MEDICAL SERVICES COMMISSION

2005/2006

ANNUAL REPORT

Table of Contents

Mandate 2

The Commission 2

Organizational Structure and Responsibilities of the Commission 2

Advisory Committees and Overview of Accomplishments 2

1. Guidelines and Protocols Advisory Committee (GPAC) 2
2. Advisory Committee on Diagnostic Facilities (ACDF) 3
3. Joint Standing Committee on Rural Issues (JSC) 4
4. Joint Utilization Committee (JUC) 4
5. Audit and Inspection Committee (AIC) 5

- Billing Integrity Program (BIP) 5
- Special Committees of the Medical Services Commission 5

6. Patterns of Practice Committee (POPC) 5
7. General Practice Services Committee (GPSC) 6

Other Delegated Bodies 7

- Medical Services Plan (MSP) 7
- Coverage Wait Period Review Committee 7

MSC Hearing Panels 8

1. Beneficiary Hearings 8

a) Residency Hearings 8

b) Out-of-Country Hearings 8

2. Diagnostic Facility Hearings 9
3. Hearings Related to Practitioners 9

a) Audit Hearings 10

b) De-enrollment of Practitioners for "Cause" 10

Other Issues 10

- Health Insurance BC (HIBC) 10
- Wait Times 10
- Laboratory Fee Review Panel 10
- Strategic Planning 11
- Payment Schedule 11
- Nurse Practitioners 11
- Tools to Manage the Available Amount 11
- MSC-Related Legal Cases 11

Appendices 14

Appendix 1: Members of the Medical Services Commission (MSC) 14

Appendix 2: MSC Organizational Chart 15

Appendix 3: Guidelines and Protocols Approved by the MSC in 2005/06 16

Appendix 4: List of Useful Websites and Addresses 17

Mandate

The mandate of the Medical Services Commission (MSC) is to facilitate reasonable access, throughout British Columbia, to quality medical care, health care and diagnostic facility services for residents of British Columbia under the Medical Services Plan (MSP).

The Commission

Established in 1968 under the *Medicare Protection Act (*the "Act"*)*, the Medical Services Commission is responsible for managing the provision and payment of medical services through the Medical Services Plan on behalf of the Government of British Columbia. The MSC is accountable to government through the Minister of Health.

Organizational Structure

In early 1994, the Commission was expanded from one member to a nine-member body. It consists of three representatives nominated by the British Columbia Medical Association (BCMA), three public members appointed on the joint recommendation of the Minister of Health and BCMA to represent MSP beneficiaries, and three members from government. This tripartite 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 BC are involved.

Responsibilities of the Commission

Overall, the Commission is responsible for managing the Available Amount, a fund which is set annually by government to pay for medical services for beneficiaries; hearing appeals from beneficiaries, diagnostic facilities and physicians as required by the Act; and making policy decisions affecting the administration of the Available Amount.

Advisory Committees and Overview of Accomplishments

The Act allows the Commission to delegate some powers and duties. As a result, advisory committees and sub-committees as well as hearing panels have been established to assist in the efficient and judicious management of the Available Amount. Appointment to committees and panels reflects the MSC tripartite representation. Below is a description of the responsibilities and an overview of the 2005/2006 accomplishments of some of the advisory committees, hearing panels and other delegated bodies.

1. Guidelines and Protocols Advisory Committee (GPAC)

The main purpose of GPAC is to maintain or improve the quality of medical care in BC, while making optimal use of medical resources principally through practice guidelines.

A GPAC strategic planning session was held in February 2006, to address the five-year vision for GPAC and steps necessary to achieve this vision. The following two recommendations made to the MSC, were subsequently approved:

- That GPAC will assume a greater leadership role in providing guidelines across the broader medical community including the hospital sector and the public, and measure its success in achieving this objective; and

- That GPAC will place increasing focus on outcomes and the provision of high-quality, evidence-based guidelines.

A 2006/2007 annual work plan was developed that includes specific performance objectives and strategies that will guide GPAC in achieving its vision.

Five guidelines including the two described below, were developed by GPAC and approved by the MSC during 2005/2006.

- The *Diabetes Care* guideline describes the care objectives for the prevention, diagnosis and management of diabetes in non-pregnant adults. It is intended primarily for family practitioners, and focuses on approaches and systems that should be in place to improve care for the majority of patients the majority of the time.

