

Study, Conclusions and Recommendations
pertaining to

Medical Audit Practice in Ontario

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Submitted to
The Hon. George Smitherman
Minister of Health and Long-Term Care
Government of Ontario

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Medical Audit Practice in Ontario

Executive Summary of the Report of The Hon. Peter Cory, C.C., C.D., Q.C., LL.D. to The Hon. George Smitherman, Minister of Health and Long-Term Care, Government of Ontario April 21, 2005

At the request of The Hon. George Smitherman, Minister of Health and Long-Term Care, The Hon. Peter Cory, retired Justice of the Supreme Court of Canada, has conducted a study of the processes for auditing the fee claims submitted by physicians to the Ontario Health Insurance Plan. In conducting his study, Mr. Cory received written submissions, held hearings, and studied the processes in other jurisdictions.

Mr. Cory's Report sets out his Terms of Reference, considers the significance of the medical audit system within the Ontario health care system, describes the medical audit system in Ontario, and summarizes features of medical audit processes in other jurisdictions. Mr. Cory then sets out the concerns raised by Ontario physicians, the responses made to those concerns by the Ministry and the College of Physicians and Surgeons of Ontario, and his conclusions and recommendations.

The medical audit system in Ontario has had a debilitating -- and, in some cases, devastating -- effect on the physicians of Ontario and their families. In turn, it has had a negative impact on the delivery of health services in the province. It has undermined Ontario's attractiveness as a place to practice medicine and has led some physicians to curtail their practices so as to stay within average billing patterns. Although Mr. Cory's Terms of Reference exclude any investigation of past claims, the accounts that physicians have provided of their unfortunate experiences with the audit process have proved very helpful in understanding the issues to be considered.

Every individual physician and medical association that made submissions to Mr. Cory agreed that some form of auditing of physicians' fee claims is essential. The billing process operates on the honour system and fee-for-service payments to physicians have reached \$5 billion a year in Ontario. The vast majority of physicians seek to bill their services appropriately and in

compliance with statutory requirements. Nonetheless, there must be protection against physicians who would obtain fees for services that have not been rendered.

Mr. Cory concludes that, to be effective, the audit process must have the complete confidence of physicians. The basis on which physicians are selected for audit must be clear, the method of auditing must be transparent, the process must be fair in all its aspects, and hearing panels must be unbiased, fair-minded, qualified and independent. The audit system must also be easily understood, functional and practical.

Mr. Cory makes 118 recommendations for the establishment of a new medical audit process. The rationales for the recommendations are set forth in Part VI of his Report. A list of the recommendations is included in the Report at p. 167. The major elements of the recommendations are as follows:

1. **Jurisdiction and Structure:** The responsibility for conducting audits of physicians' fee claims should be conferred on a new and independent Board. See recommendations (1) to (4).
2. **Purpose of the audit process:** The audit process must be employed only for the purpose of determining the appropriateness of physician fee claims. The audit system itself must be accountable. A biennial stakeholders' forum should be established to receive reports on the operation of the new audit process and to receive and consider proposals for its improvement. See recommendations (5) to (7).
3. **A new emphasis on assisting physicians to comply with billing requirements:** The primary goals of the new audit system should be (1) education to facilitate compliance with billing requirements, and (2) identification and elimination of false, fraudulent and egregiously erroneous billing in a fair and effective manner. See Recommendations (8) to (9).
4. **Schedule of Benefits:** The Schedule of Benefits must be revised and adapted. It must also be interpreted flexibly so that a physician is not deprived of payment for a service that is medically appropriate and that complies substantially with the requirements of the fee code. See Recommendations (10) to (14).

5. **Record-keeping requirements:** As a general rule, records that meet medical clinical standards should suffice for billing purposes unless additional records are specifically required. Record-keeping requirements should take account of the realities of medical practice. Templates should be developed to assist physicians in making records and billing for their services. See Recommendations (15) to (18).
6. **The Physician Audit Board:** The Board should be composed of ten members of the public and thirty physicians, in active practice and selected from as wide a range of practice settings and specialties as possible. The OMA and the College, in consultation with the Chair of the Board, should nominate the physician members. The OMA, the College and the Chair should be consulted in identifying well-qualified public members. All members should be paid a *per diem* rate of at least \$500. The members should be instructed in the billing and audit processes and the requirements of procedural fairness. Audit Hearing Panels should be composed of one member of the public and four physicians, including at least one peer of the physician. One-member panels should be discontinued. See recommendations (19) to (35).
7. **Inspectors:** The Minister should appoint twenty inspectors on the nomination of the Chair of the Board, the OMA and the College. They must be in active practice, must be qualified by disposition to conduct an inspection appropriately, and should be selected from as wide a range of practice specialties and settings as possible. They should have a Code of Conduct and should receive training. The Chair of the Board should assign an Inspector who practices in a specialty and practice setting the same or reasonably similar to that of the physician whose fee claims are under review. Inspectors will report only to the Chair of the Board. See recommendations (36) to (46).
8. **Initiating an audit investigation by OHIP:** OHIP should disclose the methods used in its statistical analysis of billing patterns and should continue to develop more refined and relevant comparative data. OHIP should continue to operate the OHIP Payment Review Program and should not refer a physician for audit without seeking and carefully assessing any explanation the physician may have for billing discrepancies. Where OHIP rejects an explanation that is subsequently accepted by the Physician Hearing Panel, the physician should ordinarily be

compensated for costs incurred in the audit process. If the rejection was unreasonable, the Panel should have authority to award the physician up to \$10,000 as compensation for the unjustified disruption an audit has created in the physician's practice and family life. See recommendations (47) to (50).

Physicians should be responsible for complying with clear billing requirements. Where a physician can establish that no reasonably informed physician could have known that the impugned fee claims did not comply with billing requirements, the claims should not be subject to repayment. See recommendations (51) to (54).

Except in cases of deliberately misleading or fraudulent fee claims, OHIP should be required to notify a physician that fee claims are subject to audit within twelve months after the physician submits the claim. In the transition period, the time period should be extended to 24 months. See recommendations (55) to (57).

9. **OHIP referral of physician to the Physician Audit Board:** If OHIP concludes, after considering any explanation provided by the physician and attempting to resolve the matter, that an audit is warranted, it should refer the matter to the Physician Audit Board. If the referral is one of the relatively rare cases in which extrapolation could apply (see item 15 below), OHIP will identify a statistically significant sample of patients, selected randomly from a list of claims for each fee code that is in dispute. The physician will produce the records of these patients. See recommendations (58) and (59).
10. **Direct recovery:** OHIP should not be able to exercise direct recovery of fee payments unless, on application to the appropriate Board or Court, it can establish reasonable grounds to believe that the physician concerned is on the verge of insolvency, departing the jurisdiction, or moving assets out of the jurisdiction. See recommendations (60) and (61).
11. **Notifying a physician of an audit:** The physician should be notified of the audit by letter, enclosing documents providing full and effective disclosure of the alleged problem with the physician's fee claims. The letter should be restrained and polite, and acknowledge that the physician may have a satisfactory explanation. See recommendations (62) and (63).

12. **Inspection:** The physician should have the right to be represented by a lawyer or agent during the inspection. After examining the patient records, speaking to the physician and to any patients or medical experts presented by the physician, the Inspector will prepare a full report and provide an assessment as to whether the fee claims substantially comply with billing requirements. The Chair of the Physician Audit Panel may, on receipt of the Inspector's report, terminate the audit, adopt the Inspector's recommendation for remedies other than repayment of fees (e.g. education or monitoring), or direct the audit to proceed. See recommendations (64) to (72).
13. **Procedure before the Audit Hearing Panel:** The Hearing Panel should be composed of one public member and three physician members, one of whom practices in a specialty and practice setting similar to that of the physician. Any three members will suffice to make a decision, but the physician's peer must be included within the three. See recommendations (73) to (75).

A Code of Conduct should be developed for those dealing with physicians in the audit process. The physician is entitled to be treated with respect, patience and courtesy, and there should be no assumption that the physician is "guilty." The case against the physician should be presented by or on behalf of OHIP. The onus should be on OHIP to establish, on a balance of probabilities, that a fee claim is not justified. The audit hearing must be subject to the *Statutory Powers Procedure Act*. The physician must be entitled to receive notice, production and disclosure, to cross-examine witnesses, to call witnesses, to make submissions, to be represented by counsel (preferably through the Canadian Medical Protective Association) and to receive written reasons, explaining the rationale of the decision, within thirty days of the close of submissions. See recommendations (76) to (82).

14. **Time for completion of review:** Timelines should be established for completion of the review, and while there should be some flexibility, the audit process should be completed in timely fashion. See recommendations (83) to (86).
15. **Remedies:**
 - **Flexibility:** The General Manager of OHIP and the Physician Hearing Panel should be authorized to reduce the amount of a repayment of fees

where the result would unfairly deprive the physician of basic and fair compensation for the services the physician has rendered to patients. The Hearing Panel should have discretion to fashion flexible remedies that take into account the nature and amount of the billing errors and the experience and circumstances of the physician. Where there has been a repetitive pattern of inappropriate billing or flagrant disregard of educational assistance provided to the physician, the Panel should also have authority to suspend or remove the physician's right to submit fee claims to OHIP. See Recommendations (87) to (90).

- **Extrapolation:** There should be limits on the use of extrapolation to calculate the extent of a physician's liability to repay fees. Extrapolation should apply only on a second or subsequent audit where the physician has previously been found liable to repay fees to OHIP or where the physician has continued to make billing errors despite documented efforts to educate the physician regarding billing requirements. Where extrapolation is utilized, the random samples must have reasonable and convincing confidence intervals. See Recommendations (91) and (92).
- **Costs** should be awarded against the physician only if, and to the extent that, the physician has unreasonably failed to produce documents and records or otherwise unreasonably failed to co-operate with the audit investigation and review, or has been responsible for unnecessary delays. See Recommendation (93) and see, also, Recommendation (50) re compensation, referred to in item 8, above.
- **Interest** on repayment of fees should accrue from the date the notice is sent to the physician of the proposed referral to the Physician Audit Board. In a second or subsequent audit of the physician's fee claims, or where a physician has flagrantly ignored the educational material and instruction provided to him or her, the Hearing Panel may direct that interest be paid on the amount found owing from the date it was paid to the physician. The Hearing Panel should have authority to relieve against the accrual of interest during any substantial delays that are the responsibility of OHIP. See recommendations (94) to (96).

16. **Publication:** The *Health Insurance Act* should be amended to specify that any information that identifies, or could lead to the identification of, a physician who has been audited or the physician's patients, should be confidential and protected from disclosure. See recommendation (97).
17. **Appeals:** A physician should have a right of appeal to the Health Services Appeal and Review Board. There should be a further right of appeal, by the physician or OHIP, to the Divisional Court. See recommendations (98) to (100).
18. **Privacy of patient records:** The *Personal Health Information Protection Act* should be amended to authorize the disclosure of patient information to Inspectors and members of the Physician Audit Board to the extent necessary to permit an effective investigation and audit. Confidentiality policies and procedures must be developed to address specified issues, and should be reviewed with members of the Board, Inspectors and staff as part of their training programs. See recommendations (101) to (103).
19. **Educational programs, materials and supports:** It is essential to focus on assisting physicians to comply with billing requirements. The Education and Prevention Committee should encourage and enhance initiatives to educate physicians and their staff about the billing and audit processes, including on-line, self-directed learning programs adapted to different types of practice. OHIP should continue to develop the Provider Education Program as a means for resolving billing concerns. OHIP should provide to each physician, without charge, an annual mini billing profile with comparative information about billing patterns. OHIP should establish a Physician Billing Advisory Service to provide summary billing advice and binding rulings, which should be posted on its web page. OHIP and the Physician Audit Board, working with the College and the OMA (and its sections) should design and offer programs which physicians must complete before they enter practices in which they will submit fee claims to OHIP for their services. Decisions of the Physician Audit Board should be edited to protect confidentiality and published on the Board's web page. See recommendations (105) to (114).
20. **Communications and Co-operation:** OHIP, the College, the OMA and the Physician Audit Board must work together in the nomination and vetting of

Inspectors and members of the Physician Audit Board, in ensuring the accountability and responsiveness of the audit system, in revising and continually updating the Schedule of Benefits, in developing comprehensive requirements for record-keeping, and in developing instructional materials and programs to assist physicians to comply with record-keeping and billing requirements and to understand the audit process. See recommendation (115).

- 21. Transitional provisions:** The transition arrangements already in place should be continued. The Transitional Physician Audit Panel should be subject to the *Statutory Powers Procedure Act*, should be flexible in interpreting the Schedule of Benefits, should rely on records and any other evidence to establish that services were substantially rendered, should not reduce payment of a physician's fee claims where a reasonably informed physician could not have known that the impugned fee claims did not comply with billing requirements, should not apply extrapolation in the absence of previous proceedings for billing deficiencies, and should not reduce or recover fees where it would unfairly deprive the physician of basic and fair compensation for services rendered. See recommendations (116) to (118).

In summary, The Hon. Mr. Cory recommends

- that a new and independent Physician Audit Board be established,
- that billing and record-keeping requirements be clarified and simplified,
- that effective supports be provided to assist physicians to comply with billing requirements,
- that OHIP move quickly to identify and resolve problematic billings, and that progressive corrective action be taken to remedy physician fee-billing problems,
- that there be flexibility in determining appropriate remedies,
- that there be extensive limits on the application of extrapolation to calculate total recovery,
- that there be strict limits on physician responsibility for costs and interest,

- that the amount of a recovery order be reduced where it would deprive the physician of basic and fair compensation for the over-all service the physician has rendered to patients,
- that audit hearings be conducted in accordance with established standards of procedural fairness,
- that the onus be on OHIP to prove the case for the recovery of funds, and
- that physicians be treated throughout the audit process with courtesy and respect.

