

# MEDICAL SERVICES COMMISSION

2019/20  
2020/21

ANNUAL  
REPORT



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## COMMISSION

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BRITISH  
COLUMBIA

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## **Preamble**

The COVID-19 pandemic that began in March 2020 affected resources in unprecedented ways throughout 2020 and 2021. Due to this unforeseen pressure, production of the 2019/20 Medical Services Commission Annual Report was delayed.

The Medical Services Commission (the Commission) has prepared this report to represent both the 2019/20 and 2020/21 fiscal years.

## **Function**

The function of the Commission is 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 Medical Services Commission**

Established under the *Medical Services Act, 1967*, and continued under the current MPA, the Commission oversees the provision, verification, and payment of medical and health services in an effective and cost-effective manner through the MSP on behalf of the Government of B.C. The Commission must have regard to the principles of 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 the individual's ability to pay. The Commission reports to the Minister of Health.

## **Organizational Structure**

The Commission, appointed by the Lieutenant Governor in Council, consists of three persons nominated by the Doctors of BC (DoBC), three public members appointed on the joint recommendation of the Minister of Health and the DoBC to represent MSP beneficiaries, and three members appointed to represent the 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 B.C. are involved.

## **Responsibilities of the Commission**

In addition to ensuring that all B.C. residents have reasonable access to medical care and prescribed diagnostic services, the Commission is responsible for managing and monitoring 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 Commission is also responsible for:

- 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).

## **Advisory Committees and Overview of Accomplishments**

The MPA allows the Commission to delegate some powers and duties to special committees, advisory committees, and hearing panels established to assist the Commission in effectively carrying out its function. The following provides description of the responsibilities and an overview of the 2019/20 and 2020/21 accomplishments of some of the advisory committees, hearing panels, and other delegated bodies of the Commission.

### ***1. Guidelines and Protocols Advisory Committee***

The Guidelines and Protocols Advisory Committee (GPAC), a joint committee of the DoBC and the Ministry of Health (MOH), is an advisory committee to the Commission. It is mandated to provide recommendations to B.C. practitioners, focused on primary care, on delivering high quality, appropriate care to patients while making optimal use of medical resources. These recommendations are published as concise, evidence-based clinical practice guidelines under the brand name BC Guidelines, on the website [www.BCGuidelines.ca](http://www.BCGuidelines.ca).

#### **New Guidelines Approved by the Commission in 2019/20:**

- Appropriate Imaging for Common Situations in Primary and Emergency Care
- Computed Tomography (CT) Prioritization
- Magnetic Resonance Imaging (MRI) Prioritization
- Prostate Cancer Part 1: Diagnosis and Referral in Primary Care
- Prostate Cancer Part 2: Follow-up in Primary Care

#### **Revised Guidelines Approved by the Commission in 2019/20:**

- Iron Deficiency – Diagnosis and Management
- Chronic Kidney Disease:  
Identification, Evaluation and Management of Adult Patients
- Vitamin D Testing
- Workup of Microscopic Hematuria
- Hypertension – Diagnosis and Management
- Urinary Tract Infections in the Primary Care Setting – Investigation

**New Guidelines Approved by the Commission in 2020/21:**

- Suspected Lung Cancer in Primary Care
- Fall Prevention:  
Risk Assessment and Management for Community-Dwelling Older Adults
- Obstructive Sleep Apnea: Assessment and Management in Adults – guideline and standardized requisition form for Home Sleep Apnea Test (HSAT)

**Revised Guidelines Approved by the Commission in 2020/21:**

- Cataract – Treatment of Adults
- Viral Hepatitis Testing
- High Ferritin and Iron Overload – Investigation and Management
- Cardiovascular Disease – Primary Prevention
- Diabetes Care

**Existing Guidelines Under Development for Revision in 2020/21:**

- Osteoporosis – Diagnosis, Treatment and Fracture Prevention
- Atrial Fibrillation
- Novel Oral Anticoagulants (NOAC) in Atrial Fibrillation Warfarin Therapy
- Warfarin Therapy
- Warfarin Therapy – Invasive Procedures and Surgery
- Stroke and Transient Ischemic Attack (TIA)
- Screening for the Purposes of Colorectal Cancer Prevention and Detection in Asymptomatic Adults
- Follow-up of Colorectal Polyps or Cancer
- Infectious Diarrhea – Guideline for Investigation
- Cobalamin (Vitamin B12) Deficiency – Investigation and Management
- Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD): Diagnosis and Management
- Asthma in Children and Adults
- Breast Cancer Diagnosis
- Breast Cancer Follow-up

**New guidelines Under Development during 2020/21:**

- Venous Thromboembolism
- Adverse Childhood Experiences and Trauma-Informed Practice
- Managing Patients with Pain in Primary Care
- Concussion

**New Partner Guidelines**

Partner guidelines are developed by other stakeholders independent of GPAC. GPAC recognizes the high quality of these guidelines and provides web links to them for informational purposes on our Partner Guidelines web page at: [www.BCGuidelines.ca](http://www.BCGuidelines.ca).

