

Report to the Deputy Minister of Health

## Review of Diagnostic Imaging Policies and Practices for Providence Health Care

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Vancouver, B.C.

British Columbia Ministry of Health  
December 8, 2006



Ministry of  
Health

## EXECUTIVE SUMMARY

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The purpose of this review was to address reports of inappropriate access by private clinics and third party brokers, who may have charged British Columbia beneficiaries for expedited access to diagnostic imaging facilities operated by Providence Health Care (PHC), affiliated through the denominational accord with Vancouver Coastal Health Authority (VCHA).

These facilities currently provide more than 87,000 magnetic resonance imaging (MRI) exams, computed tomography (CT) scans and ultrasounds annually.

The review sought to determine if a provider of diagnostic imaging services in either of these organizations, or in any Health Authority, acted in a manner which violated the Medicare Protection Act (MPA) and its regulations, the Hospital Act (HA) and its regulations, and the Hospital Insurance Act (HIA) and its regulations, as well as Ministry of Health policy regarding revenue generation by Health Authorities.

A team of officials was appointed by the Deputy Minister to meet with the appropriate administrators from the Vancouver Coastal Health Authority and Providence Health Care. Officials and staff at VCHA and Providence Health Care cooperated fully in the course of this review. Initial fact-finding activities were conducted between September 15 and September 26, 2006.

In addition to meeting with VCHA and PHC administrators, the team held onsite visits at the diagnostic imaging departments of St. Paul's and Mount St. Joseph hospitals and booking information was reviewed from department records. A meeting was held with the College of Physicians and Surgeons of British Columbia to seek their views on the practices subject to this review. Attempts were made to speak with third party brokers who referred patients to these two hospitals in return for payments made to arrange medically necessary MRI, CT, ultrasound or echo cardiogram.

Legislation, policy and correspondence relevant to the review were examined by members of the team. Data were provided by VCHA and PHC on sources of referrals and procedures provided to beneficiaries for which a third party payment was made to the respective hospitals for provision of expedited diagnostic imaging services.

The review team identified, through records provided by Providence Health Care, a list of third party "brokers" (private clinics and organizations who operate a business designed to link patients, for a fee, to medical procedures in British Columbia and in other jurisdictions) which arranged expedited access to medically necessary diagnostic imaging services at St. Paul's and Mt. St. Joseph hospitals, usually in return for a fee. Fees were charged to both beneficiaries and non-beneficiaries, such as out of province or out of country patients in need of such services. There is no prohibition on public facilities accepting payment for medical services provided to non-beneficiaries. (WorkSafe BC and federally referred patients, e.g. RCMP, military and federal prisoners, are not included in this report since they are not beneficiaries under provincial legislation). There are indications that this practice, while not widespread, has occurred at these two hospitals since 1998.

There is no evidence that any beneficiaries who were classified as emergency or urgent were bumped by a referral from a third party broker at either St. Paul's or Mount St. Joseph hospitals. Downtime on the equipment was sold as a revenue generation initiative for the diagnostic imaging departments to fund additional diagnostic imaging procedures.

Patients who chose to use a third party broker obtained and faxed their physicians' requisitions for diagnostic services to the brokers, who then determined the cost to the beneficiaries. If the patients agreed to the rate, the patients were billed by the broker who arranged for an expedited appointment for MRI or other diagnostic imaging services provided at these two hospitals, usually within two to three days of receiving the physician requisition. The brokers paid Providence Health Care monthly for the number and type of diagnostic imaging procedures provided by the hospitals.

In most cases, the brokers retained a portion of the payment given to them by the patients as a service fee. This type of arrangement for medically necessary procedures to beneficiaries is not permitted under the Canada Health Act, the Medicare Protection Act or the Hospital Insurance Act. Under the Canada Health Act, the payment of such fees for expedited access to medically necessary health services constitutes extra billing (which is often referred to in informal discussions as queue jumping). As a consequence, Health Canada normally reduces the federal health transfer payments to a province by the amount of extra billing it concludes has occurred within a province during a fiscal year.

The review team determined, based on interviews with senior Vancouver Coastal Health Authority and Providence Health Care executive officers, that the Ministry of Health policies described in this report pertaining to acceptable and unacceptable revenue generation activities were received by the executive officers, discussed in a timely manner at senior level executive and management meetings and disseminated to directors and managers throughout their organizations.

