Medical Services Commission

2024/25 Annual Report

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THE MEDICAL SERVICES COMMISSION ACKNOWLEDGES THE TERRITORIES OF FIRST NATIONS THROUGHOUT BRITISH COLUMBIA AND IS GRATEFUL TO CARRY OUT OUR WORK ON THESE UNCEDED LANDS.

WE ACKNOWLEDGE THE RIGHTS, INTERESTS, AND CONCERNS OF ALL INDIGENOUS PEOPLES – FIRST NATIONS, MÉTIS, AND INUIT – RESPECTING AND APPRECIATING THEIR DISTINCT CULTURES, HISTORIES, RIGHTS, LAWS, AND GOVERNMENTS.

FUNCTION

To facilitate reasonable access throughout British Columbia to quality medical care, health care, and prescribed diagnostic services for residents of B.C. under the Medical Services Plan (MSP) in the manner provided in the *Medicare Protection Act* (MPA).

The MPA allows the Medical Services Commission (the Commission) to delegate some powers and duties to special committees, advisory committees, and hearing panels in order to effectively carry out its function.

THE COMMISSION

Established in 1967 under the *Medical Services Act*, the Commission continues under the current MPA.

Through the MSP and on behalf of the Government of B.C., the Commission oversees the provision, verification, and payment of medical and health services in an efficient and cost-effective manner.

The Commission must have regard to the principles outlined in the *Canada Health Act* and the principle of sustainability.

Consistent with these principles is the fundamental belief that access to necessary medical care be solely based on need and not on an individual's ability to pay.

ORGANIZATIONAL STRUCTURE

The Commission reports to the Minister of Health.
(see Appendix 2).

Under appointment by the Lieutenant Governor in Council, the Commission consists of nine members, (see Appendix 1):

- three individuals nominated by the Doctors of BC (DoBC),
- three individuals designated on the joint recommendation of the Minister of Health and the DoBC to represent MSP beneficiaries, and
- three individuals representing the government.

This unique tri-partite partnership among physicians, beneficiaries, and government ensures the involvement of individuals with various roles in the provision of medical services in B.C.

RESPONSIBILITIES

- monitoring the Available Amount, a fund set annually by government to pay practitioners on a fee-for-service basis for medical services provided to MSP beneficiaries.
- establishing payment schedules for practitioners;
- administering the MPA;
- investigating reports of extra billing;
- investigating unjustifiable departure from billing patterns of practice;
- hearing appeals brought by beneficiaries, diagnostic facilities, and physicians as required by the MPA; and
- arbitrating disputes that may arise between the DoBC and the Government of B.C. under the Physician Master Agreement (PMA).

Commission Audit Functions

Delegated Commission Bodies

Additional Commission Responsibilities

Guidelines and Protocols Advisory Committee

The Guidelines and Protocols Advisory Committee (GPAC) is a joint committee of the DoBC and the Ministry of Health (HLTH).

GPAC is mandated to provide recommendations to primary care practitioners in B.C., with a focus on the delivery of high quality, appropriate care to patients while making optimal use of medical resources. These recommendations are published online as concise, evidence-based clinical practice guidelines under the brand name BC Guidelines, at www.BCGuidelines.ca.

Guidelines Approved by the Commission in 2024/25	
NEW:	**UPDATED:**
• Concussion/Mild Traumatic Brain Injury • Tobacco Use Disorder	• Antinuclear Antibody Testing • Cervical Cancer Prevention and Screening • Chronic Kidney Disease
Guidelines Under Development in 2024/25	
NEW:	**UPDATED:**
• None	• Adults with Obesity and Overweight: Diagnosis and Management • Major Depressive Disorder in Adults: Diagnosis and Management • H. Pylori • Rheumatoid Arthritis: Primary Care Management • Ischemic Stroke and Transient Ischemic Attack
• No BC Guidelines were Retired in 2024/25.	
• No new partner guidelines were added to the BC Guidelines site in 2024/25.	

Key 2024/25 GPAC Accomplishments

- The number of subscribers to the BC Guidelines e-bulletin increased by nearly 10%, up to 1500. Visits to the website increased 32% since the last fiscal year; steadily increasing the number of visits from 2020 to over 698,000.

- Two BC Guidelines were the subject of Child Health BC webinars:
    - Asthma Diagnosis, Education and Management
    - Concussion / Mild Traumatic Brain Injury (mTBI).

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- The eLearning Module: Predictable and Preventable Falls, prepared by the University of British Columbia Continuing Professional Development (UBC CPD), was based on the BC Guideline: Fall Prevention: Risk Assessment and Management for Community-Dwelling Older Adults.

- The GPAC formalized a Memorandum of Understanding with Pathways to adapt clinical algorithms for point of care use.

- The GPAC continued to strengthen its relationships with the UBC CPD group and the Practice Improvement Hub, as well as the Patterns of Practice Committee, Provincial Laboratory Medicine Services, First Nations Health Authority, and the Medical Imaging Advisory Committee.

BC Guidelines Website:
BC Guidelines are available for review and download at BCGuidelines.ca, with website traffic analyzed annually.

In 2024/25, the BC Guidelines website received 698,990 visits from more than 554,093 unique users, representing an increase of 32%, in total website visits compared to the previous year. While most users access BCGuidelines.ca from the B.C. Lower Mainland geographic region, there has been a significant increase in users from across North America and other global areas in recent years.

