

MEDICAL SERVICES

COMMISSION

2011/12 – 2013/14

**ANNUAL
REPORT**



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BRITISH
COLUMBIA

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Mandate

The Medical Services Commission (“MSC” or “Commission”) administers the Medical Services Plan (“MSP”) to facilitate reasonable access throughout British Columbia to quality medical care, health care and diagnostic facility services for residents of British Columbia, under the *Medicare Protection Act* (the “Act” or “MPA”).

The Commission

Established under the *Medical Services Act, 1967*, and continued under the current *Medicare Protection Act*, the Medical Services Commission oversees the provision, verification and payment of medical and health services in an effective and cost-efficient manner through the Medical Services Plan on behalf of the Government of British Columbia. The MSC is accountable to government through the Minister of Health.

Organizational Structure

In early 1994, the Commission was expanded from one member to a nine-member body. It consists of three representatives nominated by the Doctors of BC (formerly the British Columbia Medical Association/“BCMA”)¹, three public members appointed on the joint recommendation of the Minister of Health and the Doctors of BC to represent MSP beneficiaries, and three members from government. This tri-partite structure represents a unique partnership among physicians, beneficiaries and government. It ensures that those who have a stake in the provision of medical services in British Columbia are involved.

Responsibilities of the Commission

In addition to ensuring that all British Columbia residents have reasonable access to medical care and diagnostic services, the Commission is responsible for managing the Available Amount, a fund which is set annually by government to pay practitioners on a fee-for-service basis for medical services provided to MSP beneficiaries. The MSC is also responsible for enforcing the *Medicare Protection Act* and investigating reports of extra billing, hearing appeals brought by beneficiaries, diagnostic facilities and physicians as required by the Act, and arbitrating disputes that may arise between the Doctors of BC and the Government of British Columbia.

Advisory Committees and Overview of Accomplishments

The Act allows the Commission to delegate some powers and duties and advisory committees and working groups as well as hearing panels have been established to assist the Commission in effectively carrying out its mandate. Appointments to committees and panels reflect the MSC tri-partite representation. The following is a description of

¹ In January 2014, the British Columbia Medical Association (BCMA) officially changed its name to the Doctors of BC.

the responsibilities and an overview of the 2011/12 – 2013/14 accomplishments of some of the MSC's advisory committees, hearing panels and other delegated bodies.

1. Guidelines and Protocols Advisory Committee (“GPAC”)

The Guidelines and Protocols Advisory Committee's mandate supports both the effective utilization of medical services and high quality, appropriate patient care. This mandate is achieved through the development, publication and promotion of clinical practice guidelines and protocols. These guidelines are published under the brand BC Guidelines, and are available on www.bcguidelines.ca, a mobile friendly site.

In fiscal year **2012/13**, GPAC executive met with a facilitator to develop a strategic plan that outlined the following strategic areas and priorities to guide the current and future work of GPAC:

1. Improved health outcomes:

- Work with key stakeholders to develop BC specific guidelines;
- Measure the effectiveness of BC Guidelines by following GPAC's evaluation plan.

2. Promotion and education:

- Work effectively with other committees that develop guidelines to improve the utilization and health care delivery in BC;
- Increase and maintain awareness by promoting BC Guidelines to key stakeholders.

3. Optimized clinical care (financial sustainability):

- Focus guidelines on areas of inappropriate utilization and variation in clinical practice with the goal of eliminating waste in the health care system;
- Ensure the right resources and technology are available to deliver GPAC's mandate/work plan.

GPAC's *2012/13 Strategic Framework* was presented and approved by the Medical Services Commission at the MSC's October 2012 meeting.

The following outlines how GPAC met its strategic priorities from **2011/12 – 2013/14**:

Improved Health Outcomes

- Enhanced and continued to maintain an evaluation plan that measured the effectiveness of the published guidelines and protocols. The plan relies on the regular production and use of evaluation data and reports from a variety of data sources and agencies.

- Collaborated with and participated on other MSC advisory committees, such as Patterns of Practice and Audit and Inspection.

Promotion and Education

Achieved increased exposure for BC Guidelines through participation in the following events:

- St. Paul’s GP Continuing Medical Education conference;
- The Society of Rural Physicians of Canada conference;
- A joint University of BC (“UBC”)-BCMA committee to integrate BC Guidelines into UBC medical school curriculum;
- UBC Postgraduate Family Medicine residents orientation day;
- The International Medical Graduate (“IMG”) Orientation Week (organized by the College of Physicians and Surgeons of British Columbia);
- The BC Patient Safety and Quality Council, promoting use of BC Guidelines to improve the quality of medical practice in the province;
- UBC Residents’ Research Day to encourage residents to become involved with GPAC as part of their research projects;
- A geriatric medicine lecture to IMGs;
- Practice Survival Skills workshops.

Continued to strengthen partnerships with the following stakeholders:

- BC Association of Laboratory Physicians;
- BC Cancer Agency and Family Physician Oncology Network;
- BC Centre for Disease Control;
- BC Children’s Hospital and Child Health BC;
- BCMA Council on Health Economics and Promotion;
- Canadian Medical Association; Canadian Association of Radiologists;
- College of Physicians and Surgeons of British Columbia;
- Divisions of Family Practice;
- Emergency Department Protocol Working Group;
- General Practice Services Committee; Specialist Services Committee;
- Health Authorities;
- Heart and Stroke Foundation;
- Patterns of Practice Committee;
- St. Paul’s Hospital;
- UBC Medical School and Department of Family Practice.

Optimized Clinical Care

Accolades were received for the following guidelines:

- *Diabetes Care* – voted best work flow sheet by the Canadian Diabetes Association;

- *Problem Drinking* – received perfect marks by the Centre for Addiction and Mental Health in its 2013 report entitled: *Strategies to Reduce Alcohol-Related Harms and Costs in Canada: A Comparison of Provincial Policies*.