The review team does not have enough information to conclude that there was any deliberate attempt on the part of any officer or manager at Vancouver Coastal Health Authority or Providence Health Care to act in a manner contrary to provincial health legislation or Ministry of Health policy pertaining to revenue generation activity.

However, a breakdown in communications occurred between the executive officers and front-line managers responsible for the operation of diagnostic imaging services at St. Paul's and Mt. St. Joseph hospitals. The managers were unaware that it is not permissible for diagnostic imaging services to be provided to beneficiaries in a public hospital when they are referred by private third-party brokers. Further, there was a lack of follow-up at the executive level to ensure that the departments for which they are responsible understood and were in compliance with legislation and policy.

This review determined that the diagnostic imaging departments at St. Paul's and Mount St. Joseph hospitals engaged in a practice of accepting beneficiaries via third party brokers beginning in the late 1990s and these beneficiaries usually paid a fee for expedited access to medically necessary diagnostic imaging procedures using a third party broker. This practice is not permitted under the Medicare Protection Act or the Hospital Insurance Act.

It became evident over the course of the review, that front line managers did not understand that the revenue generation policies issued by the Ministry in 2002 and April, 2006 applied to the practice of accepting payment from third party brokers for expedited access by beneficiaries for medically necessary diagnostic imaging services. Members of the review team were told that the diagnostic imaging departments thought that this practice was a legitimate revenue generation initiative which could be used to fund additional diagnostic imaging procedures.

This review concludes that between 2002 and 2006, approximately 1,100 patients arranged expedited access to medically necessary diagnostic imaging procedures through third party brokers and that these brokers arranged for diagnostic imaging procedures on their behalf at St. Paul's and Mt. St. Joseph hospitals, usually for a fee in addition to the established cost for the specific diagnostic procedures provided by the hospitals. During this period, in total more than 334,000 MRI exams, CT scans and ultrasounds were performed at the two facilities.

Upon receipt of a letter dated September 13, 2006, from the Deputy Minister of Health, Providence Health Care immediately directed its diagnostic imaging departments to cease accepting referrals from third party brokers who had been arranging expedited access for beneficiaries under the Hospital Insurance Act. PHC acted promptly to implement this directive and no further referrals have been accepted from third party brokers for medically necessary diagnostic imaging services.

The review team consulted with all Health Authorities to determine whether the practice at PHC of accepting beneficiaries through third party brokers for medically necessary diagnostic imaging services was occurring elsewhere in the province. The other Health Authorities have confirmed that they have not been engaging in this practice since the policy directives of 2002 were disseminated to them.

The review team recommends that the Deputy Minister request that Vancouver Coastal Health Authority and Providence Health Care review their practices regarding the dissemination and clarification of policy directives received from the Ministry of Health to ensure that all staff responsible for the implementation of a policy are clear on the requirements for compliance and accountability. Furthermore, a mechanism should be put in place to do a periodic compliance review to ensure that such policy directives are adhered to.

The review team recommends to the Deputy Minister of Health that Providence Health Care be directed to make arrangements, within 90 days, to identify, notify in writing and to repay in full beneficiaries who received a medically necessary diagnostic imaging procedure between September 2002 and September 2006 that was arranged by a third party broker not authorized to perform such services under provincial legislation or policy. By payment in full, we mean the cost of the procedure and not the brokerage fee. Providence will provide a report in full to the Ministry of Health upon completion of this reimbursement activity. Patients who paid a broker a fee to obtain a medically necessary diagnostic imaging procedure at St. Paul's or Mount St. Joseph hospitals and who wish to seek reimbursement of that fee should contact the brokering agent directly.

The review team recommends that the Deputy Minister of Health request that the College of Physicians and Surgeons remind its members that it is inappropriate to refer patients to third party brokers for medically necessary services available to beneficiaries under the Medicare Protection Act and the Hospital Insurance Act.

The Ministry of Health, in collaboration with officials from all Health Authorities and hospitals providing MRI and CT diagnostic imaging services, should undertake a review of best referral practices with respect to the delivery of these services.