BC Guidelines eBulletin:
The e-newsletter promotes new BC Guidelines publications and external review opportunities and is endorsed by the GPAC at conferences and other events. New clinical practice tips from recently published guidelines are embedded as “key updates” in the e-newsletter.

BC Guidelines eBulletin subscribers represent a community of primary care practitioners, regional health authority representatives, academics, and other health system partners.

In 2024/25, three e-newsletter editions were published, reaching approximately 1,500 subscribers, an increase of nearly 10% compared to the previous year.

Medical/Research Conferences and Promotional Presentations:
GPAC participation in conferences enables connections with a broad range of primary care practitioners while increasing awareness of BC Guidelines.

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In 2024/25, BC Guidelines participated in three promotional events:

- Island Medicine Conference
- BC Rural Health Conference
- St. Paul's Continuing Medical Education Conference for Primary Care Physicians

Advisory Committee on Diagnostic Facilities

The Advisory Committee on Diagnostic Facilities (ACDF) provides advice, assistance, and recommendations to the Commission in the exercise of the Commission's duties, powers, and functions under s.33 of the MPA.

The ACDF reviews applications from existing and proposed diagnostic facilities seeking approval to perform and bill the MSP for specific services. Based on Commission-approved policy, the ACDF may approve applications or recommend the Commission deny the request.

Between April 1, 2024, and March 31, 2025, the ACDF considered 98 applications related to:

- electromyography,
- polysomnography (Level 1 and Level III),
- pulmonary function,
- radiology,
- electroencephalography,
- nuclear medicine, and
- ultrasound.

Of the total applications reviewed, 97 were approved. A single application was recommended for denial; the denial was upheld by the Commission.

ACDF Project Highlights for 2024/25

Moratorium on Applications for Diagnostic Ultrasound Facilities - Extended

On October 25, 2023, the Commission approved a HLTH recommendation to extend the current moratorium on applications for diagnostic outpatient ultrasound facilities until December 1, 2025, with modifications. This extension was determined necessary due to the continued shortage of ultrasound sonographers in the province.

The moratorium includes applications for new, relocation or expansion of diagnostic outpatient ultrasound facilities, except for those fee items currently restricted to public hospitals, i.e., echocardiography and (cardiac) Doppler Studies.

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Exceptions to the moratorium may be made for demonstrated urgent health or safety needs. Except in rare or exceptional circumstances, the Commission will only accept a moratorium request for exception from applicants with at least one facility that holds a current ultrasound or radiology Certificate of Approval from the Commission or the ACDF.

The October 2023 modifications to the moratorium included:

- Allowing the ACDF to accept an ultrasound application from any facility with current radiology-only approval (no exception request process); and,
- Requiring any Community Imaging Clinics (CICs) seeking to bill the MSP for provision of outpatient ultrasound services to demonstrate a "verifiable commitment to clinical placement of sonography students." This requirement is on a go-forward basis and has not been applied retroactively at this time.

In January 2025, HLTH began its review of the moratorium and will provide recommendations to the Commission in Fall 2025.

Moratorium on Applications for Home Sleep Apnea Testing (HSAT) Facilities - Continued

On January 1, 2022, the Commission established a temporary moratorium on applications for stand-alone HSAT facilities across the province. The moratorium was intended to allow time to generate sufficient MSP billing data to aid the ACDF and its support staff in their work to better understand the impact of allowing HSAT facilities to bill MSP for the professional fee related to this diagnostic test.

The moratorium on applications for stand-alone HSAT facilities is scheduled to remain in effect until December 31, 2026.

Digital Breast Tomosynthesis

On March 1, 2024, in response to a request from the British Columbia Radiological Society, the Commission approved a policy allowing qualifying diagnostic radiology facilities to bill MSP for provision of Digital Breast Tomosynthesis (DBT) services.

To be considered eligible for DBT services, the radiology facility must:

- Hold ACDF approval for Radiology fee items:
    - 08610 – Mammography - unilateral
    - 08611 – Mammography - bilateral
- Be accredited for mammography and DBT through the College of Physicians and Surgeon of BC's (CPSBC) Diagnostic Accreditation Program (DAP).

The expansion of radiology services includes the following MSP fee items:

- 83046 – Digital Breast Tomosynthesis – unilateral
- 83047 – Digital Breast Tomosynthesis – bilateral

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Since the announcement, 24 facilities have applied and been approved to provide DBT, and 23 facilities implemented this new service.

Recently, in response to feedback from some health authorities, HLTH has strengthened the eligibility criteria to include the requirement for facilities to have been actively billing for mammography (fee items: 08610 and 08611) prior to applying to provide DBT services.

Pulmonary Function Review

In September 2024, HLTH completed an analysis of eight years of MSP billing data (2016/17 – 2023/24) for Pulmonary Function services to determine whether access to services had improved since implementation of a policy change in 2018 that:

- Allowed appropriately credentialed private-office practitioners to bill MSP for provision of the Flow Volume Loop.
- Removed the requirement for a specialist consultation prior to spirometry testing.
- Allowed for approval upon application from appropriately credentialed physicians practicing in an accredited facility.

The findings showed that while the policy change did appear to have increased services in the short term, the COVID-19 pandemic significantly reduced these gains. As such, the Commission directed HLTH to consult with both public and private pulmonary function providers to better understand the issues and barriers impacting access to pulmonary function services.