Guidelines and Protocols Approved by the MSC – 2011/12 – 2013/14

Title	Type (New/Revised)	Date of MSC Approval
<i>Testosterone Testing</i>	New	April 4, 2011
<i>Osteoporosis: Diagnosis, Treatment and Fracture Prevention: A Patient Guide</i>	New	April 4, 2011
<i>Palliative Care for the Patient with Incurable Cancer or Advanced Disease – Part 2: Pain and Symptom Management</i>	New	June 29, 2011
<i>Palliative Care for the Patient with Incurable Cancer or Advanced Disease – Part 3: Grief and Bereavement</i>	New	September 14, 2011
<i>Abnormal Liver Chemistry – Evaluation and Interpretation</i>	Revised	September 14, 2011
<i>Cobalamin (Vitamin B₁₂) Deficiency – Investigation and Management</i>	Revised	January 18, 2012
<i>Folate Deficiency – Investigation and Management</i>	Revised	January 18, 2012
<i>Viral Hepatitis Testing</i>	Revised	January 18, 2012
<i>Rheumatoid Arthritis: Diagnosis, Management and Monitoring</i>	Revised	September 19, 2012
<i>Follow Up of Colorectal Polyps or Cancer</i>	Revised	January 16, 2013
<i>Colorectal Screening for Cancer Prevention in Asymptomatic Patients</i>	Revised	February 27, 2013
<i>HFE-Associated Hereditary Hemochromatosis Investigation and Management</i>	Revised	April 10, 2013
<i>Ambulatory ECG Monitoring (Holter Monitor and Other Devices)</i>	Revised	April 10, 2013
<i>Antinuclear Antibody (ANA) Testing</i>	Revised	May 22, 2013
<i>Breast Disease and Cancer: Diagnosis</i>	New	September 18, 2013
<i>Breast Cancer: Management and Follow Up</i>	New	September 18, 2013
<i>Major Depressive Disorder in Adults: Diagnosis and Management</i>	Revised	December 11, 2013
<i>Ankle Injury – X-Ray for Acute Injury of the Ankle or Mid-Foot</i>	Revised	February 26, 2014

In 2014, the Commission approved the standardized format of “age 19 and older” when referring to the definition of adult within the GPAC guidelines.

2. *Advisory Committee on Diagnostic Facilities (“ACDF”)*

The Advisory Committee on Diagnostic Facilities provides advice, assistance and recommendations to the MSC in the exercise of the Commission’s duties, powers and functions under s.33 of the Act. The ACDF reviews applications from existing and proposed diagnostic facilities and makes recommendations to the MSC to approve or deny the requests.

2011/12

Between April 1, 2011 and March 31, 2012, the ACDF considered 197 applications related to laboratory medicine, specimen collection stations, radiology, ultrasound, nuclear medicine, pulmonary function, polysomnography and electrodiagnostics. Thirty applications were for new facilities and other applications included requests to relocate sites, expand test menus and capacity, transfer certificates of approval or interest or change hours of operation. Of the total applications reviewed, 165 requests were approved, 24 were denied and eight applications were deferred.

The Medical Services Commission’s review of the ACDF guidelines that began in 2008, continued into 2011/12 and culminated with a proposal for an ACDF Modernization Project that the MSC approved at its September 2011 meeting. The ACDF Modernization Project, scheduled to be completed over an 18-month period in three phases, aimed for the simplification, standardization and rationalization of the ACDF operational policies and processes and built on recommendations for revisions to the ACDF guidelines by previous MSC working groups for both new and existing public and private laboratories, specimen collection stations and diagnostic facilities.

Health authorities, private laboratories and the Diagnostic Accreditation Program of the College of Physicians and Surgeons of British Columbia were among the stakeholders consulted during 2011/12. The *Phase I Report* of the ACDF Modernization Project was presented at the Commission’s February 2012 meeting and the MSC approved the following recommendations for immediate implementation:

- Revision to the expansion guideline for laboratories and specimen collection stations;
- Mandated annual reporting of key operational data for laboratories and specimen collection stations;
- Extension of the temporary moratorium for laboratories and specimen collection stations for new, relocation and expansion applications in the Lower Mainland until the ACDF Modernization Project is completed and associated changes can be implemented;
- Approval of outstanding expansion applications for laboratories and specimen collection stations based on the revised expansion guideline;
- Deferred approval of outstanding new and relocation applications for laboratories and specimen collection stations that fall under the Lower Mainland moratorium.

With the implementation of the Phase I recommendations, facilities were no longer required to submit an application to add a phlebotomy chair or to change their hours of operation.

2012/13

Between April 1, 2012 and March 31, 2013, the ACDF reviewed 92 applications related to laboratory medicine, specimen collection stations, radiology, ultrasound, nuclear medicine, pulmonary function, polysomnography and electrodiagnostics. Twenty-two applications were for new facilities and other applications included requests to relocate sites, expand capacity, transfer certificates of approval or expand test menus. Of the total applications reviewed, 71 requests were approved, 14 were denied and, as a result of the general moratorium on applications for new, expanded or relocated diagnostic outpatient services enacted in December 2012, seven applications were deferred.

The three-phased ACDF Modernization Project continued during 2012/13. Working groups were established to focus on both laboratories and specimen collection stations and the remaining diagnostic services under the authority of the ACDF. The Phase I working group was comprised of representatives from the health authorities, private laboratories and members of the Patient Voices Network and worked on the following three key recommendations that resulted from the *Phase I Report*:

- Definitions – key words used in the ACDF guidelines;
- Metrics; and
- The consolidation of all application types/forms.

Phase II of the ACDF Modernization Project began in 2012/13 and focused on diagnostic services facilities. Stakeholders were consulted regarding definitions and metrics in advance of draft recommendations being brought forward for the MSC's consideration.

At its December 2012 meeting, the Commission approved an expanded moratorium until February 2014, on applications for all diagnostic services under the authority of the ACDF.

In February 2013, LifeLabs BC LP purchased BC Biomedical Laboratories Ltd. and advised the Competition Bureau of Canada of the acquisition. To meet the legislative and regulatory requirements for this purchase, LifeLabs submitted new applications to the Commission for approval in relation to all existing 45 BC Biomedical specimen collection stations and one laboratory. The Commission convened a special meeting in March 2013 and approved LifeLabs' asset purchase.

2013/14

Between April 1, 2013 and March 31, 2014, the ACDF reviewed 79 applications related to laboratory medicine, specimen collection stations, radiology, ultrasound, nuclear medicine, pulmonary function and electromyography. Thirty-four applications were for new facilities and other applications included requests to expand test menus,

relocate sites, apply for telemetry status or transfer interest. Of the total applications reviewed, 72 requests were approved and, as a result of the general moratorium on applications for new, expanded or relocated diagnostic outpatient services enacted in December 2012, seven applications were deferred.

The three-phased ACDF Modernization Project to simplify and improve the strategic and operational framework for laboratory medicine and diagnostic facility approvals in British Columbia continued during 2013/14. Stakeholders reviewed draft recommendations and provided input prior to the Commission approving 17 priority policy recommendations at its September 2013 meeting. Twenty-five further recommendations were approved at the MSC's October 2013 meeting and at its December 2013 meeting, the Commission approved six recommendations related to wait time benchmarks, significant change and the establishment of baseline capacity. One remaining recommendation related to proposed revisions of the ACDF definitions was deferred pending completion of the final policy document in 2014/15. Building upon previously-approved recommendations, the Commission, at its February 2014 meeting, also approved six additional recommendations related to new, revised and delegated authority and three further wait time recommendations related to ACDF outpatient services.

During 2013/14, the Commission approved the transfer of CML Healthcare Inc.'s 27 diagnostic imaging licenses in British Columbia to West Coast Medical Imaging Inc. Prior to the closing of the asset sale the Commission also approved the transfer of interest (shares) from CML Healthcare Inc. to LifeLabs Ontario Inc.