- The *Rheumatoid Arthritis: Diagnosis and Management* guideline is expected to improve appropriate treatment for the approximately one percent of people in BC who have Rheumatoid Arthritis (RA). In addition to the guideline is a patient guide to help patients manage their condition and identify other useful resources.

All approved guidelines are sent to family physicians, and are available on the MSP website at http://www.health.gov.bc.ca/msp/protoguides/index.html.

2. Advisory Committee on Diagnostic Facilities (ACDF)

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

In 2005/2006, the ACDF received 143 applications (24 applications for new facilities and the rest to relocate or amalgamate sites, expand capacity, transfer certificates of approval or expand test menus). Of the total applications received, 119 requests were approved and 24 were denied. Ninety percent of all applications were handled by the ACDF within one meeting.

The ACDF identified selected policy areas for review, including the impact of technological advances and new practice guidelines on access to echocardiography and the framework related to remote interpretation of diagnostic imaging modalities.

3. Joint Standing Committee on Rural Issues (JSC)

The JSC oversees more than $60 million in rural incentive programs to sustain patient care and continuity of access in communities falling under the Rural Subsidiary Agreement for Physicians in Rural Practice. The goal of the JSC is to enhance the availability and stability of physician services in rural and remote areas of BC. The JSC attempts to achieve this goal by considering the unique circumstances experienced by rural physicians and uses this information to enhance the quality of the practice of rural medicine. Some of the funding for the work of the JSC comes from the MSC controlled Available Amount.

Several of the programs intended to help recruit, retain or provide relief to rural physicians saw significant growth last year. For example, in 2004/2005, the Rural GP Locum Program (RGPLP) provided $1.53 million in support of rural locums. Expenditures in 2005/2006 rose to $2.35 million, a 54 percent increase. Over this same period, expenditures for the Northern and Isolation Travel Assistance Outreach Program (NITAOP) (which supports physicians' travel to remote locations) went from $1.65 million to $2.13 million, a 29 percent increase. The Rural Retention Program (RRP) provides an additional premium or allocation (on both fee-for-service and service contract paid physicians) depending on the remoteness or isolation of a physician's practice, spent $49.6 million in 2004/2005. Last year, this figure climbed to more than $51 million. These are just a few of the many rural incentives that continue to help attract GPs and specialists to rural and remote areas.

The RGPLP now supports the use of weekend locums, which is intended to help resident physicians maintain a sustainable workload. The RRP has also been expanded to include the professional component of Radiology and Pathology in-patient and emergency services, as it previously applied only to out-patient services and category II and III laboratory medical services.

4. Joint Utilization Committee (JUC)

In the context of managing the Available Amount, the JUC advises the MSC and makes recommendations on utilization and quality of medical services. In September 2004, five Best Practice Budget Management Working Committees (Comprehensive Primary Care; Primary/Secondary Care Interface; Primary Care/Laboratory Interface; Specialist Care; and Quality Maternity Care) were established as per a Letter of Agreement between the government and the BCMA. During 2005/2006, the JUC provided the Commission with quarterly reports related to the work of the Best Practice Budget Management Working Committees. The MSC endorsed several recommendations including one from the Comprehensive Primary Care Committee in support of the integration of information technology (I/T) in physicians' offices, and one from the Primary Care Laboratory Interface Committee encouraging the development of an outpatient laboratory requisition form to standardize Pre-Renal Transplant and Peritoneal Dialysis laboratory testing. Both of these recommendations are examples intended to enhance best practice, meet the needs of patients and reduce unnecessary utilization of medical services.

The ratification of the 2006 Letter of Agreement has resulted in the development of new committees. Consequently, as of April 1, 2006, with the exception of the Primary Care/Laboratory Interface Working Group, the Best Practice Budget Management Working Committees have been discontinued until further notice.

5. Audit and Inspection Committee (AIC)

The AIC is a four-member committee comprised of three physicians (one representing the BCMA, one representing the College of Physicians and Surgeons of BC, and one representing government) together with one member who represents the public. It performs the powers and duties of the Commission to audit and inspect medical practitioners. Audits are done to make sure that services billed to MSP have been delivered and billed accurately. The AIC decides whether on-site audits are appropriate, and it outlines the nature and extent of the audits. The AIC reviews the audit results and makes recommendations to the Chair of the MSC regarding whether matters should be referred for recovery.