## SCOPE OF THE REVIEW

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As a result of allegations that beneficiaries were obtaining inappropriate access to diagnostic imaging services through third party brokers, the Deputy Minister of Health requested that a review team be convened consisting of Ministry of Health staff and Vancouver Coastal Health Authority executives. The team was charged with the following tasks in the conduct of the review:

1. Establish the facts related to the allegations of inappropriate access to diagnostic imaging services for medically necessary reasons.
2. Ensure compliance with provincial legislation (Hospital Act and regulations, Hospital Insurance Act and regulations and the Medicare Protection Act and regulations), as well as Ministry of Health policy relevant to the allegations.
3. If contraventions of legislation and policy have occurred:
  - Identify the nature and circumstances of the contravention(s)
  - Determine the number of contraventions
  - Identify the party or parties responsible for the contraventions
  - Determine the amount of revenue that has been inappropriately collected by the hospital and from which agencies/broker and on behalf of which patients
  - Determine the recipient of the revenue.
4. Recommend remedies based on the findings arising from the review.

The review team assessed the policies and practices of St. Paul's Hospital and Mt. St. Joseph Hospital in relation to the operation of their diagnostic imaging departments, in order to determine if any beneficiary had paid a third party to receive an expedited medically necessary diagnostic imaging test. The review team also surveyed all Health Authorities to determine if any similar policies and practices were occurring in any of their diagnostic imaging, surgical or other departments.

While the Canada Health Act (CHA) was not specifically a focus in the course of this review as the Province does not have jurisdiction over the CHA, the review team was mindful that the CHA and its regulations do require provinces, as a condition of receiving federal health transfer funding, to ensure that extra billing of beneficiaries does not occur for medically necessary services which they are entitled to receive without any fees in accordance with provincial health insurance legislation.

The time period examined for the purposes of this review was between 2002 and September 2006. Initial fact-finding activities were conducted between September 15 and September 26, 2006.

## ACKNOWLEDGEMENT

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The Ministry of Health review team wishes to express their appreciation for the full and timely cooperation of Vancouver Coastal Health Authority and Providence Health Care in making their officials available for all meetings requested by the Ministry and for providing documents, records and data to assist in the analysis of the services which are the subject of this review.

# APPLICABLE LEGISLATION AND POLICY

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The review team referred to the following statutes and policy statements in assessing the facts obtained during the course of the review:

The definition of “beneficiary” is similar for the purposes of the *Medicare Protection Act* and the *Hospital Insurance Act* [MPA S.1 and S.7, HIA, S.1]

The definition of “benefits” under the *Hospital Insurance Act* is different from the definition of benefits under the *Medicare Protection Act*.

## 1. Hospital Insurance Act

Subject to the Act and regulations, every beneficiary is entitled to receive the general hospital services provided under the Act. [s.3] No person other than a beneficiary is entitled to the benefits provided by the Act. [s.4]

### Out-Patients

For those beneficiaries requiring treatment or diagnostic services as out-patients, benefits are prescribed by regulation. Section 5.23 of the *Hospital Insurance Act* Regulations specifically provides that out-patient MRIs are general hospital services.

Where out-patient magnetic resonance imaging services are recommended for a qualified person by the attending physician and are provided to that person in a hospital, these services, including necessary interpretations, are general hospital services.

CT scans and ultrasounds (including echocardiograms) for out-patients are not general hospital services under the HIA Regulations. The funding for the technical component of these diagnostic tests is included within the hospital’s global funding, but the professional component is not.

Pursuant to the *Health Insurance Act*, if a health authority has been paid by the government for general hospital services provided under the Act, the payment is deemed to be payment in full for the service and regional health board or a hospital must not seek to recover additional payment from any other person for the services. [s. 12]

It is an offence under the Act if a person wilfully renders an account or causes an account to be rendered to a beneficiary for hospital services that are provided and to which the beneficiary is entitled under the Act. [s.13]

## 2. Medicare Protection Act

The insured services (“benefits”) under the *Medicare Protection Act* are different from the benefits provided under the *Hospital Insurance Act*. Pursuant to Section 1 of the *Medicare Protection Act*, “benefits” under the Act includes medically required services rendered by an enrolled medical practitioner if the services are provided in an “approved diagnostic facility.” [s.1]

An “approved diagnostic facility” means a diagnostic facility approved by the Medical Services Commission under Section 33.

