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COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

ADVICE TO THE PROFESSION

Charging for Uninsured Professional Services

The College of Physicians & Surgeons of Alberta (CPSA) provides advice to the profession to support physicians in implementing the CPSA Standards of Practice. This advice does not define a standard of practice, nor should it be interpreted as legal advice.

Advice to the Profession documents are dynamic and may be edited or updated for clarity at any time. Please refer back to these articles regularly to ensure you are aware of the most recent advice. Major changes will be communicated to our members; however, minor edits may only be noted within the documents.

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CPSA Perspective

Government legislation determines which medical services are publically funded and which can be provided privately for persons considered insured under the *Canada Health Act* (*CHA*) and the *Alberta Health Care Insurance Act* (*HCIA*). CPSA does NOT make these determinations.

It's important to understand exactly how government defines "insured services" as this term is often used interchangeably with "publicly funded services". However, there are important distinctions.

Insured services are defined in Section 1(n) of the *HCIA* (see Appendix), and practitioners are paid for these services by public funding, predominantly through the Schedule of Medical Benefits (SOMB).

- In compliance with the *CHA,* the *HCIA* (Sections 9 and 11) prohibits all practitioners opted into the Alberta Health Care Insurance Plan from billing patients for medically required insured services. The *CHA* and section 4 of the *HCIA* identify who is an insured

person and therefore eligible to access publically funded health care services. Insured Persons – CPSA advice document

- Under the *HCIA*, physicians also cannot require payment of a fee as a pre-condition for allowing a patient to access medically required insured services.

The second prohibition, in Section 11(1) (a) of the *HCIA*, is the basis for CPSA restricting any/all block fees in anticipation of the future provision of insured services. It applies only to services provided to individual patients; it does not apply to global payments, such as through the Physician On-Call Funding program.

The *HCIA* also identifies certain services that are only partially publically funded, such as chiropractic and optometric services. These are referred to as "basic health services" and "extended health services". There is no legislative prohibition on the private provision or payment of these services. Accordingly, the *HCIA* allows for some optometric and chiropractic services to be paid for publically and some to be paid for privately.

Other services are publically funded through the *Hospitals Act* (hospital care, MRI, CT, lab services), where payment flows through Alberta Health Services to a practitioner. While these are commonly understood to be insured services, by definition they are not. There is no prohibition on the private provision of these services, so there are private options for patients to acquire and pay for these services. For example, MRI and CT scans are available in both the public and private sectors.

Refer to the attached Appendix for additional context and information about related legislation.

Advice

Physicians are expected to adhere to the *Code of Ethics & Professionalism* in providing all professional services (insured and non-insured, public and private), specifically:

- Never exploit patients for personal advantage (Commitment to Respect for Persons)

- Discuss professional fees for non-insured services with the patient and consider their ability to pay in determining fees (Precept 26)

- Support the profession's responsibility to promote equitable access to health care resources and to promote resource stewardship (Precept 40)

- Avoid using your role as a physician to promote services (except your own) or products to the patient or public for commercial gain outside of your treatment role (Precept 24)

For all services, a physician should **first consider**, in their professional opinion, the medical need for a service based on an assessment of the patient, the patient's circumstances and best evidence.

- Before charging a fee, a physician should consider Section 16 of the *Code of Ethics & Professionalism*, as there may be circumstances when it is appropriate for the physician, at their discretion, to provide a service without charge.

- A physician may need to provide a service before and irrespective of determining insurance coverage, such as in an emergency situation.

- If the service is listed in the SOMB, a physician cannot charge an insured person for that service if it is medically required.

- A physician cannot charge a fee to an individual patient to be available to provide a service.

- Where no SOMB code exists, a physician may, in certain circumstances, apply to Alberta Health for funding.

Resources

For further information regarding whether a service can be billed to the Alberta Health Care Insurance Plan, contact:

- Alberta Medical Association
- Alberta Health

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RELATED STANDARDS OF PRACTICE

- *Charging for Uninsured Professional Services*
- *Code of Ethics & Professionalism*
- *Conflict of Interest*
- *Dispensing of Schedule 1 and 2 Drugs for a Fee*
- *Responding to Third Party Requests*
- *Sale of Products by Physicians*

COMPANION RESOURCES

- Advice to the Profession: Insured Persons
- AHCIP's Insured Physicians Services Versus Uninsured Physicians Services
- AMA's Uninsured Services Guidelines to Billing (member login required)

Appendix

CANADA HEALTH ACT

In Canada's federal system, health care is the responsibility of the provincial governments. However, to provide health care, provincial governments require funding derived through taxation. Ultimately the amount of health care provided directly relates to the tolerance of the population for the level of taxation to fund services. The Government of Canada enacted the *Canada Health Act (CHA)* in 1984, which establishes criteria a province must satisfy to receive its full share of funding transferred from the federal government – the Canada Health Transfer. The *CHA* is a funding agreement focused on physician services, hospital services and surgical-dental services. In order to get full funding, a province must establish a publicly administered health care insurance plan that pays the entire cost of a range of medical and hospital services to all populations with certain exceptions, such as the Canadian Forces, federal inmates and injured workers (worker's compensation legislation).

The *CHA* directs that "medically necessary" hospital services and "medically required" physician services must be fully covered; for full transfer of funds, provinces cannot allow user charges or extra-billing for these services. The *CHA* does not define these terms but leaves it up to the provinces to do so. This has resulted in variation of coverage for certain services amongst the provinces, for example home care, aesthetic services, long-term care, dental care, prescription drug coverage, diagnostic services and various kinds of treatment by non-physician providers.