New partner guidelines added:

- Guidance: Risk Mitigation in the Context of Dual Public Health Emergencies - BC Centre on Substance Use (BCCSU)
- Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder - BCCSU

### **Promotion and Education**

To further the strategic goals of the GPAC to increase the exposure of BC Guidelines and supporting evidence-based high-quality patient-centered care, GPAC participated in the following promotional activities during 2019/20 and 2020/21:

- B.C. Rural Health Conference
- Nurse Practitioners Conference
- University of B.C. (UBC) Family Practice Resident Scholarship Day
- Nanaimo Family Practice Residents Welcome Day
- BCCSU Conference
- Island Medical Program Student Session
- BC College of Family Physicians Annual UBC Medical Student and Resident Conference
- BC College of Family Physicians Fall Family Medicine Conference
- St. Paul's Hospital Continuing Medical Education for Primary Care Physicians
- Post Graduate Review, UBC Continuing Professional Development Conference
- BC Quality Forum
- Family Medicine Forum

### **Additional 2019/20 and 2020/21 GPAC Highlights**

- Beginning in mid-March 2020, all GPAC working groups were put on hold to enable working group members and MOH staff to address changing priorities in the face of the COVID-19 pandemic. Several GPAC Research Officers took on temporary roles supporting the Health Emergency Coordination Centre at the MOH. As a result, work on many GPAC guidelines was delayed.
- GPAC was asked to help support COVID-19-related initiatives, including the Primary Care Clinical Reference Group (CRG) Subcommittee and the Provincial Health Services Authority (PHSA). This work was supported by a portion of the GPAC budget, by time allotted by some of the GPAC work team, and by substantial guidance from GPAC primary care clinicians. The work involved creation of primary care clinical guidance and knowledge translation materials, and provision of primary care feedback on guidance from specialty groups. The need for this ongoing use of GPAC resources for support of COVID-19-related work and how best to structure this collaboration is currently being evaluated.

- GPAC reviewed the In Plain Sight report, which was prepared in December 2020 by Dr. Mary Ellen Turpel – Lafond and addressed Indigenous-specific racism and discrimination in B.C. health care, exploring ways the relevant recommendations could be incorporated into GPAC and its guideline development process. Engagement with First Nations Health Authority (FNHA) was sought and physician members representing FNHA were invited and joined the GPAC committee.
- Led by the MOH Mental Health Division, Ministry of Mental Health and Addictions (MMHA) and BCCSU, GPAC representatives were involved in both the implementation and clinical guidance working groups of the Pharmaceutical Alternatives for the Opioid Crisis work.
- GPAC representatives maintained ongoing working relationships with other health system organizations including Medical Imaging Advisory Committee (MIAC), Patterns of Practice Committee, Lifetime Prevention Schedule (LPS), Provincial Laboratory Medicine Services (PLMS), BC Centre for Disease Control (BCCDC), Provincial Health Services Authority (PHSA) and BC Cancer Agency/Family Practice Oncology Network.

## ***2. 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 section 33 of the MPA.

The ACDF reviews applications from existing and proposed diagnostic facilities seeking approval to 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, 2019 and March 31, 2021, the ACDF considered 106 applications related to electromyography (EMG), polysomnography, pulmonary function, radiology, ultrasound, nuclear medicine, and electroencephalography. Most applications were for new certificates of approval, while other applications included requests to relocate existing sites, expand capacity, add services, or transfer a material financial interest in an approved facility.

Of the total applications reviewed by the ACDF, 103 requests were approved and three were recommended to the Commission for denial, which was upheld in each case.

### **2019 - 2021 Projects Highlights**

#### **Electromyography (EMG) Policy Review - Privately-Owned Facilities**

In May 2017, ACDF policy was updated to require that any individual applying for a privately-owned EMG Certificate of Approval, physically located within a health authority-owned facility (usually, but not always, a hospital), provide a formal letter of support from the health authority for the proposed arrangement.



In June 2019, privately-owned EMG Certificate of Approval owners, approved prior to May 2017, were brought into compliance with current policy.

EMG facilities were contacted and directed to provide a health authority letter of support. Of the 59 contacted, 41 supplied the required letter of support, 12 voluntarily withdrew their Certificates of Approval and six did not respond. Appropriate action, was taken, as detailed in the MPA to remove approval for the six facilities that did not respond.

In a related action, in May 2020, the Commission approved a policy revision to allow health authorities, through formal written notice, to withdraw support for an existing privately-owned outpatient diagnostic EMG Certificate of Approval, physically located within one of its facilities.

### **Moratorium on Applications for Diagnostic Outpatient Ultrasound Facilities**

On April 16, 2020, the Commission extended the current moratorium on applications for new, expansion or relocation of diagnostic ultrasound facilities to June 1, 2022.

The extension was based on the continued and significant shortage of ultrasound sonographers in the province. Fee items restricted to public hospitals are considered exempt from the moratorium.

### **Non-cardiac Doppler Studies Pilot Program**

The non-cardiac Doppler pilot program was initiated in 2017, when the Commission approved eight privately-owned community imaging clinics (CICs) to provide select non-cardiac Doppler studies for a limited, three-year period.

To help determine impacts of the pilot program, a wait times study was planned for Spring 2020 but had to be rescheduled to Spring 2021 due to impacts of the COVID-19 pandemic.

In early 2021, the pandemic continued to affect diagnostic wait times and a valid data comparison to the 2017 study could not be obtained. The intended wait times study was cancelled and instead impacts of the pilot program were evaluated through:

- An analysis of the past three fiscal years of MSP data for the four services approved in the pilot program
- a questionnaire on the pilot program experience, completed by all pilot facilities; and
- a jurisdictional scan of non-cardiac Doppler funding policies in other provinces

The MOH collected and analyzed data in Summer 2021. Recommendations on non-cardiac Doppler studies went to the Commission in Fall 2021.

## Operational Changes Notification Form

The MOH formalized protocol and developed resources to support diagnostic facility reporting requirements in situations where approved facilities plan operational changes.