In early 2014, the Commission extended its general moratorium through to June 1, 2014, on applications for all diagnostic services under the authority of the ACDF. The MSC also enacted a specific moratorium on ultrasound applications until June 1, 2015.

3. Audit and Inspection Committee (“AIC”)

The Audit and Inspection Committee is a four-member panel comprised of three physicians (one appointed by the Doctors of BC, one appointed by the College of Physicians and Surgeons of British Columbia and one appointed by government) together with one member who represents the public. The Commission has delegated to the AIC its powers and duties under s.36 of the Act to audit and inspect medical practitioners. On December 1, 2006, s.10 of the *Medicare Protection Amendment Act 2003* was brought into force. This section expanded the audit and inspection powers of the MSC to include the power to audit clinics as corporate entities, rather than just physicians.

The AIC has responsibility for two types of audits. Patterns of practice audits are done to ensure that services billed to MSP have been delivered and billed accurately. Extra billing audits focus on whether beneficiaries are being charged for services in contravention of the *Medicare Protection Act*. The AIC decides whether onsite audits are appropriate, and it outlines the nature and extent of the audits. It also reviews the audit results and makes recommendations to the Chair of the Medical Services Commission for further appropriate action.

In **2011/12**, the AIC received and approved 34 new audit referrals related to medical practitioners. Audit reports from 15 inspections were reviewed by the AIC during this period and 11 cases were recommended for recovery.

In **2012/13**, the AIC received and approved 16 new audit referrals related to medical practitioners. Audit reports from 24 inspections were reviewed by the AIC during this period and 21 cases were recommended for recovery.

In **2013/14**, the AIC received and approved 31 new audit referrals related to medical practitioners. Audit reports from 20 inspections were reviewed by the AIC during this period and 17 cases were recommended for recovery.

- ***Billing Integrity Program (“BIP”)***

The Billing Integrity Program provides audit services to the Medical Services Plan and the Medical Services Commission. The MSC is authorized to monitor the billing and payment of claims in order to manage medical and health care expenditures on behalf of MSP beneficiaries. BIP monitors and investigates billing patterns and practices of medical and health care practitioners to detect and deter inappropriate and incorrect billing of MSP claims. In cooperation with the professions, BIP develops and applies monitoring, case finding and audit criteria, and assists the MSC in the recovery of any funds billed inappropriately. It carries out the audit and inspection function on behalf of the Audit and Inspection Committee.

In **2011/12**, the Billing Integrity Program conducted 22 onsite medical practitioner audits. It negotiated settlements for 20 cases with dollars equaling \$1,914,159. A total of \$1,153,756 was recovered by BIP this year (including recoveries negotiated in previous years).

In **2012/13**, the Billing Integrity Program conducted 19 onsite medical practitioner audits. It negotiated settlements for 10 cases with dollars equaling \$1,366,500. A total of \$1,535,592 was recovered by BIP this year (including recoveries negotiated in previous years).

In **2013/14**, the Billing Integrity Program conducted 26 onsite medical practitioner audits. It negotiated settlements for nine cases with dollars equaling \$1,915,000. A total of \$2,113,728 was recovered by BIP this year (including recoveries negotiated in previous years).

Between 2011 and 2014, the average duration of an audit fell from 484 to 282 days.

- ***Special Committees of the Medical Services Commission***

The Commission’s authority to audit claims from health care practitioners is delegated to Special Committees for each of the following professions: acupuncture, chiropractic, dentistry, massage therapy, midwifery, naturopathy, optometry, physical therapy and podiatry. The Special Committees have been given all of the powers and duties necessary to carry out audits.

The Commission's authority to make orders in regard to practitioners under sections 15 and 37 of the Act is delegated to the Health Care Practitioners Special Committee for Audit Hearings ("HCPSCAH"). Effective November 2013, the original Health Care Practitioner's Special Committee for Audit was continued under the new name of the HCPSCAH.

In **2011/12**, the profession specific Special Committees received and approved three new audit referrals related to health care practitioners. Settlements totaling \$244,047 were negotiated for three cases. A total of \$32,553 was recovered by BIP this year (including recoveries negotiated in previous years).

In **2012/13**, the profession specific Special Committees received and approved six new audit referrals related to health care practitioners. Audit reports from three inspections were reviewed by the profession specific Special Committees during this period and three cases were recommended for recovery. The Billing Integrity Program conducted four onsite health care practitioner audits. It negotiated settlements for two cases with dollars equaling \$100,000. A total of \$109,290 was recovered by BIP this year (including recoveries negotiated in previous years).

In **2013/14**, the profession specific Special Committees received and approved eight new audit referrals related to health care practitioners. Audit reports from five inspections were reviewed by the profession specific Special Committees during this period and five cases were recommended for recovery. The Billing Integrity Program conducted three onsite health care practitioner audits. It negotiated settlements for two cases with dollars equaling \$50,000. A total of \$80,345 was recovered by BIP this year (including recoveries negotiated in previous years).

4. Patterns of Practice Committee ("POPC")

The Patterns of Practice Committee is a joint committee of the Doctors of BC and the MSC and acts in an advisory capacity to the Commission. The POPC prepares and distributes an annual statistical personal profile summary (mini-profile) to fee-for-service physicians and provides educational information to physicians on their patterns of practice and the audit process. The POPC also provides advice to the Medical Services Plan regarding inappropriate billing and scrutinizes MSP's process of detecting and deterring inappropriate billing. As well, the POPC listens to physicians who wish to raise their concerns about the audit process and provides feedback on the audit practices employed by the Billing Integrity Program and in conjunction with the College of Physicians and Surgeons of British Columbia, the POPC also nominates medical inspectors and audit hearing panel members.

5. Reference Committee

The Reference Committee acts, upon requests from physicians, in an advisory capacity to the Medical Services Commission, on the adjudication of billing and payment disputes between physicians and the Medical Services Plan. The Committee does, on occasion, perform a similar service for patients billed directly by a physician and physicians providing services to third parties, such as insurance companies. Membership on the

Reference Committee is limited to representatives of the Doctors of BC.

In **2011/12**, MSP received 145 new cases from the Doctors of BC, 93 of which were referred to the Reference Committee. During this time period, the Reference Committee also closed 129 cases.

In **2012/13**, 87 new cases were received, 59 of which were referred to the Reference Committee. During this time period, the Reference Committee closed 79 cases.

In **2013/14**, 41 new cases were received, 24 of which were referred to the Reference Committee. During this time period, the Reference Committee closed 34 cases.

6. Joint Standing Committee on Rural Issues (“JSC”)

The Joint Standing Committee on Rural Issues is not a direct advisory committee to the Medical Services Commission but some of the funding for its work comes from the Available Amount that is managed by the Commission.

The JSC oversees approximately \$104 million annually in rural incentive programs to sustain patient care and continuity of access in communities falling under the *Rural Practice Subsidiary Agreement*. The goal of the JSC is to enhance the availability and stability of physician services in rural and remote areas of British Columbia by addressing some of the unique, demanding, and difficult circumstances encountered by rural physicians and to enhance the quality of the practice of rural medicine.