Part 6 of the *Medicare Protection Act* deals with the approval of diagnostic facilities. The Commission may, in accordance with the regulations, approve a diagnostic facility for the purposes of permitting benefits to be performed in it. The Commission may impose conditions on an approval or a temporary approval for a particular diagnostic facility or class of diagnostic facilities, including conditions restricting the types of benefits for which payment will be made. [s.34]

Limits on direct and extra billing are provided for in Part 4 of the Act. Generally, unless otherwise permitted by the Act, regulations or the Medical Services Commission, no person may charge a beneficiary for a benefit or for “materials, consultations, procedures, use of an office clinic or other place for any matter that relates to the rendering of a benefit”. [s.17]

### 3. Hospital Act

Hospitals have a duty to take all reasonable measures to ensure that limits on direct or extra billing established under the MPA are complied with in respect of services provided in hospitals by physicians to beneficiaries. [s.4]

### 4. Ministry of Health Policy Statements

In September, 2002, the Ministry of Health approved for distribution to the Health Authorities, Policy Communiqué 2002-31 “Hospital-based Revenue Generation.” This policy communiqué clearly stated that:

- Health Authorities must have the legal authority to implement revenue generating initiatives;
- Revenue generating initiatives must comply with relevant federal and provincial legislation;
- Revenue generation practices must not occur at the expense of providing appropriate and timely service to beneficiaries;
- In the section of the policy communiqué entitled Categories, under category 3, Not Permitted for the Purposes of Revenue Generation, the following applicable statements relate to this review:
  - i. Medically required hospital services insured under the *Canada Health Act* (Section 2), provided to beneficiaries which include:
    - Laboratory, radiological and other diagnostic procedures, together with the necessary interpretations provided in hospital;
    - Services provided by persons who receive remuneration from the hospital
  - ii. Medically required services defined in the *Hospital Insurance Act* Regulations which include:
    - Out-patient MRI services performed in hospital [s. 5.23]

In April, 2006, the Ministry of Health released Policy Communiqués 2006-03 (Health Authority Revenue Generation for Non-Clinical Services in Hospitals) and 2006-04 (Health Authority Direct Charges to Patients in Relation to Clinical Services Provided in Hospitals). These policy documents replaced Policy Communiqué 2002-31. Policy Communiqué 2006-04 states that the primary obligation of “Health Authorities” is to provide publicly-funded or insured health services to beneficiaries. Patient charges in relation to clinical services provided in hospitals must not impede patients’ reasonable access to medically required health services. Patients’ access to necessary medical and hospital care must be based solely on need and not on ability to pay.

The “Scope” section of Policy Communiqué 2006-04 states the following: “This policy applies to ‘clinical services’ provided in or by hospitals (as designated under the *Hospital Act*) operated by Health Authorities or their affiliates.” The communiqué defines “clinical services” as “medical, diagnostic or therapeutic services provided in a Hospital by medical practitioners or members of designated health professions (as designated under the *Health Professions Act*) employed, directed, contracted or credentialed (i.e., given privileges to practise) to provide such services by or under the auspices of a Health Authority.”

In the transmittal letter which accompanied the distribution of this policy communiqué to Health Authorities, the Deputy Minister of Health stated: “The policy now clarifies that patient charges are not generally permitted in relation to insured services, except for ‘not medically required’ materials or devices provided, at patient request, as alternatives or enhancements to standard, publicly-funded materials or devices.”

## CORRESPONDENCE

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The review team also considered correspondence sent to Health Authority executive officers from the Ministry of Health regarding compliance with policy directives. This correspondence reinforced the understanding that patients who are beneficiaries under provincial legislation may not be charged for medically necessary diagnostic imaging services, either directly by the patient or indirectly through a third party.



## FINDINGS

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As a result of interviews with staff and administrators responsible for the diagnostic imaging program at Providence Health Care, this review concludes that there appears to have been no deliberate attempt on the part of any Health Authority officer or manager at Vancouver Coastal Health Authority or Providence Health Care to act in a manner contrary to provincial health legislation or Ministry of Health policy pertaining to extra billing for revenue generation activity.