HLTH has commenced the consultation process and expects to report results to the Commission in Winter 2025/26.

Sleep Medicine Update

On May 7, 2024, HLTH and DAP cohosted an update for 60 diagnostic sleep medicine providers including medical directors, owners, and administrators from 5 Level I facilities and 31 Level III facilities.

During the session, DAP provided an update on the Level I accreditation standards revision process and Level III HSAT accreditation. HLTH provided a summary of:

- the Diagnostic Sleep Medicine Review project
- the Level I facility approval process and capacity following lifting of the moratorium; and
- the status of stand-alone HSAT facilities approved to bill MSP.

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Remote Access to Home Sleep Apnea (HSAT) Testing

On June 19, 2024, the Commission approved a new policy to allow remote access to HSAT for individuals residing in rural and remote locations. Remote access to HSAT involves mailing equipment to the patient, with instructions provided virtually.

Prior to the approval of this policy and as per s.1 of the MPA requiring qualification as a benefit eligible for MSP payment, facilities approved to provide HSAT were required to provide patient instructions on use of the equipment in the facility. Patients could then take the portable monitoring equipment home to self-administer the test overnight.

In response to concerns raised by facilities regarding patients residing in rural/remote locations having limited access to approved facilities, HLTH developed the Remote Access to HSAT policy.

The original Remote HSAT policy, as approved by the Commission, was limited to approved Level III HSAT facilities located in or within proximity to the Provincial Rural Retention Program's Rural Practice Subsidiary Agreement (RSA) designated communities.

On January 15, 2025, the Commission extended the policy to approved Level I polysomnography facilities, located in or within proximity to RSA designated communities.

The Commission established the following conditions of approval:

- Approved HSAT and Level I facilities located in, or with proximity/providing remote services to, RSA designated A, B, and C communities, must record all rural/remote service provision, including the rationale for each instance.
- HLTH will monitor facilities through bi-annual, rotating spot-checks of facility data.
- HLTH will amend letters of approval for each of these facilities to include permission to provide rural/remote service delivery to RSA designated A, B, and C communities and include the associated reporting requirements as a condition of approval.
- The facility will seek accreditation from DAP for an additional scope of "Remote Services".

HLTH will commence monitoring the provision of remote HSAT services once approved HSAT and Level I facilities have received provisional accreditation for this additional scope of service from DAP.

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24 - Hour Blood Pressure Monitoring Policy
Effective June 19, 2024, the Commission determined that 24-hour blood pressure monitoring by facilities providing HSAT is not a benefit based on the MPA, s.17(1).

The Commission, however, considers that the provision of 24-hour blood pressure monitoring by an approved HSAT facility is related to a benefit in that the diagnostic HSAT has been requested by a referring physician and the identification of diagnosed hypertension is a component of the Provincial Standard Requisition for HSAT.

As such, the Commission notified all approved HSAT providers that it is not appropriate to bill a patient for this procedure.

Automated Breast Ultrasound Review
The HLTH Diagnostic Services team, on behalf of the Commission, initiated a detailed review of the use of Automated Breast Ultrasound (ABUS) technology for supplemental screening and diagnostic studies in Canada.

ABUS is a non-invasive ultrasound examination that uses high-frequency broadband sensors to produce sharp, three-dimensional images of the whole breast useful for seeing through dense breast tissue. ABUS is primarily used in addition to mammography for women who have dense breast tissue. This imaging technology is reported to address some of the limitations of conventional handheld ultrasound.

The ABUS review was developed to evaluate the use of ABUS from a policy perspective, addressing its adoption, effectiveness, accessibility, and integration into the provincial health care system. This review is anticipated to be completed in Spring 2026.

Polysomnography Automation Project
The HLTH Diagnostic Services team completed a province-wide review of diagnostic sleep study services in 2019 on behalf of the Commission which resulted in new requirements for regular wait-time and utilization reporting across all Level 1 polysomnography facilities.

Polysomnography facilities must now submit wait-time reports every fiscal period (13 periods annually). These data inform evidence-based decision-making, assess medical need, monitor provincial capacity, and promote equitable access to sleep diagnostic services across B.C. The data is used for ACDF decisions related to new, relocated, or expanded polysomnography facilities.

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The current Excel-based reporting process is highly manual, labour-intensive, and dependent on a single individual with advanced data expertise. In May 2024, HLTH approved the Polysomnography Automation Project to automate the collection, analysis, and transfer of polysomnography data to HealthIdeas. The solution leverages the Common Hosted eForms Service (CHEFS) and the Ministry Enterprise Data Importing Solution (MEDIS), an established data-collection platform owned by the Ministry of Citizens' Services.

The project launched in September 2024, with the Excel-based reporting process scheduled to transition to the new CHEFS web-based platform on May 5, 2025. Due to resource constraints, automated data transfer to HealthIdeas is currently on hold and will continue to be completed manually.

Clinical Placement Verification Process

HLTH worked with post-secondary institutes in B.C. that offer Diagnostic Medical Sonography programs to develop a form and process to operationalize the requirement for CICs to demonstrate a verifiable commitment to clinical placement.

To date, 8 CICs have successfully gone through this process.

Diagnostic Facility Hearings

Under s.33 of the MPA, the Commission may add new conditions or amend existing ones to an approval of a diagnostic facility in the province. Before taking action, and as per the MPA s.33(4), the Commission is required to provide the owner of a facility an opportunity to be heard.