The Operational Changes Notification form allows facility administrators to submit capacity-related information that does not require formal application, including changes to hours of operation, equipment, operational status, signing authority, facility name/address (not physical location), services offered and ownership (shareholder change of less than 10% material financial interest).

The formal tracking of such information helps the ACDF receive the data needed to monitor the capacity, capability and performance of diagnostic facilities and services.

## Sleep Medicine: Review of Service-Delivery Environment

Since February 2019, the MOH, on behalf of the ACDF and the Commission, has been conducting a review of how diagnostic sleep testing is delivered in B.C.

Work to date has included:

- Detailed national and international jurisdictional surveys/scans.
- Scientific and Literature Review.
- Broad stakeholder engagement, including:
  - Sleep expert physicians.
  - The College of Physicians and Surgeons of British Columbia (CPSBC).
  - General practitioners/referring physicians (through DoBC).
  - Respiratory Homecare/Home Sleep Apnea Testing industry.
  - Patients who have undergone sleep testing in B.C. (through Patient Voices Network).
  - Clinical and operational leaders at all health authority and privately-owned polysomnography facilities in the province.
- Review of the previous polysomnography wait time reporting system and creation of a new, more detailed method for facilities to submit monthly wait time reports.
- Establishment of an expert Sleep Medicine Advisory Committee.

Through this work, three primary areas of focus emerged.

### 1. Education for referring practitioners

Receiving Commission approval to develop, through its Guidelines and Protocols Advisory Committee, two sleep medicine guidelines (*Obstructive Sleep Apnea; Assessment and Management in Adults* and *Sleep Disorders in Adults – Recognition and Referral*), in addition to a provincial Standard Requisition for Home Sleep Apnea Testing.

### 2. Clinical standards for Level III HSAT facilities:

Establishing accreditation standards for stand-alone Level III HSAT, through the Diagnostic Accreditation Program of the CPSBC.

### **3. Wait time gathering at Level I facilities**

Developing a new wait time reporting system which enables the MOH to gather patient wait times, from date of initial referral to date of test, including date of specialist consult, where applicable.

As a result of the scope of work undertaken, the Commission, on September 16, 2020, extended its moratorium on applications for polysomnography facilities (established February 2019) until September 30, 2022.

This work is expected to culminate in new protocols and guidelines for referring practitioners, enhanced regulatory oversight through the BC College of Physician and Surgeons Diagnostic Accreditation Program, an updated facility approval policy and other enhancements related to sleep diagnostics in B.C.

A report, *Diagnostic Sleep Medicine Review*, detailing the work and findings of the MOH was released in June 2020.

### **3. Audit Committees**

#### **Audit and Inspection Committee**

The Audit and Inspection Committee (AIC) is a four-member panel comprised of three physicians (one nominated by the DoBC, one nominated by the CPSBC and one appointed by the Commission) together with one member who represents the public. On December 1, 2006, section 10 of the *Medicare Protection Amendment Act 2003* was brought into force. This section expanded the audit and inspection powers of the Commission to include the power to audit clinics as corporate entities, rather than just physicians.

The AIC has responsibility for overseeing two types of audits. Audits for patterns of practice are done to ensure that services billed to 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 decides whether on-site 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 Commission for further appropriate action.

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

The Commission's authority to audit claims from health care practitioners is assigned 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 the powers and duties necessary to carry out audits.

The Commission's authority to make orders regarding practitioners under sections 15 and 37 of the MPA is assigned to the Health Care Practitioners Special Committee for Audit Hearings (HCPSCAH).

**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. It carries out the audit and inspection function on behalf of the audit committee.

**BIP Statistics 2019/20**

- On-site audits conducted: 19
- Extra billing audits conducted: 0
- Issued audit reports: 17
- Estimated overbillings from audit reports: \$8,859,907
- Number of settlements: 7
- Dollar amount of settlements: \$3,405,285
- Practitioners who have a section 15(2) sanction: 1
- Number of hearings: 0

**BIP Statistics 2020/21**

- On-site audits conducted: 9
- Extra billing audits conducted: 3
- Issued audit reports: 13
- Estimated overbillings from audit reports: \$11,789,443
- Number of settlements: 7
- Dollar amount of settlements: \$4,122,148
- Practitioners who have a section 15(2) sanction: 1
- Number of hearings: 1

**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 4 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.

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.

Letters were not sent out from April 2020 to July 2020 due to the COVID -19 pandemic. Letters resumed in August 2020 and starting in December 2020, the number of randomly selected practitioners was increased from the standard 100 per month to 120 per month to try and make up this deficit. In November 2020, the Enhanced Audit Confirmation Letters (EACL) program was launched to allow for online responses.

**SVA Stats 2019/20**

- Number of SVAs conducted 1,001
- Number of letters sent to patients 56,043
- Response rate: 57%

**SVA Stats 2020/21**

- Number of SVAs conducted 875
- Number of letters sent to patients 43,768
- Response rate: 52%

***4. Patterns of Practice Committee***

The Patterns of Practice Committee (POPC) is an advisory committee to the Commission.

The POPC prepares and distributes personal annual statistical billing profile summaries (mini-profiles) to fee-for- service physicians and provides educational information to physicians and sections regarding their patterns of practice and the audit process. The POPC also provides a forum for physicians who wish to raise concerns about the audit process and provides feedback on the audit practices employed by the BIP. The POPC nominates Medical Inspectors and physician Audit Hearing panel members.

The POPC met three times in 2019 and three times in 2020. The POPC met three times in 2021.