In April 2013, the JSC announced an additional \$10 million in new funding as part of *the Rural Practice Subsidiary Agreement*. This will assist the JSC to expand some of the current programs, as well as create new initiatives and programs for rural British Columbia.

The JSC is offering a new initiative called Rural Physicians for BC (“RPs4BC”). This initiative will incent physicians and specialists to practice in select British Columbia rural communities. Primary and specialist physicians, as well as medical school residents transitioning to full-time rural practice, are eligible to apply for an incentive of up to \$100,000 upon accepting an identified position in an identified rural community. A total of \$2 million has been allocated to this program.

Other Delegated Bodies

- ***Medical Services Plan (“MSP”)***

The Commission delegates day-to-day functions such as the processing and payment of claims, to the Medical Services Plan.

In 2004, the Medical Services Commission supported MAXIMUS BC’s signing of an agreement with the Ministry of Health Services to manage MSP and PharmaCare administrative services on behalf of the Government of British Columbia. Medical Services Plan and PharmaCare operations were transferred to MAXIMUS BC effective

April 1, 2005. The new program name became Health Insurance BC (“HIBC”). The MSC receives regular updates regarding HIBC’s service level requirements and program performance.

The government assists more than 1.2 million people with payment of their MSP premiums. Regular Premium Assistance offers five levels of subsidy, based on an individual’s net income (or a couple’s combined income) for the preceding tax year, less deductions for age, family size, disability and any reported Universal Child Care Benefit and Registered Disability Savings Plan Income.

MSP’s Regular Premium Assistance program was enhanced in 2010 to allow more British Columbians to qualify and to allow persons already receiving a partial subsidy to qualify for a higher level of assistance.

Temporary Premium Assistance offers beneficiaries a 100 percent subsidy for a short term, based on current unexpected financial hardship.

In **2011/12**, the Medical Services Plan paid approximately 16,088 medical and health care providers over \$2.71 billion dollars relating to over 87.7 million services, rendered on a fee-for-service basis.

MSP paid approximately 16,546 medical and health care providers over \$2.77 billion relating to over 89.1 million services in **2012/13** and in **2013/14**, approximately 16,913 providers were paid over \$2.86 billion relating to over 91.8 million services.

Medical practitioners can also be paid for services using alternative payment methods including salaries, sessional contracts and service contracts.

The *Medical Services Commission Financial Statement* (the “Blue Book”) contains an alphabetical listing of payments made by the MSC to practitioners, groups, clinics, hospitals and diagnostic facilities for each fiscal year.

- ***Coverage Wait Period Review Committee***

The *Medicare Protection Act* requires individuals to live for at least three months in British Columbia to be eligible for MSP coverage. However, there are exceptional cases based on individual circumstances where the MSC waives this requirement and enrolls new residents before the coverage wait period has expired. The MSC has delegated the power to investigate and decide cases to the Coverage Wait Period Review Committee.

The Committee reviewed 115 waiver of the wait period requests between April 1, **2011** and March 31, **2012**, and granted 26 approvals, including an application from a client who incurred a head injury and required brain surgery during his wait period. Another application was approved for a client who delivered a premature baby due to a ruptured membrane. The Committee was concerned that without necessary medical care, the mother and unborn child may be at risk.

In addition, a special waiver of the coverage wait period was approved for Canadian

citizens and holders of permanent resident status who repatriated to British Columbia in the aftermath of unrest in Libya in 2011.

During **2012/13**, 56 waiver of the wait period requests were reviewed and 18 approvals were granted, including an application from a client who suffered a heart attack during his wait period and incurred significant hospital costs. Another approval was granted for a child who received a diagnosis of neuroblastoma during her wait period requiring emergency surgery and chemotherapy.

Between April 1, **2013** and March 31, **2014**, 57 waiver of the wait period requests were reviewed and 17 approvals were issued. One application was approved for a client who was diagnosed with placenta previa during her wait period and due to the risk to the mother and unborn child, hospitalization was required. Medical substantiation and financial statements provided showed an inability to pay and the Committee concluded that the mother and child were at further risk by delaying treatment. Another application was approved for a client who developed typhoid fever during his wait period and incurred over \$50,000 in health care costs.

A special waiver of the coverage wait period was approved for Canadian citizens and holders of permanent resident status who returned to British Columbia from the Philippines in the aftermath of the typhoon that hit that country in November 2013.

The Committee denied several applications during 2011/12 – 2013/14 from new residents expecting babies during their wait periods, as the onus is on families to have medical insurance in place before arrival in British Columbia, or to budget in advance for the cost of the birth.

MSC Hearing Panels

Commission members, or delegates of the Commission, may conduct hearings related to the exercise of the MSC's statutory decision-making powers.

Some hearings are required by the Act, and some have been implemented by the Commission to afford individuals affected by its decisions the opportunity to be heard in person. Hearings are governed by the duty to act fairly. Decisions of the MSC hearing panels may be judicially reviewed by the Supreme Court of British Columbia.

1. Beneficiary Hearings

Residency (eligibility) hearings and panel reviews of claims for elective (non-emergency) out-of-country medical care funding are the two types of MSP beneficiary hearings currently conducted by the Medical Services Commission.

Residency Hearings

A person must meet the definition of resident in s.5 of the Act to be eligible for provincial health care benefits. As per s.7 of the Act, the MSC may cancel the MSP enrollment of

individuals whom it determines are not residents. Section 11 of the Act requires that prior to making an order cancelling a beneficiary's enrollment, the MSC must notify the beneficiary that he or she has a right to a hearing. Individuals whose MSP coverage is cancelled have the right to appeal to the Commission. Residency hearings are conducted by a single-person MSC panel.

Between April 1, **2011** and March 31, **2014**, the Commission received 31 requests for residency appeals and 15 hearings were held.

Out-of-Country Hearings

The Medical Services Plan will reimburse medically necessary services performed outside of Canada when the required services are not available within Canada. Appropriate British Columbia specialists recommending these services must obtain prior approval on behalf of their patients for subsequent medical claims to be considered for payment. The decision to approve MSP payments for out-of-country medical services is based on published criteria available in the *Medical Services Commission Out-of-Province and Out-of-Country Medical Care Guidelines for Funding Approval* (the "Guidelines").

An MSC appeal process is in place for beneficiaries who are denied funding for elective (non-emergency) out-of-country medical care. The Act does not impose a duty on the Commission to hear and decide requests to review MSP's decisions regarding claims for out-of-country medical care, but rather, it is the Commission's choice to offer beneficiaries the option for appeal hearings.

From April 1, **2011** to March 31, **2012**, MSP received 2,198 requests for out-of-country elective medical treatment. Funding was authorized for 2,093 requests and 105 cases were denied.