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

A hearing before the Commission may be requested based on an ACDF recommendation to the Commission that:

- an application to amend or add new conditions to an existing approval be denied; or
- an approval be suspended, amended, or cancelled because the facility owner is alleged to have contravened the MPA, the regulations, or a condition of the approval.

No diagnostic facility appeals were filed in 2024/25.

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Patterns of Practice Committee

The Patterns of Practice Committee (POPC) acts in an advisory capacity to the Commission. On behalf of the Commission, the POPC provides review, information, and education to physicians in regard to their patterns of practice. This learning may be in relation to a specific physician's billings or may be general education based on findings from anonymized audit reports.

In 2024/25, the POPC continued to meet three times per year.

Education

As one of its primary mandates, the POPC is dedicated to education to physicians about recurring billing patterns and audit findings. This is accomplished through educational letter projects, audit and billing sessions, updates to the Mini Practice Profile (MPP), and inviting sections or committees to POPC meetings, when appropriate.

Between April 1, 2024, and March 31, 2025, the POPC implemented two educational projects:

- Vitamin B12 Ordering and
- Fees for Family Practice Services Committee (FPSC) Incentives

The POPC sent a total of 587 educational letters to physicians identified as outliers in these two areas.

- **Vitamin B 12 Laboratory Project**: Between 2013 and 2020, laboratory investigation volumes for Vitamin B12 in B.C. increased by over 86.7%, resulting in annual expenditures rising from $3 million to $5.6 million.

  In October 2024, in collaboration with the GPAC, the POPC sent 159 educational letters referencing the updated BC Guideline: Vitamin B12 Ordering to physicians across various specialties. These physicians were identified as outliers in their Vitamin B12 ordering patterns compared to their peer group as follows:

Group A:	137 physicians were identified as above the 97.5th percentile **AND** 2 Standard deviations above the average, **AND** $4,000 in vitamin B 12 lab ordering.
Group B:	22 physicians were identified as above 2 standard deviations above the average, **AND** $4,000 in Vitamin B12 lab ordering.

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Project Conclusion: The HLTH Audit and Investigation Branch (AIB) conducted two reviews comparing Vitamin B12 ordering over the 3-month periods prior to and following distribution of the letters. (July 1, 2024, to September 30, 2024 and November 1, 2024, to January 31, 2025.)

In March 2025, the AIB shared preliminary data with the POPC which revealed that 125 of the 159 physicians (79%) who received letters reduced their Vitamin B12 ordering. In this group, Vitamin B12 ordering costs by these 159 physicians reduced from $329,450.13 to $247,594.78, **resulting in savings of $81,855.35 (25%).**

The POPC requested that the AIB share a one-year analysis of the data from the 159 physicians in late 2025 or early 2026. This analysis aims to determine if physicians' billing patterns and cost savings for Vitamin B12 lab ordering were sustained after receiving the POPC educational letter, or if they reverted to their previous billing patterns.

- **Family Practice Services Committee (FPSC) Fee Project:** The POPC identified concerning billing patterns from audit findings from Family Physicians over recent years in relation to select **Family Practice Services Committee (FPSC) incentive fee items.** As a result, the POPC reviewed billing data across the 2022 MPPs, comparing the billing patterns of physicians' MSP claims for these incentives to that of their peer group.

  The POPC felt that educating physicians about their outlier status provides opportunity to reflect on their patterns of practice, despite the potential switch of these physicians to the Longitudinal Family Physician (LFP) Payment Model. Their outlier status in FPSC fees may encourage a review of their overall billing patterns, and to understand that their outlier status may put them at risk of audit.

  In October 2024, the POPC sent out 428 educational letters by mail to physicians identified as outliers on one or more of the **seven FPSC Planning Fees:** 14033, 14043, 14075 and FPSC Chronic Disease Management Fees: 14050, 14051, 14052 and 14053. Physicians were then grouped into three groups: **A, B, and C** as outlined on the following page:

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Group A:	233 physicians were identified as having one of the seven FPSC fee items; two (2) or more standard deviations above the mean, **AND** at or above the 95th percentile, compared to their comparison group.
Group B:	194 physicians were identified as having between two (2) to six (6) FPSC fee items; two (2) or more standard deviations above the mean, **AND** at or above the 95th percentile, compared to their comparison group.
Group C:	1 physician was identified of having all seven FPSC fee items; two (2) or more standard deviations above the mean, **AND** at or above the 95th percentile, compared to their comparison group.

The Commission has formed an LFP Advisory Committee, of which the POPC Chair is a member, to review billing patterns for physicians enrolled in the LFP Payment Model and make recommendations addressing billing concerns for the payment model. POPC will take no further action regarding FPSC fees at this time.

In addition to the education letter projects, the POPC continues to provide education through various channels, including the DoBC Physician Business Services Team. The POPC offers the following Continuing Medical Education (CME) Accredited Audit and Billing sessions:

- An Introduction to Understanding Mini Practice Profile
- Why a Billing Audit, the Process, and Avoiding the Common Billing Errors

The POPC physician speakers conducted 5 CME audit and billing sessions for physicians between April 1, 2024, and March 31, 2025. These were hosted by UBC through the DoBC Physician Business Services:

- Transition into Practice (TIP) Academic Half Day,
- Practice Ready Assessment (PRA) BC, and
- The BC Physician Integration Program (BC-PIP).

