

**MEDICAL SERVICES COMMISSION
OUT OF PROVINCE AND OUT OF COUNTRY MEDICAL CARE
GUIDELINES**

A. PREAMBLE

The primary purpose of the *Medicare Protection Act* is "to preserve a publicly managed and fiscally sustainable health care system for British Columbia (BC) in which access to necessary medical care is based on need and not an individual's ability to pay."

The Medical Services Commission ("MSC") has authority pursuant to the *Medicare Protection Act*, R.S.B.C. 1996 c.286, s.29, the Medical and Health Care Services Regulation, B.C. Reg.426/97, s.35, the *Hospital Insurance Act*, R.S.B.C. 1996 c.204, s.24 and the Hospital Insurance Act Regulations, B.C. Reg. 25/61, s.6, to give prior written approval for elective (non-emergency) medically necessary out of country medical care. This includes dental/oral surgical services for beneficiaries of the Medical Services Plan (MSP) when such services are provided by licensed medical practitioners*, dental/oral practitioners or a facility approved by the MSC. The actual administration of the prior written approval process is conducted by the Medical Services Branch (MSB), and its service provider Health Insurance BC on behalf of the MSC.

The purpose of these Guidelines is to clarify the criteria used when considering provincial funding for emergency or elective out of country medical services.¹ The underlying objective of the Guidelines is to ensure funding decisions do not encourage beneficiaries or physicians to bypass appropriate and acceptable medical services in BC and elsewhere in Canada. The Guidelines are administered in a manner consistent with the *Medicare Protection Act*, the Medical and Health Care Services Regulations, the *Hospital Insurance Act* and the Hospital Insurance Act Regulations.

In order for elective out of country medical care to be funded, prior written approval must be provided by MSB. In cases where out of country funding is appropriate, the pre-approval process enables MSB to negotiate a reasonable and fair compensation rate from out of country service providers prior to the provision of the service.

B. PRIOR APPROVAL NOT REQUIRED FOR CERTAIN CATEGORIES OF CARE

1. OUT OF PROVINCE (WITHIN CANADA) MEDICAL CARE:

Prior approval is not required for medically necessary care obtained by a beneficiary in another province or territory of Canada.

Medical coverage is portable in Canada. A resident of BC who is eligible for MSP coverage may use medically necessary services in another province or territory within Canada. The medical services must be medically necessary, insured services that are provided by a physician who is entitled to practice medicine in the province where the services are obtained. Medical services in other provinces will be paid at the appropriate provincial rates without prior approval unless otherwise stipulated by a reciprocal agreement*. (see *Appendix 3, Exclusions under the reciprocal agreements.*)

¹ The terms "emergency" and "elective" refer to provincial coverage, rather than to the level of urgency for medical care. Provincial coverage for emergency medical treatment applies to a BC resident who unexpectedly requires medical care while travelling in another country. Provincial coverage for elective medical treatment must be pre-approved for a BC resident who travels to another country for the purpose of obtaining a medical treatment.

* Terms with an asterisk are defined in Appendix 1

Under the terms of the appropriate reciprocal agreement, BC will fund the cost of physician and acute care hospital services in other Canadian provinces and territories (except Quebec) provided the service meets the following criteria:

- a) it is medically required;
- b) it is provided by a medical practitioner or oral surgeon entitled to practice in the province or territory where the service is rendered; and
- c) it would be a benefit if performed in BC unless otherwise stipulated by the terms of the reciprocal agreement.

In other Canadian provinces and territories (except Quebec), medical practitioners are encouraged to bill reciprocally rather than bill the beneficiary directly. In most cases, medical practitioners will bill the provincial health care plan where the service is provided and then BC will reimburse the province or territory where services were provided.

In-patient hospital care at approved acute care facilities outside the province will be reimbursed at the rate established in the reciprocal agreement in accordance with the *Hospital Insurance Act* and Regulations.

2. OUT OF COUNTRY EMERGENCY CARE:

Prior approval is not required for out of country emergency medical care.

The province provides funding for emergency out of country medical and dental/oral surgical services when immediate medical treatment is necessary and the need occurs unexpectedly when a beneficiary is travelling for business or pleasure or studying outside of Canada.

The coverage for medical services outside of Canada allows payment up to the fee rates that have been established in the British Columbia Medical Services Commission Payment Schedule*, in Canadian funds.

The coverage for in-patient hospital care, when care is provided at an approved acute care facility outside of Canada is limited to the rate established under the *Hospital Insurance Act*, which is currently a maximum payment of \$75 per day, in Canadian funds.