During the next year, the Commission will be asked to delegate power to the AIC to also conduct on-site audits on physicians in diagnostic facilities.

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

The BIP is responsible for audit of fee-for-service billings, to ensure that physicians are accountable for the billings they submit. It carries out the audit and inspection function on behalf of the Audit and Inspection Committee and assists the MSC in the recovery of any funds billed unjustifiably. To help instill confidence and ensure transparency, the Commission involves the BCMA, the College of Physicians and Surgeons of BC and individual physicians in the medical audit program.

In 2005/2006, the BIP completed 15 on-site audits. It negotiated settlements for seven cases and one case was closed, with no recovery pursued. Cash received by BIP this year totaled $339,639 (including recoveries negotiated in the previous years).

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

The Commission has delegated its authority to audit claims from health care practitioners to the Health Care Practitioners' Special Committee for Audit. Special Committees have also been established for the following: chiropractic; dentistry; massage therapy; naturopathy; optometry; physical therapy; and podiatry. The Special Committees have been given all of the powers and duties necessary to carry out audits under s.36 of the Act. The same Chair is appointed to each of the eight Special Committees.

6. Patterns of Practice Committee (POPC)

The POPC is a committee of the BCMA that acts in an advisory capacity to the Medical Services Commission. The POPC prepares and distributes an annual statistical personal profile summary (mini-profile) to fee-for-service physicians; provides educational information to physicians on the audit process and their patterns of practice; listens to

physicians who wish to raise their concerns about the audit process; is informed of, and provides feedback on, the audit practices employed by the Billing Integrity Program; and jointly, with the College of Physicians and Surgeons of BC, nominates medical inspectors and audit hearing panel members.

7. General Practice Services Committee (GPSC)

The GPSC is not a direct advisory body to the Commission but it does provide recommendations to the MSC on matters affecting general practice in British Columbia. The GPSC is a vehicle for representatives of government, the BCMA and the Society of General Practitioners to work together to find innovative ways of supporting and sustaining full service family practice.

The GPSC was originally established under the 2001 Working Agreement (and Subsidiary Agreement for General Practitioners) between the government, BCMA and MSC, with a mandate to develop a proposal for the allocation of $20 million for GP services. The Full Service Family Practice Incentive Program (FSFPIP) was developed and consisted of three specific incentive programs:

- The Family Physician Obstetrical Premium, to encourage and support low to moderate volume delivery practice GPs to continue providing obstetric care in their communities.
- Provision of sessional payments to support GP participation in structured collaborative learning sessions for improved patient chronic disease management.
- The Condition Based Incentive Payment Program, that addressed the prevailing gaps in the care of patients with diabetes and congestive heart failure through an annual $75 incentive payment to GPs for each patient whose condition was managed according to BC Clinical Guidelines recommendations.

Under the 2006 Working Agreement, the FSFPIP was expanded to include the following incentives:

- The Maternity Care Network initiative, to support a group practice approach to GP provision of obstetrical care.
- A Patient Management Conference Fee, available to GPs when requested by a facility to review ongoing management of a patient in that facility or to determine whether a patient in the facility with complex supportive care needs can safely return to the community or transition to a supportive care or long-term care facility.
- A Complex Patient Clinical Conference Fee, available to GPs for the creation of a coordinated clinical action plan for the care of community-based patients with more complex needs.
- The Condition Based Incentive Payment Program has been expanded to address gaps in hypertension management.