***5. 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. The Reference Committee does, on occasion, perform similar billing adjudicative services for patients billed directly by a physician when physicians provide services to third parties, such as insurance companies. Membership on the Reference Committee is limited to representatives of the Doctors of BC.

In 2019/20, the Reference Committee received 16 new cases; closing 22 cases, with none remaining outstanding at the close of the fiscal year.

The Reference Committee received no new cases during 2020/21.

## **6. Requisition Committee**

The Requisition Committee, established in 1997, is a joint committee of the DoBC and the MOH. This committee is on hold pending further review.

## **7. Other Delegated Bodies**

### **Medical Services Plan**

The Commission delegates day-to-day functions such as the processing and payment of MSP claims to HIBC.

MSP and PharmaCare operations were transferred to Maximus Canada effective April 1, 2005. The Commission receives regular updates regarding HIBC's service level requirements and program performance. Policy direction and leadership authority remains within the responsibility of the MOH – and under the Commission in relation to MSP.

In 2020/21, the MSP paid approximately 20,220 medical and health care providers \$3.45 billion relating to more than 98.5 million services, rendered on a fee-for-service basis. 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 Commission to practitioners, groups, clinics, hospitals, and diagnostic facilities for each fiscal year.

Copies of the *Medical Services Commission Financial Statement* are available online at: [www.gov.bc.ca/msppublications](http://www.gov.bc.ca/msppublications).

### **Coverage Wait Period Review Committee**

New and returning residents are required to complete a wait period before provincial publicly funded health benefits are activated. However, there are exceptional cases based on individual circumstances where the Commission may waive this requirement and enroll new residents before the coverage wait period has expired. The Commission has delegated the power to investigate and decide these cases to the Coverage Wait Period Review Committee (the Committee). The Terms of Reference for the Committee are established in the Minute of the Commission 15-074.

In response to the COVID-19 pandemic, the Committee temporarily provided waivers of the wait period for eligible new and returning residents who arrived in B.C. from outside of Canada. This temporary MSP policy expired on July 31, 2020.

The MOH received 205 waiver inquiries from April 1, 2020 to March 31, 2021; 81 complete waiver request applications were reviewed by the Committee, including 9 appeals.

- 12 waivers met the Committee's criteria for approval as established in the Terms of Reference.
- 4 waivers were approved based on the temporary COVID-19 policy.

The Committee denied 65 waiver requests from April 1, 2020 to March 31, 2021:

- 18 denials were related to pregnancy and prenatal care during the wait period.
- 39 denials were related to conditions that were not diagnosed in the wait period and/or were not a financial hardship.
- 3 denials were related to requests from visitors.
- 2 waivers could not be approved because waivers are not granted based on the possibility that health care costs may be incurred during the wait period.

### **Medical Services Commission Hearing Panels**

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

Some hearings are required by the MPA, 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 Commission panels may be judicially reviewed or appealed (depending on the type of decision) by the Supreme Court of B.C.

### **Beneficiary Hearings**

Eligibility (residency) 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 Commission.

### **Eligibility (Residency) Hearings**

A person must meet the definition of resident in section 1 of the MPA to be eligible for provincial health care benefits. As per section 7.4 of the MPA, the Commission may cancel the MSP enrolment of individuals whom it determines are not residents of B.C. Individuals whose MSP coverage is cancelled have the right to appeal to the Commission. Section 7.4 of the MPA requires that prior to making an order cancelling a beneficiary's enrolment, the Commission must notify the beneficiary that he or she has a right to a hearing. The Commission delegates the decision-making responsibility for residency hearings to select representatives.

The Eligibility, Compliance and Enforcement Unit (ECEU) of the MOH investigated 1,454 residency cases between April 1, 2019 and March 31, 2021, verifying BC residences for 337 cases. There were 1,117 non-resident accounts identified, resulting in MSP account cancellations totaling \$7,064,672 in hospital, MSP and PharmaCare recoveries.

From 2019 - 2021, the Commission received 53 new requests for eligibility (residency) hearings. There were 7 in-person hearings and 8 written hearings held, including some cases carried forward from previous fiscal years.

There were 33 hearing requests withdrawn by the account holder or abandoned by the Commission and 15 were cancelled by the ECEU following residency verification. The Commission rendered 30 residency decisions of which 26 were upheld. There are currently 29 residency hearings pending.

### **Out-of-Country Hearings**

Provincial coverage may be requested for medical treatment outside Canada, when medically necessary treatment services are not available for a B.C. resident anywhere in Canada. To obtain provincial coverage for out-of-country medical treatment, the appropriate attending specialist in B.C. must send an application and the medical documentation to apply on behalf of the patient. The Beneficiary and Diagnostic Services Branch (BDSB) of the MOH will review the application on behalf of the Commission. The Commission publishes the *Medical Services Commission Out-of-Province and Out-of-Country Medical Care Guidelines* (January 19, 2011) for funding approval to explain the provincial coverage.

The Commission has established a review hearing process. A review can be requested when coverage has not been approved by BDSB for medical treatment outside Canada. The MPA does not impose a duty on the Commission to hear and decide requests to review, but rather, it is the Commission's choice to offer the option for review hearings.

The number of applications reviewed by BDSB has decreased significantly since 2019/20, due to COVID-19 and travel restrictions. However, out-of-country referrals have continued for B.C. patients requiring urgent (and often high-cost) procedures unavailable in Canada, such as Proton Beam Therapy or other cancer treatments.

From April 1, 2019, to March 31, 2020, BDSB received a total of 146 applications for out-of-country, elective medical treatment. Of those, BDSB approved provincial coverage for 98 applications and denied provincial coverage for 48 applications.

