of the Minister and is effective as of October 1, 2015, with revisions as necessary. The Schedule of Fees cannot be correctly interpreted without reference to the full Laboratory Services Outpatient Payment Schedule and to the notes contained within each sub-discipline section of the Schedule.

The Schedule of Fees contains the list of fees approved by the Minister and payable to approved laboratory facility operators on a FFS basis for insured outpatient laboratory medical services provided to beneficiaries enrolled with MSP.

Fee item values are subject to modification by the Minister; such modifications may affect the entire Schedule of Fees or be specific to certain fee items or groups of fee items.

The notes within each sub-discipline section of the Schedule of Fees provide the billing rules (limits and conditions) under which the fees are to be claimed. The notes are designed to clarify the use of the Schedule for operators and practitioners.

Services Covered by the Fee

The Schedule of Fees reflects FFS payments to the operator for activities essential to the provision of a high-quality laboratory medicine practice. All costs to the operator, including but not limited to administration, technical and non-technical staff, capitalization, and infrastructure necessary for a quality laboratory medicine practice to meet the requirements set by DAP, are reflected in the total fee amount for each test or procedure.

The fees also reflect both the direct and indirect laboratory services provided by the operator. These activities include overall laboratory direction, clinical applications, introduction of new analytical methodologies, systems development, continuous quality improvement, medical administration, utilization management, interpretations for referring medical or health care practitioners, and being a resource to the patient management team. These activities are an integral part of the operation and administration of the approved laboratory facility.

All benefits listed in the Schedule of Fees, except where specific exceptions are identified, must include the following as part of the service being claimed; payment to operators for these inherent components is included in the listed fees:

- Determination that the laboratory service is a benefit and the person to whom the laboratory service is provided is a beneficiary;
- Any inquiry, including review of medical records, necessary to arrive at an opinion as to the nature and/or history of the patient's condition;
- Appropriate care for the patient's condition, as specifically listed in the Schedule for the service and as traditionally and/or historically expected for the medically necessary service rendered;
- Professional support to referring medical and health care practitioners by the Laboratory Medicine physician;
- Discussion with and providing advice and information to the referring medical or health care practitioner as applicable regarding the patient's condition and recommended therapy, including advice regarding the results of any related medically necessary assessments, procedures and/or therapy which may be considered; and
- Making and maintaining an adequate medical record of the laboratory service that appropriately supports the fee item being claimed.

Prohibition on Charges for Benefits

Section 15 of the *Act* establishes a prohibition on direct or extra billing of beneficiaries (or those acting on their behalf) receiving laboratory service benefits. Except as permitted under section 15 (2) of the Act, operators must not charge a beneficiary for:

- a benefit;
- materials, consultations, procedures or the use of a laboratory facility or specimen collection station; or
- any other matter that relates to the provision of a benefit.

If a laboratory service is not a benefit, or if the person who is receiving the service is not a beneficiary, a charge can be levied by the approved laboratory facility for providing the service.

A laboratory facility must inform a beneficiary if it is not approved to provide the requested service as a benefit, and that payment from the beneficiary will be required before proceeding with the service in that facility. If a beneficiary is not informed as required, the beneficiary is not liable to pay for the service and must be refunded any amount paid.

The Practice of Laboratory Medicine

Under section 4 (1) of the *Act*, a laboratory service is a benefit if it is a medically required service provided through an approved laboratory facility, and by or under the supervision of a laboratory medicine physician (typically the Medical Director).

Referring medical and health care practitioners may consult with laboratory medicine physicians to determine the most effective test(s) and correct interpretation of test results.

Professional support to referring medical and health care practitioners by the laboratory medicine physician is an integral part of the total fee payment to the operator. Requests for tests or consultations prior to requesting a test from a referring practitioner, consultations regarding interpretation of test results with a referring practitioner, or test results from the laboratory technical staff that are directed to the laboratory medicine physician, may be subject to review/interpretation or written report.

Certain tests are marked with asterisks (*) and require consultation. These are usually complex or costly procedures and require a laboratory medicine physician's approval and/or review/interpretation or written report. Asterisks help to identify the laboratory medicine physician's additional and individual role related to the use of these specific tests.