The costs for physician and hospital services outside of Canada are very often considerably more than the provincial fee rates; therefore, **beneficiaries are very strongly encouraged to purchase additional insurance when travelling outside of the country.**

C. ELECTIVE (NON-EMERGENCY) OUT OF COUNTRY MEDICAL CARE

In order for the province to consider funding for elective out of country medical care, the attending medical specialist must forward the application for coverage prior to the out of country treatment being provided.

In cases where out of country funding is approved, the prior approval enables the province to negotiate a reasonable and fair compensation rate with the out of country service provider. The application process for out of country medical funding is detailed under *Appendix 2, Application and Review Process for Funding of Out of Country Medical Care*.

In the rare circumstances when an application is received after the provision of out of country medical services, the beneficiary's specialist must provide the appropriate documentation specified in *Appendix 2, Application and Review Process for Funding of Out of Country Medical Care*

* Terms with an asterisk are defined in Appendix 1

1. In relation to an application for elective out of country medical care, MSB may consider:
 - a) whether the treatment is recommended by the medical profession in BC and/or elsewhere in Canada;
 - b) if the treatment is experimental or developmental, Health Canada's position with respect to the efficacy of the treatment including if a drug or device has been approved by Health Canada for the proposed use;
 - c) if a procedure offered in the United States is beyond Phase III clinical trials and approved by the Centers for Medicare & Medicaid Services; and
 - d) whether all avenues for treatment within the Canadian healthcare system have been exhausted.

2. Funding approval will **not** be granted in the following circumstances:
 - a) the application is incomplete;
 - b) the application is for services that are not medically necessary;
 - c) appropriate and acceptable medical care is available in BC or elsewhere in Canada;
 - (i) If an appropriate and medically acceptable treatment (standard of care) for a beneficiary's condition is available in BC or elsewhere in Canada, funding for out of country medical services will not be approved;
 - (ii) If appropriate and medically acceptable treatment for a beneficiary's condition is not available in BC or elsewhere in Canada because of significant medical controversy, and the appropriate specialist recommends out of country medical care that is of proven value,* and when prior approval is given, funding may be approved at a negotiated usual and customary rate (U&C)*.
 - (iii) The appropriate specialist making application on behalf of a beneficiary must provide documented evidence showing the requested out of country medical care will result in a significant difference in success or mortality rates for the patient's condition.
 - (iv) The existence of a wait-list in BC or elsewhere in Canada for the requested care will not be accepted as evidence that the care is not available in BC or elsewhere in Canada. The existence of a wait-list will only be taken into account in considering whether delay in the provision of medical care available in BC or elsewhere in Canada can be shown to be immediately life-threatening or result in medically significant irreversible tissue damage.
 - d) the delay in the provision of medical care available in BC or elsewhere in Canada cannot be shown to be immediately life threatening or result in medically significant irreversible tissue damage;
 - (i) The existence of a wait-list in BC or elsewhere in Canada for the requested care will only be taken into account in the context of determining whether there is evidence that the delay caused by the wait-list can be shown to be immediately life threatening or to result in medically significant irreversible tissue damage.
 - e) the application has been made without a referral from the appropriate specialist* involved in the beneficiary's care in BC;

** Terms with an asterisk are defined in Appendix 1*

- (i) Except as noted in these Guidelines, the referral or opinion of a specialist from outside of BC will not be accepted in support of an application for out of country funding.
- f) the medical care or service applied for is unproven, experimental, or in the early stages of development;
 - (i) Funding is not provided for unconventional, experimental or developmental* treatment, emerging treatments or diagnostic processes or clinical trials where the efficacy of the service is not known.
 - (ii) The appropriate medical specialist making application on behalf of a beneficiary for pre-approval of out of country new or emerging medical services and treatment under this provision must provide documentation of reputable clinical trials beyond Phase III, published in peer reviewed medical literature.
- g) an application for services that are not considered benefits under the *Medicare Protection Act*, the Medical and Health Care Services Regulations or the *Hospital Insurance Act* and Regulations. Such services include travel and related accommodation costs, ambulance fees, out of hospital drug costs and services provided by non-physician professionals; or
- h) an application for supplementary benefits* to be provided by a health care practitioner.*

D. GUIDELINES SPECIFIC TO ELECTIVE (NON-EMERGENCY) OUT OF COUNTRY CARE

1. Additional Consultations and Investigations

- a) In the event that the appropriate specialist(s) in BC and Canada has not been able to provide a diagnosis or medical management plan, coverage may be approved for out of country consultations and medically necessary related investigations. If funding is approved, payment will be made up to negotiated U&C* rates.
- b) If there is a working diagnosis and/or medical management plan, and the appropriate BC specialist requests another opinion from an out of country centre of excellence, coverage will be reviewed and if funding is approved, payment will be made up to the BC fee rates.
- c) If the out of country medical treatment is recommended to the beneficiary as a result of out of country consultations and related investigations, coverage will be reviewed under the Guidelines.

