Consultations, Referrals and Re-Referrals

Introduction

The Medical Services Commission (MSC) requested the Tariff Committee and the Medical Services Plan (MSP) review concerns raised by patients and physicians regarding the re-referral process.

The Tariff Committee's Consultation Working Group (CWG) undertook an expedited review of the current payment rules related to referrals and consultations. The CWG focused on common misconceptions and misinterpretations of the MSC Payment Schedule. A concise list of clarifications was developed with input and agreement from MSP. FAQs have been created to provide further clarity.

A single unified and agreed-upon set of answers should benefit everyone: physicians, MOAs, and patients who may receive conflicting advice from various sources; and staff at Doctors of BC, MSP, and HIBC, who may field the same questions but at times provide differing guidance. The clarifications and FAQs are intended to help interpret the language of the Payment Schedule.

Clarifications

A. A referral is required to bill any consultation. A consultation is the consultant's response to a referral. There can be only one consultation for any one referral. Another consultation will require a second referral. *(Reference General Preamble D.2.1)*

B. Generally the consultant returns the patient to the referring practitioner's care after the consultation is complete. However, there is no automatic referral termination after consultation. Patients may remain referred cases indefinitely if there are: medical necessity, agreement between consultant and patient, and ongoing care. Re-referral is not required for a specialist to bill specialist follow up fees for continuing care. *(Reference General Preamble D.2.5)*

C. Referrals, once accepted, do not expire. Once a referral is accepted it remains valid until the consultation is performed. *(Reference General Preamble D.2)*

D. A consultation must be medically necessary and include the components listed in the MSC Payment Schedule.
For clinical specialties this will usually include:
- Review of history and test results,
- Examination, and
- A written report.

(Reference General Preamble D.2.1)

E. There is no specific requirement for a visit by the patient to the referring practitioner in order to obtain referral or re-referral. A valid referral occurs, and a consultation applies, when a referring practitioner, "in the light of his/her professional knowledge of the patient and because of the complexity, obscurity or seriousness of the case, requests the opinion of a medical practitioner competent to give advice in this field." *(Reference General Preamble D.2.1)*

Additional information was shared by the Tariff Committee to further amplify this information:

1. The consultant generally completes their tasks with completion of consultation and any needed services including timely follow-up. The consultant generally then returns the patient to the care of the referring practitioner. The referral has now been fully answered; the patient is no longer a referred case.

2. The consultant may, on occasion, make the **choice**, with the patient's agreement, to continue seeing the patient on a frequent and ongoing basis and thus continue to treat the patient as a referred case. This allows the consultant to continue to bill specialist follow-up fees. This is a **choice** available to the consultant; it is not the usual pattern of consulting practice and is **not** a rule of the Payment Schedule.

3. When the consultant recommends repeat evaluation of the patient at an interval of more than 6 months after the last service provided by that consultant to that patient, re-referral, if **required** by the consultant's practice, is a **decision** to be made by the referring practitioner and the patient. The consultant can reasonably recommend another consultation at a specified time interval, usually more than 6 months. The consultant should **define the medical reasons** for such advice to the satisfaction of both patient and referring practitioner.

In summary

1. **The decision to make a referral or re-referral is that of the referring practitioner.** The consultant cannot demand a referral.

2. **The decision to require a referral or re-referral is that of the consultant.** Once the consultant has discharged the patient upon completion of consultation, the referring practitioner cannot insist the consultant resume or continue care without another referral.

3. **The decision to accept a referral or re-referral is that of the consultant.**

General Preamble to the Payment Schedule

D. 2. Consultation

D. 2. 1. General

A consultation applies when a medical practitioner, or a health care practitioner*, in the light of his/her professional knowledge of the patient and because of the complexity, obscurity or seriousness of the case, requests the opinion of a medical practitioner competent to give advice in this field.

* “Health care practitioner” in this context is limited to the following:

- chiropractor, for orthopaedic consultations;
- midwife, for obstetric or neonatal consultations;
- nurse practitioner;
- optometrist, for ophthalmology consultations;
- optometrist, for neurology consultations for suspected optic neuritis or
- amaurosis fugax or anterior ischemic optic neuropathy (AION) or stroke or
- diplopia;
- oral/dental surgeon, for diseases of mastication;
- registered nurse or registered psychiatric nurse, for addiction medicine or
- psychiatry consultations for substance use conditions.