Laboratory medicine physicians are compensated by the operators directly, typically under a salaried or contract arrangement, separate from the FFS payment modality in place between the Minister and the laboratory operator.

Fee Item Detail

Fee Item details are contained in the following sections of the Schedule of Fees, by sub-discipline:

Section One: Hematology and Blood Bank Fee Items
Section Two: Microbiology Fee Items
Section Three: Chemistry Fee Items
Section Four: Cytogenetics Fee Items
Section Five: Virology Fee Items
Section Six: Anatomic Pathology Fee Items
Section Seven: Other Fee Items

Chapter 5	Referring Practitioners	Issued: October 1, 2015 Revised as of March 5, 2021

REFERRING PRACTITIONERS

Introduction for Operators

Operators may only accept a request from a medical practitioner, or from a person within a class of prescribed health care practitioners, for a beneficiary to receive laboratory services (benefits). The *Act* and Regulation contain provisions and requirements for referring medical and health care practitioners.

A "referring practitioner" means a person enrolled under section 13 of the *Medicare Protection Act* who makes a request for a beneficiary to receive benefits and is:

- either a Medical Practitioner, or a
- Health Care Practitioner including: Midwife, Nurse Practitioner, Dentist, Podiatrist, Registered Nurse (Certified), Registered Nurse, or a Registered Psychiatric Nurse.

Referring medical practitioners may request all tests or procedures listed in the Schedule of Fees, subject to any limits or conditions in the notes that may be associated with a specific fee item. Referring health care practitioners, including midwives, nurse practitioners, dentists, podiatrists, registered nurses in certified practice, registered nurses, and registered psychiatric nurse, may only request laboratory tests or procedures approved within their respective Laboratory Services Referral Schedule.

The Minister may establish and adopt guidelines and protocols to assist referring practitioners in determining whether provision of laboratory services is medically required for beneficiaries. A referring practitioner must consider all relevant guidelines and protocols in determining whether provision of laboratory services is medically required for beneficiaries.

Minister Referrals from Medical and Health Care Practitioners

Referring practitioners must act in accordance with the regulations when referring beneficiaries for benefits under the *Act*. Except with the prior written consent of the Minister, a medical practitioner or a prescribed health care practitioner is prohibited from referring for a service under the *Act* that does not have a corresponding benefit rendered under the *Medicare Protection Act*.

Nurse practitioners, registered nurses in certified practice, Registered Nurses, or Registered Psychiatric Nurses employed by a Regional Health Authority, providing medically required services may refer for services under the *Act*.

This prohibition is intended to clarify that there must be a benefit rendered under the *Medicare Protection Act* or a benefit approved by a Regional Health Authority before a laboratory service will be considered a benefit under the *Act*. The prohibition can be waived with the prior written consent of the Minister.

Through the audit process, the Minister will determine if an insured laboratory service had a corresponding insured referring practitioner service rendered for that beneficiary. A referring practitioner must produce all books of account and other records that an inspector under the *Act* considers necessary for the purposes of an audit or inspection.

If an amount has been paid by the Minister in relation to a laboratory service requested by a referring practitioner, where there was no corresponding benefit under the *Medicare Protection Act* or approved by Regional Health Authority, the referring practitioner must repay the amount of the laboratory service to the Minister.

The Minister may disclose information to the Medical Services Commission, including personal information, obtained through an audit or inspection conducted under the *Act*.

Prohibition on Referrals if Financial Interest

A referring practitioner must not refer a beneficiary to an approved laboratory facility in which the referring practitioner has a material or indirect financial interest unless there is no public laboratory facility that:

- is in the same catchment area as the approved laboratory facility, and
- provides the benefit.

A referring practitioner may not direct a patient to seek laboratory service benefits at an approved laboratory facility in which the referring practitioner has a financial or other interest. However, in certain rural or remote communities, it may not be possible for the beneficiary to attend at an approved laboratory facility in which the referring practitioner does not have a financial or other interest; in these situations, prior written consent of the Minister can be requested to permit referrals.

