AGREEMENT

BETWEEN:

HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF BRITISH COLUMBIA REPRESENTED BY THE MINISTRY OF HEALTH SERVICES ("Government")

AND:

THE OPTOMETRY SPECIAL COMMITTEE

AND:

THE BRITISH COLUMBIA ASSOCIATION OF OPTOMETRISTS ("BCAO")

Collectively, "the Parties"

DEFINITIONS

a) **"Beneficiary"** means a resident of British Columbia who is a beneficiary under the Medical Services Plan in accordance with Section 7 of the *Medicare Protection Act*, R.S.B.C. 1996, c. 286 (hereinafter the *Medicare Protection Act*).

b) **"BCAO"** means the British Columbia Association of Optometrists, the professional association for Optometrists and registered as number S0054633 under the *Society Act,* R.S.B.C. 1996, c. 433.

c) **"Continuing Education Fund"** means a fund administered by the BCAO to pay for continuing education for eligible Optometrists during the term of this Agreement.

d) **"Eligible Optometrists"** are Optometrists who have practiced in the Province of British Columbia since April 1, 2006, or who currently practice in the Province of British Columbia and were or are enrolled in the Medical Services Plan.

e) **"Enroll** means
   i) In respect of a Beneficiary, enrollment under Section 7 of the *Medicare Protection Act,* and
   ii) In respect of an Optometrist, enrollment under Section 13 of the *Medicare Protection Act.*

f) **"Fee items"** are those services, defined in the Payment Schedule, for which a price is identified.

g) **"HIBC"** means Health Insurance BC, the agent of Government for processing invoices and providing payment for Optometric Benefits.

h) **"MSP"** means the Medical Services Plan of British Columbia established under the *Medicare Protection Act* and under which payments to Optometrists or reimbursement to Beneficiaries are provided for Optometric Benefits.

i) **"Optometric Benefits"** are services defined in Section 23 of the *Medical and Health Care Services Regulations,* B.C. Reg. 426/97, and for which payment is provided pursuant to the Payment Schedule.

j) **"Optometrist"** means an individual authorized to practice optometry under the *Health Professions Act,* R.S.B.C. 1996, c. 183 s. 55, *Optometrist Regulation,* B.C. Reg.33/2009.

k) **"Optometry Liaison Committee"** means the committee established for the purpose of maintaining communication between the Government and the BCAO to address Payment Schedule matters and resolve disputes.

l) **"Optometry Policy Committee"** means the committee established for the purpose of reviewing policy issues of mutual interest to the Parties.

m) **"Optometry Special Committee"** means the committee delegated authority under the *Medicare Protection Act* to establish the Payment Schedule and make decisions on the provision of payments for Optometric Benefits (pursuant to OIC 222/08).

n) **"Payment Schedule"** is the payment schedule established pursuant to s. 26(l)(a) of the *Medicare Protection Act,* approved by the Optometry Special Committee and attached to this Agreement.

o) **"Scope of Practice"** is the practice of optometry as defined in sections 5 of the *Optometrists Regulation.*, B.C. Reg.33/2009.

PURPOSE OF THIS AGREEMENT

1) The purpose of this Agreement is to:

a) Establish and maintain a relationship between the Parties based on transparency, constructive collaboration and mutual respect.

b) Confirm the establishment of the Optometry Policy Committee and the Optometry Liaison Committee.

c) Verify agreed Government payments for continuing education and retroactive fees and planned increases to the Payment Schedule for Eligible Optometrists.

d) Confirm Standards of Service and eligibility for payment for Eligible Optometrists.

REPRESENTATION

2) The Government hereby grants to the BCAO the sole and exclusive right, and the BCAO hereby undertakes the obligation, to represent the collective and individual interest of Eligible Optometrists.

OPTOMETRY LIAISON COMMITTEE

3) The Parties agree to continue and maintain an Optometry Liaison Committee to deal with overall issues with respect to the Payment Schedule for the purpose of:

a) Ensuring a continuing flow of information between the Parties.

b) Maintaining ongoing discussions between the Parties with respect to Optometric Benefits that may be included in the Payment Schedule.

c) Maintaining ongoing discussion between the Parties with respect to utilization management and billing practices and making recommendations on these to the Optometry Special Committee.

d) Monitoring utilization of Optometric Benefits, which may result in concerns about the increases in utilization being addressed, and recommendations made to the Optometry Special Committee.

4) Membership of the Optometry Liaison Committee shall be composed of no more than three representatives of Government and the BCAO, appointed by those parties. The Chair of the Committee will be a representative from the Ministry of Health Services. Attendance by individuals from other government departments and professional groups, such as the College of Optometrists of British Columbia , may take place as desired, with the mutual agreement of the Parties. Each party is responsible for their own costs of participation in the Optometry Liaison Committee.

5) The Optometry Liaison Committee shall meet at least semi-annually. Additional meetings may be called at the initiative of either the Government or the BCAO with thirty (30) calendar days notice in writing.

OPTOMETRY POLICY COMMITTEE

6) The Government and the BCAO agree to establish and maintain an Optometry Policy Committee for the purpose of developing policies of interest to both parties including optometry visits in long term care facilities, and rural outreach services. Any topics for the Optometry Policy Committee are subject to discussion and agreement between the Parties.

7) Membership of the Optometry Policy Committee shall be composed of no more than three members from Government and the BCAO, including the co-chairs. The Government and the BCAO will co-chair the committee. Attendance by individuals from

other government departments and professional groups, such as the College of Optometrists of British Columbia may take place as desired, with the mutual agreement of the Parties. Each party is responsible for their own costs of participation in the Optometry Policy Committee.

8) The Government and the BCAO agree to consult on terms of reference for the Optometry Policy Committee within thirty (30) calendar days of the signing of this Agreement

STANDARDS OF SERVICE

9) The Parties agree that:

a) Any person providing Optometric Benefits in the Province of British Columbia and receiving payments from the Government must be registered with the College of Optometrists of British Columbia and enrolled in the MSP.

b) Eligible Optometrists will provide Optometry Benefits in accordance with standards of practice and professional ethics as defined by the College of Optometrists of British Columbia and in accordance with the *Optometrists Regulation* and the *Health Professions Act*.

SUBSIDIARY AGREEMENTS

10) The Parties may enter into subsidiary agreements. It is intended that all provisions of this Agreement will apply to subsidiary agreements signed after the effective date of this Agreement.

MSP PAYMENT SCHEDULE

11) A description of Optometric Benefits provided to Beneficiaries by Eligible Optometrists, and the rates to be paid by the MSP for such services, are listed in the Payment Schedule attached as Schedule A to this Agreement.

12) The list of payments for Optometric Benefits and their definitions in the Payment Schedule may be revised by the Optometry Special Committee on the recommendation of the Government.

13) Eligible Optometrists shall follow the notice provisions of Section 19 of the *Medicare Protection Act* before charging Beneficiaries for services that are not Optometric Benefits.

DATA SHARING

14) The Parties agree that sharing relevant information and data in a timely manner is necessary to support the purpose of this Agreement as set out in Section 1.

15) The Government, through the Ministry of Health Services, agrees to share information with the BCAO regarding the number and amount of payments by HIBC for Optometric Benefits. The distribution of such information is subject to the provisions of *the Freedom of Information and Protection of Privacy Act,* R.S.B.C. 1996, c. 165, and Section 49 of the *Medicare Protection Act.*

16) The BCAO agrees to provide information to the Government on optometry practice including, where appropriate, information showing trends and services within the practice of optometry.

PAYMENTS TO OPTOMETRISTS

17) By March 31, 2009, the Government will provide the BCAO with a one time grant in the amount of $961,000 to establish a Continuing Education Fund for Eligible Optometrists. The grant is intended to support the maintenance and/or improvement of practitioner skills necessary for high quality patient care. Disbursement from the Continuing Education Fund is at the discretion of the BCAO.

18) The BCAO may charge a reasonable administration fee of up to a maximum of 10% of $961,000 to administer the Continuing Education Fund.

19) Before March 31, 2009, the Government will make a one time payment of $483,000 to the BCAO in lieu of any claims or other retroactive payments for Optometric Benefits for the period April 1, 2006 to September 30, 2008. Funds will be distributed by the BCAO among the Eligible Optometrists.

20) Upon request the BCAO will provide the Government with a report in the form and manner prescribed by the Government, showing expenditures made to date and the estimated future expenditures from the $1,444,000 provided by the Government under Sections 17 and 19 of the Agreement.

21) Eligible Optometrists will receive increases in the Payment Schedule as set out in Schedule A this reflects:

a) An overall increase of 2% in projected expenditures for the period October 1, 2008 to March 31, 2009.

b) An overall increase of 3% in projected expenditures for the period April 1, 2009 to March 31, 2010.

BILLING DISPUTES

22) The Government and the BCAO agree to resolve disputes related to MSP billing by establishing a three step process if an informal discussion between an Eligible Optometrist and HIBC fails to resolve the dispute:

a) Informal discussion between the Government and the BCAO in which they make every reasonable effort to resolve the dispute.

b) Billing disputes will be referred to the Optometry Liaison Committee in the event that informal discussion does not remedy the dispute. The BCAO or the Eligible Optometrist will send, in writing, notice setting out the dispute, and the remedy sought within thirty (30) calendar days of the dispute occurring. The Liaison Committee then has thirty (30) calendar days to resolve the dispute.

c) If the Optometry Liaison Committee fails to resolve the dispute, then the matter must be referred to the Optometry Special Committee. The Liaison Committee will send written notice setting out the issues in the dispute and requesting a decision be rendered by the Optometry Special Committee within thirty (30) calendar days of the issuance of the notice.