The referring practitioner is expected to provide the consulting physician with a letter of referral that includes the reason for the request and the relevant background information on the patient. The referring practitioner is also required to notify MSP of the referral by including the practitioner number of the specialist to who the patient is being referred on their associated FFS claim. If no FFS claim is being submitted, a “no charge referral” claim under fee item 03333 is to be sent to MSP.

The service includes the initial services of a consultant necessary to enable him/her to prepare and render a written report, including his/her findings, opinions and recommendations, to the referring practitioner. A consultation must not be claimed unless the attending practitioner specifically requested it, and unless the written report is rendered. It is expected that a written report will be generated by the medical practitioner providing the consultation within 2 weeks of the date-of-service. In exceptional circumstances, when beyond the consultant’s control, a delay of up to 4 weeks is acceptable.

Additional criteria apply to certain types of specialty specific consultations. These are described in the Sectional Preambles and/or the notes to the specific fee codes.

D. 2. 2. Restrictions

i) A consultation for the same diagnosis is not normally payable as a full consultation unless an interval of at least six months has passed since the consultant has last billed a visit or service for the patient. A limited consultation may be payable within the six month interval, if medically necessary and a consultation has been specifically requested.

ii) For consultations and/or other specialty limited services to be paid by MSP, the medical practitioner rendering the service must be certified by or be a Fellow of the Royal College of Physicians and Surgeons of Canada, and be so recognized by the College of Physicians and Surgeons of British Columbia. No other specialist qualifications will be recognized by MSP and payments for visits and examinations rendered by licensed physicians not so qualified will be made on the basis of fees listed in the Family Medicine Section of this MSC Payment Schedule.

Exceptions to this limitation will only be made in cases of geographic need, as recommended by the College of Physicians and Surgeons of BC.

D. 2. 3. Limited Consultation

A limited consultation requires all of the components expected of a full consultation for that specialty but is less demanding and normally requires substantially less of the medical practitioner's time than a full consultation.

It is expected that the limited consultation, when medically necessary and specifically requested, will be billed as part of continuing care, and that a full consultation is not billed simply because of the passage of time.

A new and unrelated diagnosis can be billed as a full consultation without regard to the passage of time since the consultant has last billed any visit or service for the patient.

D. 2. 4. Special Consultation

Specific additional conditions may apply to specific types of consultation, as designated in the Preamble to the pertinent section of the MSC Payment Schedule and/or the notes to the specific listings.

D. 2. 5. Continuing Care by Consultant

Once a consultation has been rendered and the written report submitted to the referring practitioner, this aspect of the care of the patient normally is returned to the referring practitioner. However, if by mutual agreement between the consultant and the referring practitioner, the complexities of the case are felt to be such that its management should remain for a time in the hands of the consultant, the consultant should claim for continuing care according to the MSC Payment Schedule pertaining to the pertinent specialty.

Where the care of this aspect of the case has been transferred, except for a patient in hospital, the referring practitioner generally should not charge for this aspect of the patient's care unless and until the full responsibility is returned to him/her. For hospitalized patients, supportive care may apply.

Continuing care by a specialist (following consultation) normally is paid at the pertinent specialist rates. However, continuing care requires that a written update of the patient's condition and care be appropriately reported to the referring practitioner at least every six months, until the responsibility for this aspect of the patient's care is returned to the Primary Care practitioner.

D. 2. 6. Referral and Transferral

A referral is defined as a request from one practitioner to another practitioner to render a service with respect to a specific patient. Such service usually would be a consultation, a laboratory procedure or other diagnostic test, or specific surgical/medical treatment.

When the medical practitioner to whom a patient has been referred makes further referrals to other medical practitioners, it is the usual practice that the original referring medical practitioner be informed of these further referrals.

A transferral, as distinguished from a referral, involves the transfer of responsibility for the care of the patient temporarily or permanently. Thus, when one medical practitioner is going off call or leaving on holidays and is unable to continue to treat his/her cases, medical practitioners who are substituting for that medical practitioner should consider that the patients have been temporarily transferred (not referred) to their care.

The medical practitioner to whom a patient has been transferred normally should not bill a consultation for that patient. However, when the complexity or severity of the illness requires that the medical practitioner accepting the transfer reviews the records of the patient and examines the patient, a limited or full consultation may be billed when specifically requested by the transferring medical practitioner.

A new consultation is not allowed when a group or physicians routinely working together provide call for each other.