Limits and Conditions for Medical Practitioners

A medical practitioner enrolled under the *Medicare Protection Act* may submit a request for any outpatient benefit (laboratory service or test) listed in the Schedule of Fees, subject to any limitations or conditions found within specific fee items in the Schedule of Fees.

Examples of limits and conditions may include, but are not limited to:

- a laboratory service may only be requested by a prescribed Specialty (e.g. rheumatologist or internal medicine specialist);
- a specific laboratory service may require discussion with a laboratory medicine physician;
- the test or procedure may only be available in certain laboratory facilities or hospitals;
- there may be limits on the frequency of testing (e.g. annual maximum per patient);
- the test is not intended as a diagnostic screening tool; or
- the test may include age limitations for beneficiaries.

Referring medical practitioners should reference the full Laboratory Services Schedule of Fees for a comprehensive list of outpatient laboratory tests and for additional fee item detail, including notations where add-on tests may be conducted by the laboratory facility.

Requisitions

An operator of an approved laboratory facility must not give to a referring practitioner a requisition form other than one made by the Minister. A referring practitioner may make a request for benefits by submitting a requisition form to an approved laboratory facility electronically only if submitted in the manner required by the Minister.

Chapter 6	Glossary of Terms	Issued: October 1, 2015 Revised as of March 5, 2021

GLOSSARY OF TERMS

BACKGROUND

These terms may be referenced in the Payment Schedule and are consistent with definitions found in the *Act* and Regulation, as applicable.

If there is an inadvertent conflict between a definition of a term in the Payment Schedule and a definition or meaning of a term in the *Act* or Regulation, the interpretation of the term in the *Act* or Regulation, shall prevail.

Approval
An Approval document granted by the Minister to an operator to provide benefits through a specified laboratory facility

Approved Laboratory Facility
A laboratory facility that is subject to an Approval or to an Agreement

Beneficiary
A person enrolled as a beneficiary under the *Medicare Protection Act*

Benefit
A laboratory service is a benefit if it is a medically required service provided through an approved laboratory facility, and by or under the supervision of a laboratory medicine physician or a prescribed person who is acting

- at the request of a referring practitioner or a prescribed person, and
- in accordance with all applicable protocols approved by the Minister.

Fee Item Codes

*	May only be performed and billed on approval of a laboratory medicine physician
**.	May require review/interpretation or written report by a laboratory medicine physician for payment of the laboratory fee
***	Both single asterisk (*) and the double asterisk (**) requirements are applicable
+	Blood bank services are not payable by the Minister where available from Canadian Blood Services
P	Designates fee items approved on a Provisional basis and awaiting further review

Note: The P prefix should not be submitted when billing.

General Practitioner
A medical practitioner who is registered with the College of Physicians and Surgeons of British Columbia as a General Practitioner

Health Care Practitioner
A health care practitioner is prescribed under the Regulation as a referring practitioner for the purposes of the *Act* and Regulation if:

I. the health care practitioner is enrolled as a practitioner under section 13 of the *Medicare Protection Act*, **and**

II. is a member of at least one of the following classes:

- a registrant of the College of Dental Surgeons of British Columbia who is authorized to use the title Dentist, Dental Surgeon, Surgeon or Doctor and to practice in BC;
- a registrant of the College of Physicians and Surgeons of British Columbia who is authorized to use the title Podiatrist, Podiatric Surgeon, Surgeon or Doctor;
- a registrant of the British Columbia College of Nurses and Midwives who is authorized to use the title Midwife", Nurse Practitioner or Registered Nurse Practitioner";
- a registrant of the British Columbia College of Nurses and Midwives who is authorized to use the title Registered Nurse, and has successfully completed a certification program as described in the *Nurses (Registered) and Nurse Practitioners Regulation*;
- a registrant of the British Columbia College of Nurses and Midwives, who is authorized to practice Psychiatric Nursing as described in the *Nurses (Registered Psychiatric) Regulation;*
- a registrant of the British Columbia College of Nurses and Midwives, who is authorized to use the title Registered Nurse as described in the *Nurses (Registered) and Nurse Practitioners Regulation.*

Holiday
New Year's Day, Family Day, Good Friday, Easter Monday, Victoria Day, Canada Day, B.C. Day, Labour Day, Thanksgiving Day, Remembrance Day, Christmas Day, Boxing Day

The list of dates designated as statutory holidays will be issued annually by the MSP.