From April 1, **2012** to March 31, **2013**, 2,596 requests for out-of-country elective medical treatment were received. Funding was authorized for 2,452 requests and 144 cases were denied.

From April 1, **2013** to March 31, **2014**, MSP received 2,444 requests for out-of-country elective medical treatment. Funding was authorized for 2,257 requests and 187 cases were denied. Three denied out-of-country cases were appealed to the Medical Services Commission and hearings were held to review MSP's funding decisions. An additional case was settled prior to a hearing date being set and one case was abandoned.

2. Diagnostic Facility Hearings

Under s.33 of the Act, the MSC may add new conditions or amend existing ones to an approval of a diagnostic facility. This may be done either on application by the facility owner, or on the Commission's own initiative. Before taking action, the Commission is required to provide the owner of the facility an opportunity to be heard [s.33(4)].

A hearing before the MSC is usually requested for one of the following two reasons:

- The Advisory Committee on Diagnostic Facilities (“ACDF”) has recommended to the Commission that an application to amend or add conditions to an existing approval be denied; or
- The ACDF has recommended to the Commission that an approval be suspended, amended or cancelled because the facility owner is alleged to have contravened the Act, the regulations, or a condition on the approval.

Diagnostic facility hearings are conducted before either a single-person or three-person MSC panel, depending on the type of appeal.

In **2011/12**, one request for a diagnostic facility appeal hearing was withdrawn. No further appeals were filed or hearings held during **2012/13** and **2013/14**.

3. Hearings Related to Medical Practitioners

Audit hearings and de-enrollment for “cause” are the two types of MSC statutory hearings related to medical practitioners.

Audit Hearings

Under s.37 of the Act, the Commission may make orders requiring medical practitioners or owners of diagnostic facilities to make payments to the MSC in circumstances where it determines, after a hearing, an amount due to (a) an unjustified departure from the patterns of practice or billing of physicians in this category; (b) a claim for payment for a benefit that was not rendered; or (c) a misrepresentation about the nature or extent of benefits rendered. These hearings are the most formal of all the administrative hearings currently done by the MSC. Practitioners are usually represented by legal counsel and the hearings may last one to two weeks.

Since the introduction of the Alternative Dispute Resolution (“ADR”) process in 2000, fewer billing matters proceed to formal hearings. The ADR process employs both unassisted and assisted (with a mediator) negotiation to encourage medical practitioners and the MSC to reach a negotiated settlement of s.37 disputes.

No medical practitioner audit hearings were held by the MSC in **2011/12** or **2012/13**.

In **2013/14**, one audit hearing commenced but was subsequently adjourned by order of the panel, as a settlement was reached by the parties.

De-enrollment of Medical Practitioners for “Cause”

No medical practitioner de-enrollment hearings were held by the MSC in **2011/12** or **2012/13**.

In **2013/14**, four de-enrollments occurred as follows:

- Two de-enrollments were reached through settlement; one for 14 months and the other for three months; and
- Two medical practitioners agreed to cancel their enrollment.

4. Hearings Related to Health Care Practitioners

Audit hearings and de-enrollment for “cause” are the two types of Health Care Practitioners Special Committee for Audit Hearings (“HCPSCAH”) statutory hearings related to health care practitioners.

Audit Hearings

The HCPSCAH under s.4 of the *Medicare Protection Act* exercises the MSC’s hearing powers over health care practitioners. Under s.37 of the Act, the HCPSCAH may make orders requiring health care practitioners to make payments to the MSC in circumstances where it determines, after a hearing, an amount due to (a) an unjustified departure from the patterns of practice or billing of practitioner in this category; (b) a claim for payment for a benefit that was not rendered; or (c) a misrepresentation about the nature or extent of benefits rendered. These hearings are the most formal of all the administrative hearings currently done by the HCPSCAH. Practitioners are usually represented by legal counsel and the hearings may last one to two weeks.

Since the introduction of the Alternative Dispute Resolution (ADR) process in 2000, fewer billing matters proceed to formal hearings. The ADR process employs both unassisted and assisted (with a mediator) negotiation to encourage medical practitioners and the MSC to reach a negotiated settlement of s.37 disputes.

No health care practitioner audit hearings were held in **2011/12** or **2012/13**.

Two hearings were held by the HCPSCAH in **2013/14**:

- One hearing resulted in an order for repayment to the MSC of \$1,758,590; and
- A second hearing resulted in an order for repayment to the MSC of \$891,376 and lifetime de-enrollment from the Medical Services Plan.

De-enrollment of Health Care Practitioners for “Cause”

No de-enrollment of health care practitioners occurred in **2011/12**.

In **2012/13**, one de-enrollment of a health care practitioner for three years was reached through settlement.

In **2013/14**, two de-enrollments of health care practitioners occurred:

- One de-enrollment was ordered through the hearing process; and
- One de-enrollment was by default due to a licence cancellation by a practitioner’s professional body.

Other 2011/12 – 2013/14 MSC Highlights and Issues

The Medical Services Commission held six regular business meetings and conducted one email vote between April 1, **2011** and March 31, **2012**.

Between April 1, **2012** and March 31, **2013**, the Commission held eight regular business meetings and three teleconference meetings.

The Commission held eight regular business meetings and one strategic planning session between April 1, **2013** and March 31, **2014**.

- ***Physician Master Agreement (“PMA”) and Subsidiary Agreements***

The Commission is a signatory to the *Physician Master Agreement* (and subsidiary agreements) between the Government of British Columbia and the Doctors of BC (formerly the BCMA) and in 2011 and 2013 prior to the signing of the 2012 *Physician Master Agreement* and the 2014 re-opener, the MSC provided input to the negotiations by identifying points for both parties to consider.

- ***Medical Services Commission Payment Schedule***

The *Medical Services Commission (MSC) Payment Schedule* is the list of fees approved by the MSC payable to physicians for insured medical services provided to beneficiaries enrolled with the Medical Services Plan. Additions, deletions, fee changes or other modifications to the *MSC Payment Schedule* are implemented in the form of signed Minutes of the Commission.

In **2011/12**, 167 Minutes of the Commission related to the *MSC Payment Schedule* were approved, resulting in a total of 156 new fee items (105 regular fees; one General Practice Services Committee/“GPSC” fee item; and 50 new Labour Market Adjustment /“LMA” fees). Amendments were made to 234 regular fee items, 27 GPSC fees and 52 Specialist Services Committee/“SSC” (including LMA) fee items. Forty-six regular fee items and four GPSC items were deleted, and the provisional status was extended for 34 fee items.

In **2012/13**, 120 Minutes of the Commission were approved, resulting in a total of 33 new fee items (31 regular fees and two new SSC-funded items). Amendments were made to 135 regular fee items, 18 GPSC fees and 144 SSC fee items. Three regular fee items were deleted and the provisional status was extended for 151 fee items.