Cost effectiveness of proposals

The Hon. Mr. Cory considered the cost-effectiveness of his recommendations. He concluded that, although there may be additional costs in implementing an audit process that complies with formal standards of fairness, the investment is essential. There is a trend in some jurisdictions to adopt informal dispute resolution processes in their medical audit systems. Mr. Cory considers that, at this time in Ontario, there is not the requisite atmosphere of trust between the parties that would enable an informal audit process to work effectively. Physicians will not have confidence in an audit process that does not have fairness protections. In any event, the OHIP Payment Review Program provides an opportunity for informal resolution where it is practicable. Any increased cost involved in fair hearings may be balanced by the fact that the number of audits will likely be reduced in a system that provides clarity in billing requirements, effective support to physicians to facilitate compliance with those requirements, and flexible, reasonable remedies.

Redress for past audits

Organizations representing more than 17,000 Ontario physicians submitted to The Hon. Mr. Cory that those who suffered under the medical audit system should have the right to have their cases reviewed, to have money, interest and costs returned with interest, to have an amount assessed for loss of economic opportunity and to be completely indemnified for costs of the process. Mr. Cory has declined to make any recommendation in relation to this submission. His Terms of Reference exclude making findings in individual cases, or a collective finding that physicians exercised all their rights and nonetheless suffered in a manner that should be compensated. Other participants, whose interests would be affected, properly had not addressed the issue of compensation. Accordingly, The Hon. Mr. Cory concluded that he had neither the

authority, nor the necessary evidence and submissions, on which to an opinion or make a recommendation as to the need for a process to consider compensation.

Implementation

The Hon. Mr. Cory has indicated that, if his recommendations are approved, they should be implemented as quickly as possible so as to begin the process of rebuilding physicians' confidence in the medical audit process and their capacity to serve the needs of their patients. There is consensus among the parties regarding the need for an effective and fair audit process that ensures accountability in the expenditure of public funds and supports compliance by physicians. There is a considerable gap to bridge in achieving that goal, yet some steps have already been taken that indicate willingness to change on the part of all parties. This augurs well for attaining a satisfactory solution to the serious problems that have arisen in the auditing of physicians' fee-for-service claims in Ontario.

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PART I. INTRODUCTION

In this Report on medical audit practice in Ontario, I have made recommendations for a new approach to the auditing of fee claims submitted by physicians to the Ontario Health Insurance Plan (“OHIP”). The issue has generated strong feelings among physicians. Indeed, I was told that, at the time of the hearings in this matter, physicians considered it to be the most serious issue in their relationship with government. Two months after this study was announced, the Ontario Legislature, with unanimous consent of all parties, enacted legislation to suspend the audit process and establish a transitional process in its place. The transition period provides the time and opportunity to consider the permanent system that should be established.

1. The Process

I was invited to undertake this study by The Honourable George Smitherman, Minister of Health and Long-Term Care. He has emphasized the importance of completing this review as expeditiously as possible and I have endeavoured to do so. The Terms of Reference¹ specified that it should be completed in one year and that I should report in the spring of 2005. I began by publishing a notice² calling for written submissions to be delivered in July 2004. I received helpful submissions from OHIP, the Ontario Medical Association (“OMA”), the College of Physicians and Surgeons of Ontario (“the College”), various medical specialty associations, and individuals. Many of the individual submissions were from physicians who had had experience with the medical audit system. Some were from members of physician’s families. Others were from lawyers who appeared *pro bono*, in the finest traditions of the Bar, to contribute their experience and expertise to the improvement of this audit process. All were helpful in informing me as to the scope and nature of the issues to be addressed and the impacts of former policies and procedures on the lives of physicians and on their ability to serve their patients.

When the contract for the project was finally presented to me in September 2004, I was able to begin work in earnest, to meet a completion date of May 31, 2005. I had already had a briefing with OHIP and I arranged another with the College so that I could learn more about the processes and procedures of the Medical Review Committee (“MRC”). Throughout this study, I

¹ The Terms of Reference are set forth in full in Part II of this Report.

² The notice is reproduced in Appendix 1.

received excellent co-operation and assistance from OHIP, the College and the MRC. They provided helpful and comprehensive briefing materials and carefully explained their respective roles in the audit system. They also outlined initiatives they had been developing to address some of the issues that will be considered in this Report. I appreciated their professionalism, dedication, and willingness to continue to work towards solutions. To complete the briefings, I met with the Chair of the Health Services Appeal and Review Board, who provided me with useful background information about the Board's role in the medical audit process.

The written submissions prepared on behalf of the OMA and several other physician organizations and associations addressed the complaints of physicians and their recommendations for a new audit process. The leaders of these organizations, in some cases assisted by experienced and able counsel, presented cogent submissions both in writing and at the hearings. Their varying perspectives and the materials to which they referred assisted me in my examination of the issues. A list of the organizations and those who appeared on their behalf is included in Appendix 2 to this Report.

Some of the written submissions I received from individuals contained quite personal information. I adopted a Policy on Confidentiality³ and wrote to individual participants to ensure they understood that their submissions would be public and to offer them the opportunity to request that their submissions be received and heard in private. I advised them that private submissions could not form part of the record of these proceedings, nor could I rely upon them, except to the extent that they could be summarized without attribution or identification. I can confirm that the information provided to me in private was, in all respects, consistent with the information I received in public from individuals and from physician organizations.

The submissions made by individual physicians and members of their families, both in writing and in person, were informative and compelling. They confirmed the seriousness of the situation that had developed with the medical audit process and its severe impact on physicians, their families, and their ability to serve their patients. They also offered analysis and insight into the root causes of the problems and the ways in which those problems could be addressed. The

³ The Policy on Confidentiality is attached to this Report as Appendix 3.

names of individuals who made public submissions, both written and oral, are listed in Appendix 2 to this Report.

I have provided access to the public submissions filed by organizations and individuals by posting them on a web site, which can be accessed at <<http://www.petercory.org>>.

Oral submissions were scheduled for seven days in October and November. I found it useful to hear in person from many of those who had made written submissions and some who had not. The presentations reflected careful and creative preparation. The oral submissions were transcribed and are available as part of the record of this study.

Before reaching any conclusion or making any recommendation, I have carefully considered all submissions, both written and oral, and reviewed and considered the medical audit processes in the other jurisdictions referred to in Part V of this Report.

2. Acknowledgments

This is an opportune moment to thank those who assisted me in conducting this study and in preparing this report. First, let me express my gratitude to counsel.

Professor Marilyn Pilkington, the former Dean of Osgoode Hall Law School of York University, worked closely with me and assisted me in every aspect of my work. Everything she did was completed carefully, thoughtfully, quickly, and extremely well. I was fortunate to have the benefit of her fine intellect, insight, and commitment to the project.

Katie Osborne and Naomi Margo, who practice in the field of health law and policy, worked long and hard on matters of research. They undertook this work with vigour and enthusiasm, producing careful and detailed memoranda on a number of topics, including medical audit practice in other jurisdictions. I am indeed grateful for the unstinting and meticulous work of all counsel.

Vittoria Alcamo took excellent care of administrative arrangements and secretarial tasks. She responded courteously to the many inquiries from those who expressed an interest in this study, and cheerfully found effective solutions to every administrative challenge.

I would also like to thank all who made submissions to me, whether they were oral or written. They were carefully and thoughtfully prepared and all were of interest and assistance to me. The information provided by experts in other jurisdictions has also been helpful and I appreciate their generosity in contributing to this study.

3. Organization of the Report

My Report is organized into several sections. Part II sets out the Terms of Reference. Part III considers the significance of the medical audit system within the Ontario health care system. Part IV describes the medical audit system that was formerly in place in Ontario. Part V summarizes the features of medical audit processes in other Canadian provinces and in three foreign jurisdictions: Australia, New Zealand, and the United States of America. Part VI is the heart of the report. In that section, I set out the concerns that physicians have raised regarding the former medical audit process, the responses made to those concerns, and my conclusions and recommendations. Part VII is the conclusion. There are also a number of appendices, which provide material for further reference.

PART II. THE TERMS OF REFERENCE

The Terms of Reference for this initiative, which were settled on April 30, 2004, are set out below.

“Terms of Reference: Medical Audit Practice in Ontario April 30, 2004

Purpose:

To find or develop the best-practice method to audit fee-for-service claims that:

- is accountable to the people, physicians and government of Ontario; and,
- rebuilds the confidence of the medical profession in the audit process.

The initiative will be lead by the former Supreme Court Justice, Peter Cory, who will call on the expertise of experts in the field of accounting (including forensic accounting), medicine, and administrative law.

It is understood that a prerequisite to undertaking this initiative is a thorough understanding of the current “OHIP” audit system, including the legislative and policy context upon which that audit system is founded.

The initiative shall be undertaken in a manner which does not affect or impede the ongoing statutory and operational duties and functions of the Medical Review Committee and the General Manager of the Ontario Health Insurance Plan.

Objectives:

1. To recommend (and, if necessary, to design) a “best practices” system/procedure for a formal audit of medical claims submitted for insured services under the Ontario Health Insurance Act based upon predetermined criteria.
2. To identify transition and implementation considerations.

Outline of Review:

A. Understanding the Medical Audit Process in Ontario and other jurisdictions

The initiative will require an understanding of the current medical audit process including:

- accessing previous studies and reviews including government audits and reports

- examine current policy and procedures used by MOHLTC and MRC
- examining the legislative framework
- examining the legislative framework, practices and processes used in other provincial jurisdictions, and, where beneficial, other publicly funded health insurance regimes.

B. Identification of Best Practices

Criteria to be considered in assessing and identifying “best practices”:

- physician accountability for OHIP fee-for-service
- cost effective to administer
- timeliness (avoids lengthy delays between date of service and date of review/recovery)
- objective process
- yields consistent results
- opportunity for physician to be heard on relevant audit issues
- respects confidentiality issues (patient and provider)
- effective for both prevention and deterrence of improper billing
- legal framework (ie. statute & regulation)

Components of Initiative:

- critical analytical comparison of current systems in effect in other provinces and in jurisdictions whose operations are similarly structured to that of OHIP
- best methods to audit medical claims
- best methods to determine amount of overpayment, if any
- role and application of statistical methods
- role of inspectors – identity and qualifications of inspectors
- training & compensation for claims reviewers/auditors/tribunal members
- appeal process, including the level of expertise required by those hearing appeals

C. Accountability and Communications

Identification of the key stakeholders in the process and determination of most appropriate roles:

- Within the recommended “best practices” model, clarify the respective roles and accountabilities, and identify the communications roles and responsibilities of the key stakeholders: the Ministry of Health and Long-term Care, College of Physicians and Surgeons of Ontario/MRC and Ontario Medical Association
- Identify communication approaches to rebuild the confidence of the profession in the process

D. Outside of Scope:

Notwithstanding Section A: Understanding the Medical Audit Process in Ontario and other jurisdictions, the following are outside of scope:

1. Critique of the current system;
2. Changing the ground (in statute and regulation) upon which recoveries are currently based (e.g. service not medically necessary; service not provided in accordance with professional standards of practice; service does not satisfy requirements of code in the Schedule of Benefits; inadequate medical records, etc.) and
3. Critique or comment on specific cases.

Process:

The initiative does not constitute a “commission” or “inquiry” within the meaning of the *Public Inquiries Act* and does not constitute a “tribunal” within the meaning of the *Statutory Powers Procedure Act*.

The initiative is to include consultation with the Ontario Ministry of Health and Long-Term Care, the College of Physicians and Surgeons of Ontario, the Ontario Medical Association and other stakeholders.

The initiative is to be completed within 1 year.

The final report, which is to be produced no later than Spring 2005, shall recommend a “best practices” system/procedure for a formal audit of medical claims submitted for insured services under the Ontario Health Insurance Act based upon predetermined criteria, and shall identify transition and implementation considerations. The final report will be delivered contemporaneously to the Minister of Health and Long-Term Care, the President of the College of Physicians and Surgeons of Ontario, and the President of the Ontario Medical Association.

The Ministry of Health and Long-Term Care, College of Physicians and Surgeons of Ontario, and the Ontario Medical Association will be provided with a draft of the final report and shall be provided with a reasonable opportunity for review and comment to ensure the factual aspects of the report.”

PART III. SIGNIFICANCE OF THE MEDICAL AUDIT PROCESS WITHIN THE ONTARIO HEALTH CARE SYSTEM

1. The prime participants and their interests

Before dealing with the physicians' complaints pertaining to the present system of auditing their accounts, the recent responses to those complaints, and my recommendations, it may be helpful to identify the principal participants in the physician fee-for-service programs in the Ontario health care system. First, there is the Ministry of Health and Long-Term Care. It is this Ministry that is responsible for the administration of the Ontario Health Insurance Plan, which is established pursuant to the *Health Insurance Act*. OHIP pays the fees of physicians and other practitioners who are registered to provide insured services to their patients. The fees to be paid to physicians and the services to be insured or funded by the Plan are determined following negotiations between the Ministry and the Ontario Medical Association, and are set out in regulations under the *Health Insurance Act*.

Second, there are the users of OHIP. They are all the people of Ontario who at one time or another require – often urgently – the insured services of physicians to treat illnesses and heal injuries. The Health Insurance Plan is of great importance to all residents of Ontario. Indeed, such health plans are important to all Canadians. They are often considered as providing one of the great benefits of being Canadian and as a distinguishing feature of Canada. For residents of Ontario to know that medical care will be provided to them is vitally important both for their general health and their psychological well-being. There can be fewer comforts as great as knowing that health care will be available in times of need.

Third, there are the physicians and surgeons who provide the skilled diagnosis, treatment, and care that is essential to the successful operation of the Health Plan. They are dedicated to healing their patients and give unstintingly of their skill, knowledge, and time.

The government, consumers and physicians all have an interest in a Health Plan that functions efficiently and well. They recognize that funding sources for health care are finite and that costs are increasing. Fee-for-service payments to physicians have reached \$5 billion a year in Ontario. The expenditure for health services is close to being 50 percent of the provincial

budget, and if the present pattern of expenditure continues, in not too many years it will surpass that figure. There may come a time when the voters will wish to halt the endless rounds of increasing health care costs and insist that some of this money be applied to other essential services such as education. If the health care system is to survive, there must be an assurance that the funds available for physicians' services are looked upon as constituting a public trust. They should be paid to physicians only for services properly and carefully rendered in accordance with the terms of the Health Insurance Plan.