AGREEMENT DISPUTES

23) If there is a dispute over the interpretation of this Agreement then the Parties will:

a) Refer the dispute to the Optometry Liaison Committee for an informal discussion.

b) If the Optometry Liaison committee is unable to resolve the dispute then any party can initiate a dispute resolution process by issuing a written notice of the dispute to a Mediator within thirty (30) calendar days of the deliberation on the dispute by the Optometry Liaison Committee. If the Parties are unable to agree on a mediator, then the Parties will request the B.C. Arbitration & Mediation Institute to provide a mediator.

c) If the Parties are unable to achieve a resolution through mediation then any party may refer the dispute to a final and binding arbitration process within thirty (30) calendar days following mediation. If the Parties are unable to agree on an arbitrator, then the parties will request the B.C. Arbitration & Mediation Institute to provide an arbitrator.

d) Alternatively, by mutual agreement of the Parties they may choose to combine mediation and arbitration in a mediation-arbitration process.

24) Each party is responsible for its own costs for mediation and arbitration. The costs associated with engagement of a mediator or arbitrator will be shared by the Government and the BCAO.

25) The decision of the arbitrator will be final and binding on all Parties.

26) The *Commercial Arbitration Act* will guide the Parties in applying this part of this Agreement.

TERM OF AGREEMENT

27) This Agreement shall be for a term of six (6) years, commencing on April 1, 2006 and ending on March 31, 2012.

28) The fees, definitions, and adjustment dates of Optometric Benefits specified in the Payment Schedule shall apply on the dates specified and shall remain in effect until the termination of this Agreement.

29) Effective April 1, 2010, covering the period from April 1, 2010 to March 31, 2012, the Payment Schedule and Optometric Benefits may be adjusted by an amendment to this Agreement.

AMENDMENTS

30) This Agreement may be amended by the Parties at any time during the term of this Agreement. However, no amendment of this Agreement is effective unless it is in writing and signed by all Parties.

TERMINATION

32) Any party may terminate this Agreement:

a) For any reason, after giving the other parties ninety (90) calendar days written notice of termination.

b) For breach of this Agreement, on giving the other parties thirty (30) calendar days written notice of termination.

33) The party claiming the breach under Article 32(b) must notify the other parties by registered letter of:

a) The nature of the breach;

b) The article of this Agreement alleged to have been violated and any remedy sought;

c) Its intention to terminate the Agreement thirty (30) calendar days from the date of the registered letter.

34) The party that issues a notice of termination for breach of this Agreement may increase the notice period or withdraw notice subject to an appropriate plan to address the breach.

35) A waiver of any term of this Agreement or of any breach of this Agreement is not a waiver of any other term or any other breach.

RENEWAL

36) Each Party shall advise the other parties in writing no later than December 1, 2011, of its intention to renew, terminate or renegotiate this Agreement.

37) The Parties will meet no later than January 31, 2012 to review their respective positions.

38) In the event that a revised agreement is not reached by March 31, 2012, this Agreement and the Payment Schedule will continue in full force and effect until such time as this Agreement is renewed by the Parties or is terminated by one party.

39) The Parties may agree to abridge any of the time limits specified in this Section.

GENERAL

40) This Agreement is governed by and is to be construed in accordance with the laws of British Columbia.

41) Any notice contemplated by this Agreement, to be effective, must be in writing and either mailed by prepaid registered mail, personally delivered or faxed to the Parties at the following addresses:

If to the Government, at

3-1, 1515 Blanshard St.,,Victoria B.C V8W 3C8

Fax 250 952 3131

If to the Optometry Special Committee, at

(3-1, 1515 Blanshard St. Victoria B.C V8W 3C8

Fax 250 952 3133

If to the BCAO, at

502 - 1755 West Broadway, Vancouver BC V6J 4S5

Fax 604 737 9967

42) Any notice mailed in accordance with Article 36 is deemed to be received 96 hours after mailing.

43) Any of the Parties may give notice to the others of a substitute address or fax number from time to time.

Agreed this 26 day of MARCH, 2009 at Victoria.

SIGNED, SEALED and DELIVERED on behalf of
HER MAJESTY THE QUEEN IN RIGHT OF THE

PROVINCE OF BRITISH COLUMBIA as
represented by the Minister of Health Services or his
duly authorized representative:

S TBrown
CAO MOHS

Sheila Taylor
Assistant Deputy Minister, Medical Services Division
Ministry of Health Services.

AND

On behalf of the OPTOMETRY SPECIAL COMMITTEE:

Phyllis Chuly
Chair, Optometry Special Committee

AND

On behalf of the BRITISH COLUMBIA
ASSOCIATION OF OPTOMETRISTS (BCAO):

Dr. Paul Neumann
President, BCAO

Schedule A
Optometry Payment Schedule

Fee Item	Description	Fee Amount (effective April 1/08)	Fee Amount (effective October 1/08)	Fee Amount (effective April 1/09)
02899	Full optometric diagnostic examination of the eyes (includes the determination of the refractive status of the eye, the presence of any abnormality in the visual system, and all necessary tests connected thereto and the provision of a written prescription, if lenses are required)	$44.83	$44.83	46.17
02889 (effective April 1 2009)	Full optometric diagnostic examination of the eyes with Therapeutic Pharmaceutical Agent (TPA) (includes the determination of the refractive status of the eye, the presence of any abnormality in the visual system, and all necessary tests connected thereto and the provision of a written prescription, if lenses are required)			46.17
02898	Re-examination or minor examination	$21.64	27.48	29.35
02888 (Effective April 1 2009)	Re-examination or minor examination with Therapeutic Pharmaceutical Agent (TPA)			29.35
02897	Repeat Tonometry	$10.40	10.40	10.40
Contact Lenses Fitting for Keratoconus				
02894	- Unilateral	$213.95	213.95	213.95
02895	- Bilateral	$322.72	322.72	322.72

Note: Fee items 02894 and 02894 are applicable only to patients with keratonconus who are unable to achieve 20/40 visual acuity with conventional glasses and the fees include all visits and services necessary for fitting and follow-up for three months.

02892	Examination for low vision aid	$40.33	40.33	40.33

Notes:

1) Fee item 02892 billable only by optometrist having the appropriate equipment.
2) Fee item 02899 not billable in addition to 02892 when patient referred for low vision assessment.

02893	Computer assisted quantitative visual fields assessment	$31.78	31.78	31.78

Notes:

1) Fee item 02893 billable only by optometrists having the appropriate computerized equipment for quantitative perimetry examinations.
2) Claim must specify reason for visual fields examination.

AGREEMENT

BETWEEN:

HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF BRITISH COLUMBIA REPRESENTED BY THE MINISTER OF HEALTH ("Government")

AND:

THE OPTOMETRY SPECIAL COMMITTEE

AND:

THE BRITISH COLUMBIA ASSOCIATION OF OPTOMETRISTS ("BCAO")

Collectively, the "Parties"

The Parties agree as follows:

DEFINITIONS

1 In this Agreement:

"Beneficiary" means a resident of British Columbia who is a beneficiary under the Medical Services Plan in accordance with Section 7 of the *Medicare Protection Act,* R.S.B.C. 1996, c. 286 (hereinafter the *Medicare Protection Act).*

"BCAO" means the British Columbia Association of Optometrists, the professional association for Optometrists and registered as number S0054633 under the *Society Act,* R.S.B.C. 1996, c. 433.

"Continuing Education Fund" means a fund administered by the BCAO to pay for continuing education for Optometrists during the term of this Agreement.

"Enroll" or **"Enrolled"** means

i) In respect of a Beneficiary, enrollment under Section 7 of the *Medicare Protection Act,* and,
ii) In respect of an Optometrist, enrollment under Section 13 of the *Medicare Protection Act.*

"Fee items" are those services, defined in the Optometry Payment Schedule, for which a price is identified.

"HIBC" means Health Insurance BC, the agent of Government for processing invoices and providing payment for Optometric Benefits.

"MSP" means the Medical Services Plan of British Columbia established under the *Medicare Protection Act* and under which payments to Optometrists or reimbursement to Beneficiaries are provided for Optometric Benefits.

"Optometric Benefits" are services defined in Section 23 of the *Medical and Health Care Services Regulations,* B.C. Reg. 426/97, and for which payment is provided pursuant to the Optometry Payment Schedule.

"Optometrist" means an individual authorized to practice optometry under the *Health Professions Act,* R.S.B.C. 1996, c. 183 s. 55, *Optometrists Regulation,* B.C. Reg. 33/2009 and who is enrolled in the Medical Services Plan.

"Optometry Liaison Committee" means the committee established for the purpose of maintaining communication between the Government and the BCAO to address Optometry Payment Schedule matters and resolve disputes.

"Optometry Payment Schedule" is the Optometry Payment Schedule established pursuant to s.26(1)(a) of the *Medicare Protection Act,* approved by the Optometry Special Committee.

"Optometry Special Committee" means the committee delegated authority under the *Medicare Protection Act* to establish the Optometry Payment Schedule and make decisions on the provision of payments for Optometric Benefits (pursuant to OIC 222/08).

"BCAO Patterns of Practice Committee" means the committee of that name established by, and providing advisory services to, the BCAO.

"Scope of Practice" is the practice of optometry as defined in section 5 of the *Optometrists Regulation,* B.C. Reg. 33/2009.

PURPOSE OF THIS AGREEMENT

2 The purposes of this Agreement are to:

a) Maintain a relationship between the Parties based on transparency, constructive collaboration and mutual respect.

b) Confirm the establishment of the Optometry Liaison Committee.

c) Verify agreed Government payments for continuing education and planned changes to the Optometry Payment Schedule for Optometrists.

d) Confirm Standards of Service and eligibility for payment for Optometrists.

REPRESENTATION

3 The Government hereby grants to the BCAO the sole and exclusive right, and the BCAO hereby undertakes the obligation, to represent the collective and individual interest of Optometrists.

OPTOMETRY LIAISON COMMITTEE

4 The Parties agree to continue and maintain an Optometry Liaison Committee to deal with overall issues with respect to the Optometry Payment Schedule for the purposes of:

a) Ensuring a continuing flow of information between the Parties.

b) Maintaining ongoing discussions between the Parties with respect to Optometric Benefits that may be included in the Optometry Payment Schedule.

c) Maintaining ongoing discussion between the Parties with respect to utilization management and billing practices and making recommendations on these to the Optometry Special Committee.

d) Monitoring utilization of Optometric Benefits, which may result in concerns about the increases in utilization being addressed, and recommendations made to the Optometry Special Committee.

e) Developing policies of interest to both parties.

