SCHEDULE 2 TO APPENDIX G

CALL BACK CRITERIA

Part A: Call Back Payment Eligibility

All the following Criteria must be met for a physician to be eligible for the $250 MOCAP call back payment.

1. Criteria related to the person making the decision to call.

The decision to initiate the call back is made by one of the following:

a) A physician with privileges at the facility in issue who has responsibility for the care of the patient in question, including but not limited to the Most Responsible Physician.

b) Any other member of the medical or nursing staff of the facility in issue who has been specifically authorized by the Health Authority to initiate call backs eligible under these Criteria.

2. Criteria related to the person who is called.

The call is made to a physician who meets all of the following:

a) Has been designated for call back payments by the Health Authority in accordance with Part B below or falls within a category or group that has been so designated, and meets all the terms of such designation or, alternatively, has had the specific call back in issue approved for payment after-the-fact on an exception basis in accordance with Part C below.

b) Is a member of the medical staff at the facility in issue with privileges to provide the required services.

c) Is not on call or being paid to be on site, on shift, or otherwise available at the time of the call back.

d) Is not:
   i) at the time of the call back, on site at the facility at which the patient is present in accordance with Part A3(b) below;
   ii) at the time of the call back, scheduled to be on site at the facility at which the patient is present in accordance with Part A3(b) below; or
   iii) scheduled to be next on site at the facility at which the patient is present in accordance with Part A3(b) below at a time when the patient's needs could be adequately met.

e) Is not receiving isolation allowance under the Rural Subsidiary Agreement.

3. Criteria related to the clinical circumstances.

All of the following circumstances are present:

a) The call is for an identified patient who is not a patient of the physician being called or of a colleague for whose patients the physician has accepted responsibility.

b) The patient is present in:
   i) an acute care hospital, or
   ii) a diagnostic and treatment centre or specified emergency treatment room that has been approved as a call back payment eligible facility by the MOCAP Advisory Committee.

c) The patient requires medical services on an emergency basis as assessed by the person deciding to initiate the call at the time the call is made.

d) Reasonable steps are taken to determine that the medical services required by the patient could not be provided (due to issues of competence or availability) by a physician who has ongoing responsibility for the care of the patient (either directly or by virtue of his/her call group), by a physician who is on-call, or by a physician who is being paid to be on site, on shift, or otherwise available.

e) The physician being called personally attends the patient at the site contemplated by Part A3(b) above within the time dictated by the patient's needs but in any event no later than within 3 hours of being called**.**

4. Administrative Criteria

All of the following administrative rules are complied with:

a) Only one $250 payment is available per call back, regardless of the number of patients seen.
b) Only one $250 payment is available per patient per physician (i.e. for each episode of illness/injury).
c) Within 30 days of the call back, an invoice in the form attached must be submitted to the Health Authority by the physician claiming the call back payment.
d) Within 30 days of the call back, a verification, in the form attached must be submitted to the Health Authority by the person who made the decision to initiate the call back (that is the person referred to in Part A1 above).

Part B: Designation

1. Each Health Authority may designate physicians and/or services for call back payments.

2. The Health Authorities may designate individual physicians by name, groups of individual physicians by name, or practice categories/services without naming specific physicians (in which case any physician who is a member of the medical staff of the facility in issue with the privileges and qualifications required to provide the services and who meets all other terms of the designation will be deemed to be designated).

3. The Health Authorities may specify additional terms as being applicable to any designation so long as such additional terms are not inconsistent with these Criteria. Permissible additional terms include, but are not limited to:

a) Specific sites;
b) Specific services;
c) Specific times (e.g. hours in a day, days in a week);
d) Maximum dollar amounts for call back payments in a given time period (e.g. monthly, annually); and
e) Maximum number of call backs in a given time period (e.g. monthly, annually).

4. If the designation is in respect of a specific physician or group of specific physicians, then each such physician or group, respectively, will be provided with a standardized Call Back Designation Letter that expresses the names of the physicians that are the subject of the designation, expresses all additional terms applicable to the designation, and encloses a copy of these Criteria and a copy of the form of invoice to be used to submit claims for payment, and in the event the designation is cancelled or altered will be provided with a letter advising of same.

