Lacking special authority

"Anything else I can do for you, Bob?"

"Yeah doc, the pharmacist said you can get my medications paid for."

"But Bob, you don't qualify for Special Authority coverage."

"What do you mean, doc? My pharmacist said all I had to do was talk to you and I could save money. What's the matter—you keeping it for yourself?"

I frequently have conversations like this one in my office. As I age I have less and less tolerance for the Special Authority program. From the outset I was a little concerned that this program would lead to more unpaid work.

Initially, there were five classes of medications included in the Reference Drug Program—H_2-blockers, NSAIDs, nitrates, ACE inhibitors, and calcium channel blockers. Pharmacare would provide full coverage for the drug(s) they deemed most medically effective and cost effective in each category.

The program then expanded to include the Low Cost Alternative Program and Limited Coverage Drugs. Essentially, Pharmacare will pay for the generic form of a medication under the Low Cost Alternative Program and not pay for medications under the Limited Coverage program as these are medications not generally accepted as first-line treatment and for which cheaper alternative medications exist.

Lastly, the Alzheimer's Drug Therapy Initiative was born, which stipulates the criteria for Pharmacare coverage of cholinesterase inhibitors for dementia.

Initially, there was one form for medical practitioners to fill out requesting Special Authority coverage for a medication falling outside of the referenced category. The forms have proliferated as programs have expanded. The criteria for coverage have also become more complex, often including multiple situations such as, "must have tried all medications past and present with at least one from each continent starting 2 years before they were born until death with a dose range from a microgram to a kilogram," followed by the instructions, "please list all of the medications tried in alphabetical order, spelled backwards with the corresponding number of days tried documented by their cube root."

Specialists often have prescribing exemptions for certain medications so no Special Authority is required. However, the rest of us are stuck filling out these ever-more-involved forms with no remuneration. We are unable to charge for completion of these forms, which is somewhat ironic considering their completion saves the patient a significant amount of money. Pharmacare has a number you can call to verbally apply for Special Authority, but again this requires a time investment. Not that money is our major motivation, but considering this process also saves the government money, why did we get nominated to provide this free service?

My biggest complaint is that patients are directed to my office to request this special coverage without being advised of the entire process. This sets up an adversarial situation where their advocate (me) has to tell them they don't qualify.

Perhaps pharmacies could add the Special Authority criteria to the medication information printouts they provide to patients, or maybe Pharmacare

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Biology vs career

Several of my friends have had battles with biology over the past few years. It occurred to me that we doctors—who should know the most about biology—are often the ones who think we can outsmart it or that it doesn't apply to us. Among other things, I'm talking about fitness, sleep, mental illness, injuries, cancer risk reduction, and alcohol use. We should know better.

There is one biology battle that, as a female surgeon, I feel a bit more of a personal connection to: having babies. There is no good time in a medical career to have a baby—or at least no better time than any another. No matter what you do, how much time you plan to take off, or how tightly you schedule your dates, having a baby brings uncertainty and interferes with your ability to undertake your practice or training. It will affect your colleagues, your ability to keep up your usual pace of learning and practice, your life partner's ability to cope with your changed schedules, and your workplace commitments. And that's when everything goes well and according to plan.

So it worries me when I see that busy female residents perceive they should finish their training before having a baby. Most female specialists finish their training when they are nearing their mid-30s, some even a bit later. After age 35, the ability to conceive and carry a healthy pregnancy to term is significantly different from what it was before age 30. And unless you take advantage of the higher prevalence of multiples born to older moms—if you want more than one child after your training—your second and third babies will almost always arrive after your mid-30s. All of us who have hit certain age milestones know that one still feels very young and vital at 35. Unfortunately, one's reproductive biology will often fight back bitterly in this battle of age. One of the most heartbreaking scenarios I encounter is when one of my colleagues finally has her social, financial, academic, and career ducks in a row and feels she is ready to have a baby but can no longer easily conceive or carry one. It happens much earlier in life than we are so cavalierly led to believe. We choose to ignore the medical literature, and when we see celebrities having babies in their 40s we assume it must be reasonably easy—we can do it when we are good and ready. And we're doctors for goodness sake; we'll know the best ways to go about it! What those celebrities don't reveal is that many of them conceived thanks to expensive and somewhat invasive technology and often with donor eggs. Biology quietly plays the upper hand.