From April 1, 2020, to March 31, 2021, BDSB received a total of 86 applications for out-of-country, elective medical treatment. Of those, BDSB approved provincial coverage for 54 applications and denied provincial coverage for 32.

In 2019/20 and 2020/21, there were no hearings before the Commission to review provincial coverage for out-of-province medical treatment.



## **Diagnostic Facility Hearings**

Under section 33 of the MPA, the Commission 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 [section 33(4)]. A hearing before the Commission is usually requested for one of the following two reasons:

- The ACDF has recommended to the Commission that an application to amend or add new 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 MPA, the regulations, or a condition on the approval.

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

No diagnostic facility appeals were filed, and no hearings were held in 2019/20 or 2020/21.

## **Hearings Related to Medical Practitioners**

Audit hearings are held before the Commission for medical practitioners in relation to Section 37 repayment matters and/or section 15 de-enrolment from MSP for "cause".

### **Audit Hearings for Repayment of Money and De-enrollment**

Under section 37 of the MPA, the Commission may make orders requiring medical practitioners or owners of diagnostic facilities to make payments to the Commission 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.

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

Since the introduction of the Alternative Dispute Resolution (ADR) process in 2000, fewer audits proceed to formal hearings. The ADR process employs both unassisted and assisted (with a mediator) negotiation to encourage medical practitioners and the Commission to reach a negotiated settlement of matters related to sections 37 and 15.

In 2019/20, there were no audit hearings relating to a medical practitioner. In 2020/21, there was one audit hearing relating to a medical practitioner.

**De-enrollment of Medical Practitioners for “Cause”**

In 2019/20, there were no medical practitioners de-enrolled for “cause”.  
In 2020/21, one medical practitioner was de-enrolled for “cause”.

**Hearings Related to Health Care Practitioners**

Audit hearings for health care practitioners in relation to either section 37 repayment matters and/or section 15 de-enrolment from MSP for “cause” are held before the Health Care Practitioners Special Committee for Audit Hearings (HCPSCAH).

**Audit Hearings for Repayment of Money and De-Enrollment**

The HCPSCAH exercises hearing powers over health care practitioners under the MPA, as specified by the Lieutenant Governor in Council under section 4 of the MPA.

Under section 37 of the MPA, the HCPSCAH may make orders requiring health care practitioners to make payments to the Commission 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.

Under section 15 of the MPA, the HCPSCAH may also determine that a practitioner should be de-enrolled from MSP after providing him or her an opportunity to be heard. These are formal administrative hearings by the HCPSCAH. Practitioners are usually represented by legal counsel and the hearings may last one to two weeks.

Since the introduction of the ADR process, fewer audits proceed to formal hearings. The ADR process employs both unassisted and assisted (with a mediator) to attempt to reach negotiated settlements related to sections 37 and 15.

Due to the restrictions of the COVID-19 pandemic, there were no audit hearings related to health care practitioners in 2019/20 or 2020/21.

**De-enrolment of Health Care Practitioners for “Cause”**

There were no health care practitioners de-enrolled for “cause” during 2019/20 or 2020/21.

**Further Commission Highlights and Issues for 2019 - 2021**

The Commission held 10 regular meetings from April 1, 2019 to March 31, 2020.  
The Commission held 10 regular meetings from April 1, 2020 to March 31, 2021.

## Physician Master Agreement and Subsidiary Agreements

As a result of negotiations between the Government of BC and the DoBC, a comprehensive *2019 PMA*, including five subsidiary agreements, is in effect until 2022. The PMA provides a consolidated agreement structure and administrative committees with health authority representation. The Commission is a signatory to the PMA and subsidiary agreements.

Copies of the negotiated agreements are available online at:  
[https://www2.gov.bc.ca/health/msp/DoBC negotiated-agreements](https://www2.gov.bc.ca/health/msp/DoBC%20negotiated-agreements)

The Physician Services Committee (PSC) is the senior body that oversees the relationship between the government and the DoBC, and the implementation and administration of the PMA and subsidiary agreements. The Chair of the Commission attends PSC meetings as a non-voting member.

## Medical Services Commission Payment Schedule

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

In 2019/20, 130 MOCs related to the *MSC Payment Schedule* were approved, resulting in 31 new fee items; these included 7 new temporary fees created in response to the COVID-19 pandemic. These fee items and fee item amendments will remain in effect until the effective date noted or until the end of the pandemic, as determined by the Public Health Officer.

- Effective March 13, 2020, the definition of ‘telehealth service’ was amended in Preamble D.1, which included temporarily including counselling by telephone, and edited in Preamble D.3.3. of the Payment Schedule.
- Effective March 13, 2020, the daily volume limit (DVL) on office visits, counselling, and office complete examinations was suspended; the DVL was reinstated on October 1, 2020.
- Effective March 17, 2020: 2 fee codes were added for office visits for COVID-19.
- Effective March 27, 2020: 5 fee codes were added for management of telehealth care, including one for Urgent Specialist COVID-19 advice.

In 2020/21, 121 MOCs related to the *MSC Payment Schedule* were approved, resulting in 37 new fee items; these included 26 new temporary fees created in response to the COVID-19 pandemic. These fee items and fee item amendments will remain in effect until the effective date noted or until the end of the pandemic, as determined by the Public Health Officer.

- Effective March 29, 2020, a fee code was added for COVID-19 perioperative complexity.
- Effective April 15, 2020: 2 fee codes were added for Specialist and Urgent Specialist Advice.