With positive reception of these sessions the POPC will continue to provide them annually, where possible.

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Mini Practice Profiles

In early 2023, the POPC formed a MPP Working Group (MPP WG) to modernize the static, twenty-year-old MPP. This two-year project continued into 2024–2025, during which time the MPP WG meetings gathered input to inform the redesign of a modernized MPP. An aim of the MPP WG is to create an improved audit and billing educational tool for specialists and family physicians, with plans to release the new interactive 2023 MPP in May 2025.

Reference Committee

The Reference Committee acts in an advisory capacity to the Commission in circumstances where a physician disputes the adjudication of a billing claim. On occasion, the Reference Committee performs a similar billing adjudicative service for patients billed directly by a physician, or when physicians provide services to third parties, such as insurance companies.

Membership on the Reference Committee is limited to representatives of the DoBC.

During 2024/25, the Reference Committee closed 4 cases.

In 2024/25, MSP received no new cases with none outstanding at the close of fiscal year to be scheduled for referral in 2025/26.

Audit and Inspection Committee

The Audit and Inspection Committee (AIC) is a four-member panel comprised of:

- one member who represents the public, and
- three physicians:
    - one nominated by the DoBC
    - one nominated by the CPSBC
    - one appointed by the Commission

The AIC has responsibility for overseeing two types of audits:

- Audits for patterns of practice are carried out to ensure that services billed to the MSP have been delivered and billed accurately.
- Audits for extra billing focus on whether beneficiaries are being charged for services in contravention of the MPA.

The AIC determines when on-site audits are appropriate and outlines the nature and extent of the audits. The AIC also reviews the audit results and makes recommendations to the Commission for further appropriate action.

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Billing Integrity Program

The Billing Integrity Program (BIP) provides audit services to the MSP and the Commission. The Commission 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 Commission in the recovery of any funds billed inappropriately. The audit and inspection function is carried out by BIP on behalf of the AIC.

Billing Integrity Program	
Approved Projects (all)	15
On-sites Conducted	16
Audit Reports Completed and Approved	11
Referred for Recovery	9
Settled	8
De-enrollments	3
Estimated Overbilling	$9,553,452
Settled for Recovery	$4,077,119
Settlements Collected	$3,886,807
** 2024/25 fiscal year stats at Jan 9, 2026	

Service Verification Audits

Each year, survey letters are sent to patients to confirm they received practitioner services which have been billed to the MSP on their behalf. A minimum of 1,200 practitioners (100 per month) are chosen annually (at random) and letters are sent to approximately 50 of their patients who have received MSP billed services in the preceding four months.

A “select” service verification audit (SVA) may be initiated due to findings from a random service verification audit, follow-up of a previous audit, complaints received from the public/other doctors/referrals by licensing bodies and professional associations, or by atypical practitioner billing profiles.

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Letters may be sent to some of the selected practitioner's patients to confirm they received the specific services that have been billed to MSP on their behalf.

Service Verification Audits	
Number of service verification audits of practitioners	578
Number of letters sent to patients to verify services	29,057
Response rate from patients	41.4%
*Note: ***2024/25 fiscal year stats at Jan 9, 2026. Numbers were lower due to an inability to fill vacant positions and subsequently developing an automated system to replace the manual process of processing letters. SVG has increased number of monthly letters since starting the automated process.***	

Delegated Commission Bodies

MSP Coverage Wait Period Review Committee

New and returning residents to B.C. are required to complete a wait period before access to provincial publicly funded health benefits begin. There are exceptional cases based on individual circumstances where the Commission may waive this requirement and enroll new residents before the MSP coverage wait period has expired.

Under its authority in s. 5(1)(o) of the MPA, the Commission has delegated the power to review these cases to the Coverage Wait Period Review Committee (the Waiver Committee). The Terms of Reference for the Waiver Committee are established in a Minute of the Commission (MOC) [15-074.]

HLTH received 588 waiver inquiries from April 1, 2024 to March 31, 2025, with 168 complete waiver request applications reviewed by the Waiver Committee, including 11 appeals.

A total of 47 waiver requests met the criteria of the Waiver Committee for approval as established in the Terms of Reference.

From April 1, 2024 to March 31, 2025, the Waiver Committee denied 114 waiver requests:

- 54 denials were related to conditions that were not diagnosed in the wait period and/or were not a financial hardship.
- 58 denials were related to pregnancy that were not diagnosed in the wait period and/or were not a financial hardship.
- 2 denials resulted from individuals who had private insurance.

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Commission Hearing Panels

Under authority of the MPA, s.6, Commission members, or delegates of the Commission, may conduct hearings related to the exercise of the Commission's statutory decision-making powers.

Commission hearings are governed by the duty to act fairly and can be required by the MPA. Other hearings are implemented by the Commission as an opportunity for individuals who are affected by its decisions to be heard.

Depending on the type of decision, Commission panel decisions may be judicially reviewed or appealed to the Supreme Court of BC.

Eligibility (Residency) Beneficiary Hearings

Eligibility (residency) hearings are one type of MSP beneficiary hearing conducted by the Commission. To be eligible for provincial health care benefits, a person must meet the definition of a B.C. resident as outlined in the MPA, s.1.

Section 7.4 of the MPA outlines that the Commission may cancel the MSP enrolment of individuals whom it determines are not residents of B.C., however, prior to making an order, the Commission must notify the beneficiary of their right to a hearing.