5 Membership of the Optometry Liaison Committee shall be composed of no more than three representatives from each of Government and the BCAO, appointed by those parties, including the Chair. The Chair of the Committee will be a representative from the Ministry of Health. Attendance by individuals from other government departments and professional groups, such as the College of Optometrists of British Columbia, may take place as desired, with the mutual agreement of the Parties. Each party is responsible for their own costs of participation in the Optometry Liaison Committee.

6 The Optometry Liaison Committee shall meet at least twice per year. Additional meetings may be called by either the Government or the BCAO with thirty (30) calendar days' notice in writing.

STANDARDS OF SERVICE

7 The Parties agree that:

a) Any person providing Optometric Benefits in the Province of British Columbia and receiving payments for these services from the Government must be registered as an Optometrist in good standing with the College of Optometrists of British Columbia and be enrolled in the MSP.

b) Optometrists will provide Optometric Benefits in accordance with standards of practice and professional ethics as defined by the College of Optometrists of British Columbia and in accordance with the *Optometrists Regulation* and the *Health Professions Act.*

SUBSIDIARY AGREEMENTS

8 The Parties may enter into subsidiary agreements. It is intended that all provisions of this Agreement will apply to subsidiary agreements signed after the effective date of this Agreement.

PAYMENTS TO OPTOMETRISTS

9 A description of Optometric Benefits provided to Beneficiaries by Optometrists, and the rates to be paid by the MSP for such services, are listed in the Optometry Payment Schedule. The Optometry Payment Schedule will be updated as needed and will be made readily accessible to Optometrists on the Ministry of Health website.

10 A Preamble to the Optometry Payment Schedule has been created to provide additional information for Optometrists and Beneficiaries on medically required eye examinations, referrals by Optometrists to ophthalmologists and neurologists and direct requests from medical practitioners to optometrists. The Preamble to the Optometry Payment Schedule will be made readily accessible to Optometrists on the Ministry of Health website.

11 Amendments to the Optometry Payment Schedule will be made as follows over the term of this Agreement, in addition to any general increases in accordance with the Economic Stability Dividend as outlined in Appendix A of this Agreement.

a) Subject to paragraphs (b), (c), (d), (e), and (f) below, the following new fee items will be added to the Optometry Payment Schedule:

i. effective January 1, 2016, a new fee item for *Extended Diagnostic Testing* services will be added to the Optometry Payment Schedule. The new fee item can only be claimed for patients who are classified as per ICD9 code 365 (glaucoma). The Parties agree the new fee item will have an estimated annual cost of $575,000. The fee will be $23.00 per visit, up to 2 times per year, and the fee item definition in the preamble to the Optometry Payment Schedule will be as follows:

Glaucoma patients are as defined by the Standards, Limits and Conditions for Practice – Anti-Glaucoma Medication Prescribing (SLCs) set by the College of Optometrists of British Columbia. The SLCs set out the criteria including any and all testing required. The new fee item 2891 – Extended Diagnostic Testing, which comes into effect January 1, 2016 for this condition, is to be used for this purpose.

Patients who present with Glaucoma or with risk factors that classify them as glaucoma suspects as per the ICD9 code 365 criteria are eligible for this semi-annual benefit billed in conjunction with 2889, 2899, 2888, 2898 fee items only.

ii. effective January 1, 2016, a new fee item for *Therapeutic Contact Lens Bandages* will be added to the Optometry Payment Schedule. The Parties agree the new fee item will be set at $50.00 and will have an estimated annual cost of $90,000.

iii. effective April 1, 2017 the fee item for *Extended Diagnostic Testing* will be expanded to include treatment and management for ICD9 code 370 (keratitis). The Parties agree the expansion of this fee item will have an estimated additional annual cost of $379,500. The fee will continue to be $23.00 per visit, up to 2 times per year, and the fee item definition in the preamble to the Optometry Payment Schedule will be as follows:

Patients who present with keratitis, ICD9 code 370, as defined by the Screening, Diagnosis and Management of Dry Eye Disease: Practical Guidelines for Canadian Optometrists, Canadian Journal of Optometry, Vol. 76 Suppl. 1, 2014. Inflammation

must be confirmed by vital dye staining or tear osmolarity to be eligible for this semi-annual benefit billed in conjunction with 2889, 2899, 2888, 2898 fee items only.

iv. effective April 1, 2018 the fee item for *Extended Diagnostic Testing* will be expanded to include the treatment and management of ICD9 code 362 (other retinal disorders). The Parties agree the expansion of this fee item will have an estimated additional annual cost of $828,000. The fee will be $23.00 per visit, up to 2 times per year, and the fee item definition in the preamble to the Optometry Payment Schedule will be as follows:

Patients who present with Other Retinal Disorders, ICD9 code 362, defined as limited to pathologies with best corrected visual acuity 20/30 or worse and cross sectional imaging is performed to confirm the nature of the vision loss are eligible for this semi-annual benefit billed in conjunction with 2889, 2899, 2888, 2898 fee items only.

b) The Parties agree to closely monitor the utilization of these new fee items during the term of this Agreement and will engage in annual assessments, described further in paragraphs c), d), and e) of the budgetary impact of the new fees. As part of this monitoring process, information will be provided by the Ministry of Health to the BCAO as part of the quarterly utilization reporting process.

c) By each February 1 of the term of this Agreement, beginning in 2016, the Ministry of Health and the BCAO will jointly undertake an assessment of the current fiscal year expenditures for the new fee items, in order to determine if the actual expenditure is aligned to the estimated costing as agreed to by the Ministry of Health and the BCAO.

d) If the annual assessment reveals that the projected total annual expenditure relating to any new fee item is less than the amount estimated for the new fee items for that year, by a difference of 5% or more, then the difference will be applied to the Continuing Education Fund in a manner agreed to by the Ministry of Health and the BCAO.

e) If the annual assessment reveals that the projected total annual expenditure relating to any new fee item is more than the amount estimated for the new fee items for that year, by a difference of 5% or more, the Ministry of Health and the BCAO will meet to discuss the cause and implications. The Ministry of Health and the BCAO will determine and agree on subsequent steps to ameliorate any negative expenditure effect of the new fee items, which may include a fee decrease and/or a lesser amount being applied to the Continuing Education Fund for the year.

f) The overall growth of the total optometry MSP expenditure will be excluded from the assessment for the purposes of d) and e) above.

12 The list of payments for Optometric Benefits and their definitions in the Optometry Payment Schedule may be revised by the Optometry Special Committee on the recommendation of the Government.

13 The BCAO will ensure that Optometrists are aware of the requirements to follow the notice provisions of Section 19 of the *Medicare Protection Act* before charging Beneficiaries for services that are not Optometric Benefits.

CONTINUING EDUCATION FUND

14 The Continuing Education Fund is intended to support the maintenance and/or improvement of practitioner skills necessary for high quality patient care. Disbursement from the Continuing Education Fund is at the discretion of the BCAO.

a) The Continuing Education Fund is an annual allotment of monies used to assist Optometrists with eligible educational expenses. The specific terms, conditions, and eligibility criteria applicable to, and benefits available from, the Continuing Education Fund are as approved and published by the Board of Directors of BCAO from time to time.

b) In the 2015/16 fiscal year, the Government will make a one-time lump sum payment in the amount of $338,288 to the BCAO. This payment will be made no later than 8 weeks after ratification of this Agreement by both Parties.

c) In the 2016/17 fiscal year, the Government will provide an amount of $75,179 to the BCAO for the Continuing Education Fund. This payment will be split evenly such that half is provided on April 1, 2016 and the remaining half is provided by March 31, 2017.

d) In the 2017/18 fiscal year, the Government will provide an amount of $150,000 to the BCAO for the Continuing Education Fund. This payment will be split evenly such that half is provided on April 1, 2017 and the remaining half is provided by March 31, 2018.

e) In the 2018/19 fiscal year, the Government will provide an amount of $227,459 to the BCAO for the Continuing Education Fund. This payment will be split evenly such that half is provided on April 1, 2018 and the remaining half is provided by March 31, 2019.

f) The funding identified in 14 b) to 14 e) is subject to the assessment of the new fee items as identified in 11 b) to 11 f), such that an amount lower or higher than what is identified for the Continuing Education Fund could be provided by Government to the BCAO.

g) It is understood that the payment of $338,288 made in the 2015/16 fiscal year represents approximately 0.2% of the entire optometry expenditure over the 5 year term of this Agreement based on 2015/16 expenditure estimates as agreed to by the Parties.

h) It is the intention of the Parties to negotiate in years subsequent to the Term of this Agreement, annual funding provided to the Continuing Education Fund at a rate of 0.2% of the annual optometry expenditure subject to paragraph i) below.

i) Despite paragraph g) above, the Parties agree that they may alter the 0.2% Continuing Education Fund formula as a part of future negotiations.

j) BCAO may charge a reasonable administration fee of up to a maximum of 10% per year to administer the Continuing Education Fund. This administration fee will be charged to the Continuing Education Fund.

k) Upon request BCAO will provide the Government with a report in the form and manner prescribed by Government, showing expenditures made to date from the Continuing Education Fund.

SCOPE OF PRACTICE CHANGES

15 The Government and the BCAO will consult and collaborate with each other to ensure the provision of high quality optometric services to the residents of British Columbia.

16 It is acknowledged and agreed that this Agreement requires ongoing dialogue and consultation on major issues of significance to the provision of optometric care, including, but not limited to, policy, changes to scope of practice, billing integrity, data sharing and how optometric services are funded.

17 Where a scope of practice change is anticipated or proposed by either Party to this Agreement, the Parties shall meet within 30 calendar days of a written request by either Party. Consultation with respect to scope of practice changes will be informal and collaborative and will include areas such as requirements of the College of Optometrists of British Columbia regarding the standard of care for Optometrists, legislative or regulatory changes, and the funding requirements for new optometric services.

DATA SHARING

18 The Parties agree that sharing relevant information and data in a timely manner is necessary to support the purpose of this Agreement.