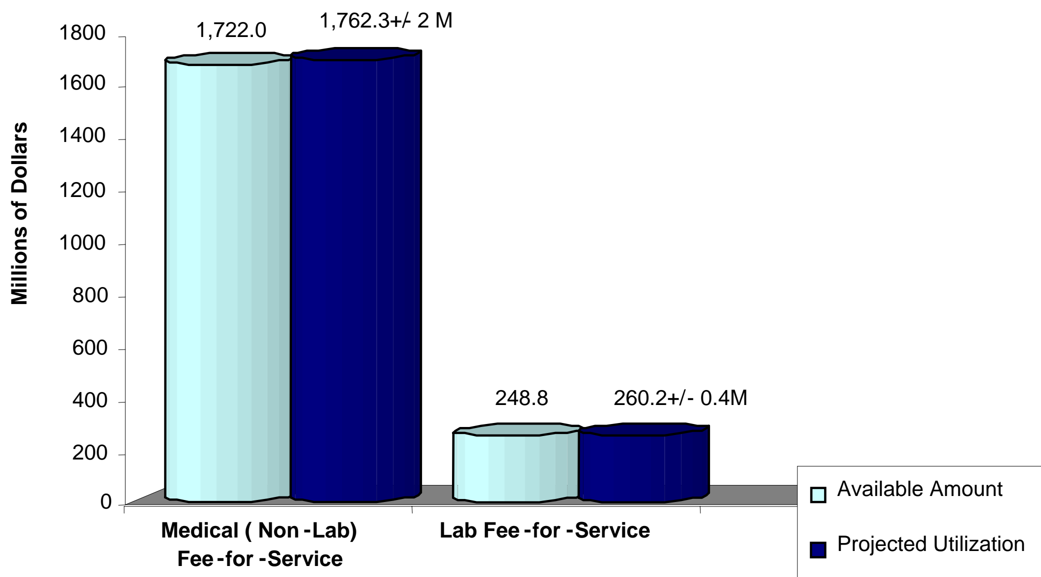
Under the 2006 Working Agreement, over the next four years, the GPSC will be developing proposals to support GP provision of full service family practice. Innovations aimed at better enabling shared care, supporting GPs' role in hospital care, disease

prevention, and recruiting and retaining full service family practitioners are examples of priority areas that will be addressed by the General Practice Services Committee.

Other Delegated Bodies

- ***Medical Services Plan (MSP)***

The Commission delegates the day-to-day functions such as processing and payment of claims to MSP. The Medical Services Plan pays over 12,500 medical and healthcare practitioners over $2 billion dollars relating to approximately 70 million services, rendered on a fee-for-service basis. Doctors can also receive their payments through other alternative payment methods including salaries, sessions and service contracts.



* Actual expenditures will be reported when MSP finalizes payments for 2005/2006.

The government assists over 1.2 million people with payment of their MSP premiums**.** On July 1, 2005, the Regular Premium Assistance Program was enhanced to allow more British Columbians to qualify and to allow those already receiving partial assistance, to qualify for a higher level of subsidy. The income thresholds to qualify for each of the five available subsidy levels increased by $4,000. As an example, the maximum adjusted net income to qualify for 100 percent subsidy increased from $16,000 to $20,000. These changes eliminated or reduced monthly premiums for an estimated 215,000 British Columbians. Additional information regarding premium assistance is available on the MSP website at http://www.health.gov.bc.ca/msp/infoben/premium.html.

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

The *Medicare Protection Act* requires individuals to live for at least three months in the province to be eligible for MSP coverage. However, there are exceptional cases where

the MSC waives this requirement and enrolls new residents. The MSC has delegated the power to investigate and decide cases to the Coverage Wait Period Review Committee.

In 2005/2006, the MSC endorsed revised Terms of Reference for the Coverage Wait Period Review Committee to include waiver of the three-month wait period for a public health reason.

The Committee reviewed 37 requests and granted six approvals, including an application to waive the wait period for a returning resident from out-of-country hospitalized with highly infectious advanced tuberculosis, due to a threat to public safety. Another application was approved because a profoundly disabled child required a Personal Health Number (PHN) in order to access "At Home" services through the Ministry of Children and Family Development.

The Committee denied several applications from new residents expecting babies during their wait periods, as the onus is on families to have medical insurance in place before arrival or to budget for costs of birth.

MSC Hearing Panels

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

Some hearings are required by the Act, and some have been implemented by the Commission to afford individuals affected by its decisions, the opportunity to be heard in person. Hearings are governed by the duty to act fairly. All decisions of MSC hearings are subject to judicial review in the Supreme Court of British Columbia.

1. Beneficiary Hearings

Currently, there are two types of beneficiary hearings: residency, and claims for elective (non-emergency) out-of-country medical care.

a) Residency Hearings

A person must meet the definition of resident in the Act (s.5) in order to be eligible for benefits. As per s.7 of the Act, the MSC may cancel the MSP enrollment of an individual whom it determines is not resident. Section 11 of the Act requires that notice be given to a beneficiary of the intention to cancel enrollment. Individuals whose MSP coverage is cancelled have the right to appeal to the Commission.