The Commission delegates the decision-making responsibility for residency hearings to select representatives. These individuals are appointed by the Commission Chair through an MOC.

The HLTH Eligibility, Compliance and Enforcement Unit (ECEU) investigated 367 residency cases between April 1, 2024 and March 31, 2025.

B.C. residency was verified for 63 of these cases, with 304 non-resident accounts identified, resulting in MSP account cancellations totaling $889,627.76 in hospital, MSP, and PharmaCare recoveries.

For the same period noted above, the Commission received 27 new hearing requests, with 11 hearing requests withdrawn by the beneficiary or abandoned by the Commission.

Between April 1, 2024 and March 31, 2025, the Commission conducted 12 hearings, including 9 written and 3 held in-person. The Commission delegate upheld the ECEU investigation recommendations for 7 of the 12 files.

Residency hearings for 27 incoming requests were pending at the end of the 2024/25 fiscal year.

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Out-of-Country Administrative Review Beneficiary Hearings

Panel reviews of claims for elective (non-emergency) out-of-country medical care funding are one type of MSP beneficiary hearings conducted by the Commission.

Provincial health care coverage may be requested for treatment outside Canada, when medically necessary services are not available for residents of B.C. elsewhere in Canada. As the MPA does not impose a duty on the Commission to hear requests for Administrative Review in these cases, the Commission has established a hearing process wherein a review can be requested by MSP enrolled beneficiaries.

The Beneficiary and Diagnostic Services Branch (BDSB), HLTH, reviews applications for elective medical services on behalf of the Commission. The Commission publishes the *Medical Services Commission Out-of-Province and Out-of-Country Medical Care Guidelines* (the Guidelines) (January 19, 2011) to outline the provincial coverage for funding approval, including processes for review of BDSB decisions.

From April 1, 2024, to March 31, 2025, MSB received a total of 123 applications for out-of-country, elective medical treatment.

BDSB approved provincial coverage for 39 applications and denied provincial coverage for 35. The BDSB considered the remaining 49 cases abandoned or incomplete as per Appendix 2, Section D of the Guidelines.

In 2024/25, there were 2 panel hearings held by the Commission to review provincial coverage for out-of-province medical treatment.

Commission Audit Hearings

Audit hearings are held before the Commission for medical practitioners and health care practitioners in relation to the MPA s.37 for matters of repayment and/or s.15 for de-enrolment from the MSP for “cause”.

Under s.37 of the MPA, the Commission may make orders requiring medical practitioners or owners of diagnostic facilities to make payments to the Commission. These orders are made following a hearing, in circumstances where the Commission determines an amount due to:

a) an unjustified departure from the patterns of practice or billing of physicians in a 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.

In 2024/25, there were no audit hearings relating to a medical practitioner.

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Under s.15, the Commission may determine that a practitioner should be de- enrolled from the MSP after providing them an opportunity to be heard. These formal administrative hearings may last one to three weeks and practitioners are often represented by legal counsel.

In 2024/25, there were three medical practitioners de-enrolled from the MSP for "cause".

Additional Commission Responsibilities

Medical Services Plan
The Commission delegates day-to-day functions such as the processing and payment of MSP claims to Health Insurance BC (HIBC).

HLTH works closely with Pacific Blue Cross, doing business as PBC Solutions (PBCS) on the delivery of HIBC services. resources, and technology.

The Commission receives regular updates regarding service level requirements and program performance for HIBC. Policy direction and leadership authority remains within the responsibility of the HLTH – and under the Commission in relation to the MSP.

In 2024/25, MSP paid approximately 22,535 medical and health care providers $4.82 billion relating to more than 117.9 million services rendered on a fee-for-service basis.

Medical practitioners in the province 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 Commission to practitioners, groups, clinics, hospitals, and diagnostic facilities for each fiscal year.

Copies of the Blue Book are available online at: www.gov.bc.ca/msp/publications.

Medical Services Commission Payment Schedule
The *MSC Payment Schedule* is the list of billing fees codes approved by the Commission which are payable to MSP enrolled physicians for insured medical services provided to MSP enrolled beneficiaries.

Additions, deletions, fee changes, or other modifications to the *MSC Payment Schedule* are implemented in the form of MOC's signed by the Chair of the Commission.

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In 2024/25, 83 MOCs related to the MSC Payment Schedule were approved. These included:

- introduction of 30 new fees to reflect current practice standards, including:
  - 1 for surgical assistance,
  - 4 for Urology
  - 1 for additional body regions for computed tomography (CT) scans,
  - 1 for emergency medicine reassessment,
  - 1 for long-term care admission,
  - 2 for allergy provocation testing, and
  - 1 for specialist conferencing with physicians or allied care providers.
- amendments to 108 fee items, and
- changes made to the preamble of the MSC Payment Schedule which:
  - allowed podiatrists to refer to Rheumatologists,
  - created a generic referring practitioner number for referral by the BC Cancer Screening Program

As part of the MSP monitoring program, 9 reviews resulted in the provisional (P) status or temporary (T) status for the fees being removed, and 1 review resulted in the P status being extended to allow for further monitoring.

Medical Services Commission Longitudinal Family Physician Payment Schedule

On February 1, 2023, the *Medical Services Commission Longitudinal Family Physician Payment Schedule* (LFP Payment Model) was implemented in B.C. as an alternative to fee-for-service to support physicians in family practice who provide longitudinal family medicine care.