19 The Government, through the Ministry of Health, agrees to share information with the BCAO regarding the number and amount of payments for Optometric Benefits. The distribution of such information is subject to the provisions of the *Freedom of Information and Protection of Privacy Act,* RSBC 1996, c. 165, and Section 49 of the *Medicare Protection Act*, and any other applicable laws or Government policies.

20 The BCAO agrees to provide information to the Government on optometry practice including, where appropriate, information showing trends and services within the practice of optometry.

BCAO PATTERNS OF PRACTICE COMMITTEE

21 For the purposes of section 5(1)(r) of the *Medicare Protection Act* , the BCAO Patterns of Practice Committee may be provided information by the Medical Services Commission concerning claims submitted by an Optometrist to the Medical Services Commission in accordance with section 46(h) of the Medical and Health Care Services Regulation, BC Reg 426/97.

22 The Parties acknowledge that the Medical Services Commission has the right and responsibility to appoint inspectors to audit the patterns of practice of Optometrists as part of a random review or in response to service verification irregularities.

BILLING DISPUTES

23 The Government and the BCAO agree to resolve disputes related to MSP billing by establishing a three step process, in the order set out below:

a) Informal discussion between the Government, HIBC, and the BCAO in which they make every reasonable effort to resolve the dispute.

b) Billing disputes will be referred to the Optometry Liaison Committee in the event that informal discussion does not remedy the dispute. The BCAO or the Optometrist will send, in writing, notice setting out the dispute, and the remedy sought within thirty (30) calendar days of the dispute occurring. The Optometry Liaison Committee then has thirty (30) calendar days to resolve the dispute.

c) If the Optometry Liaison Committee fails to resolve the dispute, then the matter must be referred to the Optometry Special Committee. The Optometry Liaison Committee will send written notice setting out the issues in the dispute and requesting a decision be rendered by the Optometry Special Committee within thirty (30) calendar days of the issuance of the notice.

d) The decision of Optometry Special Committee will be binding on all Parties.

AGREEMENT DISPUTES

24 If there is a dispute over the interpretation of this Agreement then the Parties will, in the order set out below:

a) Refer the dispute to the Optometry Liaison Committee for an informal discussion.

b) If the Optometry Liaison Committee is unable to resolve the dispute then any Party can initiate a dispute resolution process by issuing a written notice of the dispute to a Mediator agreed upon by the Parties within thirty (30) calendar days of the deliberation on the dispute by the Optometry Liaison Committee. If the Parties are unable to agree on a mediator, then the Parties will request the B.C. Arbitration & Mediation Institute to provide a mediator.

c) If the Parties are unable to achieve a resolution through mediation then any Party may refer the dispute to a final and binding arbitration process within thirty (30) calendar days following the termination of the mediation process. If the Parties are unable to agree on an arbitrator, then the Parties will request the B.C. Arbitration & Mediation Institute to provide an arbitrator.

d) Alternatively, by mutual agreement of the Parties they may choose to combine mediation and arbitration in a mediation-arbitration process.

25 Each Party is responsible for its own costs for mediation and/or arbitration. The costs associated with engagement of a mediator or arbitrator will be shared equally by the Government and the BCAO.

26 The decision of the mediator or arbitrator will be final and binding on all Parties.

27 The *Commercial Arbitration Act* will guide the Parties in applying this part of this Agreement.

TERM OF AGREEMENT

28 This Agreement shall be for a term of five (5) years, commencing on April 1, 2014 and ending on March 31, 2019.

AMENDMENTS

29 This Agreement may be amended by agreement of the Parties in writing at any time during the term of this Agreement. However, no amendment of this Agreement is effective unless it is in writing and signed by the Parties.

TERMINATION

30 Any Party may terminate this Agreement:

a) For any reason, after giving the other Parties ninety (90) calendar days written notice of termination.

b) For breach of this Agreement by any Party, on giving the other Parties thirty (30) calendar days written notice of termination.

31 The Party claiming the breach under Article 28(b) must notify the other Parties by registered letter of:

a) The nature of the breach;

b) The article of this Agreement alleged to have been violated and any remedy sought;

c) Its intention to terminate the Agreement thirty (30) calendar days from the date of the registered letter.

32 The Party that issues a notice of termination for breach of this Agreement may increase the notice period or withdraw notice subject to an appropriate plan to address the breach which is accepted by the Party that provided notice of termination.

33 A waiver of any term of this Agreement or of any breach of this Agreement by any Party is not a waiver of any other term or any other breach.

RENEWAL

34 Each Party agrees to advise the other Parties in writing by December 1, 2018, of its intention to renew or renegotiate this Agreement.

35 The Parties may commence negotiations for renewal of this Agreement after December 1, 2018.

36 If the Parties do not reach agreement by March 31, 2019, then any one of the Parties may refer the unresolved issues identified through negotiations to a mutually acceptable mediator from the BC Roster of Arbitrators and Mediators for mediation. The costs for mediation will be shared equally between the Government and BCAO.

37 If renegotiation of this Agreement through the mediator does not resolve the issues referred to in Section 37, or if one Party does not agree to mediation, then either the Government or BCAO may refer the matter to binding arbitration under the *Commercial Arbitration Act*.

38 Where a renegotiation of this Agreement is referred to binding arbitration under Section 38, each Party must pay its own cost and the cost of the arbitrator will be shared equally between the Government and the BCAO.

39 In the event that a revised agreement is not reached by March 31, 2019, this Agreement will continue in full force and effect until such time as this Agreement is renewed by the Parties or is terminated by one Party.

40 The Parties may agree to amend any of the time limits specified in this Agreement.

GENERAL

41 This Agreement is governed by and is to be construed in accordance with the laws of British Columbia.

42 Any notice contemplated by this Agreement, to be effective, must be in writing and either mailed by prepaid registered mail, personally delivered or faxed to the Parties at the following addresses:

If to the Government, at: 3-1, 1515 Blanshard St., Victoria B.C. VSW 3C8 Fax 250 952 3131

If to the Optometry Special Committee, at: 3-1, 1515 Blanshard St., Victoria B.C. VSW 3C8 Fax 250 952 3133

If to the BCAO, at: 610 – 2525 Willow Street, Vancouver BC V5Z 3N8 Fax 604 737 9967

43 Despite Section 42, any of the Parties may give verbal or written notice to the others of a substitute address or fax number from time to time.

ATTACHMENTS

Appendix A – Letter of Agreement Re: Economic Stability Dividend

Agreed this 4 day of December, 2015 at Victoria.

SIGNED, SEALED and DELIVERED on behalf of
HER MAJESTY THE QUEEN IN RIGHT OF THE
PROVINCE OF BRITISH COLUMBIA as represented
by the Minister of Health or his duly authorized representative:

Ted Patterson, Assistant Deputy Minister, Ministry of Health

AND

On behalf of the OPTOMETRY SPECIAL COMMITTEE:

ROBYN WHITE DEPUTY CHAIR OD.D
Stephanie Power, Chair, Optometry Special Committee

AND

On behalf of the BRITISH COLUMBIA ASSOCIATION OF OPTOMETRISTS (BCAO):

Dr. Gurpreet Leekha, President

Appendix A: Letter of Agreement Re: Economic Stability Dividend

LETTER OF AGREEMENT

BETWEEN:

HER MAJESTY THE QUEEN IN THE RIGHT OF
THE PROVINCE OF BRITISH COLUMBIA
As represented by the
MINISTER OF HEALTH
(the "Government" or the "Province")

AND:

THE OPTOMETRY SPECIAL COMMITTEE

AND:

THE BRITISH COLUMBIA ASSOCIATION OF OPTOMETRISTS
("BCAO")

Re: ECONOMIC STABILITY DIVIDEND

Definitions

1. In this Letter of Agreement:

"Agreement year" means each twelve (12) month period commencing on the first day of the renewed Optometry Master Agreement. For example, the agreement year for the Optometry Master Agreement that commences on April 1, 2014 is April 1, 2014 to March 31, 2015 and each period from April 1 to March 31 for the term of the Optometry Master Agreement;

"Economic Forecast Council" means the Economic Forecast Council appointed under s. 4 of the *Budget Transparency and Accountability Act*, [S.B.C. 2000] c. 23;

"Forecast GDP" means the average forecast for British Columbia's Real GDP growth made by the Economic Forecast Council and as reported in the annual February budget of the government;

"Fiscal year" means the fiscal year of the government as defined in the *Financial Administration Act* [1996 S.B.C.] c. 138 as 'the period from April 1 in one year to March 31 in the next year';

"Calendar Year" Is a twelve (12) month period starting January 1st and ending December 31st of the same year based upon the Gregorian calendar;

"GDP" or **"Gross Domestic Product"** for the purposes of this LOA means the expenditure side value of all goods and services produced in British Columbia for a given year as stated in the BC Economic Accounts;

"GI" or **"General Increase"** means an increase resulting from the formula set out in this LOA and applied as a percentage increase to Fees in the Optometry Agreement as described at paragraph 9 of this Letter of Agreement on the first pay day after the commencement of the eleventh (11^{th}) month in an agreement year;

"Real GDP" means the GDP for the previous fiscal year expressed in constant dollars and adjusted for inflation produced by Statistics Canada's Provincial and Territorial Gross Domestic Product by Income and by Expenditure Accounts (also known as the provincial and territorial economic accounts) and published as "Real Gross Domestic Product at Market Prices" currently in November of each year;

The Economic Stability Dividend

2. The Economic Stability Dividend shares the benefits of economic growth between Optometrists in the public sector and the Province contingent on growth in BC's Real GDP.

3. Optometrists will receive a general increase (GI) equal to one-half (1/2) of any percentage gain in Real GDP above the forecast of the Economic Forecast Council for the relevant Calendar Year.

4. For greater clarity and as an example only, if Real GDP were one percent (1%) above Forecast GDP then Optometrists would be entitled to a General Fee Increase of one-half of one percent (0.5%).

Annual Calculation and publication of the Economic Stability Dividend

5. The Economic Stability Dividend will be calculated on an annual basis by the Minister of Finance for each Agreement year commencing in 2015/16 to 2018/2019 and published through the PSEC Secretariat.