2. Trust funds and the role of audits

The public funds that are provided for the health care system are obviously a form of trust funds. All participants recognized that the vast majority of physicians respect this trust. They are the soul of integrity and seek to bill their services appropriately and in compliance with statutory requirements. Nonetheless, there must be protections against physicians who would fraudulently obtain fees for a service that has not been rendered. These physicians steal not only from the public but also from their colleagues. When physicians overstate their claims for benefits, misrepresent the services they have rendered, provide excessive and medically unnecessary services, or act fraudulently, they must be identified and held accountable. Every individual physician and medical association that made submissions agreed that some form of auditing of physicians' fee claims is essential. On the other hand, those same physicians and organizations stressed that the audit should be a true audit and not a means of unfairly taking back monies that had been properly paid to physicians for services they had rendered.

The system of billing and payment itself indicates that a reasonable auditing process must be in place. The billing of fees operates on the honour system. Physicians submit their accounts to OHIP and not to their patients. OHIP has no means of knowing which services were provided. The Plan is publicly funded and all parties must appreciate that the resources are not and cannot be infinite. All these factors indicate the need for a fair and reasonable system for auditing physicians' accounts.

Thus it is clear that an auditing system is required. It is also essential, in a fee-for-service health care system, that the audit process have the complete confidence of physicians. The basis

on which physicians are selected for audit by OHIP must be clear, the method of auditing must be transparent, and most of all the process must be fair in all its aspects.

There can be no doubt that the present audit system has had a debilitating – and, in some cases, devastating – effect on the physicians of Ontario, their families, their practices and their patients, and as well a negative impact on the delivery of health services in the Province. I have heard the moving submissions of physicians and I can appreciate their concerns with the present system. It is sad to hear of competent and respected doctors reducing the number of patients they see and the work they do in order to avoid becoming the target of an audit process. An audit system should not deprive patients of medical services or communities of the benefit of physicians' work. I trust that an audit system can be designed that adequately and properly protects public funds from fraudulent and exorbitant billing claims yet is fair in its procedures and hearings so that it enjoys the respect, co-operation and confidence of physicians.

My goal is to design an audit system that is easily understood, functional and practical. Above all, the audit system must be fair. The ideal of fairness must be apparent and be seen to function in every step of the audit process. The Hearing Panels must be unbiased, fair-minded, qualified and independent. They must strive to be patient, courteous and fair in their approach to all who appear before them. Their goal must be to demonstrate to all participants that they have listened carefully to all the evidence and submissions. Their conduct should show to all that they are truly dedicated to providing fair hearings and delivering carefully considered and fair decisions.

PART IV. DESCRIPTION OF MEDICAL AUDIT PROCESS IN ONTARIO⁴

In this Part of the Report, I describe the process for auditing physicians' fee for service claims in Ontario, the significant changes that were made to the process by the legislature from 1996 to 2002, and the transitional provisions that were put in place when the amended process was suspended in 2004.

1. Fee-for-service system:

The Ontario Health Insurance Plan ("OHIP"), operating pursuant to the *Health Insurance Act*⁵ ("HIA"), pays most Ontario physicians on a fee-for-service basis for delivering insured medical services. Physicians are responsible for ensuring that their fee claims comply with the HIA and the *Schedule of Benefits for Physician Services under the Health Insurance Act*⁶ ("Schedule of Benefits"). The services, fee codes, and amounts payable are established in the Schedule of Benefits, which is negotiated between the Ministry of Health and Long-Term Care ("Ministry") and the Ontario Medical Association ("OMA").

Fee claims paid by OHIP to physicians: Approximately 150 million claims for insured services are paid yearly to more than 20,000 physicians and 5,000 other practitioners, with fees to physicians constituting \$5 billion of the \$6 billion in payments.⁷

Numbers of referrals to the Medical Review Committee for audit: A relatively small number of physicians' fee claims are referred to the Medical Review Committee ("MRC") for investigation and audit, but the number doubled in a one-year period, between 1998-99 and 1999-2000:

⁴ Note that the existing medical audit process was temporarily replaced by the *Transitional Physician Payment Review Act, 2004*. See text at note 130.

⁵ R.S.O. 1990, c. H.6, as amended by 1992, c. 32, s. 15; 1993, c. 2, s. 12; 1993, c. 10, s. 53; 1993, c. 32, s. 2; 1994, c. 17, ss. 68-74; 1996, c. 1, Sched. H, ss. 1-35; 1996, c. 21, s. 51; 1997, c. 16, s. 7; 1998, c. 18, Sched. G., s. 54; 1999, c. 10, ss. 1,2; 2000, c. 26, Sched. H., s. 1; 2000, c. 42, Sched., ss. 17-19; 2001, c. 8, ss. 32, 33; 2002, c. 18, Sched. I, s. 8; 2004, c. 3, Sched. A, s. 85; 2004, c. 5, ss. 36-43; 2004, c. 13, s. 1; attached as Appendix 4 to this Report.

⁶ *Schedule of Benefits for Physician Services under the Health Insurance Act* ("SOB"), part of Regulation 552 under the HIA, ss. 45(2), (2.1) - (2.7).

⁷ Ministry of Health and Long-Term Care, Submission to The Hon. Mr. Cory (July 2004); *Members' Dialogue*, College of Physicians and Surgeons of Ontario, January/February 2003, at 9.

Year	Number of referrals to the MRC ⁸
1998-99	52
1999-2000	103
2000-01	101
2001-02	127
2002-03	102
2003-04	12

MRC directions to physicians to repay OHIP:⁹ The College reports that, in the last four years, an average of 12.75% of audits resulted in no repayment and that, in cases where repayment was ordered, no physician was ordered to repay 100% of the amount they had received from OHIP.

Year	Number of directions with no order to repay	Number of directions to repay	Total amount to be repaid
2000-01	12	62	\$3.5 million
2001-02	2	96	\$5.7 million
2002-03	3	107	\$7.1 million
2003-04	30	71	\$1.9 million

2. Record-keeping requirements:

The *HIA* requires that physicians maintain the necessary records (1) to establish whether the physician provided an insured service to a person,¹⁰ (2) to demonstrate that a service for which the physician submitted an account is the service that the physician provided,¹¹ and (3) to establish that the service the physician provided was medically necessary.¹² The required records

⁸ College of Physicians and Surgeons of Ontario, Additional Material requested by The Hon. Mr. Cory (October 2004) at 66.

⁹ Information drawn from Ministry of Health and Long-Term Care, Submission to The Hon. Mr. Cory (July 2004) at 16, and College of Physicians and Surgeons, Reply Submission to The Hon. Mr. Cory, November 2, 2004.

¹⁰ *Health Insurance Act*, *supra* note 5, at s. 37.1(1).

¹¹ *Ibid.*, s. 37.1(2).

¹² *Ibid.*, s. 37.1(3).

must be prepared promptly when the service is provided.¹³ If there is a question concerning whether an insured service was provided, the physician is obliged to provide all information within his or her control to the General Manager of OHIP, to an Inspector assigned by the MRC or to a Member of the MRC.¹⁴

In the event that the physician's records do not establish that he or she provided an insured service, or that it was medically necessary, it is presumed that an insured service was provided, but that the basic fee payable is nil.¹⁵ In the event that the physician's records do not establish that the service provided meets the criteria for the fee code claimed, the General Manager of OHIP may determine what service (if any) the records indicate was provided.¹⁶ Accordingly, when a physician's fee claims are reviewed, the primary focus is on whether the physician's records justify the fees claimed, whether a lower fee should be substituted, or whether the fee should be nil.

The standards of record-keeping established by the College for clinical purposes are not necessarily sufficient for the purposes of establishing that a particular fee code, specified in the Schedule of Benefits, is justified in the circumstances. The fee payable for a service that is conceded to be clinically appropriate may depend upon whether the service meets the definition for a lower-paying fee code or a higher-paying fee code in the Schedule of Benefits.¹⁷ In the written and oral submissions, there was widespread agreement that the current Schedule of Benefits is antiquated, complex, incomplete, confusing, and would benefit from substantial revision. This view is supported by evidence of the history of the Schedule and its interpretation,

¹³ *Ibid.*, s. 37.1(5).

¹⁴ *Ibid.*, s. 37.1(6).

¹⁵ *Ibid.*, s. 37.1(7a).

¹⁶ *Ibid.*, s. 37.1(8).

¹⁷ The Schedule of Benefits was initially produced by the OMA to guide physicians in billing their services. After Ontario entered the federal Medicare scheme in 1969, the Ontario government adopted the OMA 1969 Schedule as the basis for payment of physician fees. The Joint Committee on Physicians' Compensation, comprised of three OMA physician representatives, three government representatives and a neutral Chair, was later established to negotiate the global percentage increase to fee payments. In 1978, the government produced its own Schedule of Benefits, based on the original OMA Schedule but assigning different dollar amounts for fees. The Physicians Services Committee, a joint committee of the Ministry and the OMA, examines issues relating to the Schedule of Benefits and makes recommendations to the Ministry.

reviewed by the HSARB in *Lyttle v. MRC* (attached as Appendix 11). The Ministry conceded only that the Schedule has evolved over time, is complex, and needs to be revised, and indicated that most physicians are able to adapt to its complexity by using only a few of the fee codes.

3. Submission and payment of claims

A physician must submit a claim within six months of rendering the service.¹⁸ The Ministry^{18a} uses computerized systems to conduct a preliminary screening of all claims. Simple checks are performed to verify basic requirements including form and completeness of information, physician and patient eligibility, and compliance with “medical rules” that block certain claims (e.g. where a code may be billed only once per year per patient) or block certain prohibited fee combinations.¹⁹ If a claim complies with pre-payment screening, it is paid.

4. Post-payment review of claims

After payment, the Ministry may undertake further investigation of a physician’s claims. Payments already made may be recovered where it is found that all or part of a service (a) was not rendered, (b) was deliberately or inadvertently misrepresented, (c) was not medically necessary, or (d) was not provided in accordance with accepted professional standards and practice. Payments cannot be recovered solely on the basis of the last two criteria.²⁰

Post-payment screening: The Ministry monitors, verifies and reviews physician claims using the following processes:²¹

Statistical computer analysis: With advances in computer program capability, the Ministry can perform increasingly sophisticated analysis and comparison of physicians’ fee profiles. A physician’s monthly profile indicates the total number of services provided, the dollar cost per patient, the number of services per patient, the number of times a patient is seen, the gender and age of patients seen, and the total amount billed per fee code, together with comparative data for other physicians in the same specialty, by province and district.

¹⁸ *O. Reg. 222/02*, s. 2.

^{18a} The responsible unit of the Ministry is the Monitoring and Control Unit, Provider Services Branch, Health Services Division.

¹⁹ *Health Insurance Act*, *supra* note 5 at s. 18(2), (7); R.R.O, Regulation 552 as amended, s. 38.01(1).

²⁰ *Health Insurance Act*, *supra* note 5 at s. 18(2), (5), (6).

²¹ Ministry of Health and Long-Term Care, Submission to the Hon. Mr. Cory (July 2004) at 9.

Verification letter: Letters may be sent to patients seeking verification that services were provided.

Detailed screening: Medical Consultants at the Ministry undertake detailed screening of fee claims for individual physicians (or groups of physicians in the same specialty). They do so in response to an unexplained irregularity in a patient's response to a verification letter;²² complaints from the public, a Ministry office, or the police; or concerns arising from statistical analysis.²³ Examples of concerns arising from statistical analysis include high cost per patient ratios, high proportion of high value fee codes, high volumes of high value fee codes in a day, frequent patient encounters, repeat consultations at high value fee codes, time-based codes that exceed a reasonable number of hours per day, and an unreasonable number of high-volume days.

The Ministry has reported that a Medical Consultant examines the statistical data and attempts to evaluate the physician's billings in the context of the physician's medical practice, taking into account the fact that practices may vary significantly, even within a particular field of specialization. Relevant variables include the practice setting, the nature of the practice, the geographic location, the age distribution of patients, the state of their health, etc. The Medical Consultant tries to identify an appropriate peer group for comparison of claims patterns, and may also seek advice from appropriate specialists in an effort to determine what the claims of a typical medical practice in a particular specialty should look like. The Medical Consultant's recommendation is reviewed by at least one other Medical Consultant before any action is taken.²⁴

5. Referral to Provider Education Program

Where the Medical Consultants conclude that a physician's claims are open to dispute, they may recommend to the General Manager of OHIP, in a less serious case, that the physician be referred to the Ministry's Provider Education Program ("PEP"), which was launched in July

²² *Ibid.*

²³ *Ibid.*, at 10 and 11, and see Ministry Bulletin Part A: "Post-Payment Review and Auditing of OHIP Claims" (2003-09-01). The Ministry has indicated that the majority of MRC referrals are made in cases where there are concerns on more than one of the bases noted (at 11).

²⁴ See Ministry of Health and Long-Term Care, Submission to The Hon. Mr. Cory (July 2004), at 12.

2001. The purpose of the program is to educate the physician regarding billing requirements with a view to ensuring future compliance.

6. Referral to Police

It is an offence under the *HIA* to knowingly obtain, or attempt to obtain, payment for any service that a physician is not entitled to obtain, to knowingly aid or abet another person to commit such acts or to knowingly give false information in a return or statement made to OHIP.²⁵ Prescribed persons are required to report such acts.²⁶ Where the General Manager of OHIP concludes that there are reasonable grounds to believe that a physician has acted fraudulently, the matter is referred to the police. Further, it is an offence to contravene any provision of the Act or regulations, subject to a penalty, on a first offence, of a fine of not more than \$25,000 or imprisonment of not more than twelve months, or both, and, on a subsequent offence, a fine of not more than \$50,000 or imprisonment of not more than twelve months, or both.²⁷

7. Referral to College of Physicians and Surgeons of Ontario

In cases where the General Manager of OHIP or the Medical Review Committee has reasonable grounds to believe that a physician is incompetent, incapable, or has committed professional misconduct, they are authorized to refer the matter to the College.²⁸

8. Direct Recovery

Where the General Manager of OHIP determines, on the basis of the internal review of billing records, that all or part of the service claimed does not meet the payment criteria for the fee code,²⁹ the General Manager can refuse to pay the claim, reduce the amount paid to the physician or recover payments already made, known as “direct recovery.”³⁰

²⁵ *Health Insurance Act*, *supra* note 5, at s. 43.