As a blended model of practice, the LFP Payment Model compensates family physicians for their time, patient interactions, and the number and complexity of care for patients on their panel. LFP Payment Model eligibility criteria for physicians includes:

- participating in the Provincial Attachment System (PAS);
- submitting an accurate list of empanelled patients;
- having at least 250 empanelled patients;
- providing LFP clinic-based services for at least 1 day per week, distributed equitably over the year; and
- ensuring that LFP clinic-based services to non-panel patients are no more than 30% of all LFP clinic-based services provided in a calendar year.

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Locum physicians are eligible for enrolment and billing under the LFP Payment Model when providing care on behalf of LFP enrolled family physicians. Locums must meet similar eligibility criteria as family physicians, including ensuring that clinic non-panel services do not exceed 30% of LFP clinic-based services provided in one calendar year at each clinic where a Locum LFP physician provides services. Locums are not eligible for panel payment as they do not have their own distinct patient panels.

The LFP Payment Model also establishes the following for LFP family physicians and LFP Locums:

- eligibility criteria for enrollment,
- enrolment and withdrawal processes,
- compensation for services through 3 methods:
  - LFP time codes,
  - LFP physician-patient interaction codes, and
  - a quarterly panel payment
- terms of payment, and
- a list of required services and services excluded from the LFP Payment Model.

Similar to the *MSC Payment Schedule*, additions, deletions, fee changes, or other modifications to the LFP Payment Model are implemented in the form of an MOC signed by the Chair of the Commission.

In 2024/2025, the Commission approved 7 LFP Payment Model related MOCs, resulting in:

- 88 net new fee codes,
- amendments to 8 fee codes, and
- modifications to the LFP Payment Model providing clarification and reflecting program changes, including:
  - clarifying instructions for billing time codes and claims submission,
  - clarifying rules for billing consultations under the LFP Payment Model and across other payment models,
  - excluding payment for services related to Medical Assistance in Dying and Hospital at Home patients,
  - expanding the list of procedures payable under LFP procedure fee codes,
  - expanding the LFP Payment Model to allow those physicians providing clinic-based services to also bill for:
    - Long-Term and Palliative Care,
    - Pregnancy and Newborn care, and
    - Inpatient care provided in facility settings.

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- extending the LFP Transition Code to accommodate physicians transitioning onto the Model and introduction of a new LFP Transition Form;
- extending the period during which those longitudinal physicians remunerated under Alternative Payments Subsidiary Agreement can act as Host Physicians for LFP Locums, and
- reactivating the temporary fee code for respiratory immunization by an Allied Care Provider for the 2024/2025 immunization season.

Physician Master Agreement and Subsidiary Agreements

The Physician Master Agreement (PMA) covers the relationship and economic arrangements between the Government of B.C. and the DoBC. The Commission is a signatory to the PMA and its subsidiary agreements.

The three-year term of the PMA, which ran from April 1, 2022 to March 31, 2025, saw the next round of negotiations begin in June 2024. Copies of the negotiated agreements are available online at: Health/MSP/DoBC negotiated-agreements

The Physician Services Committee (PSC) is the senior body that oversees the relationship between the government and the DoBC, as well as the implementation and administration of the PMA and subsidiary agreements.

The Chair of the Commission attends PSC meetings as a non-voting member.

BC Services Card

The BC Services Card (BCSC) program is a partnership involving the Ministry of Citizens' Services, the Insurance Corporation of BC (ICBC), and HLTH.

The partnership actively participates in cross-government working groups focused on priority initiatives to modernize government systems and services. Over the past year, in addition to ongoing operations, a key area of focus was advancing work to include Indigenous language names on provincial identification.

Several cross-government initiatives, ranging from interim solutions to full system integration, are underway to implement a phased approach for displaying Indigenous peoples' names on identification, including the BCSC.

As of December 31, 2025, 98% of MSP beneficiaries had been issued a BCSC.

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Commission Related Legal Cases

As part of its oversight of the MSP under the MPA, the Commission monitors legal issues that arise in relation to the provision of services in the delivery of health care in B.C. From time to time, it is also actively involved in litigation as a named party.

Extra Billing Issues and Investigations

The purpose of the MPA is to preserve a publicly managed and fiscally sustainable health care system for B.C. in which access to necessary medical care is based on need and not an individual's ability to pay for services. As such, there are prohibitions within the MPA for "extra billing", which is charging B.C. residents who are enrolled in the MSP, known as beneficiaries, to access MSP covered medical services, known as benefits.

Processes are established by the Commission for responding to cases that come to its attention when concerns or complaints about extra billing arise.

In 2024/25, the Commission completed zero audits of private clinics to determine compliance with the extra billing provisions of the MPA.

Extra Billing Litigation

In 2024/25, the Commission pursued no extra billing litigation.

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COMMISSION HIGHLIGHTS AND ISSUES FOR 2024/25

- 10 regular Commission meetings were held from March 31, 2024 to April 1, 2025.

March 2025 Strategic Planning

With the understanding that priorities may be contingent on the changing healthcare landscape, the Commission pursued the following strategic priorities:

- Enable monitoring and oversight of the 2023 LFP Payment Model.
- Continue to bring providers offering bundled service into compliance with the MPA.
- Update the HLTH audit program to enhance efficiency and accountability.
- Analyze and report on the Available Amount spending.
- Review implications of the corporatization of healthcare.