ALBERTA HEALTH CARE INSURANCE ACT

In compliance with the *CHA*, Alberta has the *Alberta Health Care Insurance Act (HCIA)* which predominately deals with physician and dentist services that are "medically required". The *HCIA* defines insured, basic and extended health services in the Alberta context. Sections 9 and 11 of the *HCIA* mandate that no individual can "charge or collect from any person an amount" for insured services provided by physicians and dentists who are opted-in to this Health Care Insurance Plan, either directly for the service itself or as a pre-condition to providing an insured service. Conceptually, insured services are a subset of basic services while basic services are a subset of extended services. Basic health services and extended health services have less than complete coverage by government. The definitions from the *Act* are:

- (1)(n) "insured services" means

- (i) all services provided by physicians that are medically required;
- (ii) those services that are provided by a dentist in the field of oral and maxillofacial surgery and are specified in the regulations; and
- (iii) any other services that are declared to be insured services pursuant to section 2, but does not include any services that a person is eligible for and entitled to under any *Act* of the Parliament of Canada or under the *Workers' Compensation Act* or any law of any jurisdiction outside Alberta relating to workers' compensation;

- (1)(b) "basic health services" means
  - (i) insured services,
  - (ii) those services that are provided by a dentist in the field of oral and maxillofacial surgery and are specified in the regulations but are not within the definition of insured services,
  - (iii) optometric services,
  - (iv) chiropractic services,
  - (v) services and appliances provided by a podiatrist, and
  - (vi) services classified as basic health services by the regulations;
- (1)(k) "extended health services" means those goods and services or classes of goods and services that are specified in the regulations and provided to a resident or the resident's dependents under section 3(2).

Further to the definition of an insured service, Section 2 of the *HCIA* states "The Lieutenant Governor in Council may by regulation declare any basic health services referred to in section 1(b)(ii), (iii), (iv), (v) or (vi) to be insured services for the purposes of the Plan." Therefore, it is the right and responsibility of the Government of Alberta through the *HCIA* to determine and define insured services.

SCHEDULE OF MEDICAL BENEFITS

Insured physician services under the *HCIA* are listed in the Alberta Schedule of Medical Benefits (SOMB), which is approved by the Minister of Health and enacted through a ministerial order. The Alberta Medical Association (AMA) provides direction and advice to its members as to both (a) the SOMB services and rules plus (b) Guidelines to Billing Uninsured Services for those services that are not insured.

HOSPITALS ACT AND HEALTH CARE PROTECTION ACT

The Alberta *Hospitals Act (HA)* outlines "medically necessary" hospital services in the Alberta context. These services are defined in Section 36(h) of the *Hospitals Act* as "the hospital services the operating costs of which will be provided for" and the *HA* goes on to list these basic services. The *HA* establishes the Hospitalization Benefits Plan and prohibits supplementary payments for services provided through the *HA*.

The *Health Care Protection Act* limits the provision of surgical services to a public hospital or approved surgical facility, with only public hospitals being allowed to provide "major" surgical services. The *Health Care Protection Act* specifically differentiates between insured services (for which patients cannot be charged) and "enhanced medical goods or services" (which can be purchased by patients either with or independent of insured services). Policies such as the "Preferred Accommodation and Non-Standard Goods or Services Provincial Policy Framework" outline the scope of these enhanced goods.

The Special Case of Diagnostic Services in the Alberta Context

When the *CHA* was proclaimed in 1984, many specialized diagnostic services were considered part of hospital services as they had been previously included in the preceding *Hospital Insurance and Diagnostic Services Act* of 1957. As these services were provided solely in hospital, they were not included as insured health services. With advances in technology, some diagnostic procedures previously provided only in hospital (such as CT scans) are increasingly provided in private clinics, often with the addition of facility fees to cover costs. As technology continues to evolve, more diagnostic services will be potentially provided outside the hospital environment.

In 1995, then-federal Health Minister Diane Marleau wrote a letter to the provinces in an attempt to clarify divergent views as to whether the provision of diagnostic procedures in private clinics was outside the *CHA*. She indicated that deductions would be made in the federal transfer of monies to provinces that allowed private clinics (including diagnostic imaging facilities) to charge facility fees for these services. The letter failed to clarify whether diagnostic imaging was "in" or "out". Professor Lahey, in his testimony at the Access Inquiry[1], advanced an argument that was accepted by some provinces (including Alberta) that while the provision of diagnostic services inside a facility was considered

[1] *Alberta Health Services Preferential Access Inquiry. Volume 2: Research and Expert Opinions.* Alberta: Health Quality Council of Alberta, 2013

"medically necessary", there were two scenarios where diagnostic services provided outside a facility would not be considered "medically necessary":

- The procedure is medically necessary within a defined time interval (such as six weeks) but the patient wants it and is willing to pay to have it early (such as two weeks when deemed not *yet* a medically necessity); and
- The procedure is not strictly necessary but the patient wants it and is willing to pay for it nevertheless.

Funding for certain diagnostic services, most notably CT, MRI and PET scans, is provided as a block payment from the Government of Alberta to the hospital system through Alberta Health Services. The Alberta SOMB does not define a physician fee for a CT, PET, or MRI interpretation. These are publicly funded services when provided in the hospital environment as defined in the *Hospitals Act* and, under the *CHA* are considered "medically necessary" hospital services in Alberta.

In 2002, the Romanow report recommended an amendment to the *CHA* to explicitly include diagnostic services in the definition of insured health services and also a significant investment in the capacity of the public system to provide timely diagnostic procedures; neither recommendation has been adopted by any level of government to date.