²⁶ *Ibid.*, s. 43.1

²⁷ *Ibid.*, s. 44.

²⁸ *Ibid.*, s. 38(4).

²⁹ See text, *supra*, at note 5.

³⁰ *Health Insurance Act*, *supra* note 5, at s. 18.(2), (5).

9. Review by MRC of direct recovery decision (at request of physician)

A physician can request that the MRC review a direct recovery decision.³¹ The request must be made within sixty days of receiving notice of the General Manager's decision and must be accompanied by a fee equal to five percent of the amount in dispute but in no case more than \$2,500 or less than \$350.³² The physician may request review by a single member of the MRC, provided that the amount in dispute is less than a prescribed amount (currently \$100,000), or the General Manager consents.³³ In other circumstances, the review is by a three-member panel. Within thirty days of a determination by a single member of the MRC, the physician may request reconsideration by a three-member panel.³⁴ The physician must pay an additional application fee (currently \$350).³⁵

10. Referral to the MRC by OHIP

Where the General Manager of OHIP does not order a direct recovery but concludes that further investigation is warranted, he or she can request the MRC to review the matter (known as a "MRC referral").³⁶ The General Manager specifies the types of insured services (or fee codes) to be reviewed and the period under review.³⁷ I am advised that the review period is usually 24 months, but there is no statutory limit. The General Manager may request review by a single member of the MRC or by a three-member panel.³⁸ Alternatively, the General Manager may, with the consent of the physician, seek to resolve the matter through the OHIP Payment Review Program ("OPRP").

11. OHIP Payment Review Program ("OPRP")

The Ministry implemented the OPRP in January 2003, acting on the recommendation of

³¹ *Ibid.*, s. 18.1(1).

³² *Ibid.*, s. 18.1(1); Regulation 552, s. 38.2(1).

³³ *Health Insurance Act*, *supra* note 5, at s. 18.1(2); Regulation 552, s. 38.1(1).

³⁴ *Health Insurance Act*, *supra* note 5, at s. 18.1(8); Regulation 552, s. 38.2(2).

³⁵ *Health Insurance Act*, s. 18.1(5).

³⁶ *Ibid.*, s. 39.1.

³⁷ *Health Insurance Act*, s. 39.1 provides that the request *may* specify the types of insured services to be reviewed and the period during which the services were provided.

³⁸ *Ibid.*, s. 39.1(3).

the November 2001 Joint OMA/Ministry review of the MRC. The OPRP provides an opportunity for the physician to respond to OHIP's concerns and a possibility to resolve the matter without a referral to the MRC.³⁹ The Ministry discloses the materials that would otherwise be referred to the MRC (e.g. charts, reports, physician's twelve-month profile, patient verification letters, etc.) and identifies the particular fee codes to be reviewed. For each fee code, OHIP randomly selects⁴⁰ forty-five claims from the physician's total population of paid claims in the period under review. The physician produces to the Ministry copies of the patient records for the selected claims. Medical Consultants assess each claim on the basis of what was recorded in the patient record and any other information provided by the physician. The Consultants determine whether the claim meets the payment criteria specified in the Schedule of Benefits. Unless the Medical Consultants agree that the claim is incorrect, the claim is allowed. The physician is notified of the Ministry's findings and has an opportunity to respond in writing. The Ministry considers the response and makes a final determination. A physician who accepts the findings can enter into a settlement agreement with the Ministry.⁴¹ If the physician rejects the findings, the Ministry may then refer the matter to the MRC.

12. The Medical Review Committee

Jurisdiction: The MRC was established in 1972, pursuant to the *HIA*.⁴² It has jurisdiction to review or audit physician fee claims and to direct the General Manager of OHIP to increase the amount paid to a physician for an insured service or to require the physician to repay all or part of any payment received under the Plan.⁴³ A direction requiring the physician to repay OHIP may be made only where all or part of a service was not rendered, was deliberately or inadvertently misrepresented, was not medically necessary, or was not provided in accordance

³⁹ Ministry of Health and Long-Term Care, Submission to The Hon. Mr. Cory (July 2004), at 14.

⁴⁰ In a case where a physician has billed a certain fee code 1,000 times in the past two years, the claims for the code in question are numbered consecutively from 1 to 1,000. The random number generator in Microsoft Excel is used to select randomly 45 different numbers. The services corresponding to these 45 numbers constitute the random sample. See Malcolm Griffin and Marshall Godwin, "Report on the Statistical Sampling Methods Used by the Ministry of Health and Long-term Care in their Audits" (February 2004), at 1. Ministry of Health and Long-Term Care, Submission to The Hon. Mr. Cory (July 2004), at 26 (Appendix 2).

⁴¹ See the text at note 90, *infra*.

⁴² *Health Insurance Act*, *supra* note 5, at s. 5.

⁴³ *Ibid.*, s. 39.1(5).

with accepted professional standards and practice.⁴⁴ The Act specifies that the MRC may direct a repayment, provided that it has “reasonable grounds to believe” that one of these conditions is satisfied. Additional circumstances justifying an order for repayment may be prescribed.⁴⁵ The MRC has no jurisdiction to entertain applications made pursuant to the *Charter of Rights and Freedoms*.⁴⁶

A Committee of the College: The MRC is a committee of the College of Physicians and Surgeons of Ontario.⁴⁷ Unlike other standing committees of the College, the MRC is constituted by the *HIA* rather than by the legislation governing the College. The College administers the MRC and leases office space to the MRC, but is not involved in its day-to-day decision-making operations.⁴⁸

Composition: Initially, the MRC was composed of five physician members and one public member, later six physician members and two public members. In response to a report from the Provincial Auditor in 1993, and in order to accommodate significant increases in the number of referrals and consequent delays, the Committee was increased to eighteen physician members and six public members.⁴⁹

Appointment: The Minister appoints all the members of the MRC.⁵⁰ Physician members are nominated by the College Council. Nominees are vetted by the College and the Ministry to ensure that they are in good standing and have no conflicts of interest regarding the billing process. The College has invited the OMA to suggest nominees, and seeks to nominate members who are representative of the diverse physician population in Ontario.⁵¹

⁴⁴ *Ibid.*, s. 39.1(6).

⁴⁵ Pursuant to *Health Insurance Act*, s. 39.1(6).

⁴⁶ Pursuant to the *Government Efficiency Act, 2002*, the legislature amended the *Ministry of Health Appeal and Review Boards Act* to exclude from the HSARB any inquiry or decision concerning the constitutional validity of a provision of an Act or a regulation. The amendment thus removed from the HSARB (and the MRC) jurisdiction to consider any challenge to the legislation pursuant to the *Charter of Rights and Freedoms*. See the *Ministry of Health Appeal and Review Boards Act*, s. 6(3), attached as Appendix 6 to this Report.

⁴⁷ *Health Insurance Act*, s. 5.

⁴⁸ Ministry of Health and Long -Term Care, Submission to The Hon. Mr. Cory (July 2004) at 17.

⁴⁹ O. Reg, 222/94, s. 1.

⁵⁰ *Health Insurance Act*, *supra* note 5, at s. 5(2).

⁵¹ College of Physicians and Surgeons of Ontario, Submission to The Hon. Mr. Cory (July 2004), at 6.

Remuneration: Members are remunerated on an hourly, daily or other basis at a rate determined by the Lieutenant Governor in Council.⁵² Currently, the rate for physician members' attendance, preparation and travel is \$218.00 per half day or \$436.00 per day. The rate for public members is \$181.50 per half day or \$363.00 per day. In comparison, physician members of other College panels and of College Council are paid \$750 per day, and public members of other College panels are paid \$37.50 for each quarter of a day, up to \$150 per day.⁵³

Funding: Government funds the costs of operating the MRC, including the *per diem* rates paid to members. MRC expenditures for the fiscal year 2003-04 totalled \$2,093,336.⁵⁴

Materials provided by OHIP to the MRC: In relation to each referral, the General Manager of OHIP provides the MRC with the following documents:⁵⁵ (1) a letter to the Chair of MRC identifying the referred services by fee code and specifying the time period under review; (2) the Medical Consultant's Memorandum outlining the reasons for the referral, supported by charts and data; (3) Daily Distribution of Services Reports ("DDS") consisting of monthly reports during the referral period showing total claims by fee code for each day of the month; (4) Profile of Physician's Practice (including age and sex of patients, monthly average dollar cost for all services, dollar cost per service, and number of patients seen) and comparisons with county and provincial averages for each fee code; (5) copies of correspondence between the physician and the Ministry during the referral period; and (6) copies of verification letters received from patients.

MRC Procedures on Expedited Reviews: Amendments to the *HIA*⁵⁶ established an expedited review procedure that can be requested by the General Manager⁵⁷ or by a physician⁵⁸ who seeks review of a direct recovery. On an expedited review, a single member of the MRC meets with the physician and examines relevant charts. No inspector is appointed. The *HIA*

⁵² *Health Insurance Act*, s. 5(4).

⁵³ College of Physician and Surgeons of Ontario, Additional Material requested by The Hon. Mr. Cory (October 2004), at 40.

⁵⁴ Medical Review Committee Annual Report, April 1, 2003 to March 31, 2004, at 10, included in College of Physicians and Surgeons of Ontario, *loc.cit.* n.53, at 257.

⁵⁵ Ministry of Health and Long-Term Care, Submission to the Hon. Mr. Cory (July 2004), at 53 (Appendix 7).

⁵⁶ 1996, c. 1, Sched. H, s. 33, see *Health Insurance Act*, *supra* note 5, at s. 18.1, s. 39.1((3), (4).

⁵⁷ *Health Insurance Act*, s. 39.1(3).

⁵⁸ See the discussion in the text, *supra*, at note 31.

requires that the MRC member commence the review promptly, conduct it expeditiously and give notice of his or her finding promptly, but does not specify time limits.⁵⁹ Either the physician or the General Manager may request reconsideration by a three-member panel of the MRC.⁶⁰ Written reasons are required only upon request.⁶¹

MRC Procedures on Regular Reviews: More MRC reviews have proceeded as regular reviews than as expedited reviews:

Number of Directions issued in Regular and in Expedited Reviews⁶²

Year	Regular Reviews	Expedited Reviews
1999-2000	46	18
2000-2001	55	19
2001-2002	69	29
2002-2003	63	49
2003-2004	75	26

On receipt of a request to conduct a review, the MRC assigns a case facilitator, who will maintain primary responsibility for the matter throughout the review process.⁶³ In a regular review, the MRC also assigns an inspector. A Notification Package is provided to the physician, consisting of (1) a Notification Letter from the Medical Director of the MRC introducing the MRC, outlining the services and period under review, encouraging the physician to contact the OMA or the Canadian Medical Protective Association (“CMPA”) for advice or assistance, advising that an inspector has been assigned to meet with the physician and obtain copies of patient records, offering a choice of three dates for the meeting, and informing the physician that he or she has twenty working days to respond with choice of date and location for meeting with the inspector;⁶⁴

⁵⁹ *Health Insurance Act*, s. 18.1(6), s. 39.1(4).

⁶⁰ *Ibid.*, s. 18.1(7), s. 39.1(4).

⁶¹ *Ibid.*, s. 18.1(13).

⁶² Expedited reviews include physician-initiated reviews. Medical Review Committee, Annual Report, April 1, 2003 to March 31, 2004, *loc cit.*, note 53, at 262.

⁶³ College of Physicians and Surgeons of Ontario, The Medical Review Committee: an Overview (September 10, 2004), at slide 18 ff.

⁶⁴ *Ibid.*, at slide 61 ff.

(2) all referral materials received from OHIP; (3) a copy of relevant statutory provisions; (4) MRC Procedural Directions and Fact Sheet explaining the process and requirements; (5) an Inspection List consisting of forty-five randomly selected examples of services provided by the physician for each of the service codes under review, listing patient names and dates of birth but not service dates (so as to minimize the possibility of altering the selected records); and (6) a Questionnaire to be completed by the physician providing information about his or her practice, qualifications, etc.

The regular review is comprised of an inspection process, a settlement process, and a non-settlement process.

13. Inspection

Appointment of Inspectors: The Ministry appoints Inspectors from names put forward by the College.⁶⁵ The MRC places notices in College publications seeking physicians interested in serving as Inspectors, and occasionally recruits Inspectors in an effort to ensure the availability of inspectors experienced in a range of specialties and practice settings.⁶⁶

Role: The Inspector's role is to gather facts on behalf of the MRC.⁶⁷

Powers: Inspectors have the power⁶⁸ to interview the physician, members of his or her staff, and employees in a hospital or health facility,⁶⁹ to question a person on relevant matters, to enter premises and inspect the operations carried out on the premises, and to inspect and copy information from health records and accounts. An Inspector must give five days' written notice to the physician or administrator of the hospital or health facility before conducting an interview.⁷⁰

⁶⁵ *Health Insurance Act*, *supra* note 5, at s. 40(1).

⁶⁶ Several members of the MRC's non-medical departmental staff have been appointed as Inspectors under the *HIA*, but inspections are carried out by physician inspectors. See College of Physicians and Surgeons of Ontario, The Medical Review Committee: an Overview (September 10, 2004), at slide 51.

⁶⁷ *Ibid.*, at slide 55.

⁶⁸ *Health Insurance Act*, s. 40.1.

⁶⁹ Under the *Health Insurance Act*, s. 40.1(2), an inspector has the powers of a commission under Part II of the *Public Inquiries Act*, but may exercise them only in relation to the interviewing of the physician, staff, employees of hospitals or health services.

⁷⁰ *Health Insurance Act*, s. 40.1(3).