- Effective April 17, 2020, Diagnostic Radiology and Diagnostic Ultrasound Preambles were amended, to suspend restrictions preventing radiologists from billing the Medical Services Plan for some remote readings.
- Effective May 1, 2020 telehealth fees were added to the list of eligible fees for Business Cost Premium (BCP) and were subsequently added to the BCP list as appropriate.
- Effective May 31, 2020: 6 telehealth fee codes were suspended.
- Effective June 1, 2020: 18 new fee codes were edited for family physician age-based telehealth office visit, counselling and consultation, and revisions were made to the 13 Family Physician (FP) Mental Health Management and Chronic Disease Management Incentive fees.
  - Effective July 23, 2020, a fee code was amended for the Management of Maintenance Opioid Agonist Treatment (OAT) for Opioid Use Disorder.
- Effective October 1, 2020: 2 fee codes were added for respiratory immunization, with an end date of April 30, 2021.
- Effective October 1, 2021, the fee codes for respiratory immunization were reinstated, and covered an additional respiratory immunization (pertussis during pregnancy) with an end date of April 30, 2022.
- Effective January 25, 2021: 3 fee codes were added for COVID-19 immunization.
- Effective April 15, 2021, a fee code was added for COVID-19 immunization advice.

Additionally, there were 33 fees moved from General Practice Services Committee (GPSC) funding into the Available Amount on a provisional basis; 3 fees moved from mixed GPSC funding and Available Amount to Available Amount only; and 61 fees were moved from Specialist Services Committee funding into the Available Amount on a provisional basis.

### **Medical Services Plan Updates resulting from the COVID-19 pandemic**

In response to the COVID-19 pandemic, the MOH and the Commission made several temporary exceptions with respect to MSP coverage requirements. Changes were implemented in March 2020 and were intended to expire in July 2020. These MSP coverage changes included:

- Waiving the MSP coverage wait period and approving date of arrival coverage for new and returning eligible B.C. residents.
- Extending the absence limit for eligible B.C. residents who exceeded the temporary absence time limit, as well as for those individuals who were out of B.C. on extended absence at the start of the pandemic.
- Granting temporary MSP coverage to short-term temporary foreign workers who did not meet the six-month residency requirement.
- Access to COVID-19 specific medical treatment was made available to those non-MSP eligible individuals present in B.C.
- Eligible MSP applicants who were unable or unwilling to attend an Insurance Corporation of BC (ICBC) driver licensing office were temporarily enrolled in MSP and given a Confirmation of Temporary Coverage letter.
- Beneficiaries with existing MSP coverage whose BC Services Card (BCSC) was coming due for renewal and were unable or unwilling to attend ICBC could request a Confirmation of Coverage letter.

- MSP enrolled beneficiaries whose temporary documentation had expired and could prove Maintained Status with Immigration, Refugees and Citizenship Canada (IRCC) were provided with temporary MSP coverage.

The following change to MSP coverage remains extended through April 2022:

- MSP enrolled beneficiaries whose temporary documentation had expired and could prove Maintained Status with Immigration, Refugees and Citizenship Canada (IRCC) were provided with temporary MSP coverage.

## ***1. Strategic Planning***

The Commission reviewed and re-established its objectives at strategic planning sessions held in March 2020 and March 2021. The objectives for the Commission are:

- facilitating reasonable access to quality medical care;
- managing and monitoring the Available Amount;
- administering the MPA; and
- hearing appeals initiated by beneficiaries, diagnostic facilities, or physicians.

In 2020, the Commission quickly adjusted focus to support the provincial response to the COVID-19 pandemic. This work included working to ensure the provincial health system could support the use and delivery of virtual health care, and increasing the attention given to understanding the impacts on patient needs not related to the pandemic. Among the strategic priorities established outside the response to the pandemic, the Commission identified the following:

- Engage with the MSP and the Tariff Committee to propose Virtual Care fees that align with the MOH Primary Medical Home principle of longitudinal and continuity of care.
- Investigate and document health system capabilities to identify list of 3<sup>rd</sup> party Virtual Care providers operating in B.C.
- Communicate with the appropriate authorities regarding privacy and security, technological requirements, and compliance for 3<sup>rd</sup> party Virtual Care providers.
- Improve methods to better identify and manage repeat inappropriate billing offenders, including a report from BIP on Audit Outcomes related to sections 37 and 15.
- Respond to the implications of the outcome of the Cambie Surgery et al litigation.
- Develop a reporting dashboard to monitor the Available Amount.
- Confirm MOH timeline for implementing location codes as part of billing of physician services

In 2021, some strategic priorities identified for the Commission included:

- Initiate discussions with the MOH on setting information technology priorities based on patient, clinical, and public population health needs.
- Introduce a Virtual Care fee structure that provides incentive and support for longitudinal primary care and appropriate specialty services.
- Request the MOH provide an update on their surveillance of Artificial Intelligence in provision of medical care, including point of care testing and impacts on the health system.
- Monitor the implementation of Location Codes and evaluate if the location codes meet MSC and CPSBC needs.

- Request an analysis of billing data that identifies:
  - codes most frequently mis-billed
  - codes most at risk of being misused
  - codes most used by physicians found to have inappropriately billed
  - codes that are problematic  
(e.g.: fee code is not clear on what action or service is associated)
- Request BIP identify how they will monitor billing to identify billing outliers with fewer false positives, and with fewer months of billing data to identify outliers.
- Share analysis of billing data with POPC to inform education and training activities.
- Gather information about what billing training is provided to new physicians and to practicing physicians.
  - i.e.: meet with POPC, University of BC and the MSP
- Follow up with MOH Financial Officer about improving the effectiveness of the audit program.
- Create an operational plan for better monitoring of outliers and offenders.
- Evaluate implications of allowing Home Sleep Study providers to bill MSP fees.
- Monitor data provided by private clinics to identify services provided within waitlist period as outlined in the Cambie Injunction.