In **2013/14**, 107 Minutes of the Commission pertaining to the *MSC Payment Schedule* were approved, resulting in a total of 97 new fee items (90 regular fees and 7 new GPSC fee items). Amendments were made to 242 regular fee items, 10 GPSC fees and seven SSC fee items. Four amendments to the *MSC Payment Schedule* Preamble were also made. Eighteen regular fee items and one SSC-funded item were deleted and the provisional status was extended for 81 fees.

- ***Dermoscopy Fee Proposal***

At its October 2012 meeting, the Commission heard representations from the BCMA and the Ministry of Health with respect to the BCMA Section of Dermatology's application to have a new fee item for dermoscopy established in the *Medical Services Commission Payment Schedule*. The Commission deliberated the matter in detail and concluded that dermoscopy is an expected part of a dermatology office visit and consultation and that a separate fee should not be established.

- ***Office of the Auditor General ("OAG") – Oversight of Physician Services Audit***

During 2013/14, the Commission provided input to the Office of the Auditor General's broad audit of the oversight of physician services in British Columbia including the fee-for-service model, and responded to the OAG's draft report prior to its final release.

- ***Strategic Planning***

The Commission identified its objectives and priority directions at a planning session in 2013/14. Strategies included developing and promoting guidelines and protocols to support appropriate patient care, monitoring the effective administration of the Medical Services Plan, and responding to extra billing complaints pursuant to the *Medicare Protection Act*. The Commission also engaged in dialogue with the Ministry of Health and the Doctors of BC regarding expenditure analysis, utilization and management of the Available Amount and continued to receive regular reports from its advisory committees.

The Commission invited the Deputy Minister of Health as well as the CEO of the Doctors of BC to attend a portion of its strategic planning session.

- ***BC Services Card***

The Commission received regular updates throughout 2011/12 – 2012/13 regarding the BC Services Card project and continued to endorse proposed policy changes associated with the introduction of the new card.

Changes to the *Medicare Protection Act* and the Medical and Health Care Services Regulation in support of the BC Services Card program have resulted in the requirement for all eligible adult beneficiaries aged 19 and over to complete two steps in order to enrol in the MSP. The new *Two-Step Enrolment* process consists of submitting an application to HIBC with proof of status in Canada, and visiting an ICBC office or appointed agent to confirm residency and be identity proofed (showing a piece of primary and secondary ID, having a photo taken and providing a signature).

Adult beneficiaries aged 19 to 75 have a new requirement to renew enrolment by February 10, 2018. For most adult beneficiaries renewal is completed by attending an ICBC office or appointed agent to confirm residency and be identity proofed.

The regulatory and legislative changes also establish a duty for practitioners to verify enrolment prior to charging for MSP services. A second duty was established for

practitioners, health authority employees, and diagnostic facility employees who suspect that a person is attempting to obtain MSP benefits to which they are not entitled, to report those suspicions to the Commission.

- ***Presentations to the MSC***

The Commission received presentations on several additional issues during 2011/12 – 2013/14, including:

- A discussion with the Deputy Minister of Health regarding Ministry priorities, health spending management and the government's *Budget and Fiscal Plan for 2013/14 – 2015/16*;
- Information pertaining to physician quality assurance and health sector changes that have occurred in British Columbia as a result of Dr. Doug Cochrane's *Investigation Into Medical Imaging, Credentialing and Quality Assurance* report;
- An overview of the *Laboratory Services Act* ("LSA") that was introduced in the Legislature in 2014, establishing a framework to strengthen and standardize British Columbia's clinical laboratory system. The new LSA will fall under the authority of the Minister of Health and once in force, will remove laboratory services from the *Medicare Protection Act* and the *Hospital Insurance Act*. The Minister will be responsible for governance and accountability, audit and provision of benefits and compensation for all laboratory services in British Columbia.
- Details regarding the Ministry of Health's new policy related to cataract surgery and intraocular lenses ("IOLs") that prompted the Commission to refer a proposal from an ophthalmologist to the Ministry and the Doctors of BC that the fee item for an Ophthalmic A-Scan be renamed to include a newer IOL Master Measurement procedure;
- An update on wait list management policies and surgical priorities in British Columbia;
- An overview of the role of the College of Physicians and Surgeons of British Columbia and a discussion regarding quality medical care;
- Background regarding provincial telehealth services;
- An outline of the Ministry's Health Technology Review and the process for making evidence-informed recommendations about public coverage of new non-drug, non-IT health technologies in British Columbia.

The Commission also invited the co-chairs of the General Practice Services Committee (“GPSC”), the Specialist Services Committee (“SSC”) and the Shared Care Committee (“SCC”) to update on their committees’ various collaborative initiatives throughout 2011/12 – 2013/14.

- *MSC-Related Legal Cases*

As part of its oversight of the Medical Services Plan, the Commission monitors legal issues that arise as a result of MSP or Ministry of Health-related decisions and is sometimes actively involved in litigation as a named party.

The following cases were considered and/or participated in by the Commission during 2011/12 – 2013/14:

Extra Billing/Private Clinic Issues

The purpose of the *Medicare Protection Act* is to preserve a publicly managed and fiscally sustainable health care system for British Columbia in which access to necessary medical care is based on need and not on an individual’s ability to pay. Extra billing occurs when an MSP beneficiary receives a medically necessary benefit from an enrolled physician and is charged for it or for services in relation to that benefit by a person or entity (e.g., a clinic). Extra billing violates the *Medicare Protection Act*. Section 17 of the Act prohibits a person from charging a beneficiary for a benefit or for materials, consultations, procedures, the use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit.

Sections 10 and 11 of the *Medicare Protection Amendment Act 2003* were brought into force through regulation on December 1, 2006. These sections contained an expansion of the audit and inspection powers in s.36 of the MPA and included a new s.45.1 giving the Commission the power to seek an injunction from a Court regarding contravention of certain stated provisions including the prohibition against extra billing.

Extra Billing Investigations

The Commission has developed processes for dealing with cases that come to its attention when concerns or complaints of extra billing arise.

In **2011/12**, one new case of suspected extra billing in a private clinic and/or by practitioners was referred to the Commission. Investigation of this case continued during the reporting period. The Commission also investigated a company offering private medical access insurance and a company operating as a broker of private clinic services in British Columbia.

Three extra billing cases from the previous year resulted in the Commission ordering audits in 2011/12. Three additional extra billing cases were closed in 2011/12, with no further action required.

Two extra billing audits ordered by the MSC in 2007 that commenced in January 2011

(as per the Extra Billing Litigation section below), continued during 2011/12. Nine additional extra billing audits ordered by the MSC (six in 2008 and three in 2011) have not yet occurred pending completion of these two audits.

During 2011/12 the Commission received eight extra billing referrals related to four private clinics where audits have already been ordered.

In **2012/13**, one extra billing case investigated by the Commission in 2011/12 was closed, with no further action required. An extra billing case related to a previously closed case was reopened and subsequently closed again.

Nine extra billing audits ordered by the MSC between 2008 and 2011 remained pending during 2012/13.