Part C: Approving Payments on an Exception Basis

1. Approval for call back payment on an exception basis may be sought for specific call backs by physicians who are not designated in accordance with Part B above and by physicians who are designated in accordance with Part B above but in circumstances where all terms applicable to the designation have not been met (e.g. the call back was to a non-designated site, for non-designated services, and/or at a non-designated time of day; or if paid, the maximum dollar amount would be exceeded and/or the maximum number of call backs would be exceeded).

2. To seek approval on an exception basis, a physician must submit an invoice in accordance with Part A4(c) above which clearly and expressly indicates that payment is sought on an exception basis.

3. Each Health Authority will specify an individual by name or position/title with authority to approve call back payments on an exception basis.

4. The individual specified in accordance with Part C3 above will approve exceptional claims for payment if all criteria for call back payment eligibility as set out in Part A above (except that set out in Part A2(a)) have been met.

Part D: Appeal of Denied Call Back Claims

1. In the event that a physician's claim for call back payment is denied the physician may, within 30 days of being advised by the Health Authority of the denial of the claim, request the BCMA to initiate a Call Back Dispute on his/her behalf. If the BCMA agrees to do so, the BCMA must provide notice of same to the applicable Health Authority and to the Joint Agreement Administration Group within 30 days of being requested by the physician to initiate a Call Back Dispute. The notice must be in writing and must include the facts upon which the physician relies including a copy of the invoice submitted in association with the claim as required by Part A4(c) above but with the name(s) and personal health number(s) of the patient(s) expunged, the identification of the ground upon which the Call Back Dispute is advanced, an outline of argument supporting the physician position, and a written consent to release information signed by the physician, in the form attached**.**

2. Upon receipt by the Ministry of Health Services of a consent to release information in the form attached, the Ministry will forward to the Joint Agreement Administration Group and to the applicable Health Authority a list of the information that the Ministry proposes to release. After providing the applicable Health Authority and the physician with the opportunity to comment on the list, the Joint Agreement Administration Group will request the Ministry to release some or all of the information on the list. The Ministry will then release the information as requested by the Joint Agreement Administration Group.

3. The only ground upon which a Call Back Dispute may be advanced is that all the criteria for call back payment eligibility as set out in Part A above have been met (except where the Call Back Dispute relates to a physician not designated in accordance with Part B above or a claim that does not fall within the terms of such a designation, in which case the only ground upon which such a Call Back Dispute may be advanced is that all the criteria for call back payment eligibility as set out in Part A above, except that in Part A2(a), have been met).

4. The Joint Agreement Administration Group will consider each Call Back Dispute referred to it and, after providing the physician and the applicable Health Authority with the opportunity to be heard, may decide the merits of the Call Back Dispute, following any further process stipulated by it, by consensus decision (as that term is defined in section 1.2 of the Physician Master Agreement), in which case the decision of the Joint Agreement Administration Group will be final and binding on the physician and the Health Authority.

5. In the event that the Joint Agreement Administration Group is unable to reach a consensus decision with respect to the resolution of any Call Back Dispute within 60 days of receipt of the associated notice, or any longer period agreed to by the Joint Agreement Administration Group, the BCMA or the Government may, within a further 30 days, refer the Call Back Dispute to Rod Germaine or any other person agreed to by the BCMA and the Government (the "Call Back Adjudicator")

6. Where, within the time limits in Part D5 above, the Joint Agreement Administration Group has not reached a consensus decision with respect to the resolution of any Call Back Dispute and the Call Back Dispute is not referred to the Call Back Adjudicator, then there will be no further

process under these Criteria or otherwise for the physician to advance his/her claim for call back payment, and the Health Authority's denial of such claim will be final and binding on the physician.

7. Where a Call Back Dispute is referred to the Call Back Adjudicator pursuant to Part D5, the Call Back Adjudicator will determine whether the criteria set out in Part A above have been met, following any further process stipulated by him/her. If the Call Back Adjudicator determines that the criteria set out in Part A have not been met then he/she will render a final and binding award confirming the Health Authority's denial of the claim for call back payment. If the Call Back Adjudicator determines that the criteria set out in Part A have been met then he/she will render a final and binding award allowing the claim for call back payment following which the applicable Health Authority will make the payment.

8. The Government and the BCMA will share the costs associated with the referral of Call Back Disputes to the Call Back Adjudicator.