## **BC Services Card**

The BCSC program is a partnership involving the MOH, the Ministry of Citizens' Services and the ICBC. As of March 31, 2021, 94.2% of MSP beneficiaries had been issued a BCSC.

Throughout 2019/20, major focuses of activity included implementing solutions for name mismatches and implementing policies to support individuals during the COVID-19 pandemic.

In February 2020, phase 3 of the name mismatch project was implemented to reduce the number of name mismatches between HIBC and ICBC. This phase of the project addressed complex names such as mononyms, individuals with names that contain punctuation and spaces, and names that exceed the allowable number of characters in systems.

In March 2020, in response to the COVID-19 pandemic, temporary policies were implemented for individuals who were unwilling or unable to attend an ICBC counter to enrol or renew enrollment in the MSP.

## ***2. Presentations to the Commission***

In 2019/20, the Commission received a number of presentations including the following topics:

- MSP Premium elimination update.
- MSP Service Location Code project updates.
- Overview of the Health Sector Information Analysis and Reporting Division.
- GPAC work plan and Annual Report.
- Updates to access to health care services and providers as related to the COVID-19 pandemic.
- Updates to MSP coverage for beneficiaries as related to the COVID-19 pandemic.
- Setting of the Available Amount by the MOH Finance and Corporate Services.
- Physician audits including statistics and extra billing audits by the MOH AIC and BIP.
- Updates to the implementation of Bill 92.

In 2020/21, the following topics were presented to the Commission:

- Updates on Virtual care issues.
- MSP Service Location Code project updates.
- Telemedicine Survey Results from the CPSBC.
- An update on implementation of the MOH Digital Health Strategy.
- Updates to the implementation of Bill 92.
- Updates to MSP coverage for beneficiaries as related to the COVID-19 pandemic.

## ***3. Commission-Related Legal Cases***

The Commission monitors legal issues that arise in relation to MSP, as part of its oversight of MSP. From time to time, it is also actively involved in litigation as a named party.

The following cases were considered and/or participated in by the Commission during 2019/20 and 2020/21:

### **Extra Billing/Private Clinic Issues**

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 on an individual's ability to pay. As such, the MPA prohibits "extra billing", which is a charging to an MSP beneficiary for or in relation to an insured medical service that is provided by a physician who is enrolled in MSP.

### **Extra Billing Investigations**

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

In 2019/20, the Commission commenced no audits of private clinics.

In 2020/21, the Commission commenced audits of three private clinics to determine compliance with the extra billing provisions of the MPA.

Additional extra billing clinic audits ordered by the Commission remained pending during 2020/21.

### **Extra Billing Litigation**

In January 2009, Cambie Surgeries Corporation and others commenced litigation in B.C. Supreme Court that challenges the validity of the extra billing provisions in the MPA, and the provision in the MPA that prohibits private insurance contract for insured services.

On September 10, 2020, the B.C. Supreme Court issued a decision in *Cambie Surgeries Corporation v. British Columbia (Attorney General)*, 2020 BCSC 1310, in which the Court confirmed that the provisions of the MPA related to extra-billing are constitutional. At that time, the limited injunction that had been in place in relation to aspects of extra-billing expired.

The September 10, 2020 decision was appealed by *Cambie Surgeries Corporation* to the British Columbia Court of Appeal.

On December 8, 2020, the B.C. Court of Appeal issued a limited form of injunction in relation to extra-billing under the Act in *Cambie Surgeries Corporation v. British Columbia (Attorney General)*, 2020 BCCA 349. The Court ordered that until June 18, 2021 (or further order of the Court):

- a) The Commission is enjoined from exercising the powers of enforcement pursuant to subsections 21(2) and (3), 45.1 and 46(5.1) and (5.2) of the Medicare Protection Act, R.S.B.C. 1996, c. 286, in respect of any privately funded surgeries for patients whose medically necessary surgery
  - i. has been scheduled for a date beyond the MOH wait time benchmarks associated with the patient's priority code as assigned by their treating physician, or
  - ii. has not taken place by the date set according to such wait time benchmarks, for reasons of insufficient capacity in the public system.
- b) This order will be in effect until June 18, 2021 or further order of this Court.
- c) It is a term of this order that any physician who conducts surgery at any private surgical clinic pursuant to the exemption granted in this order comply with the Practice Standards of the CPSBC in relation to Conflict of Interest.
- d) It is a further term of this order that physicians who conduct surgeries under these conditions and clinics where such surgeries are conducted maintain adequate records that permit the Commission to determine that surgeries are being conducted in accordance with this interim order and make these records available to the Commission on demand.
- e) The parties have liberty to apply if any part of this order requires modification in order to give effect to these reasons for judgment.

The injunction was further extended to September 30, 2021.



With the expiry of the injunction on September 30, 2021, enrolled physicians at private surgical centres are no longer permitted to charge patients whose medically necessary surgeries are scheduled for, or have not taken place by, the dates defined by the MOH wait time benchmarks for reasons of insufficient capacity in the public health system; such charges would constitute extra-billing.

In June 2021, the B.C. Court of Appeal held a hearing in relation to the appeal by *Cambie Surgeries Corporation*, and the parties are awaiting a decision.

