BC Health Coalition

backgrounder

June 2011

Highlights of material received through FOI of the Medical Services Commission's audit of the Copeman Health Care Centre.

These documents were received between July 2008 and March 2011

May 2006: MSC Chair Tom Vincent provides assurances to then-NDP health critic that the terms of reference for MSC audit will be broad:

> The MSC's role in this matter is simply to determine whether or not the activities of a particular business are within or outside the *Medicare Protection Act*. That said, the Commission does indeed understand that, as you state in your letter, this is an important issue. I will therefore make every effort to reply to the rest of your questions as fully and quickly as I am able.

Vincent, in a later letter to health minister George Abbot, advises him that the audit will be conducted through the Billing Integrity Program (BIP). The BIP purpose and function is narrower than the type of investigation initially indicated:

> On November 9, 2006, Mr. Copeman was advised that the Commission had passed a motion recommending that the Audit and Inspection Committee (AIC) approve an audit under s.36(2) of the *Medicare Protection Act* of the claims for payment and the patterns of practice or billing followed by the medical practitioners at the Centre.

Copeman's Physician Services agreement clearly stating it's policy that non-members are not required to pay for insured services:

> 1.2.1.2 **No Preferential Access**
>
> If a person who is not a CHC client requests an insured medical service (and provided that the person is a beneficiary under legislation), then CHC physicians will provide that person with the service at the first available opportunity considering their existing appointment obligations. If a CHC client subsequently presents themselves with a provincially-insured medical issue on the same walk-in basis, then *the CHC client will be given no preferential access*. All walk-in clients, whether CHC clients or not, will be treated in the order in which they present themselves. Any violation of this policy will be grounds for immediate dismissal of the CHC physician or termination of their services contract.

Audit Report section addressing access to insured services states that auditors "found no evidence" that Copeman's fees are a barrier but does not indicate how or if it attempted to

produce any evidence. The report simply cites Copeman's written policy and assurances that there has been no demand for insured services from non-members – suggesting that a test of access was not performed.

COPEMAN HEALTHCARE CENTRE
Audit Report
For the period January 1, 2006, to May 11, 2007

ACCESS TO INSURED SERVICES BY NON-ENROLLED PATIENTS

Fees a Barrier to Insured Services

We found no evidence that CHC fees represent a barrier to access insured services.

CHC's policy is that walk-in patients, or non-enrolled patients seeking primary care from CHC physicians, would not be turned away or incur additional fees in order to obtain insured services.

However, CHC does not advertise as a walk-in clinic or as accepting new patients for primary care. We were advised by CHC that there has been a very limited demand for walk-in services and no demand for primary care services except from enrolled clients.

c) Primary Care for Non-Enrolled Patients

There were no patients receiving primary care from CHC physicians who were not either clients enrolled in the Core Program or a dependent of a client so enrolled.

We were advised by CHC staff that in accordance with CHC policy, provided time permits, CHC physicians were not prevented from providing primary care to non enrolled patients.

December 2007: After the audit report was completed, MSC Chair Tom Vincent writes to Audit and Inspection Committee Chair Robin Hutchinson in response to a media report that Copeman staff had demanded payment from a reporter for access to it's physician services. Vincent wants to know now or if the auditors performed a similar test of access to verify Copeman's policy:

From: Vincent, Tom AVED:EX
Sent: Thu 13/12/2007 4:50 PM
To: Hutchinson, Robin HLTH:EX
Subject: FW: Copeman Clinic -- report by The Tyee

Hi, Robin. I'm writing to ask for information concerning how the auditors who did the Copeman audit determined that there was no charging to see a physician. Did they ask and accept the answer, phone to make an appointment, try booking an appointment or .....?

The response from the Director of Audit and Investigations clearly reveals that a test of access was not undertaken, and that the AIC referred to Copeman's own policy as sufficient information to assure it that there were no unlawful user charges required to see a physican.

The response reveals that the audit applied BIP methodology that is designed to check a random sample of internal billing records to find evidence of the billing of current/actual members for insured services ("extra-billing"). The audit did not seek to find evidence that Copeman's practice of charging user fees (selling memberships) denied patients access to publicly insured services. Extra-billing and user charges are distinct. The BIP is designed to address the former. However, the initial and ongoing calls for enforcement of the Medicare Protection Act are driven by concerns about the latter.

From: Anderson, David R HLTH:EX
Sent: Wednesday, December 19, 2007 11:28 AM
To: Vincent, Tom AVED:EX
Cc: Hutchinson, Robin HLTH:EX; Day, George HLTH:EX
Subject: RE: Copeman Clinic -- report by The Tyee

Tom,

The question is: how the auditors who did the Copeman audit determined that there was no charging to see a physician? Did they ask and accept the answer provided?; phone to make an appointment?; try booking an appointment; or .....?

I have discussed with BIP staff and compiled the following information for you:

The information determining that there was no charging to see a physician was provided by [redacted] at the exit meeting attended by Copeman; [redacted] CHC; two Senior Auditors and the Senior Medical Inspector.

The audit process did not include phoning to make an appointment or try booking an appointment. As you know the Billing *Integrity* Program uses standard audit practices. This audit involved a complete review of a statistically valid sample of patient files. Separate audits were undertaken of the clinic as a corporate entity and the three physicians who delivered care. The records reviewed include patient documentation related to claims for services billed to MSP, and services covered by the fees charged by the clinic directly to the patient. The audit examined medical records, non-medical records, consultation reports, lab reports, X-ray reports, billing records, etc. related to the audit sample. The on-site audit was conducted by the most Senior Medical Inspector (a practicing physician) contracted by the ministry for audit purposes, as well as two Billing Integrity Program Senior Auditors and an audit assistant.

The auditors did not phone or try to book an appointment as the audit methodology used to obtain evidence was both appropriate and sufficient to determine if the CHC was extra-billing.

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