No one told me this when I was young and completing a surgical residency. For a woman to have children during or before surgical training was rare 20 years ago and would invite raised eyebrows, occasional expressions of doubt or awe, and varying degrees of support from colleagues and associates. As a resident, I remember reading an editorial in a major plastic surgical journal by an academic leader who wrote that his program was considering no longer

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could send this information directly to patients. This would allow patients to be better prepared and informed prior to meeting with their physician. Meanwhile, I will continue to field these questions about medication coverage, which leaves me feeling less than special and without authority.

—DRR

Audit tip: Billing for call-out charges

Audits reveal that physicians commonly bill fee codes 01200, 01201, and 01202 incorrectly.

As defined in the *Doctors of BC Guide to Fees,* call-out charges are applicable when a physician is called to render emergency or non-elective services and must travel from one location to another to attend the patient. All call-out fee items must state the time of call and time of service rendered.

If the physician remains at the same site to answer the call, such as being called from one location to another within the same hospital, the fee for call-out charges is not applicable.

This article is the opinion of the Patterns of Practice Committee and has not been peer reviewed by the BCMJ *Editorial Board. For further information contact Juanita Grant, audit and billing advisor, Physician and External Affairs, at 604 638-2829 or jgrant@doctorsofbc.ca.*

The following examples describe scenarios that do not qualify for call-out charges:

- A physician is called at 1 p.m. and arranges to see a patient after a clinic or OR shift, after 6 p.m. This is considered to be a booked appointment.

All call-out fee items must state the time of call and time of service rendered.

- A physician is located in the hospital or emergency department and is called after hours to see a patient in either the emergency department or elsewhere in the same hospital.
- Multiple patients are seen during the same call out. Billing for separate call-out charges is incorrect.
- A visit at 6:05 p.m. is billed to fee code 01200, with the call placed prior to 6 p.m. A call-out charge should not be billed when it appears the visit was timed to collect the fee.

Medical inspectors look for proper documentation in the patient's chart or dictation to support the criteria to bill a call-out fee code—time called and service rendered. Having little or no documentation in your clinical records to support your claim is interpreted as "you didn't do the work."

Always refer to the *Doctors of BC Guide to Fees* and its Preamble for interpretations of all fees.

—Keith J. White, MD
Chair, Patterns of Practice Committee

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hiring women as fellows because they so often used the year between residency and practice to get pregnant. It wreaked too much havoc on his school's training and call schedule and the workload planning for the fellowship. I can understand his perspective; however, for some women, even waiting 1 more year at that age might be too long.

I knew before I started residency that I wanted children; I just blithely assumed it would be easy to start having them in my mid-30s. The process didn't end up being that straightforward—and I had luck on my side. Some of my colleagues were not so fortunate. I now tell young women early in their training that, if they are sure they want to create families with their partners, they should plan to conceive when they are biologically best able regardless of how far along they are in their training. The process will throw a wrench into your life and the lives of your associates no matter when you do it—medical school, residency, early practice, or later practice. Planning children when it's easier to conceive at least decreases the chance of biology dictating whether you have children at all. I was heartened to see a baby born to a resident in my surgical program for the first time 3 years ago, and another two residents have become pregnant during training since then. It's my impression that surgery may be behind other more traditionally female-populated specialties, but I think we are getting there. Last year in our program, we drafted our first pregnancy/maternity policy for residents to officially clarify for women, their partners, and their co-residents the expectations and supports, training time requirements, and call considerations surrounding pregnancy within the surgical program.

We may live in an era of amazing advances in reproductive choices, but the biological clock still ticks. I'm not advocating that everyone should get pregnant tomorrow, or when they aren't otherwise ready, or at all, but we need to make it clear to our young female colleagues, especially those in longer training programs, that we support them in embracing their biological needs when the time is best for them.

—CV