2. Coverage for Continuing Out Of Country Medical Care

- a) If coverage is approved for out of country medical care and the attending specialist wishes to extend the treatment period, the specialist must submit the application to extend funding for out of country treatment and must include the current medical evaluation, the treatment plan and the transfer protocol.

3. Support Network

- a) If a beneficiary does not have a family/support network in BC, and the appropriate specialist supplies evidence to detail how family support is essential to a patient's recovery, coverage may be considered for out of country medical care in the location in which that family support is available. The coverage decision will take into consideration the broad range of provincially funded community and social services that are available in BC.
- b) If coverage is approved under this provision, payment will be made at the BC rates for physician and hospital services, in Canadian funds.

* Terms with an asterisk are defined in Appendix 1

4. Laboratory and Medical Imaging Tests

- a) Funding will not be provided for experimental or developmental laboratory and medical imaging tests where the efficacy of such services is not known.
- b) In order for proven laboratory and medical imaging tests to be funded out of country, all diagnostic avenues in BC and Canada must have been exhausted.
- c) If laboratory and medical imaging tests are not available in Canada, but are of proven value, the appropriate specialist may request coverage for out of country tests. Funding will be approved only when the test information is expected to significantly alter the management of the beneficiary's condition. In limited circumstances, US Food and Drug Administration (FDA) approved laboratory and medical imaging processes may be deemed medically necessary if promising outcomes have been substantiated by reputable clinical trials, beyond Phase III published in peer reviewed medical literature.
- d) It is the responsibility of the appropriate medical specialist to provide peer reviewed medical literature, with the application for out of country laboratory or medical imaging tests

5. Genetic Tests

Genetic testing performed within BC is not funded by MSP, but it is funded through health authority* funding when it is medically necessary to the medical management of the beneficiary's condition.

If out of country genetic testing is medically necessary to create a new medical treatment plan for the beneficiary or to significantly alter current medical treatment for the beneficiary, funding may be approved by MSB, subject to these Guidelines.

6. Oncology Services

- a) Any service that is considered the responsibility of the British Columbia Cancer Agency (BCCA), because the modality of treatment is delivered by the BCCA or its programs, requires a written recommendation by the Medical Director of the BCCA. The attending specialist must include the BCCA recommendation with the application for pre-approval of funding for out of country medical treatment. Such treatments include chemotherapy, radiation or surgery.
- b) It is the responsibility of the attending medical specialist to provide written documentation of a review and recommendation from the appropriate conference or team review of the BCCA regarding the referral for out of country treatment.
- c) If medically necessary cancer treatment is not available in Canada, a negotiated U&C* rate will apply for out of country treatment.

7. Stereotactic Radiotherapy/Radiosurgery by Gamma Knife

- a) Prior authorization must be sought by the attending specialist, with expert knowledge of the proposed treatment
- b) Referrals for treatment of trigeminal neuralgia (tic douloureux) must include medical documentation to confirm severe disability and medical/surgical treatment has not proven successful or is not indicated in the clinical circumstances
- c) Authorization for treatment of movement disorders will not be granted.

* Terms with an asterisk are defined in Appendix 1

8. Solid Organ Transplants

Applications for solid organ transplants must be made directly to the British Columbia Transplant Society (BCTS). MSP funds physician services in connection with solid organ transplants by agreement with the BCTS. Out of country facility* charges are funded by the BCTS.

9. Elective Medical Psychotherapy and/or Addiction Treatment Services

- a) Generally, elective medical psychotherapy and/or addiction treatment services are not eligible for out of country funding because treatment services are available in BC.

The determination of whether treatment services are available in BC may be made in consultation with the appropriate health authority, Mental Health and Addictions Director. Exceptions may be funded pursuant to these Guidelines.

- b) Applications for out of country funding for elective medical psychotherapy and/or addiction treatment services require the following information to be submitted by the appropriate specialist involved in the beneficiary's care:
- (i) details of the referring physician's attempts to locate appropriate medical care within Canada;
 - (ii) a written treatment plan and transfer protocol*;
 - (iii) proof of accreditation of the proposed facility; and
 - (iv) approximate length of stay for the treatment plan and an undertaking by the out of country treating physician to provide MSP and the referring specialist with monthly follow-up reports on the outcomes of the treatment program.
- c) If funding is approved under this provision, payment will be at the negotiated U&C* or contract rate.