However, a breakdown in communications occurred between the executive officers and front-line managers responsible for the operation of diagnostic imaging services at St. Paul's and Mt. St. Joseph hospitals. The managers were unaware that it is not permissible for diagnostic imaging services to be provided to beneficiaries in a public hospital when they are referred by private third-party brokers. Further, there was a lack of follow-up at the executive level to ensure that the departments for which they are responsible understood and were in compliance with legislation and policy.

The funding of various diagnostic imaging procedures and the related reading of the scan by a qualified practitioner differs depending on which diagnostic imaging procedure is involved. CT scans and ultrasonography diagnostic imaging procedures are paid for from a hospital's global budget, but the professional component to the radiologist for interpreting the scan is paid for by the *Medical Services Plan*. The full cost of providing an MRI, including the professional fee component, comes out of a hospital's global budget. The review determined that as early as 1998, some facilities sold downtime in their diagnostic imaging equipment to third parties for the purpose of revenue generation in order to provide additional diagnostic procedures to beneficiaries.

Health Authorities have established a common professional fee for radiologists working in hospital diagnostic imaging departments. Radiologists who read any MRI scan are paid a fee of \$150 per scan from the budget of the diagnostic imaging department. Radiologists did not receive any additional external payments from scans read for beneficiaries who were referred to the hospitals by a third party broker.

Providence Health Care, at the direction of the Deputy Minister of Health in 2001, ceased the practice of allowing patients to directly purchase expedited access to medically required CT scans and subsequently ceased the practice of accepting patient payment for screening diagnostic imaging. In 2002, Providence Health Care subsequently reimbursed those beneficiaries who had paid directly out of pocket for a diagnostic imaging procedure at St. Paul and Mt. St. Joseph hospitals between 1998 and 2002.

The review determined that there are a number of third party agents who refer beneficiaries as well as non-beneficiaries to the diagnostic imaging departments at St. Paul's and Mt. St. Joseph hospitals. There has been a long standing practice across the province of accepting patients referred by WCB and federal patients (e.g. RCMP, military and federal prisoners) to expedite their access to medically necessary diagnostic imaging procedures. These latter patients are defined under the *Canada Health Act* as not being "insured persons," therefore these referrals do not result in a breach of the *Canada Health Act* or provincial legislation. However, the review team learned that these two hospitals have accepted beneficiaries referred by other third party agencies, which is not permitted under provincial legislation or the *Canada Health Act*.

The review team identified, through records provided by Providence Health Care, a list of third party “brokers” who arranged expedited access to medically necessary diagnostic imaging services at St. Paul’s and Mt. St. Joseph hospitals, usually in return for a fee. St. Paul’s and Mt. St. Joseph hospitals invoiced and received payments from these third party brokers for diagnostic imaging services for patients who are beneficiaries under the *Hospital Insurance Act*. That revenue was applied against the budget of the diagnostic imaging departments of the two hospitals, and this appears to have occurred with the knowledge of the directors of the department as well as the Chief Financial Officers who were accountable for Providence Health Care’s budgets during the time period covered by the scope of this review. The operations director worked directly with the accounting department to establish a billing account for each third party broker referring patients to the two hospitals in order to send third party brokers requisitions for payment to the hospitals. The accounts were included in the category of Uninsured Patients, although many of the patients were in fact beneficiaries under *Hospital Insurance Act*.

Patients were made aware of third party brokers by friends, their physician or surgeon as well as through advertisements in media or on the internet. Patients then contacted a broker, faxed their physician’s requisition for diagnostic services to the broker, who then determined the cost to the beneficiary. If the patient agreed to the rate, the patient was billed by the broker who arranged for an expedited appointment for MRI or other diagnostic imaging services at these two hospitals. The broker received a monthly statement from the finance department of Providence Health Care for the number and type of diagnostic imaging procedures. The broker paid the invoice and generally retained a portion of the payment given to them by the patient as a service fee. This type of arrangement for medically necessary procedures to beneficiaries is not permitted under the *Canada Health Act*, the *Medicare Protection Act* or the *Hospital Insurance Act*.