The Commission received four referrals related to three private clinics where audits have already been ordered and one referral related to a private clinic that has not been referred for audit.

In **2013/14**, one new case of suspected extra billing in a private clinic and/or by practitioners was referred to the Commission. Investigation of this case continued during the reporting period.

Nine extra billing audits ordered by the MSC between 2008 and 2011 remained pending during 2013/14.

The Commission received three referrals related to three private clinics where audits have already been ordered and two referrals related to two private clinics that have not been referred for audit.

Extra Billing Litigation

The private clinic litigation that commenced in the Supreme Court of British Columbia in January 2009 and which raised a *Canadian Charter of Rights and Freedoms* challenge to the validity of the extra billing prohibition in the *Medicare Protection Act*, was ongoing throughout 2011/12 – 2013/14.

In January 2009, legal proceedings were commenced against the Medical Services Commission, the Minister of Health Services of British Columbia, and the Attorney General of British Columbia (the government) alleging that sections 14, 17, 18, and 45 of the *Medicare Protection Act* are in breach of sections 7 and 15 of the *Canadian Charter of Rights and Freedoms* (the “*Charter*”). Sections 14, 17, and 18 relate to direct and extra billing, and s.45 prohibits private insurance for medical services covered by the Medical Service Plan. The current plaintiffs in this action (there have been several changes over the years) are Cambie Surgeries Corporation (“Cambie”), Specialist Referral Clinic (Vancouver) Inc. (“SRC”), and five individual patients.

The plaintiffs initially sought to prevent the Commission from conducting an audit of Cambie and SRC until the constitutional challenge had been resolved, but were

unsuccessful. The audit began in January of 2011. On May 20, 2012, the Ministry of Health auditors presented their completed audit report to the Commission. The audit report identified numerous violations of the *Medicare Protection Act* at both clinics, and supported the Commission's counterclaim for an injunction against the two clinics. In addition, the audit report indicated that some of the physicians at both clinics appear to have been involved in double billing (i.e., billing both the patient and the MSP in connection with the same service). The Commission therefore instructed the auditors to undertake a further audit of those physicians, focused on the issue of double billing. The Commission sought an interim injunction against Cambie and SRC in the fall of 2012. Procedural delays caused by the plaintiffs caused the Commission to agree to defer the injunction application in favour of a speedy trial. The trial, however, has repeatedly been delayed. Originally set for September of 2013, it was adjourned to January of 2014, and then again to September of 2014.

The parties have exchanged numerous expert reports, which are expected to be key to the resolution of the litigation. The defendants have produced thousands of documents, and the plaintiffs have produced approximately a thousand. The defendants examined some of the plaintiffs for discovery in the summer of 2013. The defendants were also granted the right to examine under oath several physicians who practice at Cambie and/or SRC. The plaintiffs have not yet conducted any examinations for discovery of representatives of the defendants.

Numerous parties have been granted leave by the Court to intervene in this litigation. One group of individuals had earlier petitioned the Court to compel the Commission to enforce the *Medicare Protection Act* provisions against private clinics; their petition has been put into abeyance pending the outcome of the constitutional challenge, but they have been granted the right to intervene. Another group of intervenors includes the British Columbia Health Coalition, Canadian Doctors for Medicare, two physicians, and two patients. The final intervenor is the British Columbia Anaesthesiologists' Society.

Pacific Centre for Reproductive Medicine

On June 28, 2013, the Pacific Centre for Reproductive Medicine ("PCRM") filed a petition for judicial review, seeking an order granting it a "license as an approved diagnostic facility, retroactive to August 16, 2012, so that it can bill the British Columbia Medical Services Plan for the provision of obstetrical and gynecological diagnostic ultrasound procedures." This proceeding arose from the Commission's refusal of an application made by PCRM on August 16, 2012 for approval of PCRM, under the Medical Services Plan, as a diagnostic facility.

The hearing of the petition was set to take place in February of 2014 in the Supreme Court of British Columbia and, following discussion between counsel as to what the nature of the application was and what the petitioner intended it to be, the hearing was adjourned in order to permit the Commission to consider an application that more precisely articulated the approval sought by the petitioner.

Class Action Lawsuit

This is a class proceeding brought against the Province of British Columbia and the Medical Services Commission by Dr. James Halvorson, a Cowichan District Hospital emergency room physician, on behalf of fee-for-service medical practitioners enrolled in the Medical Services Plan claiming payment of fees for services provided to patients whose enrollment as beneficiaries of MSP had been cancelled by the Commission for non-payment of premiums (during the period 1992 – 1996) or a period of no-contact (for the period from 1996 to the present).

The proceeding was originally filed in 1998 and has a lengthy procedural history. A certification hearing was held in July 2012, during which the parties reached an agreement on the terms of a Consent Order, which was approved by a justice of the Supreme Court of British Columbia on July 12, 2012. The Consent Order certified the action as a class action, and certified the two threshold legal issues concerning the authority of the Commission to de-enroll beneficiaries for non-payment of MSP premiums.

At a summary trial in April 2013, the Supreme Court found that the Commission did have the power to de-enroll beneficiaries under the statute that governed the Medical Services Plan after July 23, 1992. However, the plaintiff still has leave to apply to certify further common issues.

The plaintiff has served the Province and the Medical Services Commission with a Notice to Mediate, requiring the defendants to attend a mediation. No date has been fixed for the mediation.

The next steps will be to schedule a certification hearing once the plaintiff files his application to certify further common issues, and to schedule a mediation pursuant to the Notice to Mediate.

Human Rights Challenge re Multiple Sclerosis and the Treatment of Chronic Cerebrospinal Venous Insufficiency

In September 2010, a man suffering from multiple sclerosis (“MS”) filed a complaint with the Human Rights Tribunal against the Province of British Columbia (as represented by the Ministry of the Health, the Medical Services Commission, the College of Physicians and Surgeons of British Columbia and the Vancouver Island Health Authority) alleging discrimination in the provision of a service customarily available to the public.

The complainant contended that he was denied access to, and funding for, a controversial medical procedure promoted by Italian physician Dr. Paolo Zamboni. The procedure, frequently termed “liberation”, involves the application of venous angioplasty techniques to persons with MS. According to Dr. Zamboni’s theory, chronic cerebrospinal venous insufficiency (“CCSVI”) may be a cause of MS and venous angioplasty techniques may be a possible treatment for CCSVI resulting in improved drainage blood flow from the

brain. Liberation therapy has been a source of hope and interest for persons in the MS community.

The complainant alleged that although conventional angioplasties are provided by the public health care system and funded by the Medical Services Plan he was denied both MSP-funded screening and diagnostic services and the venous angioplasty procedure itself, because he had MS.

In early 2011 an application to dismiss the complaint was filed by all respondents. The respondents denied any discriminatory conduct and submitted affidavits, expert opinions and other supporting documentation.