Hospital
An institution designated as a hospital under Section 1 of the *BC Hospital Act* - except in Parts 2 and 2.1, means a non-profit institution that has been designated as a hospital by the Minister and is operated primarily for the reception and treatment of persons:

a) suffering from the acute phase of illness or disability,
b) convalescing from or being rehabilitated after acute illness or injury, or
c) requiring extended care at a higher level than that generally provided in a private hospital licensed under Part 2.

Identify Number
Means the identity number referred to in section 8 of the *Act* (Misuse of Identity Number)

Laboratory Facility
Means the following:

a) in respect of a hospital within the meaning of paragraph (a) or (e) of the definition of "hospital" in section 1 of the *Hospital Insurance Act*, that part of the hospital that provides laboratory services;
b) a facility that provides laboratory services;
c) a specimen collection station associated with a hospital or facility referred to in paragraph a) or b) of this definition.

Laboratory Medicine Physician
A medical practitioner registered with, and authorized to practise in a prescribed specialty by, the College of Physicians and Surgeons of British Columbia

Laboratory Service
A laboratory service, subject to the regulations, means:

- the taking or collecting, or the analysis, of specimens for the purposes of preventing, diagnosing or treating human injury, disease or illness, or
- a prescribed service or the reporting of laboratory test results.

Laboratory Services Agreement (Agreement)
Means an agreement made under section 12(1) of the Act, that the Minister may enter, with one or more persons, into agreements in relation to the provision of benefits

Laboratory Services Regulation
Refers to the Laboratory Services Regulation under the Act, as amended from time to time.

Medical Practitioner
A medical practitioner as entitled to practice under the Medical Practitioners Regulation to the *Health Professions Act*

Operator
An operator in relation to a laboratory facility means either:

- the owner;
- the person having responsibility for the daily operation of the laboratory facility;
- a regional health board or prescribed agency.

Outpatient
A person who is not admitted as an inpatient to a hospital, is not a day care surgical services patient, or registered as an emergency room patient, and is receiving treatment and/or medical services within a hospital or community setting; or is a patient receiving community laboratory services

Laboratory Services Outpatient Payment Schedule
Approved by the Minister and functions as the primary claim processing and payments policy document for insured FFS outpatient laboratory services in BC. It contains billing and payment detail for laboratory operators and a schedule of laboratory medicine fees, as well as limits regarding tests ordered by referring healthcare practitioners.

Preamble
Complements the Schedule of Fees, providing notes within each section by sub discipline. It assists operators in billing for insured outpatient laboratory services.

Referring Practitioner
A referring practitioner means a person who is either

- a medical practitioner enrolled under section 13 of the *Medicare Protection Act*, or
- a person within a class of prescribed health care practitioners, and
- makes a request for a beneficiary to receive benefits.

Schedule of Fees
The Schedule provides fee item information by discipline, and includes fee item codes, test descriptions, test limits and conditions (notes), and reimbursement value.

- Section 1 - Hematology and Blood Bank
- Section 2- Microbiology
- Section 3 - Chemistry
- Section 4 - Cytogenetics
- Section 5 - Virology
- Section 6 - Anatomic Pathology
- Section 7 - Other

Specialist
A medical practitioner who is a Certificant or a Fellow of the Royal College of Physicians and Surgeons of Canada; and/or be so recognized by the College of Physicians and Surgeons of British Columbia in that particular specialty

Specimen Collection Station
A place that is principally equipped for the taking or collecting of specimens

Third Party
A person or organization other than the patient, his/her agent, or the Minister that is requesting and/or assuming financial responsibility for a medical or medically related service

Time Categories

- 12-month period – any period of twelve consecutive months
- Calendar year – the period from January 1 to December 31
- Day – a calendar day
- Fiscal year – from April 1 of one year to March 31 of the following year
- Month – a calendar month
- Week – any period of 7 consecutive days
- Calendar week – from Sunday to Saturday