COMMISSION HIGHLIGHTS AND ISSUES FOR 2024/25

Presentations to the Commission in 2025

- Ongoing review of the proposed updates to the MSP Waiver of the Wait Period Terms of Reference by the BDSB.
- Updates by the HLTH Billing Integrity Program and the Audit Inspection Branch to the scope of practitioner audits.
- A review of the work and mandate of the Ultrasound Working Group, established in January 2024.
- Outgoing First Nations Health Authority (FNHA) CEO, Richard Jock, outlined the ongoing journey of transformation and innovation within FNHA.
- Overview of an ongoing litigation by the Legal Services Branch of the Attorney General.
- The BC Family Doctors provided an update on initiatives being advanced to identify improvements in the Fee-For-Service and alternative payment models for physicians.
- A review of the implementation processes of Bill 92.
- Ongoing review of the LFP Payment Model, launched on February 1, 2023, including updates from the LFP Advisory Committee, established in February 2025.

APPENDIX 1:

COMMISSION MEMBERS AS OF MARCH 31, 2025

Government of B.C. Representatives:
Dr. Robert Halpenny (Chair)
Dr. Maureen O'Donnell (Deputy Chair)
Dr. Bill Cavers

Government Alternates:
Stephanie Power
Ian Rongve
Marie Ty

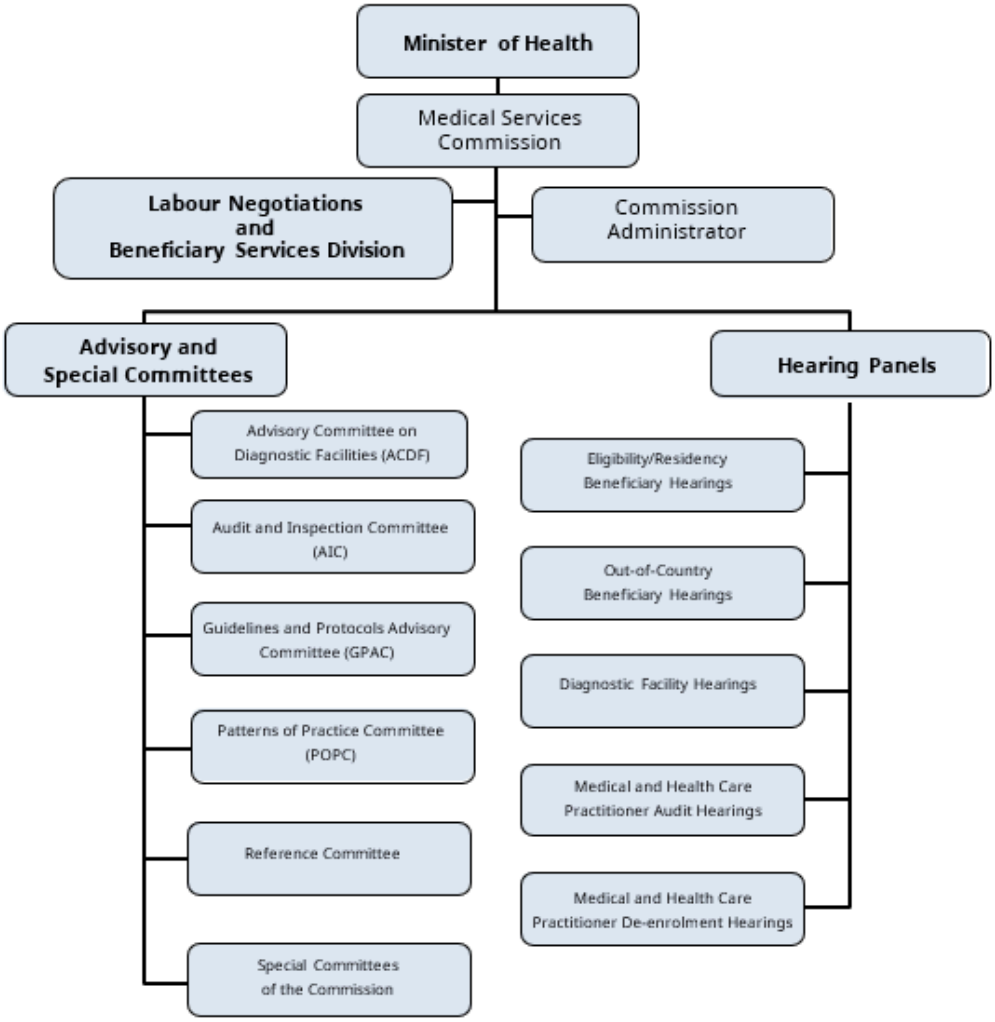
DoBC Representatives:
Dr. Johann Cunningham
Dr. Alan Ruddiman
Dr. Nancy Humber

DoBC Alternates:
Dr. Joshua Greggain
Dr. Charlene Lui
Mr. Anthony Knight

Public (Beneficiary) Representatives:
Jillianne Code
Kenneth Werker
Vacant

Information regarding Commission appointments is available on the B.C. government Central Agencies website:
Crown Agencies and Board Resourcing and Office.

APPENDIX 2:
COMMISSION ORGANIZATIONAL CHART



Information regarding Commission appointments is available on the B.C. government Central Agencies website:
Crown Agencies and Board Resourcing and Office.

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