On November 9, 2011, the applications to dismiss were granted and the complaint was dismissed against all respondents.

Appendices

Appendix 1: Members of the Medical Services Commission

Medical Services Commission representatives and alternate members are appointed by Order of the Lieutenant Governor in Council (“OIC”).

As of March 31, 2012:

Government of British Columbia Representatives:

- Mr. Bob Nakagawa (Chair) *
- Ms. Sheila Taylor (Deputy Chair) *
- Dr. Robert Halpenny

- Alternate Members: Ms. Nichola Manning *, Ms. Heather Davidson *, Ms. Stephanie Power *

British Columbia Medical Association (BCMA) Representatives:

- Dr. Brian Gregory
- Dr. Bryan Norton
- Mr. Darrell Thomson

- Alternate Members: Dr. Ian Gillespie **, Dr. Shelley Ross **, Mr. Allan Seckel *

Public Representatives:

- Ms. Isobel Mackenzie
- Ms. Melanie McKenzie
- Ms. Carol Collins *

* New OIC appointments – February 2012; ** New OIC appointments – October 2011

As of March 31, 2013:

Government of British Columbia Representatives:

- Mr. Tom Vincent (Chair) *
- Ms. Sheila Taylor (Deputy Chair)
- Dr. Robert Halpenny

- Alternate Members: Ms. Nichola Manning, Ms. Heather Davidson, Ms. Stephanie Power

British Columbia Medical Association (BCMA) Representatives:

- Dr. Brian Gregory
- Dr. Bryan Norton
- Dr. William Rife **

- Alternate Members: Dr. Nasir Jetha **, Dr. William Cunningham **,
Mr. Allan Seckel

Public Representatives:

- Ms. Isobel Mackenzie
- Ms. Melanie McKenzie
- Ms. Carol Collins

* New OIC appointment – April 2012; ** New OIC appointments – October 2012

As of March 31, 2014:**Government of British Columbia Representatives:**

- Mr. Tom Vincent (Chair)
- Ms. Sheila Taylor (Deputy Chair)
- Dr. Robert Halpenny

- Alternate Members: Ms. Nichola Manning, Ms. Heather Davidson,
Ms. Stephanie Power

Doctors of BC (formerly the BCMA) Representatives:

- Dr. Brian Gregory
- Dr. Bryan Norton
- Dr. William Rife

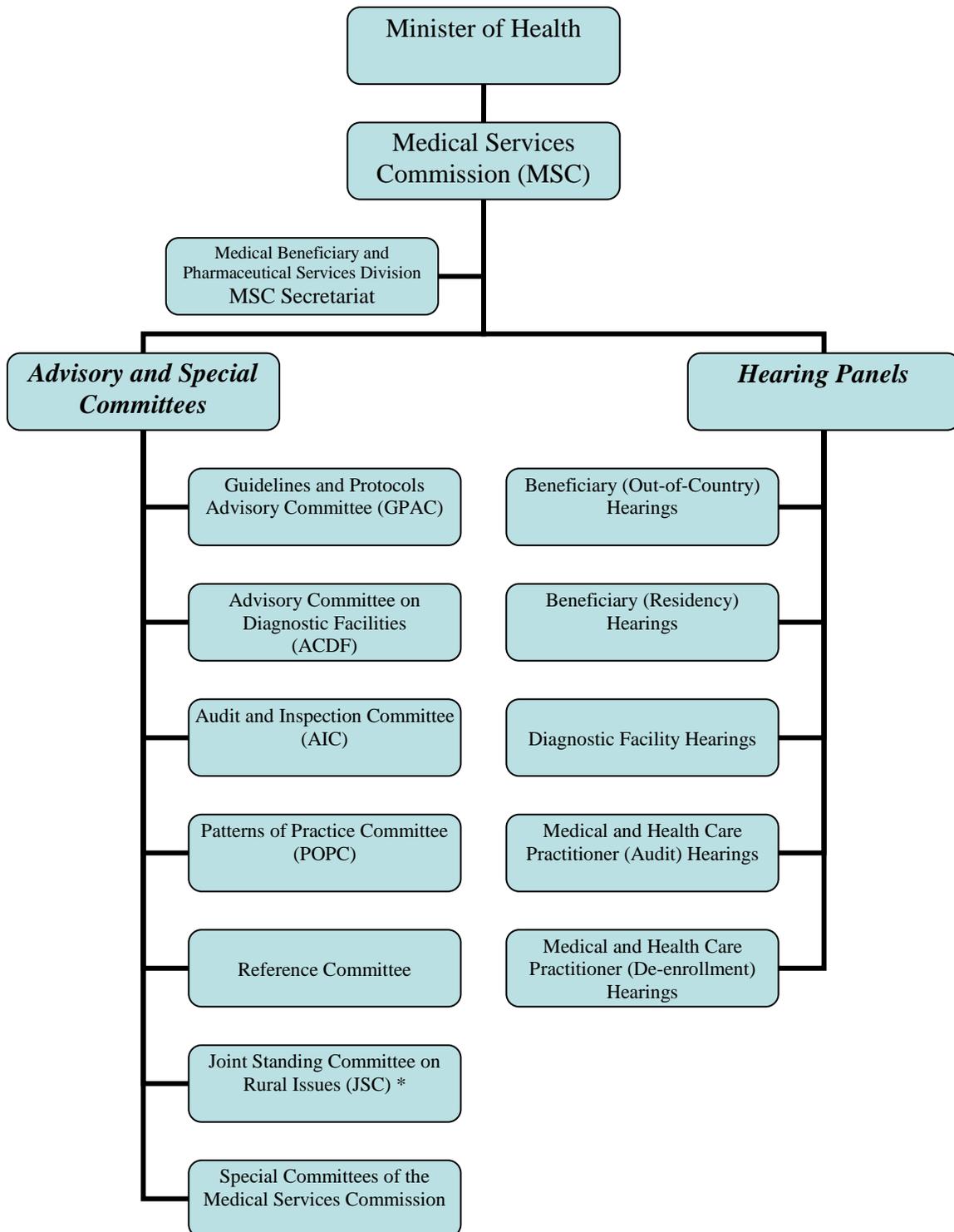
- Alternate Members: Dr. Shelley Ross *, Dr. William Cavers *, Mr. Allan Seckel

Public Representatives:

- Ms. Isobel Mackenzie
- Ms. Melanie Mahlman (formerly McKenzie)
- Ms. Carol Collins

* New OIC appointments – October 2013

Appendix 2: Medical Services Commission Organizational Chart



* Some of the funding for the work of the JSC comes from the Available Amount managed by the MSC.

Appendix 3: Medical Services Commission Mailing Address and Website

1515 Blanshard Street
PO BOX 9652 STN PROV GOVT
Victoria, BC
V8W 9P4

Telephone: 250-952-3073
Fax: 250-952-3133

Further information about the Medical Services Commission can be found online at:
<http://www.gov.bc.ca/medicalservicescommission> .