6. The timing in each Calendar Year will be as follows:

    (i) February Budget – Forecast GDP for the upcoming Calendar Year;
    (ii) November of the following Calendar Year – Real GDP published for the previous Calendar Year;
    (iii) November - Calculation by the Minister of Finance of fifty percent (50%) of the difference between the Forecast GDP and the Real GDP for the previous Calendar Year;
    (iv) Advice from the PSEC Secretariat to employers' associations, funders, employers, agencies, professional associations, and unions of the percentage allowable General Increase, if any, for each bargaining unit or group with authorization to employers and agencies to implement the Economic Growth Dividend.

7. For greater clarity and as an example only:

    For agreement year 3 (2016/17):

    (i) February 2015 – Forecast GDP for the 2015 Calendar Year;
    (ii) November 2016 – Real GDP published for the 2015 Calendar Year;
    (iii) November 2016 - Calculation of the fifty percent (50%) of the difference between the 2015 Forecast GDP and the 2015 Real GDP by the Minister of Finance through the PSEC Secretariat;

(iv) Direction from the PSEC Secretariat to employers' associations, employers, agencies and unions of the percentage allowable General Increase, if any, for each bargaining unit or group with authorization to employers and agencies to implement the Economic Growth Dividend;
(v) Payment will be made concurrent with the General Increases on the first pay period after February, 1, 2016, February 1, 2017, February 1, 2018 and February 1, 2019, respectively.

Availability of the Economic Stability Dividend

8. The Economic Stability Dividend will be provided for each of the following agreement years: 2015/16 (based on 2014 GDP); 2016/17 (based on 2015 GDP); 2017/18 (based on 2016 GDP); and, 2018/19 (based on 2017 GDP).

Allowable Method of Payment of the Economic Stability Dividend

9. The Economic Stability Dividend must be applied as a percentage increase only on Fees in the Optometry Payment Schedule and for no other purpose or form.

PREAMBLE TO MSC PAYMENT SCHEDULE: OPTOMETRY SERVICES

A. GENERAL PROVISIONS

1. Eye Examination Benefits

Optometric benefits are services defined in Section 23 of the *Medical and Health Care Services Regulations,* B.C. Reg. 426/97, and for which payment is provided pursuant to the Optometry Payment Schedule.

Routine eye examinations are not a MSP benefit for individuals aged 19 to 64 years. MSP provides as an insured benefit routine eye examinations for children under the age of 19 years and over the age of 65.

Medically required eye examinations are a benefit for all MSP beneficiaries. The diagnoses that meet the MSP definition of medically required are listed below by ICD9 code, and are payable at the frequency indicated. To support exceptions to these frequencies or for other special circumstances, practitioners should ensure this information is included with billing claims.

In general, the criteria for medically required include:

- ocular disease, trauma or injury
- systemic diseases associated with significant ocular risk (e.g. diabetes)
- medications associated with significant ocular risk

Refractive change (needing glasses or contact lenses) with no other pathology does not meet the MSP medically required criterion for payment. Patients presenting with refractive change only should not be formally referred for an eye exam. These patients should contact their optometrist or ophthalmologist directly to request an eye exam and they should also be advised that payment for the eye examination will be their responsibility.

Formal referrals to ophthalmologists or direct requests to optometrists by a medical practitioner for an eye examination on behalf of patients are appropriate only if, in the practitioner's judgment and based on clinical evidence, there is medical necessity for the examination.

MSP will accept claims and make payment for services provided by optometrists and ophthalmologists upon direct requests or referral from medical practitioners.

It is the responsibility of medical practitioners to exercise their judgment in referring those patients for whom an eye examination is medically required. This does not include visits for patients with refractive change (needing glasses or contact lenses) but with no other pathology. MSP will monitor referral patterns to ensure adherence to this policy.

For patients insured under the First Nations Health Authority (FNHA), prior approval is required for health benefits.

2. Medically Required Eye Examinations

The diagnoses which meet the MSP definition of medically required are listed below by ICD9 code, and are payable at the frequency indicated.

Practitioners must ensure that information necessary to support exceptions to these frequencies or for other special circumstances is included with referrals or billing claims.

Payment for services for conditions not listed below is the responsibility of the patient unless a referral is medically indicated and provided to the ophthalmologist or optometrist directly by the referring physician.

Please note, under each three digit diagnostic code – the four and five digit codes in the same category would be limited to the same frequency guidelines. The exceptions are listed below (3620, 36201 and 36202).

MSC PREAMBLE AND PAYMENT SCHEDULE: OPTOMETRY SERVICES

SCHEDULE A – DIAGNOSTIC CODES FOR MEDICALLY-REQUIRED EYE EXAMINATIONS

Eye examinations billed with the following diagnostic codes are payable once every 24 months:

360	Disorders of the globe
363	Chorioretinal inflammations, scars and other disorders of choroid
368	Visual disturbances
369	Blindness and low vision
375	Disorders of lacrimal system
379	Other disorders of eye
4019	Hypertensive disease not specified as malignant or benign
05440	Herpes simplex – ophthalmic (acute onset)
05320	Herpes zoster – ophthalmic (acute onset)
94010	Burns of eyelids and periocular area
92190	Unspecified contusion of eye
9182	Superficial injury – conjunctiva
9301	Foreign body in conjunctival sac
9181	Superficial injury – cornea
9300	Corneal foreign body
8026	Fracture – orbital floor (blow out), closed
9502	Injury to optic pathways
9503	Injury to visual cortex
99520	Unspecified adverse effect of drug, medicament and biological (allergic reaction to medication)

Eye examinations billed with the following diagnostic codes are payable once every 12 months:

361	Retinal detachments and defects
362	Other retinal disorders
364	Disorders of iris and ciliary body
365	Glaucoma
366	Cataract
370	Keratitis
371	Corneal opacity and other disorders of cornea
372	Disorders of conjunctiva
373	Inflammation of eyelids
374	Other disorders of eyelids
376	Disorders of the orbit
377	Disorders of optic nerve and visual pathways
378	Strabismus and other disorders of binocular eye movements
27910	Deficiency of cell mediated immunity (AIDS (HIV))
7200	Ankylosing Spondylitis
43600	Cerebrovascular disease – acute but ill defined
17400	Malignant neoplasm of breast
16200	Malignant neoplasm of trachea, bronchus and lung
34000	Multiple sclerosis
35800	Myasthenia Gravis
23700	Neoplasm – pituitary gland and craniopharyngeal duct
13500	Sarcoidosis
24000	Goitre, specified as simple
71020	Sicca Syndrome (Sjogren's Syndrome)
71000	Systemic Lupus Erythematosus
44650	Giant Cell Arteritis (Temporal Arteritis)
224	Benign neoplasm of eye
8717	Unspecified ocular penetration
E07	Intraocular surgery or injury with penetrating wound
9404	Burn – Cornea / Conjunctiva
V6751	Following high risk medications ***

*** Claims with this code must be accompanied by a note stating type of medication.

Eye examinations billed with the following diagnostic codes are payable once every 6 months:

250	Diabetes Mellitus
3620	Diabetic Retinopathy
36201	Background diabetic retinopathy
36202	Proliferative diabetic retinopathy
365	Glaucoma (effective January 1, 2016)
370	Keratitis (effective April 1, 2017)
362	Other Retinal Disorders (effective April 1, 2018)

3. "Referral"

Notifying MSP of a referral is usually done by including the practitioner number of the physician to whom the patient is being referred on your claim. If no FFS (Fee for Service) claim is being submitted, a "no charge referral" is a claim submitted to MSP under fee item 03333 with a zero dollar amount.

On occasion, a practitioner's number is not available. For these rare cases, the following generic number has been established for optometry:

99992 – Referral by an optometrist to an ophthalmologist and referral by an optometrist to a neurologist

4. Treatment and Management of Glaucoma

Glaucoma patients are as defined by the Standards, Limits and Conditions for Practice – Anti-Glaucoma Medication Prescribing (SLCs) set by the College of Optometrists of British Columbia. The SLCs set out the criteria including any and all testing required. The fee item 2891 – Extended Diagnostic Testing, which comes into effect January 1, 2016 for this condition, is to be used for this purpose.

Patients who present with Glaucoma or with risk factors that classify them as glaucoma suspects as per the ICD9 code 365 criteria are eligible for this semi-annual benefit billed in conjunction with 2898, 2899, 2889, 2888 fee items only.

5. Treatment and Management of Keratitis and Other Retinal Disorders

Patients who present with keratitis, ICD9 code 370, as defined by the *Screening, Diagnosis and Management of Dry Eye Disease: Practical Guidelines for Canadian Optometrists, Canadian Journal of Optometry, Vol. 76 Suppl. 1, 2014.* Inflammation must be confirmed by vital dye staining or tear osmolarity to be eligible for this semi-annual benefit billed in conjunction with 2898, 2899, 2889, 2888 fee items only.

Fee item 2891 – Extended Diagnostic Testing, which comes into effect April 1, 2017 for this condition, is to be used for this purpose.

Patients who present with Other Retinal Disorders, ICD9 code 362, defined as limited to pathologies with best corrected visual acuity 20/30 or worse and cross sectional imaging is performed to confirm the nature of the vision loss are eligible for this semi-annual benefit billed in conjunction with 2898, 2899, 2889, 2888 fee items only

Fee item 2891 – Extended Diagnostic Testing, which comes into effect April 1, 2018 for this condition, is to be used for this purpose.

B. ADMINISTRATION

1. Fees Payable by the Medical Services Plan (MSP)

A Payment Schedule for optometrists is established under Section 26 of the *Medicare Protection Act* and is referred to in the Agreement between the Government of the Province of British Columbia and the Medical Services Commission (MSC) and the British Columbia Association of Optometrists. The fees listed are the amounts payable by the Medical Services Plan (MSP) for listed benefits.

2. MSP Billing Number

A billing number consists of two numbers - a practitioner number and a payment number. The practitioner number identifies the practitioner performing and taking responsibility for the service. The payment number identifies the person or party to whom payment will be directed by the MSP. Each claim submitted must include both a practitioner number and payment number.