10. Eating Disorders

- a) Generally, eating disorder treatment services are not eligible for out of country funding because treatment services are available in BC. Exceptions may be funded pursuant to these Guidelines.
- b) Applications for out of country funding for treatment of eating disorders outside of Canada require the following information to be submitted by the appropriate specialist involved in the beneficiary's care:
- (i) a written recommendation based on an assessment by the Director of the St. Paul's Hospital Eating Disorders Program (located at St. Paul's Hospital in Vancouver) following assessment and referral from a BC tertiary eating disorder program (for adults, St. Paul's Hospital Eating Disorders Program, for children, B.C. Children's Hospital Eating Disorders Program);
 - (ii) details of the referring physician's attempts to locate appropriate medical care within Canada;
 - (iii) a written treatment plan and transfer protocol*;
 - (iv) proof of accreditation of the proposed facility; and
 - (v) approximate length of stay for the treatment plan and an undertaking by the out of country treating physician to provide MSP and the referring specialist with monthly follow-up reports on the outcomes of the treatment program.
- c) If funding is approved under this provision, payment will be at the negotiated U&C* or contract rate.

* Terms with an asterisk are defined in Appendix 1

For further information please contact:

Authorization Coordinator – Out of Country Programs
Health Insurance BC
866 456-6950 Toll Free Victoria and Other Areas in BC
604 456-6950 Vancouver
250 405-3588 Facsimile

Appendix 1

DEFINITIONS

"**appropriate specialist**" means a medical practitioner actively involved in the beneficiary's care with expert knowledge in the proposed service and/or specialty that will deliver the out of country service;

"**BC rate**" means insured emergency medical services, provided by an out of country physician, will be paid up to the payment rates listed in the Medical Services Commission Payment Schedule. "BC rate" for in-patient hospital services is the standard ward rate, established for in-patient care in BC

"**Emergency rate**" means insured emergency in-patient hospital services, in an accredited out of country hospital, will be paid up to \$75 per day in accordance with the *Hospital Insurance Act* and Regulations, Section 6 (2) (b)

"**experimental and developmental treatment**" means treatment that **has not** been the subject of reputable Phase III clinical trials with the trial findings published in peer reviewed medical literature;

"**facility**" means a hospital or part of a hospital, the prime function of which is to provide medically necessary services and/or treatment to patients. A facility must be duly registered as a medical hospital, by the appropriate accreditation body, in the jurisdiction where the facility is located;

"**health authority**" means the Provincial Health Services Authority (PHSA) or one of the five health authorities that provide access to a coordinated network of health care services, in BC;

"**health care practitioner**" means a person who is entitled to practice under an enactment:

- a) a chiropractor,
- b) a dentist,
- c) an optometrist,
- d) a podiatrist,
- e) a midwife,
- f) a nurse practitioner,
- g) a physical therapist,
- h) a massage therapist,
- i) a naturopathic practitioner, or
- j) an acupuncturist;

"**medical practitioner**" means a person who is entitled to practice under the *Medical Practitioners Act*;

"**practitioner**" means a medical practitioner, as defined above, or a health care practitioner who is registered with the Medical Services Plan;

"**payment schedule**" means a payment schedule established under section 26 of the *Medicare Protection Act*;

"**proven value**" means a treatment that has been the subject of a reputable Phase III clinical trial with the results of the trial published in peer reviewed medical literature;

"**reciprocal agreement**" means an agreement between BC and another Canadian province or territory to pay for insured services provided in a province or territory to a resident of another province or territory when that resident presents with a valid Provincial Health Registration Card;

"**supplementary benefits**" means services provided by a chiropractor, podiatrist, physical therapist, naturopath, optometrist, massage therapist, acupuncturist or osteopath;

"transfer protocol" means a written plan detailing date and manner of return of the beneficiary to BC following the provision of out of country medical care;

"usual and customary rate" (U&C) is the preferred customer rate that MSB will negotiate in advance of the provision of out of country medical services during the pre-approval process. It is a preferred rate received by large insurance providers.

Appendix 2

APPLICATION AND REVIEW PROCESS FOR FUNDING OF OUT OF COUNTRY MEDICAL CARE

A. INTRODUCTION

Prior approval of provincial coverage for elective out of country medical care is the responsibility of Out of Country Claims Branch, HIBC, and the Medical Services Branch, Ministry of Health Services, in accordance with Guidelines established by the Medical Services Commission. These Guidelines are established under the authority of the *Medicare Protection Act* and the *Hospital Insurance Act*.

In order to consider provincial coverage for elective out of country medical care, an application for prior approval must be received by HIBC. In cases where out of country funding is appropriate, the pre-approval process enables the province to negotiate a reasonable and fair compensation rate from out of country service providers prior to the provision of the service.