One of the MSC's public representatives conducts the residency hearings. In the reporting period, no residency hearings have been held.

b) Out-of-Country Hearings

The Medical Services Plan will reimburse medically necessary services performed outside of Canada when the required services are not available in Canada. Appropriate

BC specialists recommending these services must obtain prior approval on behalf of their patients for subsequent medical claims to be considered for payment. The decision to approve MSP payment for out-of-country medical services is based on published criteria available in the *Medical Services Commission Out-of-Province and Out-of-Country Medical Care Guidelines for Funding Approval* (the "Guidelines").

More information regarding out-of-country services is available on the MSP website at http://www.health.gov.bc.ca/msp/infoben/leavingbc.html.

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

From April 1, 2005 to March 31, 2006, MSP received 588 requests for out-of-country elective treatment. Funding was authorized for 530 requests and 58 cases were denied or deferred for additional information. Of the denied out-of-country cases, seven were appealed to the MSC. Panel hearings were held for three of the appeals, and four cases were settled prior to hearing dates being set.

2. Diagnostic Facility Hearings

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

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

An MSC panel is currently in the process of reviewing one ACDF appeal.

The ACDF is planning to review and streamline its hearing panel procedures during the coming year.

3. Hearings Related to Practitioners

There are two types of statutory hearings related to practitioners: audit hearings, and de-enrollment of practitioners for "cause."

a) Audit Hearings

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

Since the introduction of the Alternate Dispute Resolution process in 2000, fewer billing matters proceed to formal hearings.

b) De-enrollment of Practitioners for "Cause"

In the reporting period, there have been no de-enrollment hearings.

Other Issues

- ***Health Insurance BC (HIBC)***

In November 2004, the Medical Services Commission supported MAXIMUS BC's signing of an agreement with the Ministry of Health to manage the MSP and PharmaCare administrative services on behalf of the Government of British Columbia. Medical Services Plan and PharmaCare operations were transferred to MAXIMUS BC effective April 1, 2005. The new program name is Health Insurance BC (HIBC). The Commission receives regular updates regarding HIBC's program performance.

For more information, visit HIBC's website at http://www.hibc.gov.bc.ca.

- ***Wait Times***

Wait times is one of the major public concerns regarding health care in BC. One of the MSC's public members is currently serving on the Steering Committee headed by the Provincial Health Services Authority to coordinate the province-wide Surgical Services Project. This Project aims to establish some fair criteria for a common surgical waitlist.

- ***Laboratory Fee Review Panel***

Laboratory fees have been growing faster and posing a continuing challenge to managing the Available Amount. A Laboratory Fee Review Panel, comprised of three independent professionals, was appointed in 2004 to come up with recommendations on managing lab fees without compromising access and quality. The Panel presented its final report to the MSC in January 2006. The Ministry of Health and the BCMA are reviewing the report and should either party disagree on the adjustments recommended by the Panel, the Commission will be asked to adjudicate.

- ***Strategic Planning***

The Commission met in November 2005 to identify its strategic objectives and priority actions for 2006/2007. The work plan developed by the Commission includes a focus on improving the uptake of guidelines and protocols by physicians and measuring the outcomes, establishing linkages with the health authorities and Leadership Council, and supporting prevention initiatives, where appropriate. The Commission will continue to receive regular reports and review annual work plans from its advisory committees.

- ***Payment Schedule***

As per the Master Agreement between the government, BCMA and the MSC, the Commission decides upon additions, deletions, fee changes or other modifications to the MSC Payment Schedule upon advice from the BCMA's Tariff Committee.

- ***Nurse Practitioners***

In June 2005, the Commission endorsed changes to the Preamble of the MSC Payment Schedule that ensure referrals by Nurse Practitioners to laboratory/diagnostic services, GPs and specialists are recognized appropriately.

- ***Tools to Manage the Available Amount***

In November 2005, the Ministry of Attorney General, Health and Social Services Group, conducted a review of tools available to the MSC in managing the Available Amount. Concurrently, the Commission was provided with more extensive, electronic reports on fee-for-service expenditures and paid services by service type and practitioner specialty.