3. Group Practice, Partnerships, and Locum Tenens

The *Medicare Protection Act* requires that the practitioner will charge for his/her own services. For MSP and WorkSafeBC (WSBC) billings this requires the use of the individual's personal practitioner number. This includes members of Group Practices, Partnerships and Locum Tenens.

4. Assignment of Payment

An "Assignment of Payment" is a legal agreement by which an attending practitioner designates payment for his/her services to another party. In this circumstance, the designated party may use the attending practitioner's practitioner number in combination with its own payment number when submitting claims to MSP. To authorize MSP to make payment to a designated party, the attending practitioner must complete and file an "Assignment of Payment" form. However, even though the payment has been assigned, the responsibility for the clinical service and its appropriate billing remains with the practitioner whose practitioner number is used.

5. Balance Billing

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

Before providing services, practitioners must inform the patient:

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

6. Personal Services

Section 29 of the Medical and Health Care Services Regulation specifies the nature of personal services which are not benefits.

> ***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.*

7. Adequate Clinical Record

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.

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.

MSC PREAMBLE AND PAYMENT SCHEDULE: OPTOMETRY SERVICES

Fee Item	Fee Item Description	January 1, 2016 ($)	February 1, 2016 ($)
02899	Full optometric diagnostic examination of the eyes ***Notes:*** *1) Includes the determination of the refractive index of the eye, the presence of any abnormality in the visual system, and the provision of a written prescription, if lenses are required.* *2) Routine eye exams for children 18 years of age or younger are billable once every 11 months.*	46.17	46.38
02889	Optometric diagnostic examination of the eyes with TPA ***Note:*** *Includes the determination of the presence of any abnormality in the visual system with TPA and/or the provision of a written report to the referring physician.*	46.17	46.38
02898	Re-examination or minor examination ***Note:*** *Cannot be billed within 72 hours of a 2899 or 2889.*	29.35	29.48
02888	Re-examination or minor examination with TPA ***Note:*** *Cannot be billed within 72 hours of a 2899 or 2889.*	29.35	29.48
02897	Repeat Tonometry (maximum 3x per 24 hour period) ***Note:*** *Cannot be billed on the same day as 2899, 2889, 2898, 2888.*	10.40	10.45
02891 (new)	Extended Diagnostic Testing ***Notes:*** *1) Only payable in conjunction with 02889, 02899, 02888, 02898.* *2) Semi-annual benefit - maximum payable is 1 service per 6 months for each diagnosis* *3) ICD9 365 – Glaucoma* *4) as per guidelines set out in the Preamble*	23.00	23.10
02892	Examination for low vision aid ***Notes:*** *1) Fee item 02892 billable only by optometrist having appropriate equipment.* *2) Fee item 02899 not billable in addition to 02892 when patient referred for low vision assessment.*	40.33	40.51
02893	Computer assisted quantitative visual fields ***Notes:*** *1) Fee item 02893 billable only by optometrists having the appropriate computerized equipment for quantitative perimetry examinations.* *2) Claim must specify reason for visual fields examination.*	31.78	31.92

02890	Contact Lens Bandage ***Notes:*** *1) Payable when the patient requires a therapeutic contact lens bandage after damage to the cornea.* *2) Includes all costs associated with fitting and/or re-bandage within 90 days but does not include any examination fees.*	50.00	50.23
02894	Contact Lenses Fitting – Unilateral ***Notes:*** *1) Applicable only to patients who are unable to achieve 20/40 visual acuity with conventional glasses or that report diplopia due to anisometropia or irregular astigmatism that cannot be eliminated with the use of conventional glasses but can be through the use of contact lenses.* *2) Includes all visits and services necessary for fitting and follow-up for three months.*	213.95	214.91
02895	Contact Lenses Fitting – Bilateral ***Notes:*** *1) Applicable only to patients who are unable to achieve 20/40 visual acuity with conventional glasses or that report diplopia due to anisometropia or irregular astigmatism that cannot be eliminated with the use of conventional glasses but can be through the use of contact lenses.* *2) Includes all visits and services necessary for fitting and follow-up for three months.*	322.72	324.17

PREAMBLE TO MSC PAYMENT SCHEDULE: OPTOMETRY SERVICES

A. GENERAL PROVISIONS

1. Eye Examination Benefits

Optometric benefits are services defined in Section 23 of the *Medical and Health Care Services Regulations,* B.C. Reg. 426/97, and for which payment is provided pursuant to the Optometry Payment Schedule.

Routine eye examinations are not a MSP benefit for individuals aged 19 to 64 years. MSP provides as an insured benefit routine eye examinations for children under the age of 19 years and over the age of 65.

Medically required eye examinations are a benefit for all MSP beneficiaries. The diagnoses that meet the MSP definition of medically required are listed below by ICD9 code, and are payable at the frequency indicated. To support exceptions to these frequencies or for other special circumstances, practitioners should ensure this information is included with billing claims.

In general, the criteria for medically required include:

- ocular disease, trauma or injury
- systemic diseases associated with significant ocular risk (e.g. diabetes)
- medications associated with significant ocular risk

Refractive change (needing glasses or contact lenses) with no other pathology does not meet the MSP medically required criterion for payment. Patients presenting with refractive change only should not be formally referred for an eye exam. These patients should contact their optometrist or ophthalmologist directly to request an eye exam and they should also be advised that payment for the eye examination will be their responsibility.

Formal referrals to ophthalmologists or direct requests to optometrists by a medical practitioner for an eye examination on behalf of patients are appropriate only if, in the practitioner's judgment and based on clinical evidence, there is medical necessity for the examination.

MSP will accept claims and make payment for services provided by optometrists and ophthalmologists upon direct requests or referral from medical practitioners.

It is the responsibility of medical practitioners to exercise their judgment in referring those patients for whom an eye examination is medically required. This does not include visits for patients with refractive change (needing glasses or contact lenses) but with no other pathology. MSP will monitor referral patterns to ensure adherence to this policy.

For patients insured under the First Nations Health Authority (FNHA), prior approval is required for health benefits.

2. Medically Required Eye Examinations

The diagnoses which meet the MSP definition of medically required are listed below by ICD9 code, and are payable at the frequency indicated.

Practitioners must ensure that information necessary to support exceptions to these frequencies or for other special circumstances is included with referrals or billing claims.

Payment for services for conditions not listed below is the responsibility of the patient unless a referral is medically indicated and provided to the ophthalmologist or optometrist directly by the referring physician.

Please note, under each three digit diagnostic code – the four and five digit codes in the same category would be limited to the same frequency guidelines. The exceptions are listed below (3620, 36201 and 36202).

MSC PREAMBLE AND PAYMENT SCHEDULE: OPTOMETRY SERVICES

SCHEDULE A – DIAGNOSTIC CODES FOR MEDICALLY-REQUIRED EYE EXAMINATIONS

Eye examinations billed with the following diagnostic codes are payable once every 24 months:

360	Disorders of the globe
363	Chorioretinal inflammations, scars and other disorders of choroid
368	Visual disturbances
369	Blindness and low vision
375	Disorders of lacrimal system
379	Other disorders of eye
4019	Hypertensive disease not specified as malignant or benign
05440	Herpes simplex – ophthalmic (acute onset)
05320	Herpes zoster – ophthalmic (acute onset)
94010	Burns of eyelids and periocular area
92190	Unspecified contusion of eye
9182	Superficial injury – conjunctiva
9301	Foreign body in conjunctival sac
9181	Superficial injury – cornea
9300	Corneal foreign body
8026	Fracture – orbital floor (blow out), closed
9502	Injury to optic pathways
9503	Injury to visual cortex
99520	Unspecified adverse effect of drug, medicament and biological (allergic reaction to medication)

Eye examinations billed with the following diagnostic codes are payable once every 12 months:

361	Retinal detachments and defects
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365	Glaucoma
366	Cataract
370	Keratitis
371	Corneal opacity and other disorders of cornea
372	Disorders of conjunctiva
373	Inflammation of eyelids
374	Other disorders of eyelids
376	Disorders of the orbit
377	Disorders of optic nerve and visual pathways
378	Strabismus and other disorders of binocular eye movements
27910	Deficiency of cell mediated immunity (AIDS (HIV))
7200	Ankylosing Spondylitis
43600	Cerebrovascular disease – acute but ill defined
17400	Malignant neoplasm of breast
16200	Malignant neoplasm of trachea, bronchus and lung
34000	Multiple sclerosis
35800	Myasthenia Gravis
23700	Neoplasm – pituitary gland and craniopharyngeal duct
13500	Sarcoidosis
24000	Goitre, specified as simple
71020	Sicca Syndrome (Sjogren's Syndrome)
71000	Systemic Lupus Erythematosus
44650	Giant Cell Arteritis (Temporal Arteritis)
224	Benign neoplasm of eye
8717	Unspecified ocular penetration
E07	Intraocular surgery or injury with penetrating wound
9404	Burn – Cornea / Conjunctiva
V6751	Following high risk medications ***

*** Claims with this code must be accompanied by a note stating type of medication.

Eye examinations billed with the following diagnostic codes are payable once every 6 months:

250	Diabetes Mellitus
3620	Diabetic Retinopathy
36201	Background diabetic retinopathy
36202	Proliferative diabetic retinopathy
365	Glaucoma (effective January 1, 2016)
370	Keratitis (effective April 1, 2017)
362	Other Retinal Disorders (effective April 1, 2018)

3. "Referral"

Notifying MSP of a referral is usually done by including the practitioner number of the physician to whom the patient is being referred on your claim. If no FFS (Fee for Service) claim is being submitted, a "no charge referral" is a claim submitted to MSP under fee item 03333 with a zero dollar amount.