B. APPLICATION BY APPROPRIATE SPECIALIST

Applications for prior approval of funding for medically necessary out of country services must be submitted to HIBC by an appropriate specialist actively involved in the beneficiary's care in BC. An appropriate specialist is one with the most knowledge in the proposed service and/or specialty that will be provided out of country.

C. DOCUMENTATION

It is the responsibility of the appropriate medical specialist making application on behalf of the beneficiary to submit all supporting documentation, including, when appropriate or required, a written recommendation from the tertiary care centre or appropriate agency responsible for standards of care in BC regarding the proposed out of country medical care.

D. APPLICATIONS

Only complete applications will be considered. Incomplete or abandoned applications are not eligible for review by an authority delegated by the MSC.

An incomplete application is one that does not include a recommendation from the appropriate attending medical specialist and/or does not include the required documentation or written recommendation from a tertiary care centre or the appropriate agency responsible for the medical standard of care in BC.

If additional information is requested during the course of reviewing an application, the information must be received within 45 days of the request, or on an agreed date. If the information is not received, the application for out of country funding will be considered abandoned.

E. SUMMARY OF THE DECISION PROCESS

Stage 1 - Consideration and decision by Medical Services Branch

The completed application for funding approval and any supporting documentation is considered by MSB or its designate, Health Insurance BC, and a decision is made as to whether or not funding for out of country care will be provided. The beneficiary will be notified of the decision in writing.

Stage 2 - Administrative Review by Medical Services Branch

If the decision made by MSB is to deny the application for funding, the beneficiary may request an administrative review of the denial. To request the administrative review, the beneficiary must supply MSB with additional relevant information from the appropriate specialist.

The request for an administrative review must be made by the beneficiary within six months after the date of the initial determination made by MSB under Stage 1 (above). If the request for administrative review is not made within six months, the administrative review will not take place.

The beneficiary will be notified of the decision resulting from the administrative review in writing.

Stage 3 - Formal Review by Medical Services Commission

If, after the administrative review is concluded, the application for funding is denied again, the beneficiary may request that the MSC formally review the decision of MSB. The question for the MSC to determine in the formal review is whether MSB properly applied the Out of Province and Out of Country Medical Care Guidelines for Funding Approval.

The formal review is conducted by an MSC Review Panel, which consists of three members -- one representative from each of the Ministry of Health Services, the British Columbia Medical Association and the general public.

The following guidelines apply to the MSC formal review process:

- a) Beneficiaries may request an MSC Review Panel hearing only after an application for coverage has been through the regular application process and an administrative review has been completed by MSB.
- b) The request for a formal review by the MSC of the administrative review decision must be made by the beneficiary within six months after the date of the administrative review decision. If the request for the formal review is not made within six months, a formal review will not take place.
- c) Incomplete out of country funding applications and applications that are deemed abandoned by MSB are not eligible for review by the MSC Review Panel.
- d) MSC Review Panel hearings may be conducted through written submission, teleconference (depending on location) or in person. Travel, accommodation and other ancillary costs such as legal fees are the responsibility of the beneficiary or his or her legal representative.
- e) The MSC Review Panel will notify MSB and the beneficiary of their decision within 90 working days of the hearing unless otherwise agreed to by both parties.

Appendix 3

EXCLUSIONS UNDER THE RECIPROCAL AGREEMENTS

Effective April 1, 1989

Medical Practitioners in other Canadian provinces and territories (except Quebec) are encouraged to bill reciprocally rather than bill the beneficiary directly. The following are medical services excluded under the inter-provincial agreements for the reciprocal processing of out of province medical claims:

- Surgery for alteration of appearance (cosmetic surgery)
- Gender reassignment surgery
- Surgery for reversal of sterilization
- Therapeutic abortions
- Routine periodic health examinations including routine eye examinations
- In-vitro fertilization, artificial insemination
- Acupuncture, acupressure, transcutaneous elector-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy
- Services to persons covered by other agencies: RCMP, Armed Forces, Worker's Compensation Board, Department of Veteran's Affairs, Corrections Services of Canada (federal penitentiaries).
- Services requested by a "third party"
- Team conferences
- Genetic screening and other genetic investigations including DNA probes
- Procedures still in the experimental or developmental phase
- Anaesthetic services and surgical assistant services associated with all of the foregoing
- Supplementary practitioners' services, (e.g. chiropractic, physiotherapy, naturopathy)
- Oral surgery/dental surgery may be reimbursable however the scope of treatment may vary according to terms of other individual provincial benefit plans.