The review also found that the vast majority of beneficiaries who require medically necessary diagnostic imaging services are referred directly to St. Paul’s and Mt. St. Joseph hospitals by their physician or surgeon and not through a third party broker. The usual referral process when a beneficiary requires a diagnostic imaging procedure involves the completion of a requisition for medically necessary diagnostic imaging services, which is faxed directly to the diagnostic imaging department at the appropriate hospital. However, physicians and surgeons also gave patients who chose to use a third party broker a copy of this referral form. The form includes patient identifier information and the medical problem for which the referring physician believes diagnostic imaging is required in order to determine the appropriate course of treatment. Once received by the diagnostic imaging department, these requisitions are date and time stamped by the booking clerks and sent to a staff radiologist for assessment in regard to urgency: Priority 1, 2 or 3. Priority 1 patients are considered emergency and are seen within hours of the requisition being received in the department. Priority 2 patients are seen within a few days due to the severity of their health condition. Priority 3 patients are generally assessed as routine and in most cases are given a scheduled date for their diagnostic imaging procedure.

The review team learned that referrals from third party brokers were routinely treated as Priority 1 or 2 and generally seen within two to three days of their requisition being received by the hospital’s diagnostic imaging department, regardless of the medical urgency of their condition. The requisitions for all patients requiring medically necessary diagnostic imaging services are assessed by a hospital radiologist. The review team found that all of the patients referred by the third party brokers were considered by the radiologist to be Priority 3 patients who would otherwise routinely be seen within three to six months of the submission of their requisition. MRI waits are longer than those for CT and ultrasound scans. Mt. St. Joseph’s wait list for routine, non-urgent CT scans is one month. Hospital staff stated that

no beneficiary who is an emergency or urgent patient waits more than a few hours to three days for their diagnostic procedure. They also stated that no emergency or urgent patient was bumped to accommodate a referral from a third party broker.

The review team determined, based on interviews with senior Health Authority and Providence Health Care executive officers, that the policies described in this report pertaining to acceptable and unacceptable revenue generation activities were received by the executive offices, discussed in a timely manner at senior executive and management level meetings and disseminated to directors and managers throughout their organizations. In Providence Health Care, the Chief Financial Officer is accountable for compliance with the policies that were the subject of this review. It was determined in the course of this review that these policies were provided to managers responsible for the operation of the diagnostic imaging departments, but were not fully explained as to the practice of accepting referrals from third party brokers.

In discussions with management in Providence Health Care it became evident that front line managers did not understand that the revenue generation policies issued by the Ministry of Health in 2002 and April, 2006 applied to the practice of accepting payment from third party brokers for expedited access for beneficiaries referred by these brokers for medically necessary diagnostic imaging procedures. While they clearly ceased the practice of charging patients directly in 2002 and they did not implement other revenue generation ideas which had been under consideration, they were of the view that it was still permissible to accept patients referred from third party brokers since the hospital was not billing the patient directly. They did not determine if the referred patient was a beneficiary or not, even when the patient presented a BC Care Card when they arrived at the registration desk for their procedure and the requisition was reviewed by a staff radiologist for prioritizing in their queue.

The review determined that approximately 1,100 beneficiaries paid an unauthorized third party broker to access medically necessary diagnostic imaging services at St. Paul's or Mt. St. Joseph hospitals between 2002 and 2006, out of a total of over 334,000 MRI exams, CT scans and ultrasounds performed at the two facilities during that period.

This review queried all Health Authorities twice during the timeframe of the review to determine if the practice identified at St. Paul's and Mt. St. Joseph hospitals was occurring at any other B.C. hospital which offers MRI, CT or ultrasound diagnostic imaging services. The review concludes that this practice was not in effect at any other hospital in the province.

This review concludes that while there was no deliberate attempt to do so, the letter and the spirit of *Canada Health Act*, the *Hospital Insurance Act* and the *Medicare Protection Act* were contravened. This is a serious matter in that Health Canada, which is responsible for the enforcement of the Canada Health Act, will generally follow through on its practice of reducing the health transfer payments to the province if beneficiaries are not reimbursed for medically necessary procedures.

Upon receipt of a letter dated September 13, 2006 from the Deputy Minister of Health, Providence Health Care immediately directed its diagnostic imaging departments to cease accepting referrals from unauthorized third party brokers who had been arranging expedited access for beneficiaries under the *Hospital Insurance Act*.