On occasion, a practitioner's number is not available. For these rare cases, the following generic number has been established for optometry:

99992 – Referral by an optometrist to an ophthalmologist and referral by an optometrist to a neurologist

4. Treatment and Management of Glaucoma

Glaucoma patients are as defined by the Standards, Limits and Conditions for Practice – Anti-Glaucoma Medication Prescribing (SLCs) set by the College of Optometrists of British Columbia. The SLCs set out the criteria including any and all testing required. The fee item 2891 – Extended Diagnostic Testing, which comes into effect January 1, 2016 for this condition, is to be used for this purpose.

Patients who present with Glaucoma or with risk factors that classify them as glaucoma suspects as per the ICD9 code 365 criteria are eligible for this semi-annual benefit billed in conjunction with 2898, 2899, 2889, 2888 fee items only.

5. Treatment and Management of Keratitis and Other Retinal Disorders

Patients who present with Keratitis, ICD9 code 370, as defined by the *Screening, Diagnosis and Management of Dry Eye Disease: Practical Guidelines for Canadian Optometrists, Canadian Journal of Optometry, Vol. 76 Suppl. 1, 2014.* Inflammation must be confirmed by vital dye staining or tear osmolarity to be eligible for this semi-annual benefit billed in conjunction with 2898, 2899, 2889, 2888 fee items only.

Fee item 2891 – Extended Diagnostic Testing, which comes into effect April 1, 2017 for this condition, is to be used for this purpose.

Patients who present with Other Retinal Disorders, ICD9 code 362, defined as limited to pathologies with best corrected visual acuity 20/30 or worse and cross sectional imaging is performed to confirm the nature of the vision loss are eligible for this semi-annual benefit billed in conjunction with 2898, 2899, 2889, 2888 fee items only

Fee item 2891 – Extended Diagnostic Testing, which comes into effect April 1, 2018 for this condition, is to be used for this purpose.

6. Referrals to Neurologists

Patients who present with the following conditions may be referred to Neurologists:

- Suspected optic neuritis;
- Amaurosis Fugax;
- Aion (Anterior ischemic optic neuropathy);
- Stroke; or
- Diplopia

In order for the neurologist to be paid for follow-up care, the referral must include one of the following ICD9 codes:

377, 3773, 362, 3623, 36234, 3774, 37741, V171, 431, 433, 434, 436, 368, 3682

These conditions were made effective July 15, 2013.

B. ADMINISTRATION

1. Fees Payable by the Medical Services Plan (MSP)

A Payment Schedule for optometrists is established under Section 26 of the *Medicare Protection Act* and is referred to in the Agreement between the Government of the Province of British Columbia and the Medical Services Commission (MSC) and the British Columbia Association of Optometrists. The fees listed are the amounts payable by the Medical Services Plan (MSP) for listed benefits.

2. MSP Billing Number

A billing number consists of two numbers - a practitioner number and a payment number. The practitioner number identifies the practitioner performing and taking responsibility for the service. The payment number identifies the person or party to whom payment will be directed by the MSP. Each claim submitted must include both a practitioner number and payment number.

3. Group Practice, Partnerships, and Locum Tenens

The *Medicare Protection Act* requires that the practitioner will charge for his/her own services. For MSP and WorkSafeBC (WSBC) billings this requires the use of the individual's personal practitioner number. This includes members of Group Practices, Partnerships and Locum Tenens.

4. Assignment of Payment

An "Assignment of Payment" is a legal agreement by which an attending practitioner designates payment for his/her services to another party. In this circumstance, the designated party may use the attending practitioner's practitioner number in combination with its own payment number when submitting claims to MSP. To authorize MSP to make payment to a designated party, the attending practitioner must complete and file an "Assignment of Payment" form. However, even though the payment has been assigned, the responsibility for the clinical service and its appropriate billing remains with the practitioner whose practitioner number is used.

5. Balance Billing

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

Before providing services, practitioners must inform the patient:

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

6. Personal Services

Section 29 of the Medical and Health Care Services Regulation specifies the nature of personal services which are not benefits.

> ***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.*

7. Adequate Clinical Record

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.

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.

MSC PREAMBLE AND PAYMENT SCHEDULE: OPTOMETRY SERVICES

Fee Item	Fee Item Description	February 1, 2016 ($)	February 1, 2017 ($)
02899	Full optometric diagnostic examination of the eyes ***Notes:*** *1) Includes the determination of the refractive index of the eye, the presence of any abnormality in the visual system, and the provision of a written prescription, if lenses are required.* *2) Routine eye exams for children 18 years of age or younger are billable once every 11 months.*	46.38	46.54
02889	Optometric diagnostic examination of the eyes with TPA ***Note:*** *Includes the determination of the presence of any abnormality in the visual system with TPA and/or the provision of a written report to the referring physician.*	46.38	46.54
02898	Re-examination or minor examination ***Note:*** *Cannot be billed within 72 hours of a 2899 or 2889.*	29.48	29.58
02888	Re-examination or minor examination with TPA ***Note:*** *Cannot be billed within 72 hours of a 2899 or 2889.*	29.48	29.58
02897	Repeat Tonometry (maximum 3x per 24 hour period) ***Note:*** *Cannot be billed on the same day as 2899, 2889, 2898, 2888.*	10.45	10.49
02891 (new)	Extended Diagnostic Testing ***Notes:*** *1) Only payable in conjunction with 02889, 02899, 02888, 02898.* *2) Semi-annual benefit - maximum payable is 1 service per 6 months for each diagnosis* *3) ICD9 365 – Glaucoma or ICD9 370 – Keratitis* *4) as per guidelines set out in the Preamble*	23.10	23.18
02892	Examination for low vision aid ***Notes:*** *1) Fee item 02892 billable only by optometrist having appropriate equipment.* *2) Fee item 02899 not billable in addition to 02892 when patient referred for low vision assessment.*	40.51	40.65
02893	Computer assisted quantitative visual fields ***Notes:*** *1) Fee item 02893 billable only by optometrists having the appropriate computerized equipment for quantitative perimetry examinations.* *2) Claim must specify reason for visual fields examination.*	31.92	32.03

02890	Contact Lens Bandage ***Notes:*** *1) Payable when the patient requires a therapeutic contact lens bandage after damage to the cornea.* *2) Includes all visits and services necessary for fitting and follow-up for three months.*	50.23	50.41
02894	Contact Lenses Fitting – Unilateral ***Notes:*** *1) Applicable only to patients who are unable to achieve 20/40 visual acuity with conventional glasses or that report diplopia due to anisometropia or irregular astigmatism that cannot be eliminated with the use of conventional glasses but can be through the use of contact lenses.* *2) Includes all visits and services necessary for fitting and follow-up for three months.*	214.91	215.66
02895	Contact Lenses Fitting – Bilateral ***Notes:*** *1) Applicable only to patients who are unable to achieve 20/40 visual acuity with conventional glasses or that report diplopia due to anisometropia or irregular astigmatism that cannot be eliminated with the use of conventional glasses but can be through the use of contact lenses.* *2) Includes all visits and services necessary for fitting and follow-up for three months.*	324.17	325.30

PREAMBLE TO MSC PAYMENT SCHEDULE: OPTOMETRY SERVICES

A. GENERAL PROVISIONS

1. Eye Examination Benefits

Optometric benefits are services defined in Section 23 of the *Medical and Health Care Services Regulations,* B.C. Reg. 426/97, and for which payment is provided pursuant to the Optometry Payment Schedule.

Routine eye examinations are not a MSP benefit for individuals aged 19 to 64 years. MSP provides as an insured benefit routine eye examinations for children under the age of 19 years and over the age of 65.

Medically required eye examinations are a benefit for all MSP beneficiaries. The diagnoses that meet the MSP definition of medically required are listed below by ICD9 code, and are payable at the frequency indicated. To support exceptions to these frequencies or for other special circumstances, practitioners should ensure this information is included with billing claims.

In general, the criteria for medically required include:

- ocular disease, trauma or injury
- systemic diseases associated with significant ocular risk (e.g. diabetes)
- medications associated with significant ocular risk

Refractive change (needing glasses or contact lenses) with no other pathology does not meet the MSP medically required criterion for payment. Patients presenting with refractive change only should not be formally referred for an eye exam. These patients should contact their optometrist or ophthalmologist directly to request an eye exam and they should also be advised that payment for the eye examination will be their responsibility.

Formal referrals to ophthalmologists or direct requests to optometrists by a medical practitioner for an eye examination on behalf of patients are appropriate only if, in the practitioner's judgment and based on clinical evidence, there is medical necessity for the examination.

MSP will accept claims and make payment for services provided by optometrists and ophthalmologists upon direct requests or referral from medical practitioners.

It is the responsibility of medical practitioners to exercise their judgment in referring those patients for whom an eye examination is medically required. This does not include visits for patients with refractive change (needing glasses or contact lenses) but with no other pathology. MSP will monitor referral patterns to ensure adherence to this policy.

For patients insured under the First Nations Health Authority (FNHA), prior approval is required for health benefits.

2. Medically Required Eye Examinations

The diagnoses which meet the MSP definition of medically required are listed below by ICD9 code, and are payable at the frequency indicated.

Practitioners must ensure that information necessary to support exceptions to these frequencies or for other special circumstances is included with referrals or billing claims.

Payment for services for conditions not listed below is the responsibility of the patient unless a referral is medically indicated and provided to the ophthalmologist or optometrist directly by the referring physician.

Please note, under each three digit diagnostic code – the four and five digit codes in the same category would be limited to the same frequency guidelines. The exceptions are listed below (3620, 36201 and 36202).