The notice must state the subject matter of the interview and the person(s) to be interviewed.⁷¹ It must also specify that the person to be interviewed is entitled to be represented by legal counsel.⁷²

Memorandum for Inspectors: The case facilitator prepares a memorandum for the Inspector consisting of questions for use by the Inspector in obtaining relevant information, directions for reviewing and photocopying records, and the date for submission of the inspector's report. In some situations, the Inspector may expand the interview beyond the questions outlined in the inspection memorandum (e.g. where it appears that the records selected for copying may have been altered).⁷³

Location of inspection: The inspection generally takes place at the physician's place of practice. If the physician does not have a private office, a meeting may be arranged elsewhere.⁷⁴

Interviewing and photocopying: The Inspector interviews the physician and invites him or her to provide any additional relevant information. The Inspector identifies and photocopies the relevant records. A member of the MRC staff assists the Inspector as needed.⁷⁵

Inspection Report: The Inspector prepares a report and sends it to the MRC together with copies of the patient records, the questionnaire completed by the physician, and any other material provided by the physician.⁷⁶

Notice to Physician: The inspection report and material previously disclosed is compiled and provided to the physician. The covering letter explains that, if settlement is achieved, the referred physician will not be liable for the costs of the review, which can be substantial.⁷⁷ The physician has fifteen working days to notify the MRC that he or she intends to pursue settlement.⁷⁸

⁷¹ *Ibid.*, s. 40.1(4).

⁷² *Ibid.*, s. 40.1(5).

⁷³ College of Physicians and Surgeons, The Medical Review Committee: An Overview, (September 10, 2004), at slide 72.

⁷⁴ *Ibid.*, at slide 68.

⁷⁵ *Ibid.*, at slide 70 ff.

⁷⁶ *Ibid.*, at slide 71 ff.

⁷⁷ See the text at note 113.

⁷⁸ *Ibid.*, at slide 76.

14. Settlement Process

Opportunity to pursue settlement: Every physician referred to the MRC is offered the opportunity to pursue settlement, and roughly 50% have settled in the past three years.⁷⁹

2001-02:	64 of 98 physicians reviewed settled
2002-03:	55 of 110 physicians reviewed settled
2003-04:	38 of 101 physicians reviewed settled

Where a physician indicates that he or she wishes to pursue settlement, a panel of the MRC, consisting of two physician members and one public member is assigned, taking into account their expertise, availability and workload. Where a large volume of services is under review, an additional physician member may be assigned.⁸⁰ One member of the panel is designated to serve as “speaker” or team leader of the panel, and a date is set for a Preparatory Meeting.

Preparatory Meeting: Panel members receive copies of the Inspection Report and prepare independently for the Preparatory Meeting. At the meeting, they discuss the issues and determine whether they need an opinion from an expert in the physician’s field of practice (especially where that field is not represented among members of the MRC). The MRC Medical Director is informed of the decision to seek an expert opinion and provides assistance to the Committee in recruiting experts. The College database is used to search for physicians with the required expertise. Experts are remunerated at the same rate as physician members of the MRC (i.e. \$436 per diem).⁸¹ All expert opinions are shared with the referred physician and counsel.

Meeting with the physician: The Panel meets with the physician where the physician has requested a meeting or the Panel considers that it would be helpful.⁸² A lawyer or another advisor may accompany the physician.⁸³ In an effort to minimize costs to the physician and delays in scheduling, the MRC sought to minimize the number of meetings with physicians.⁸⁴

⁷⁹ College of Physicians and Surgeons of Ontario, Additional Material Requested by The Hon. Mr. Cory (October 2004), at 68.

⁸⁰ College of Physicians and Surgeons of Ontario, The Medical Review Committee: an Overview, (September 10, 2004) at slide 55.

⁸¹ College of Physicians and Surgeons of Ontario, Additional Material requested by The Hon. Mr. Cory (October 2004), at 40.

⁸² College of Physicians and Surgeons of Ontario, The Medical Review Committee: an Overview, (September 10, 2004) at slides 81-83.

⁸³ *Ibid.*, at slide 82.

⁸⁴ *Ibid.*, at slide 12.

Preliminary findings: The Panel attempts to reach consensus on preliminary findings regarding the code(s) that should have been billed for the services in question. If the physician's fee claims were in error, the MRC will specify the correct billing codes and extrapolate the result over the review period. A summary of the findings, and the reasons in support of the findings, is communicated to the physician and provided to OHIP. OHIP calculates the repayment amount in accordance with the MRC Direction.⁸⁵ The MRC provides the recalculation to the physician who must deliver any response within twenty working days.⁸⁶

Physician response: The physician can (1) request that the Panel reconsider its findings based on a written and/or oral submission; (2) agree, in writing, to pay the amount calculated; or (3) abandon, in writing, the attempt to achieve settlement, requesting that the matter enter the non-settlement process to be reviewed by another Panel of the MRC having no previous knowledge of the matter.⁸⁷

Reconsideration: On reconsideration, if the Panel amends its preliminary findings, it will request a new calculation of the repayment amount from OHIP and send it to the physician who must indicate, within twenty working days whether he or she accepts the new calculations.⁸⁸ The physician must also indicate, in writing, whether he or she agrees to pay the new amount.⁸⁹ If the physician does not agree to settle, the case is assigned to a new Panel, and it proceeds through the non-settlement process.

Settlement Agreement: If the physician agrees to repay the amount, the MRC drafts a settlement agreement, which includes the following terms: (1) the physician forfeits the right to appeal to the Health Services Appeal and Review Board ("HSARB"); (2) the physician agrees to pay applicable costs and interest; and (3) OHIP guarantees that it will not refer the physician to the MRC for the same service provided during the same period of time.⁹⁰ On execution of the settlement agreement, the MRC prepares a Final Direction, a copy of which is provided to the

⁸⁵ *Ibid.*, at slide 83.

⁸⁶ *Ibid.*, at slide 83.

⁸⁷ *Ibid.*, at slide 85.

⁸⁸ *Ibid.*, at slide 87.

⁸⁹ *Ibid.*, at slide 88.

⁹⁰ *Ibid.*, at slides 94-5

physician and the General Manager of OHIP.⁹¹ OHIP contacts the physician to arrange for payment.

15. Non-Settlement Process

If the physician elects not to pursue settlement, either following receipt of the inspection report or following an attempt at settlement the case enters the non-settlement process. This process largely mirrors the settlement process except that the Panel always meets with the referred physician.

Panel examines additional files: In a majority of cases, an additional list of 25 randomly selected examples of service is generated for each code under review and the physician is requested to bring to the meeting with the Panel the entire original patient chart for each of the patients.

Proposed direction: Following the interview, the Panel issues a Proposed Direction, setting out its findings, with reasons, and indicating what portion, if any, of the physician's accounts for the codes in the period under review are to be repaid. The Proposed Direction is sent to the physician and to OHIP, which calculates the repayment amount.⁹²

Physician's written submission: The physician may make one written submission in response to the Proposed Direction. The Panel reviews the submission, and advises the physician and the General Manager of OHIP regarding any amendments to the Proposed Direction.⁹³

Final direction: The Final Direction, reviewed and approved by the Panel members is issued.

16. Appeals

The physician may appeal to the Health Service Appeal and Review Board ("HSARB") from a final direction of the MRC, following a review (or a reconsideration of a review by a single member panel).⁹⁴ The General Manager of OHIP has no right of appeal.

⁹¹ *Ibid.*, at slide 96.

⁹² *Ibid.*, at slide 91.

⁹³ *Ibid.*, at slide 92.

⁹⁴ *Health Insurance Act*, *supra* note 5, at s. 20(1), (3). There is no appeal from a determination made by a single member of the MRC, but rather a right to have the determination reconsidered by a three-member panel.

Parties on the appeal: The physician, the General Manager of OHIP, and the MRC are parties on an appeal from a decision of the MRC.⁹⁵ The HSARB may add other parties to the appeal proceeding, as it considers appropriate.⁹⁶ In practice, the MRC responded to physician appeals. OHIP might or might not participate, depending on the issues arising in the case.⁹⁷

Procedure on appeal: The HSARB hears oral evidence, which is recorded. The Board is required to base its findings of fact on evidence that is admissible (or on matters that may be noticed) under section 15 or 16 of the *Statutory Powers Procedure Act*.⁹⁸ Parties are entitled to disclosure of any reports or documentary evidence that will be given in evidence.⁹⁹ Members of the HSARB panel must not have taken part in any prior consideration of the matter and must not communicate with the parties or their representatives except on notice to all parties.¹⁰⁰

Jurisdiction of HSARB: The HSARB may direct the General Manager to take such action as it considers the General Manager should take in accordance with *the HIA* and regulations,¹⁰¹ and is authorized to amend a direction issued by the MRC or the General Manager.¹⁰² The HSARB has no jurisdiction to deal with arguments of constitutional validity.¹⁰³

Order for security: The HSARB is authorized to make an order directing a physician to provide security for payment of all or part of the amount directed to be paid by the General Manager or the MRC, and may impose conditions it considers appropriate.¹⁰⁴

Appeal to the Divisional Court: Any party to the proceedings before the HSARB may appeal from its order to the Divisional Court.¹⁰⁵

⁹⁵ *Health Insurance Act*, s. 22(1), (2).

⁹⁶ *Ibid.*, s. 22(4).

⁹⁷ College of Physicians and Surgeons on Ontario, *The Medical Review Committee: an Overview* (September 10, 2004), at slides 97-100.

⁹⁸ *Health Insurance Act*, s. 22.

⁹⁹ *Ibid.*, s. 23(1).

¹⁰⁰ *Ibid.*, s. 23(2).

¹⁰¹ *Ibid.*, s. 21(1).

¹⁰² *Ibid.*, s. 21(1.0.1).

¹⁰³ See the text, *supra*, at note 46.

¹⁰⁴ *Health Insurance Act*, *supra* note 5, at s. 21(1.1), (1.2).

¹⁰⁵ *Ibid.*, s. 24.

17. Timelines of procedures

The MRC has developed procedural guidelines in an effort to increase the consistency and timeliness of its processes.¹⁰⁶ The MRC reports that the following factors result in delays: (1) receipt of a large number of referrals at the same time, (2) unavailability of inspectors, (3) arranging to inspect charts in institutional settings, (4) scheduling meetings for oral submissions, (5) awaiting written submissions when there are many services under review, (6) obtaining repayment calculations from OHIP, (7) obtaining the final letter from OHIP stating the results of the MRC review, (8) obtaining the executed settlement agreement documents, and (9) awaiting decisions on appeal to the HSARB which often take up to one year and also create delays in other matters that are held in abeyance pending resolution of an issue on appeal.

18. Sampling and Extrapolation

As I stated earlier, an MRC Inspector will conduct a review of 45 charts for each fee code under review, randomly selected by OHIP. An additional random sample of 25 charts for each fee code will be considered by the MRC when it meets with the physician. The purpose of the random samples is to provide the basis for an inference regarding the physician's claims under a specific fee code (or code combination) without having to review each claim.¹⁰⁷ The sample of records is used as the basis for estimating the percentage of incorrect claims and the total amount to be repaid. The results from the random samples are extrapolated across the total number of claims for each fee code.

Malcolm Griffin and Marshall Godwin, in their "Report on the Statistical Sampling Methods Used by the Ministry of Health and Long-Term Care in their Audits,"¹⁰⁸ concluded that the sampling method used by the Ministry will produce a random sample. However, the authors recommended that, at the request of a physician, a second random sample of 135 be added to the sample of 45, and that the calculations be based on the total sample of 180 records. Dr. Susan

¹⁰⁶ See College of Physicians and Surgeons of Ontario, The Medical Review Committee: An Overview, (September 10, 2004); Additional Material in response to a request by The Hon. Mr. Cory (October 2004), at 18-32.

¹⁰⁷ See S. Bondy, "Report to the CPSO/MRC regarding sample size calculations for billing audits" (July 2004).

¹⁰⁸ February 2004, included in Appendix 2 to the Submission of the Ministry of Health and Long-Term Care (July 2004).

Bondy, in a “Report to the College of Physicians and Surgeons of Ontario, Medical Review Committee with respect to Sample Size Requirements for Physician Billing Audits,”¹⁰⁹ concluded that Ministry sampling techniques were appropriate, but offered a number of potential options for reducing sampling error.

19. Repayment and Recovery by Set-off

The General Manager of OHIP is authorized to recover money that a physician owes to OHIP by set-off against money payable to the physician under the Plan.¹¹⁰ The recovery by set-off can be exercised even though it relates to a matter under review by the MRC or under appeal to the HSARB or Divisional Court.¹¹¹ OHIP advised that its policy is to collect repayment as quickly as possible and within twelve months. In exceptional cases, the recovery period is extended beyond twelve months, but only when the extension is justified by full financial disclosure.¹¹²

20. Costs

Until 1996, the Ministry paid the entire cost of an MRC review. Amendments to the *HIA* in 1996 (implemented in 1998) made the physician responsible for the cost of the review (and any reconsideration of a review) where (1) the General Manager’s decision is confirmed, (2) the physician is required to reimburse OHIP, or (3) the physician recovers less than he or she billed to OHIP.¹¹³ Costs were calculated in accordance with a complex formula prescribed by regulation.¹¹⁴ The effect of the onerous costs provisions established in 1996 was ameliorated by amendments in 2002 and 2004, which in effect provide for two full days of MRC deliberations without cost consequences to the physician.

The HSARB may award costs only where a party has acted unreasonably, frivolously, vexatiously or in bad faith, and only for the additional hearing time attributable to the

¹⁰⁹ S. Bondy, July 2004, *supra* note 107.

¹¹⁰ *Health Insurance Act*, *supra* note 5, at s. 27.2(1).

¹¹¹ *Ibid.*, s. 27.2(2).

¹¹² Ministry of Health and Long-Term Care, Submission (July 2004), at 15.

¹¹³ *Ibid.*, s. 18.1(15), (16).