## Appendices

### *Appendix 1:*

#### *Members of the Medical Services Commission as of March 31, 2021*

Representatives and alternate members of the Commission are appointed by Order of the Lieutenant Governor in Council (OIC). Information regarding Commission appointments is available on the B.C. government Central Agencies website: [Crown Agencies and Board Resourcing and Office.](#)

#### **Government of B.C. Representatives:**

- Dr. Robert Halpenny (Chair)
- Dr. Heather Davidson (Deputy Chair)
- Mr. Colin Kinsley
- Alternate Members:
  - Ms. Stephanie Power – 1<sup>st</sup> Alternate
  - Dr. Ian Rongve – 2<sup>nd</sup> Alternate
  - Ms. Marie Ty – 3<sup>rd</sup> Alternate

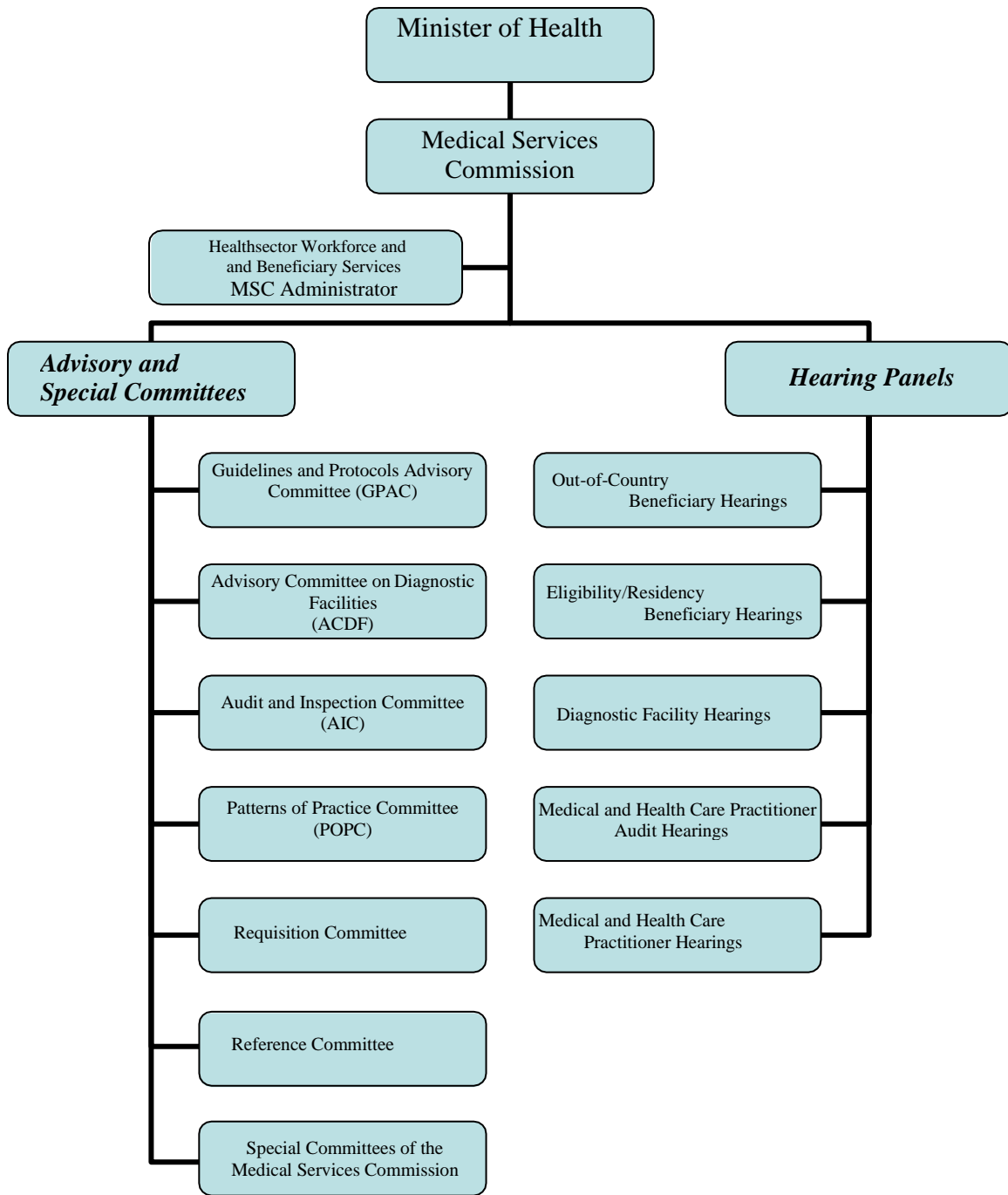
#### **DoBC Representatives:**

- Dr. Sam Bugis
- Dr. Alan Ruddiman
- Dr. William Cavers
  - Dr. Matthew Chow – 1<sup>st</sup> Alternate
  - Dr. Ramneek Dosanjh – 2<sup>nd</sup> Alternate
  - Allan Seckel – 3<sup>rd</sup> Alternate

#### **Public (Beneficiary) Representatives:**

- Ms. Ellen Godfrey
- Mr. Kenneth Werker
- Dr. Jillianne Code

**Appendix 2:**  
**Medical Services Commission Organization Chart**



***Appendix 3:***

***Medical Services Commission Mailing Address and Website***

1515 Blanshard Street  
PO BOX 9649 STN PROV GOVT  
Victoria BC V8W 9P4

Email: [MSC@gov.bc.ca](mailto:MSC@gov.bc.ca)

Further information regarding the Commission can be found  
online at: [www.gov.bc.ca/medicalservicescommission](http://www.gov.bc.ca/medicalservicescommission).