MSC PREAMBLE AND PAYMENT SCHEDULE: OPTOMETRY SERVICES

SCHEDULE A – DIAGNOSTIC CODES FOR MEDICALLY-REQUIRED EYE EXAMINATIONS

Eye examinations billed with the following diagnostic codes are payable once every 24 months:

360	Disorders of the globe
363	Chorioretinal inflammations, scars and other disorders of choroid
368	Visual disturbances
369	Blindness and low vision
375	Disorders of lacrimal system
379	Other disorders of eye
4019	Hypertensive disease not specified as malignant or benign
05440	Herpes simplex – ophthalmic (acute onset)
05320	Herpes zoster – ophthalmic (acute onset)
94010	Burns of eyelids and periocular area
92190	Unspecified contusion of eye
9182	Superficial injury – conjunctiva
9301	Foreign body in conjunctival sac
9181	Superficial injury – cornea
9300	Corneal foreign body
8026	Fracture – orbital floor (blow out), closed
9502	Injury to optic pathways
9503	Injury to visual cortex
99520	Unspecified adverse effect of drug, medicament and biological (allergic reaction to medication)

Eye examinations billed with the following diagnostic codes are payable once every 12 months:

361	Retinal detachments and defects
362	Other retinal disorders
364	Disorders of iris and ciliary body
365	Glaucoma
366	Cataract
370	Keratitis
371	Corneal opacity and other disorders of cornea
372	Disorders of conjunctiva
373	Inflammation of eyelids
374	Other disorders of eyelids
376	Disorders of the orbit
377	Disorders of optic nerve and visual pathways
378	Strabismus and other disorders of binocular eye movements
27910	Deficiency of cell mediated immunity (AIDS (HIV))
7200	Ankylosing Spondylitis
43600	Cerebrovascular disease – acute but ill defined
17400	Malignant neoplasm of breast
16200	Malignant neoplasm of trachea, bronchus and lung
34000	Multiple sclerosis
35800	Myasthenia Gravis
23700	Neoplasm – pituitary gland and craniopharyngeal duct
13500	Sarcoidosis
24000	Goitre, specified as simple
71020	Sicca Syndrome (Sjogren's Syndrome)
71000	Systemic Lupus Erythematosus
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*** Claims with this code must be accompanied by a note stating type of medication.

Eye examinations billed with the following diagnostic codes are payable once every 6 months:

250	Diabetes Mellitus
3620	Diabetic Retinopathy
36201	Background diabetic retinopathy
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365	Glaucoma (effective January 1, 2016)
370	Keratitis (effective April 1, 2017)
362	Other Retinal Disorders (effective April 1, 2018)

3. "Referral"

Notifying MSP of a referral is usually done by including the practitioner number of the physician to whom the patient is being referred on your claim. If no FFS (Fee for Service) claim is being submitted, a "no charge referral" is a claim submitted to MSP under fee item 03333 with a zero dollar amount.

On occasion, a practitioner's number is not available. For these rare cases, the following generic number has been established for optometry:

99992 – Referral by an optometrist to an ophthalmologist and referral by an optometrist to a neurologist

4. Treatment and Management of Glaucoma

Glaucoma patients are as defined by the Standards, Limits and Conditions for Practice – Anti-Glaucoma Medication Prescribing (SLCs) set by the College of Optometrists of British Columbia. The SLCs set out the criteria including any and all testing required. The fee item 2891 – Extended Diagnostic Testing, which comes into effect January 1, 2016 for this condition, is to be used for this purpose.

Patients who present with Glaucoma or with risk factors that classify them as glaucoma suspects as per the ICD9 code 365 criteria are eligible for this semi-annual benefit billed in conjunction with 2898, 2899, 2889, 2888 fee items only.

5. Treatment and Management of Keratitis and Other Retinal Disorders

Patients who present with Keratitis, ICD9 code 370, as defined by the *Screening, Diagnosis and Management of Dry Eye Disease: Practical Guidelines for Canadian Optometrists, Canadian Journal of Optometry, Vol. 76 Suppl. 1, 2014.* Inflammation must be confirmed by vital dye staining or tear osmolarity to be eligible for this semi-annual benefit billed in conjunction with 2898, 2899, 2889, 2888 fee items only.

Fee item 2891 – Extended Diagnostic Testing, which comes into effect April 1, 2017 for this condition, is to be used for this purpose.

Patients who present with Other Retinal Disorders, ICD9 code 362, defined as limited to pathologies with best corrected visual acuity 20/30 or worse and cross sectional imaging is performed to confirm the nature of the vision loss are eligible for this semi-annual benefit billed in conjunction with 2898, 2899, 2889, 2888 fee items only

Fee item 2891 – Extended Diagnostic Testing, which comes into effect April 1, 2018 for this condition, is to be used for this purpose.

6. Referrals to Neurologists

Patients who present with the following conditions may be referred to Neurologists:

- Suspected optic neuritis;
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- Stroke; or
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In order for the neurologist to be paid for follow-up care, the referral must include one of the following ICD9 codes:

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> *(e) a parent of a spouse,*
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> *(g) a grandchild,*
> *(h) a brother or sister, or*
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7. Adequate Clinical Record

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.

Appendix A - Medical and Health Care Services Regulation (Part 4)

Services of Health Care Practitioners

Definition

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(a) the date, time and location of the service;

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(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.

MSC PREAMBLE AND PAYMENT SCHEDULE: OPTOMETRY SERVICES

Fee Item	Fee Item Description	February 1, 2016 ($)	February 1, 2018 ($)
02899	Full optometric diagnostic examination of the eyes ***Notes:*** *1) Includes the determination of the refractive index of the eye, the presence of any abnormality in the visual system, and the provision of a written prescription, if lenses are required.* *2) Routine eye exams for children 18 years of age or younger are billable once every 11 months.*	46.54	46.73
02889	Optometric diagnostic examination of the eyes with TPA ***Note:*** *Includes the determination of the presence of any abnormality in the visual system with TPA and/or the provision of a written report to the referring physician.*	46.54	46.73
02898	Re-examination or minor examination ***Note:*** *Cannot be billed within 72 hours of a 2899 or 2889.*	29.58	29.70
02888	Re-examination or minor examination with TPA ***Note:*** *Cannot be billed within 72 hours of a 2899 or 2889.*	29.58	29.70
02897	Repeat Tonometry (maximum 3x per 24 hour period) ***Note:*** *Cannot be billed on the same day as 2899, 2889, 2898, 2888.*	10.49	10.53
02891 (new)	Extended Diagnostic Testing ***Notes:*** *1) Only payable in conjunction with 02889, 02899, 02888, 02898.* *2) Semi-annual benefit - maximum payable is 1 service per 6 months for each diagnosis* *3) ICD9 365 – Glaucoma, ICD9 370 – Keratitis or ICD9 362 – Other Retinal Disorders (effective April 1, 2018)* *4) as per guidelines set out in the Preamble*	23.18	23.27
02892	Examination for low vision aid ***Notes:*** *1) Fee item 02892 billable only by optometrist having appropriate equipment.* *2) Fee item 02899 not billable in addition to 02892 when patient referred for low vision assessment.*	40.65	40.81
02893	Computer assisted quantitative visual fields ***Notes:*** *1) Fee item 02893 billable only by optometrists having the appropriate computerized equipment for quantitative perimetry examinations.* *2) Claim must specify reason for visual fields examination.*	32.03	32.16

Fee Item	Fee Item Description	February 1, 2016 ($)	February 1, 2018 ($)
02890	Contact Lens Bandage ***Notes:*** *1) Payable when the patient requires a therapeutic contact lens bandage after damage to the cornea.* *2) Includes all visits and services necessary for fitting and follow-up for three months.*	50.41	50.61
02894	Contact Lenses Fitting – Unilateral ***Notes:*** *1) Applicable only to patients who are unable to achieve 20/40 visual acuity with conventional glasses or that report diplopia due to anisometropia or irregular astigmatism that cannot be eliminated with the use of conventional glasses but can be through the use of contact lenses.* *2) Includes all visits and services necessary for fitting and follow-up for three months.*	215.66	216.52
02895	Contact Lenses Fitting – Bilateral ***Notes:*** *1) Applicable only to patients who are unable to achieve 20/40 visual acuity with conventional glasses or that report diplopia due to anisometropia or irregular astigmatism that cannot be eliminated with the use of conventional glasses but can be through the use of contact lenses.* *2) Includes all visits and services necessary for fitting and follow-up for three months.*	325.30	326.60

Eye examinations billed with the following diagnostic codes are payable once every 24 months:

360	Disorders of the globe
363	Chorioretinal inflammations, scars and other disorders of choroid
368	Visual disturbances
369	Blindness and low vision
375	Disorders of lacrimal system
379	Other disorders of eye
4019	Hypertensive disease not specified as malignant or benign
05440	Herpes simplex – ophthalmic (acute onset)
05320	Herpes zoster – ophthalmic (acute onset)
94010	Burns of eyelids and periocular area
92190	Unspecified contusion of eye
9182	Superficial injury – conjunctiva
9301	Foreign body in conjunctival sac
9181	Superficial injury – cornea
9300	Corneal foreign body
8026	Fracture – orbital floor (blow out), closed
9502	Injury to optic pathways
9503	Injury to visual cortex
99520	Unspecified adverse effect of drug, medicament and biological (allergic reaction to medication)

Eye examinations billed with the following diagnostic codes are payable once every 12 months:

361	Retinal detachments and defects
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366	Cataract
370	Keratitis
371	Corneal opacity and other disorders of cornea
372	Disorders of conjunctiva
373	Inflammation of eyelids
374	Other disorders of eyelids
376	Disorders of the orbit
377	Disorders of optic nerve and visual pathways
378	Strabismus and other disorders of binocular eye movements
27910	Deficiency of cell mediated immunity (AIDS (HIV))
7200	Ankylosing Spondylitis
43600	Cerebrovascular disease – acute but ill defined
17400	Malignant neoplasm of breast
16200	Malignant neoplasm of trachea, bronchus and lung
34000	Multiple sclerosis
35800	Myasthenia Gravis
23700	Neoplasm – pituitary gland and craniopharyngeal duct
13500	Sarcoidosis
24000	Goitre, specified as simple
71020	Sicca Syndrome (Sjogren's Syndrome)
71000	Systemic Lupus Erythematosus
44650	Giant Cell Arteritis (Temporal Arteritis)
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E07	Intraocular surgery or injury with penetrating wound
9404	Burn – Cornea / Conjunctiva
V6751	Following high risk medications ***

*** Claims with this code must be accompanied by a note stating type of medication.

Eye examinations billed with the following diagnostic codes are payable once every 6 months:

250	Diabetes Mellitus
3620	Diabetic Retinopathy
36201	Background diabetic retinopathy
36202	Proliferative diabetic retinopathy