- ***MSC-Related Legal Cases***

As part of its oversight of the Medical Services Plan (MSP), the Commission monitors legal issues that arise as a result of MSP or Ministry of Health related decisions. In 2005/2006, the following cases were considered by the Commission:

BC Nurses' Union (BCNU) Litigation

On April 21, 2005, the BCNU filed a Petition for judicial review seeking relief arising from its allegation that there has been "extra-billing" by doctors in private clinics, contrary to the *Medicare Protection Act* (*MPA*). It seeks a declaration that the Medical Services Commission is in breach of the *MPA* by failing to enforce the extra-billing restrictions of the Act, and seeks orders to compel the Commission:

- to adhere to s. 5(2) of the *MPA*;
- to take action in specific instances to address extra-billing of named individuals;
- to require sufficient particulars from all practitioners to determine if they are in compliance with the *MPA*; and

- to appoint an auditor under s. 36 of the *MPA* to investigate specific claims for payment by practitioners associated with the False Creek Surgical Centre, the Cambie Surgical Centre and the Pezim Clinic.

No date for hearing has been set and the matter has been dormant for a number of months. Correspondence from the Union's counsel in late 2005 indicated that the Petitioner was going to amend its pleadings, but to date no amended pleadings have been received.

BC Government and Service Employees' Union (BCGSEU) Litigation

In this case, the BCGSEU sought to have the Master Services Agreement (MSA) relating to the administration of the Medical Services Plan and PharmaCare quashed on the basis that it does not meet the public administration requirement of the *Canada Health Act* which is alleged to be incorporated into the *Medicare Protection Act*.

At the BC Supreme Court level, the Court dismissed the Union's challenge on the basis that the relief sought was not available by way of judicial review. The judge went on, however, to consider the substance of the Union's allegations and rejected them. The BCGSEU then appealed the decision to the BC Court of Appeal.

The appeal was heard June 6, 2006 by Madam Justice Rowles, Madam Justice Levine and Mr. Justice Smith, who reserved their decision. It is not known when their decision will be handed down.

Private Clinic/Extra-Billing Issues

At a special meeting of the Commission held on March 14, 2006, the Ministry of Health made a presentation regarding the billing practices of physicians working at a private medical clinic in Vancouver, which it was concerned might constitute extra-billing. The Commission unanimously agreed to make inquiries into those billing practices, based on the Ministry's presentation and on legal advice taken by the Commission.

The Commission has the power to examine the billing practices of physicians who provide services at a private clinic. The Commission decided to:

- request the names of all physicians enrolled in the Medical Services Plan practicing at the clinic or receiving referrals through it;
- make inquiries of the owner of the clinic and of the physicians practicing at the clinic, including sending a letter to each advising of the concerns and requesting documented evidence to explain the fees paid and services provided.
- based on the responses, address the matter at a subsequent Commission meeting.

The letters have been sent, and responses received. The Commission will be considering the matter further at future meetings.

Dr. Jacques Chaoulli and George Zelotis v. AG Quebec and AG Canada

In light of the Supreme Court of Canada's landmark 2005 decision in the Chaoulli case (concerning the effect of the *Canadian Charter of Rights and Freedoms* on Quebec provincial legislation prohibiting private insurance contracts for publicly insured health and hospital services), it was suggested that the Commission's policy regarding appeals and hearings on out-of-country funding cases be re-examined with legal counsel, especially with respect to wait times.

Appendices

Appendix 1: Members of the Medical Services Commission (MSC) as of March 31, 2006

Government Representatives:

- Tom Vincent (Chair) *
- Craig Knight (Deputy Chair)
- Dr. Robert Halpenny

BCMA Representatives:

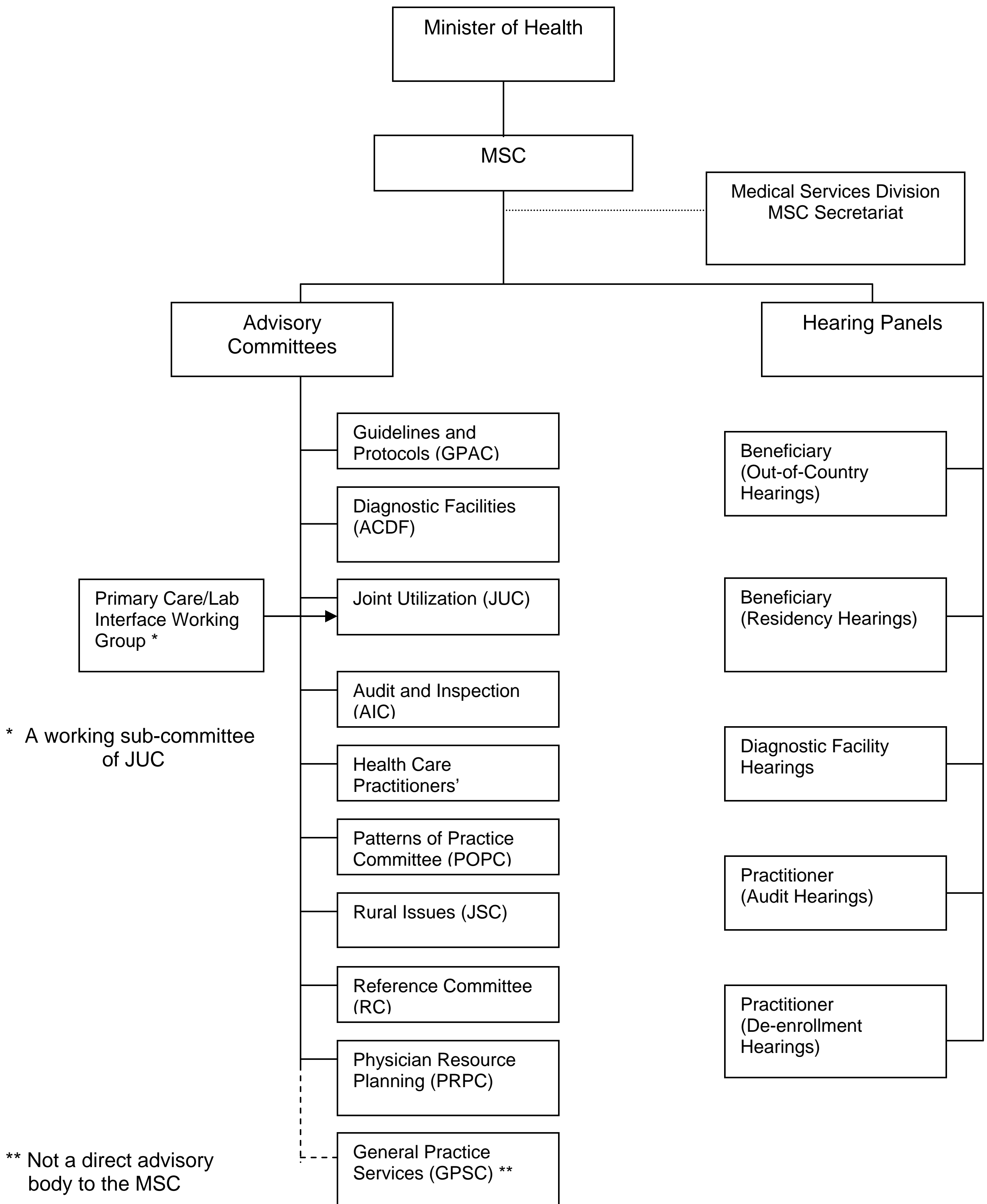
- Dr. Marshall Dahl
- Dr. Douglas McTaggart
- Dr. Derryck Smith

Public Representatives:

- Robert Cronin
- Gordon Denford
- Isidor Wolfe **

* New appointment – September 2005
** New appointment – November 2005

Appendix 2: MSC Organizational Chart



Appendix 3: Guidelines and Protocols Approved by the MSC in 2005/2006

Title	Type (New/Revised)	Date of MSC Approval
Assessment and Management of Obstructive Sleep Apnea in Adults	Revised	April 13/05
Diabetes Care	New	July 27/05
Overweight, Obesity and Physical Inactivity	New	July 27/05
Treatment of Cataracts in Adults	Revised	July 27/05
Rheumatoid Arthritis: Diagnosis and Management	New	March 1/06

Available at http://www.health.gov.bc.ca/msp/protoguides/index.html

Appendix 4: List of Useful Websites and Addresses

- Medical Services Commission (MSC) (Legislation and Governance; Advisory Committees; Negotiated Agreements with the BCMA): http://www.health.gov.bc.ca/msp/legislation/msc.html
- Medical Services Plan (MSP): http://www.health.gov.bc.ca/msp/index.html
- Guidelines and Protocols: http://www.health.gov.bc.ca/msp/protoguides/index.html
- Health Insurance BC (HIBC): http://www.hibc.gov.bc.ca
- British Columbia Medical Association (BCMA): http://www.bcma.org

Medical Services Commission Mailing Address:

3-1, 1515 Blanshard Street
Victoria, BC
V8W 3C8

Telephone: 250-952-3073
Fax: 250-952-3131