## CONCLUSIONS

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The review team had access to all Vancouver Coastal Health Authority and Providence Health Care executive officers, directors and providers responsible for diagnostic imaging services and other staff essential to the review of the allegations described in the purpose of this review. The review team visited the diagnostic imaging departments of St. Paul's Hospital and Mt. St. Joseph Hospital, meeting with the managers and staff involved in the provision of diagnostic imaging services. The team toured the departments and received information on the booking procedures and operation of the diagnostic imaging equipment at both hospitals.

In addition to these activities, a meeting was held with the College of Physicians and Surgeons. A member of the team met with the CEO of Timely Medical Alternatives. All Health Authorities were surveyed to determine if they had provided medically necessary diagnostic imaging services to beneficiaries who paid a third party broker for expedited access to these services.

Although not a part of the scope for this review, Health Authorities were also asked to identify any medically necessary services provided by their facilities to beneficiaries who may have paid a third party broker for expedited access to medically necessary health services funded by the government. Aside from the cases reviewed at St. Paul's and Mount St. Joseph hospitals, no other violations of legislation or ministry policy were found to be occurring.

Although technically beyond the scope of this review, it became apparent that there are increasing pressures on hospitals from a number of sources to provide more screening and diagnostic procedures. It is also apparent that the utilization of MRI, CT and ultrasound by physicians and surgeons for diagnosis of disease and injury has been increasing steadily in recent years. MRIs are requested more frequently because of the increasing number of appropriate reasons for seeking an MRI as part of the diagnostic process for determining the best course of treatment for a patient. This has resulted in a steady increase in the number and sophistication of MRI machines (19 in the public system at present) and CT scanners (41 in the public system) and the number of scans performed on this equipment.

Demand for these diagnostic services is not only driven by an expanded range of medically appropriate indications for these procedures, but also by an aging population and the degree to which patients and their physicians can tolerate uncertainty when the nature of a health problem is unknown. MRI in particular plays a significant role in the diagnosis of neurological and orthopaedic conditions. With the increased use of the internet to access medical information and the tendency to self diagnose health problems, there is a cultural drive toward conducting more and more high tech diagnostic tests and less use of the medical method of establishing a diagnosis based on the gathering of information from a patient's health history and habits. These factors result in increasing pressure on publicly funded diagnostic imaging services to deliver timely access to ensure quality patient care.

This review concludes that beneficiaries arranged expedited access to medically necessary diagnostic imaging procedures through 10 third party brokers and that these brokers arranged for diagnostic imaging procedures on their behalf at St. Paul's and Mt. St. Joseph hospitals, usually for a fee in addition to the amount required by the hospitals to cover their costs for providing these procedures. These third party brokers received invoices from PHC for diagnostic imaging procedures for which they in turn paid PHC. This arrangement is not permitted under the *Medicare Protection Act* or the *Hospital Insurance Act*. PHC has, as of September 2006, ceased this practice.

## RECOMMENDATIONS

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1. The review team recommends that the Deputy Minister request that Vancouver Coastal Health Authority and Providence Health Care review their practices regarding the dissemination and clarification of policy directives received from the Ministry of Health to ensure that all staff responsible for the implementation of a policy are clear on the requirements for compliance and accountability. Furthermore, a mechanism should be put in place to do a periodic compliance review to ensure that such policy directives are adhered to.
2. The review team recommends to the Deputy Minister of Health that Providence Health Care be directed to make arrangements, within 90 days, to identify, notify in writing and repay in full beneficiaries who received a medically necessary diagnostic imaging procedure between September 2002 and September 2006 that was arranged by a third party broker not authorized to perform such services under provincial legislation or policy. By payment in full, we mean the cost of the procedure and not the brokerage fee. Providence will provide a report in full to the Ministry of Health upon completion of this reimbursement activity. Patients who paid a broker a fee to obtain a medically necessary diagnostic imaging procedure at St. Paul's or Mount St. Joseph hospitals and who wish to seek reimbursement of that fee should contact the brokering agent directly.
3. The review team recommends that the Deputy Minister of Health request the College of Physicians and Surgeons to remind its members that it is inappropriate to refer patients to third party brokers for medically necessary services available to beneficiaries under the *Medicare Protection Act* and the *Hospital Insurance Act*.
4. The Ministry of Health, in collaboration with officials from all Health Authorities and hospitals providing MRI and CT diagnostic imaging services, should undertake a review of best referral practices with respect to the delivery of these services.