¹¹⁴ O. Reg. 552, s. 38.2.2.

unreasonable conduct of the party.¹¹⁵

21. Interest

Interest is payable on the amount OHIP is directed to pay to a physician and on the amount a physician is directed to pay to OHIP.¹¹⁶ The rate is set by the Minister of Finance.¹¹⁷ Where a physician is directed to repay OHIP, interest is payable from the payment day that follows the end of the review period.

22. Publication

As the result of amendments to the *HIA* in 1996, the Ministry has authority to publish the names of those required to make repayments following a review (other than a review by a single member of the MRC from which no reconsideration is requested)¹¹⁸ No information can be made public until any appeal is finally determined.¹¹⁹ The decision to make information public is final and cannot be appealed.¹²⁰ The information which can be published includes: the name and specialty of the physician, the location where the physician practised when the services were provided and the location where the physician practices at the time of publication, the underlying facts (without revealing patient identities), the amount the physician is required to pay, and other information prescribed.¹²¹ The Ministry has refrained from exercising its statutory authority to disclose or publish information about physicians who are required to make repayments.

23. Confidentiality

Members of the MRC, the HSARB and their employees, as well as the General Manager and every person engaged in the administration of the *HIA* are required to preserve the confidentiality of information obtained in the course of their employment or duties and cannot

¹¹⁵ Health Services Appeal and Review Board, Rules of Practice and Procedure, rule 19, at <<http://www.hsarb.on.ca/english/rules/default.htm#rule19>>.

¹¹⁶ *Health Insurance Act*, *supra* note 5, at s. 18.1(14); Regulation 552, s. 38.2.1.

¹¹⁷ Ministry of Health and Long-Term Care, Submission (July 2004), at 15.

¹¹⁸ *Health Insurance Act*, *supra* note 5, at s. 18.1(18), (21).

¹¹⁹ *Ibid.*, s. 18.1(20).

¹²⁰ *Ibid.*, s. 18.1(19).

¹²¹ *Health Insurance Act*, *supra* note 5, at s. 18.1(18).

communicate such information except as otherwise provided in the Act.¹²² *The Personal Health Information Protection Act* (“PHIPA”), which takes precedence over the *HIA* in the event of any conflict, explicitly authorizes disclosure of personal health information to the Ministry for the purpose of determining payment for health care services. In addition, it provides for the disclosure of personal health information with an individual’s consent.

24. Educational Initiatives

The Ministry offers a number of educational programs and services to assist physicians to understand and comply with billing requirements, and is developing new programs. In addition, the MRC had developed materials, posted on a website, to explain the audit process.¹²³ Current programs and services offered by the Ministry include:¹²⁴

Resource Manual for Physicians: Available since 1999, the Resource Manual provides physicians with information about legislation, policies and Ministry Procedures. Subjects addressed include billing numbers, the Schedule of Benefits, submission of fee claims and the monitoring and control of physicians’ fee claims. The Manual is available on the Ministry’s website.¹²⁵

District Office Support: The Ministry reports that, since 1972, physicians have been able to contact their local district office (with access to a medical consultant) if they have questions about billing.

Ministry Bulletins: Since 1972, OHIP has provided a regular mailing to physicians when changes are made to the fee schedule or to fee codes. Other Bulletins explain billing policy or administrative changes in billing practice.

Physician Profile: Since 1976, OHIP has made available to physicians a profile providing a twelve-month summary of the physician’s claims together with some comparative data in relation to other physicians. The profile is available on request and subject to payment of a fee that, in 2004, was reduced from \$80 to \$16.

¹²² *Ibid.*, s. 38(1).

¹²³ College of Physicians and Surgeons of Ontario, Additional Material requested by The Hon. Mr. Cory (October 2004), at 71.

¹²⁴ See Ministry of Health and Long-Term Care, Submission (July 2004), at 14-15.

¹²⁵ <http://www.health.gov.on.ca/English/providers/pub/ohip/physmanual/physmanual_mn.html>

New Graduates Meeting: Until 2003, OHIP held annual meetings with residents at medical schools to introduce the OHIP system. The meetings were discontinued because of decreasing attendance.

Provider Education Program: The Ministry now identifies physicians who appear to be billing specific fee codes incorrectly or whose claims appear to be irregular in comparison with their peers. Through the Provider Education Program (“PEP”), the Ministry writes to these physicians, and provides them with educational materials and information designed to assist them in complying with billing requirements. Physicians may address questions to PEP in writing and obtain a written response.

Education and Prevention Committee: In July 2002, the Ministry and the OMA jointly established the Education and Prevention Committee (“EPC”) with the primary goal of educating physicians to submit appropriate fee claims, thereby reducing the need for audit and recovery procedures. The EPC has developed a number of educational initiatives, including (1) the provision of regular Interpretive Bulletins which provide advice and guidance to physicians on billing matters, (2) a program which enables a physician to inquire anonymously about material presented in the bulletins and receive a response from the Ministry through the EPC, and (3) a billing course which will be offered in 2005.

In addition, the EPC has recommended that the General Preamble of the Schedule of Benefits be re-written and reorganized, and is exploring the development of mini physician profiles as a tool for alerting physicians to potential billing problems.¹²⁶

25. Statutory Amendments from 1996 to 2002

I have been advised that physicians began to become concerned about the medical audit process in 1998. Their concerns, the responses made to those concerns, and my conclusions and recommendations are addressed in Part VI of this Report. Some of the changes giving rise to those concerns are referred to in the preceding description of medical audit practice in Ontario. A brief description of the relevant amendments and initiatives, in the period 1996-2002, follows:¹²⁷

¹²⁶ Ministry of Health and Long-Term Care, Submission (July 2004) at 14.

¹²⁷ Ministry of Health and Long-Term Care, Submission (July 2004), at 5-6.

Savings and Restructuring Act, 1996 (“SRA 1996”): The omnibus *SRA 1996* included a number of amendments to the *HIA* that affected the medical audit process, including:

- (1) providing for “direct recovery” provisions, which authorize OHIP to recover payments from a physician without hearing;
- (2) establishing an “application fee,” which really amounted to a deposit towards any repayment to OHIP, payable if the physician sought review of a direct recovery by the MRC;
- (3) providing for audits by a single member of the MRC (rather than a panel of three), either at the request of the physician or the General Manager of OHIP;
- (4) providing that interest accrues on any repayment resulting from an MRC audit, from a date to be prescribed by regulation;
- (5) requiring that the physician pay an additional amount towards the costs of an MRC audit, calculated in a manner to be prescribed by regulation;
- (6) authorizing the General Manager to publish information about the results of a review by a full panel of the MRC;
- (7) authorizing the General Manager to suspend payments to a physician who refuses to co-operate with an MRC audit; and
- (8) authorizing the General Manager to require a physician to submit his or her accounts directly to OHIP in circumstances where they would have billed the patient, so as to facilitate collection of a debt by set-off against future payments.

Regulation 475/98 implemented provisions of the 1996 amendments by prescribing:

- (1) the amount of the “application fee” payable by a physician requesting an MRC audit;
- (2) the method for calculating interest, specifying that interest accrues from the end of the period for which the physician’s services were being audited;
- (3) the method for calculating the costs a physician is required to pay, being the actual costs incurred by the Ministry and the MRC to conduct the audit.

Regulations 149/00 and 150/00, adopted following objections made by the OMA, ameliorated this onerous costs provision by:

- (1) excluding the costs of the Ministry and the MRC inspection costs;
- (2) basing the calculation on the number of days MRC members worked on the case;
- (3) reducing the calculation in cases where the physician had requested MRC review by the ratio of any reduction in the repayment that had been claimed by OHIP;
- (4) capping the cost contribution amount at 35% of the repayment amount;
- (5) excluding costs for the period in which the MRC was considering and agreeing to a successful settlement offer from the physician; and
- (6) specifying circumstances in which the General Manager could reduce the cost contribution amount, on the recommendation of the MRC.

In November 2001, a Joint Committee of the Ministry and the OMA, which had been established to review the MRC process recommended establishment of:

- (1) the OHIP Payment Review Program to provide physicians with an opportunity to resolve apparent claims irregularities prior to a referral to the MRC, and
- (2) the Education and Prevention Committee, to assist physicians to comply with billing requirements.

Appendix D to the 2003 Memorandum of Agreement between the Ministry and the OMA identified eight “MRC Initiatives,” which have now been implemented, including:

- (1) an expert review of the statistical methods used by the OHIP Payment Review Program;
- (2) amendments to reduce the “application fee” (deposit), (implemented in June 2003 by Regulation 256/03);
- (3) development of criteria as to when a security deposit can make a security deposit as an alternative to the Ministry setting off a portion of the physician’s OHIP payments towards the debt claimed by OHIP;
- (4) further revisions to the method for calculating the costs of an MRC review, excluding from the calculation any time spent by MRC members prior to an actual meeting with the physician and up to two days of time meeting with the physician (implemented in February 2004 by Regulation 5/04).

Pursuant to the *Government Efficiency Act, 2002*,¹²⁸ the legislature amended the *Ministry of Health Appeal and Review Act* to exclude from the HSARB any inquiry or decision concerning the constitutional validity of a provision of an Act or a regulation. The amendment thus removed from the HSARB (and the MRC) jurisdiction to consider any challenge to the legislation pursuant to the *Charter of Rights and Freedoms*.¹²⁹

Despite the progress in addressing some of the sources of physicians' concerns with the medical audit process, significant issues remained. Physician confidence in the fairness of the audit system had been eroded, leading to Government's decision in 2004 to establish this study and suspend the MRC audit process.

26. *Transitional Physician Payment Review Act, 2004*¹³⁰

The preamble to the 2004 legislation recognizes that, the Government, in consultation with the College, has retained me to "conduct a 'best practices' comparative analysis of medical audit systems and standards, to report back on any conclusions reached, and to make recommendations based upon those conclusions." Further, the preamble recognizes that, "pending the outcome of that report, confidence in Ontario's medical audit system may be enhanced by providing a transitional alternative audit process for physician accounts."

Transitional Physician Audit Panel: The statute amends the *Health Insurance Act* and the *Ministry of Health Appeal and Review Boards Act, 1998* to create a new tribunal to review decisions of the General Manager concerning physician fee claims. The physician and the General Manager of OHIP are the parties to the review.¹³¹ The Transitional Physician Audit Panel is a panel of the Health Services Appeal and Review Board, composed of six physicians, who are selected in consultation with the OMA and the College, and three lawyers.¹³² The members of the Panel do not otherwise sit as members of the HSARB.¹³³

¹²⁸ S.O. 2002, c. 18, Sched. I, s. 16.

¹²⁹ See the *Ministry of Health Appeal and Review Boards Act*, s. 6(3).

¹³⁰ S.O. 2004, c.13.

¹³¹ *Ibid.*, s.1 (adding s. 18.0.1 (5) to the *Health Insurance Act*).

¹³² *Ibid.*, s. 2 (adding s.7.1(1)-(5) to the *Ministry of Health Appeal and Review Boards Act, 1998*). A physician who has been reviewed by the MRC, or required to reimburse the Plan under the HIA, is not eligible to be appointed until at least ten years have passed.

¹³³ *Ibid.*, s. 2 (adding s. 7.1(5) to the *Ministry of Health Appeal and Review Boards Act, 1998*).

Procedures: Audit reviews must be conducted by a panel of three: two physicians and one lawyer.¹³⁴ The parties must exchange witness statements, summaries of evidence and copies of any documents that are proposed to be adduced at least fifteen days before the review.¹³⁵ No evidence or document that was not disclosed is admissible.¹³⁶ The review is to be conducted orally unless the General Manager of OHIP and the physician consent to the review being conducted electronically or in writing.¹³⁷ The Panel must render its decision within 45 days after the last day on which it heard evidence in the matter, unless the parties agree to an extension.¹³⁸

Powers: The Panel may give any direction that could have been given by the MRC under subsection 18.1,¹³⁹ but the Panel may not award costs.¹⁴⁰ If the Panel finds that an amount is payable by the physician, interest is payable from the date the account was paid by the Plan.¹⁴¹

Confidentiality: The Panel's reviews are closed to the public, and the confidentiality of health information is protected.¹⁴²

Appeal to Divisional Court: There is a right of appeal from the decision of a Transitional Physician Audit Panel to the Divisional Court, with provisions to protect the confidentiality of personal health information.¹⁴³

Suspension of matters pending before the MRC: Matters pending before the Medical Review Committee at the time the Act came into force are suspended unless the physician elects otherwise.¹⁴⁴ The physician may elect that the Transitional Physician Audit Panel hear the matter if it pertains to a review, pursuant to *HIA*, s. 18.1, of a determination by the General Manager to refuse or reduce payment for an amount billed to OHIP. The physician may elect that the General

¹³⁴ *Ibid.*, s. 2 (adding s. 7.1(6) 1. and 2. to the *Ministry of Health Appeal and Review Boards Act*, 1998).

¹³⁵ *Ibid.*, s. 2 (adding s.7.1(6) 7. to the *Ministry of Health Appeal and Review Boards Act*, 1998).

¹³⁶ *Ibid.*, s. 2 (adding s.7.1(6) 8. to the *Ministry of Health Appeal and Review Boards Act*, 1998).

¹³⁷ *Ibid.*, s. 2 (adding s.7.1(6) 10. to the *Ministry of Health Appeal and Review Boards Act*, 1998).

¹³⁸ *Ibid.*, s. 1 (adding s. 18.0.1 (4) to the *Health Insurance Act*).

¹³⁹ *Ibid.*, s. 1 (adding s. 18.0.1 (6) to the *Health Insurance Act*).

¹⁴⁰ *Ibid.*, s. 2 (adding s. 7.1(6) 4. to the *Ministry of Health Appeal and Review Boards Act*, 1998).

¹⁴¹ *Ibid.*, s. 1 (adding s. 18.0.1 (7) to the *Health Insurance Act*).

¹⁴² *Ibid.*, s. 2 (adding s. 7.1(6) 5. & 6. to the *Ministry of Health Appeal and Review Boards Act*, 1998).

¹⁴³ *Ibid.*, s. 1 (adding s. 18.0.1(10) to the *Health Insurance Act*).

¹⁴⁴ *Ibid.*, s. 1 (adding s.18.0.2. to the *Health Insurance Act*).

Manager of OHIP determine any matter that pertains to a review, pursuant to *HIA*, s. 39.1, of the provision of insured services provided by the physician (which may specify the type of services and the period during which they were provided). Where the physician elects not to suspend a matter, no conclusion, decision or deliberation of the MRC, whether of a preliminary, draft or final nature, is admissible in any subsequent review, proceeding or appeal.¹⁴⁵ If the physician makes no such election and a suspension applies in respect of a request for reconsideration, no interest is payable during the suspension.¹⁴⁶

Suspension for failure to co-operate continues: Where a physician had failed to co-operate with an inspector as of June 21, 2004, and his or her payments from OHIP had been suspended pursuant to *HIA*, s.40.2(6), the suspension remains in effect until such time as the physician complies.¹⁴⁷

Appeals from MRC continue: Appeals from decisions of the MRC to the HSARB and the Division Court are not suspended, and the General Manager of OHIP may elect to stand in the place of the MRC as a party to an appeal.¹⁴⁸

The serious concerns and problems that led the Legislature to suspend the MRC and replace it with the Transitional Physician Audit Panel are considered in Part VI of my Report.

¹⁴⁵ *Ibid.*, s. 1 (adding s. 18.0.1 (5) to the *Health Insurance Act*).

¹⁴⁶ *Ibid.*, s. 1 (adding s. 18.0.1 (9) to the *Health Insurance Act*).

¹⁴⁷ *Ibid.*, s. 1 (adding s. 18.0.2. (11) to the *Health Insurance Act*).

¹⁴⁸ *Ibid.*, s. 1 (adding s. 18.0.2. (10) to the *Health Insurance Act*).

PART V. MEDICAL AUDIT PRACTICE IN OTHER JURISDICTIONS

In accordance with the Terms of Reference, I have examined “the legislative framework, practices and procedures used in other provincial jurisdictions, and, where beneficial, other publicly funded health insurance regimes.”

These jurisdictions differ substantially in population, numbers of physicians, geography, and health care systems. They also differ in the nature of the relationships between their governments and physician organizations, and the relationships of physicians themselves with government and with their physician organizations. As a result, none of these other medical audit systems should be slavishly followed in Ontario. Yet they demonstrate that there are different ways of approaching the challenge of encouraging compliance with billing requirements and conducting audits to test that compliance. Each jurisdiction must be reviewed and carefully considered in the course of determining the best method of auditing that should be utilized in Ontario.

What follows is a summary of the audit systems in the other Canadian provinces,¹⁴⁹ and in three relevant foreign jurisdictions (Australia, New Zealand and Medicare in the United States of America). The summaries of other Canadian jurisdictions are presented first, in alphabetical order, followed by the foreign jurisdictions. In each case, the summaries are current to the fall of 2004.

Some of these systems are complex, and I have not summarized every aspect of every jurisdiction. Rather, I have outlined features that are relevant to this study. For those who wish to examine one or more jurisdictions in greater detail, I have provided references in the notes. In addition, in Appendix 9, I have provided citations for the relevant statutory materials and the web pages where they can be found.

¹⁴⁹ I have also reviewed the medical audit processes in the Yukon, Northwest Territories and Nunavut, but have not included them in this summary. There is great disparity between Ontario and these jurisdictions in terms of population, numbers of physicians and circumstances. Accordingly, these jurisdictions are of limited assistance in this study.

1. Summary of Medical Audit Practice in Alberta¹⁵⁰

Grounds for assessment of fee claims: The Alberta Minister of Health and Wellness may reassess fee claims on the following bases:

- (1) an error has been made in the information provided by the physician to support a fee claim or the assessment of the fee claim by the Ministry;
- (2) the frequency of a medical service cannot be justified;
- (3) the physician was paid more for a service than was warranted; or
- (4) the service provided was not medically required.

Basis for initiating an audit: The Compliance and Quality Assurance Section (“CQA”) of the Ministry may initiate an audit in response to

- (1) complaints received from patients, physicians, staff members, or others;
 - (2) variation between the physician’s billing profile and the average profile for Alberta physicians in the same specialty, type of practice (clinic or solo) and geographical setting (urban or rural) with regard to the total amount claimed, surcharges and call backs, average cost per patient, total number of services and average number of services per patient;
 - (3) concerns about utilization rates for specific fee codes or by specific groups of physicians;
- or
- (4) patient responses to random letters seeking verification as to whether services were actually provided.

Initial Investigation: If a review of the physician’s charts is required, a nurse consultant performs the first review with a billing officer and consults with the medical consultant only if assistance is required. Generally, charts from the previous two years are reviewed. In the event that no anomalies are found, no further action is taken. Any issues that arise with respect to the quality of care or professional ethics are referred to the College of Physicians and Surgeons of Alberta.

¹⁵⁰ *Alberta Health Care Insurance Act*, R.S.A. 2000, c. A-20, in particular s. 18 and s. 49; *Medical Benefits Regulation*, A.R. 173/93; Alberta Health and Wellness, “Claims Reassessment Process,” Bulletin Med 87. February 20, 2004.

Notice to, and Consultation with, the Physician: If billing anomalies are found, notice is given to the physician, who may provide an explanation in writing. If the anomalies are resolved after a discussion with the physician, no further action is taken.

Report and Disclosure: If the concerns are not resolved, the review team prepares a report setting out a summary of its findings, summarizing the evidence, identifying the possible grounds for reassessment, noting the circumstances the Minister must consider pursuant to statute and assessing whether the matter is eligible for review by the Peer Review Committee. A copy of the report is provided to the physician.

Referral to the Peer Review Committee: If the issues are within the jurisdiction of the Peer Review Committee (“PRC”), either the physician or the CQA may refer the matter to the PRC. In the absence of a referral to the PRC, or if the PRC declines jurisdiction, the physician may forward submissions to the Minister’s Delegate (that is, the Director of the Innovation and Monitoring Branch). The Minister’s Delegate considers the CQA Report and the physician’s submissions, and determines the amount of any reassessment of fees paid to the physician. Where possible, the Minister’s Delegate issues a decision within thirty days.

Peer Review Committee (Alberta Medical Association):

Composition: The PRC is composed of five licensed physicians appointed by the Board of the Alberta Medical Association. As of October 2004, the PRC was composed of an internist/cardiologist, a general surgeon, two family physicians (urban and rural) and an anesthetist. The PRC may consult with specialists in other fields.

Role: The PRC advises the Minister on medical practice issues which may affect the fee claims in dispute, including normal patterns of practice, accepted standards of practice or reasonable compensation for the services provided. The PRC does not have jurisdiction in relation to calculation errors, issues that have already been decided, or issues that are under consideration by other committees.

Process: The PRC operates informally and establishes its own procedures. The physician is entitled to attend in person or be represented by an agent or counsel at the physician’s expense. Members of the staff of CQA may be requested to attend. The PRC

receives the CQA report and documents. If the physician wants to submit new information, the PRC adjourns and refers the information to the CQA for consideration and report.

Witnesses are not sworn and there is no cross-examination. The PRC listens to submissions and asks questions. It may seek advice from legal and medical experts. The physician may also present opinions of experts. Minutes are kept of PRC decisions, but the proceedings are not recorded. The PRC has as its goal the completion of its review within sixty days of the referral. Fourteen days after the PRC review is completed, a written report is sent to the Minister's delegate and to the physician.

Physician response to PRC report: Upon receipt of the PRC report, the physician has fourteen days in which to make a submission to the Minister's Delegate.

Minister's Delegate, Final Decision: The Minister's Delegate reviews the report from CQA, the report or recommendation (if any) made by the PRC and any response made by the Physician, and decides whether or not to reassess the physician. The Minister's Delegate is not required to adopt the report or recommendations of the PRC, but assesses the matter in accordance with the statutory criteria. If no reassessment is made, the physician is so advised by the Ministry. Where possible, the Minister's Delegate issues the decision within thirty days of receiving the reference.

Appeal to Court of Queen's Bench: Within sixty days of receiving any notice of reassessment, the physician may appeal to the Court of Queen's Bench.

PRC Referrals and Annual Reports: The PRC may refer an issue to the Schedule of Medical Benefits Committee so that it may consider the need for an amendment to the Schedule. In addition, the PRC reports annually to the AMA and the Ministry. These referrals and annual reports are edited so as not to disclose the identities of physicians or patients.

Recovery of amounts owing: Generally, no recovery is made until the Minister's Delegate makes a final decision. However, in extenuating circumstances (if, for example, the physician is not accredited to provide the claimed service), early direct recovery will be implemented. The amount of any reassessment is a debt owing to the Minister and may be recovered by action or by set-off against payments owing to the physician for insured services. There are special provisions regarding physicians practicing as professional corporations.

Costs: The physician is not required to pay either fees or costs of proceedings before the CQA, the PRC, or the Minister's Delegate.

Interest: The Minister may charge or pay simple interest on amounts owing at a rate determined by the Minister but not to exceed eight percent. Interest runs from the date the "service was made".

Education: The AMA reports to members, through its newsletters, on billing code issues and audit process developments. As discussed above, the PRC periodically reports to the AMA. From time to time, members of the PRC are requested to participate in presentations to physicians concerning fee billing and audits.

2. Summary of Medical Audit Practice in British Columbia¹⁵¹

The Medical Services Plan ("MSP"): British Columbia's health insurance system, the Medical Services Plan (MSP), is established pursuant to the *Medicare Protection Act*. The purpose of the Act is "to preserve a publicly managed and fiscally sustainable health care system for the residents of British Columbia." The MSP processes more than 67 million fee-for-service claims annually, worth almost \$2.5 billion. Approximately 85% of these claims are from physicians; the remaining 15% are from other health care practitioners. Administrative costs are approximately \$24.3 million, or 1% of total expenditure.

The Medical Services Commission ("MSC"): The Medical Services Commission ("MSC") manages the MSP on behalf of the Government. It is a tripartite, nine-member statutory body

¹⁵¹ *Medicare Protection Act*, R.S.B.C., 1996, c. 286; *Medical and Health Care Services Regulation*, B.C. Reg. 426/97; British Columbia Ministry of Health Services, Submission to the Hon. Mr. Cory (March 2005); 2001 Working Agreement between the Government of British Columbia and the Medical Services Commission and the British Columbia Medical Association; B.C.M.A., "Patterns of Practice Mini-Profile 2001;" David J. Fairbothams, Report on Post-Implementation Review – ACG Software, Ministry of Finance, fieldwork completed May 2003; Edward J. Mansfield, Ph.D., Medical Services Plan Statistical Sampling Practices used in audits of medical practitioners: A guide for audit hearing panels, Arthur Anderson, August 2000; Ministry of Health Services, Billing Integrity Program, "Policy and Procedures Manual," August 22, 2003; Robert Reid, Lorne Verhulst, and Christopher B. Forrest, "Comparing Apples with Apples in Clinical Populations: Applications of the Adjusted Clinical Group System in British Columbia," Healthcare Management Forum, undated; Dr. Graham E. White, "Auditing Doctors' Practices," BC Medical Journal, vol. 45:10, December 2002, at 523-24; Interviews with Senior Manager, Billing Integrity Program, July-August 2004 and with a representative of the Patterns of Practice Committee, September 2004.

composed of three representatives appointed by the Government of B.C., three representatives appointed by the B.C. Medical Association (“BCMA”), and three public representatives jointly nominated by the Government and the BCMA. This tripartite structure is designed to ensure that the government, physicians and residents of the province all have a voice in the administration of the MSP.

The Billing Integrity Program (“BIP”): In 1997 the MSP established the Billing Integrity Program (“BIP”) to coordinate processes for service verification, audit, legal and recovery processes. The BIP has primary responsibility for screening and investigating billings and reviewing patterns of practice. Its mission is to detect and deter inappropriate billings and patterns of practice, and recover amounts inappropriately billed to the MSP.

Audit and Inspection Committee (“AIC”): Pursuant to s. 36 of the *Medicare Protection Act*, the MSC has delegated the powers of inspection and audit of physicians to the Audit and Inspection Committee (“AIC”). The AIC is a four-member Committee, composed of three physicians (one from each of the BCMA, the College of Physicians and Surgeons of British Columbia (“the College”), and the Government) and one member of the public. The AIC authorizes audits of physicians’ services and billing practices, reviews all audit reports and makes recommendations to the MSC as to whether recovery of funds should be pursued.¹⁵²

Patterns of Practice Committee (“PPC”): The PPC is a tripartite advisory committee to the MSC, composed of three representatives of the BCMA, one representative of the College, and one representative of government. The mandate of the PPC is to educate physicians in matters pertaining to their patterns of practice and billings and to advise the MSC on the audit process. The Committee provides an annual statistical profile in summary form (a “mini-profile”) to each practicing fee-for-service physician in the Province. The distribution of mini-profiles heightens awareness among physicians that their fee claims are monitored. It also generates inquiries that may lead to improvements in billing. Most important, it supports compliance with billing requirements by educating physicians regarding their own billing patterns and how they compare with those of their peers.

¹⁵² From <http://www.healthservices.gov.bc.ca> (retrieved July 26, 2004).

The PPC also provides advice to the MSP concerning inappropriate billing, the appointment of inspectors, screening and audit criteria and the dispute resolution process. The involvement of the BCMA is intended to maintain physicians' confidence in all aspects of the Billing Integrity Program.¹⁵³

Guidelines and Protocols Advisory Committees: The Guidelines Committee was established by the MSC to coordinate the development and implementation of guidelines and protocols concerning the effective use of medical resources. Members include representatives of the BCMA and the MSP.

Grounds for assessment of fee claims: A fee claim can be recovered if the service was not rendered, if the nature or extent of the service was misrepresented, or if there is an unjustified discrepancy between the physician's billing patterns and those of the physician's peers.

Basis for initiating an audit: Most billing errors are identified through a computerized screening process that rejects claims and returns them to a physician's office for correction and resubmission. Some services that have been incorrectly billed pass through the prepayment screen and are paid by the MSP. When inappropriate billings are detected, an audit may be initiated. BIP may detect inappropriate billings through service verification audits, comparison of physician profiles, complaints, referrals from the College, and other statistical tools.

Service Verification Audit: MSP makes two types of inquiries to verify whether a service was rendered and, if so, the nature of the service. First, MSP conducts random monthly audits: It mails 50,000-75,000 questionnaires to patients for whom claims have been submitted within the previous four months. Patients are selected randomly from claims submitted by physicians. There are ten to twenty services that are excluded from the survey because of their sensitive nature (for example, abortion and psychiatric services). Second, MSP conducts select service audits. It sends more specific verification questionnaires to 100-200 patients of a physician who is under investigation for possible billing irregularities. A select service audit may focus on specific types or dates of service.

¹⁵³ Billing Integrity Program, *Policy and Procedures Manual*, Section 3: Committees, August 2003.

Complaints: The BIP investigates complaints from a number of sources, including the PPC, the College, physicians and their staff members, and members of the public. If such an investigation generates concern about billing irregularities, an audit may be initiated.

Physician Profiles and Peer Comparisons: An automated computer screening process compares each physician's annual billing profile to the profiles of physicians in the appropriate peer group. The profile summarizes the services, patients and costs of claims paid to the physician or referred by the physician to other physicians and facilities. The profiles also summarize the total claims experience of the patients seen by the physician. It thus places the physician's payments in the overall context of the patients' (as a group) total medical services and costs. When a physician's billing profile deviates significantly from the profiles of others in the peer group, the matter is reviewed and investigated further. The purpose of the investigation is to determine whether or not the deviation is justified.

Case-mix Adjustment¹⁵⁴: In 1997, MSP began adjusting physician profiles to take account of age and gender differences in a physician's panel of patients that might justify a deviation in the physician's profile. The adjustment addresses the danger that a physician will be identified for investigation because of high-billings when, in fact, his or her billings are justified by a different mix of patients.

In 2000, MSP refined its approach and began adjusting physician profiles on the basis of the case-mix (disease severity) in the physician's panel of patients, which provides more accurate results than adjusting only for age and gender.

Since 2001, the MSP has used the adjusted clinical group ("ACG") case-mix adjustment system, which accounts and adjusts for patient-mix and morbidity factors which could justify higher per-patient costs. The ACG case-mix adjustment software assigns individuals to illness categories based on all the diagnoses they receive over an extended period of time. It takes account of the severity of particular illnesses as well as the number and complexity of co-morbid conditions. ACGs have been extensively evaluated in the United States and are now considered the gold standard case-mix adjustment method for physician profiling¹⁵⁵. To the extent that ACG

¹⁵⁴ See L. Verhulst, R. Reid, and C. Forrest, "Hold it – my patients are sicker!: The importance of case-mix adjustment to practitioner profiles in British Columbia", (2001) 43:6 *B.C. Medical Journal* at 328-33.

¹⁵⁵ *Ibid.*, at 331. See also, Robert J. Reid, Lorne Verhulst and Christopher b. Forrest, "Comparing Apples with Apples in Clinical Populations: Applications of the Adjusted Clinical Group System in British Columbia", *Health Care Management Forum* (2002) Summer 15(2) at 11-16.

case-mix adjustment software provides more accurate screening, it may (1) protect physicians from unnecessary and disruptive audits and (2) provide more useful comparative information to physicians.

Other Statistical Screening Tools: The BIP is adopting an issue-based approach to screening by designing specific *ad hoc* projects and analytic models to examine practitioner statistical information, including fee codes, particular specialties or types of services. The BIP also generates daily distribution statistics to examine the number and type of services rendered by physicians on a daily basis.

Investigation: Where concerns arise about a physician's billings, the BIP may review the physician's profile in the context of his or her long-term patterns of practice, and may conduct a further investigation, which normally focuses on over-servicing (rendering more services than are clinically required) or mis-billing (substituting fee items not consistent with the actual service rendered). The physician is compared with a peer group. The Patterns of Practice Committee may be consulted to ascertain whether the variations appear to be clinically justified. In most cases, the BIP will contact the physician for an explanation.

On-Site Audits – Audit and Inspection Committee: If the billing issue cannot be resolved without further information, it may be necessary to conduct an on-site review of the relevant clinical records. The inspection cannot proceed unless it is authorized by the AIC.

Authorized audits are conducted by physician inspectors¹⁵⁶ appointed by the AIC from a list of physicians jointly recommended by the College and the BCMA. The AIC develops guidelines for inspections, inspectors and inspection reports. Staff members from the BIP, and also from the Ministry of the Attorney General, conduct information and training sessions for inspectors.

Audit Reports: When an on-site audit has been completed, a comprehensive audit report is prepared, providing detailed information on the conduct and findings of the audit investigation.¹⁵⁷

¹⁵⁶ *Medicare Protection Act*, s. 36(3) provides that medical records may be inspected only by an inspector who is a medical practitioner.

¹⁵⁷ Ministry of Health Services, "Billing Integrity Program Policy and Procedures Manual," Sample Audit Report, August 22, 2003.

The AIC reviews the report and determines either that the case should be closed or that it should be referred to the MSC with recommendations for further action.

The audit report and a quantification of any amount of potential recovery are provided to the physician. The physician is given an opportunity to discuss settlement and to provide any further information or explanation that might assist in resolving the matter. If the parties are unable to negotiate a settlement, the MSC, through its legal counsel, notifies the physician of its intention to convene an audit hearing panel.

Alternative Dispute Resolution: The ADR process is intended to encourage a co-operative, non-adversarial climate, achieve flexible, fair and appropriate settlements, and avoid the financial, psychological and procedural costs associated with formal audit hearings. A negotiated or mediated settlement may be reached at any time before the date set for hearing.

Formal Audit Hearing: The *Medicare Protection Act* provides that a physician has a right to a hearing before an order is made for recovery of fees or for “de-enrollment” from the MSP.¹⁵⁸ In practice, very few matters proceed to a formal audit hearing.

Composition of Panel: The MSP appoints an Audit Hearing Panel (“AHP”) to conduct a formal audit hearing. The AHP is composed of three or five members: one government representative, one public representative and either one or three BCMA representatives. They are selected by rotation from a roster of panel members. The panel typically will include at least one physician from the same specialty or sub-specialty as the audited physician. The government representative is a lawyer and acts as the Chair.

Conduct of Hearing: The AHP is a quasi-judicial body and the hearing is governed by the rules of natural justice. The physician’s legal representative is provided with full disclosure of the MSC’s case as soon as possible after the notice of hearing is issued. The physician and the MSC are generally each represented by counsel and witnesses give evidence under oath.

Powers: By Order, the AHP may require the physician to compensate MSP for inappropriate billings or referrals or require the physician to adopt an appropriate pattern of practice. If it is determined that the physician cannot provide proper care or is guilty of serious

¹⁵⁸ *Medicare Protection Act*, ss. 15, 37.

violations such as fraud, the AHP may cancel the physician's enrollment in the MSP, or restrict the physician's ability to bill MSP.¹⁵⁹

Extrapolation: Repayments may be calculated using extrapolation, based on unit sampling methodology, which is used in financial accounting. I am advised that a sampled service is traced back to the patient to whom it corresponds, and that all claims arising from that patient are reviewed. This method may involve reviewing 1,000-3,000 services relating to 40-60 patients. The BIP aims for a 90-95% confidence interval in extrapolated results.¹⁶⁰

Repayment: Repayment arrangements may permit the physician to repay monies owing in installments or by set-off. Set-off arrangements occur when a specified amount of money is deducted from monies owing to a physician and applied to the physician's outstanding debt.¹⁶¹

Interest: As of July 2002, amounts of money that a physician is ordered to repay or agrees to repay are subject to a surcharge of 5%. They are also subject to interest on the amount, charged from the last day of the audit period to the date of the order, compounded semi-annually at a rate equal to the government's prime lending rate.

Costs: The AHP has jurisdiction to award costs against the physician.¹⁶² In light of the decision of the Court of Appeal in *Roberts v. College of Dental Surgeons of B.C.*,¹⁶³ costs are calculated in accordance with the tariff in the Supreme Court Rules. The tariff does not include the audit costs, or *per diem* compensation for the AHP panel members.

Publication: The findings of the AHP, including the name of the physician, may be published without the consent of the physician.¹⁶⁴

Appeals: An appeal of a MSC Order may be made to the Supreme Court of British Columbia within thirty days of the date of the Order.

Education Initiatives: MSP takes a number of steps to educate and assist physicians to comply with billing requirements and avoid an audit:

¹⁵⁹ *Medicare Protection Act*, s. 15.

¹⁶⁰ Information provided by Beverly Romeo-Beehler, Senior Manager, Billing Integrity Program, Ministry of Health Services, British Columbia.

¹⁶¹ *Medicare Protection Act*, s. 30.

¹⁶² *Ibid.*, s. 37(8).

¹⁶³ (1999), 63 B.C.L.R. (3d) 116 (C.A.)

¹⁶⁴ *Medicare Protection Act*, s. 49.

Physician mini-profiles are distributed to physicians annually and free of charge.

MSP Annual Profile and Guide to Interpretation: For a nominal fee, physicians may purchase a copy of their detailed profile, which is identical to the profile used by BIP investigators. The accompanying guide assists in interpreting the statistical data in the profile.

MSCommuniqué informs physicians of legislation, policy and protocols that directly affect physicians' practice and billing under the Medical Services Plan.

Physicians' Newsletters and MSP Bulletins provide current information for physicians on MSP administration and operations, including new and changed procedures, billing rules, programs and services. The articles also clarify issues such as what records need to be maintained and communicate case findings.

Medical Services Plan Resource Manual for Physicians provides information on governance of the MSP, enrollment, billing processes, and monitoring procedures.

Medical Services Plan Report on Audit and Investigation reports on audit and inspection activities undertaken through the Billing Integrity Program and includes decisions rendered by the Hearing Panels as well as details of settlements between physicians and the MSC.

The Medical Services Commission Financial Statement contains an alphabetical listing of payments made to physicians and other health care practitioners, groups, clinics, hospitals and diagnostic facilities for each fiscal year.

The Ministry's Billing Support Unit assists with billing, answers questions about benefits and payment schedules, and handles adjudication of disputes.

MSP Tutor is an on-line, self-directed learning program that was developed to assist physicians and medical office staff in understanding how to bill claims correctly. The program consists of a number of modules that contain important information for billing specific services to the MSP. There is a self-evaluation test at the end of each module.

Guidelines and Protocols, developed under the authority of the Guidelines and Protocol Advisory Committee, provide current information to physicians and others.

3. Summary of Medical Audit Practice in Manitoba¹⁶⁵

In 1993, Manitoba Health (MH), the Manitoba Medical Association (“MMA”) and the College of Physicians and Surgeons of Manitoba, entered into an agreement (as authorized by the *Health Services Insurance Act*) to establish the medical audit review process.

Basis for initiating an audit: An audit may be initiated in response to:

- (1) complaints received about the physician;
- (2) variations between the physician’s patterns of practice and the norm; or
- (3) investigation by Manitoba Health of a particular billing code, service, or group of physicians.

Manitoba Health – Audit Investigation Unit: The physician is contacted by an auditor and asked to provide copies of selected charts. On the basis of the chart review, MH forms an opinion about the validity of the physician’s fee claims, which is communicated to the physician. The physician, either in person or represented by the MMA or the Canadian Medical Protective Association (“CMPA”), may seek to resolve the matter with MH. If the matter is resolved, the file is closed, with the likelihood that the physician will be subject to subsequent verification audits. If no settlement is reached, the matter is referred to the MRC.

Medical Review Committee (“MRC”):

MRC Composition: The MRC is composed of seven members (six physicians and one layperson). Three members are appointed by, but are not accountable to, the MMA. Manitoba Health appoints three members and these usually include the lay member. The College appoints one member, who usually serves as Chair. The physician members must be in full-time active practice. The members are appointed for terms of up to five years. Members are compensated on a *per diem* basis.

MRC Mandate: The MRC must meet at least monthly. Its mandate extends to:

¹⁶⁵ *Health Services Insurance Act*, C.C.S.M., c.H35, ss. 76-84.2, s. 95.1; *Medical Services Insurance Regulation*, Man. Reg. 49/93; Agreement between the Manitoba Health Services Commission, the Manitoba Medical Association and the College of Physicians and Surgeons of Manitoba, January 4, 1993; Manitoba Health, Manitoba Medical Review Committee, Process for Review of Patterns of Practice, June 7, 2004; Manitoba Medical Association, “Questions about fee-for-service claims?” Bulletin, undated.

- (1) determining whether the physician's pattern of practice departs unjustifiably from the average;
- (2) the conduct of hearings with respect to disputes between physicians and MH on billing matters in accordance with protocols established in the Physicians' Manual;
- (3) at the request of MH, investigating and making recommendations on disputes between a physician and MH that do not fall within the process outlined in the Physician's Manual;
- (4) providing advice to MH on the medical interpretation of insured services and on any exclusions from those insured services; and
- (5) reviewing patterns of practice. If the MRC determines that a physician's pattern of practice deviates from a pre-determined statistical "norm," the MRC refers the matter to MH for investigation.

MRC annual review of practice patterns: As part of its billing monitoring function, the MRC identifies groups of physicians on the basis of specialty, type of practice and location of practice, and compares their individual billing patterns with the norms established for the group. Cost per patient is adjusted to take into account the age and sex of patients.

Physicians whose billing patterns have been reviewed and accepted for two consecutive years are manually excluded from the following year's review. If there is a letter on file that satisfactorily explains a physician's deviation from the norm, the deviation is accepted. The data is reviewed in four steps:

- (1) **Chi-square statistic:** This process selects physicians for review based on a departure from a bloc number of rendered and referred services per 100 patients. For each physician a calculation is made of the total number of rendered and referred services per 100 patients in each National Grouping Code ("NGC"). For each bloc of practice or group of physicians, a calculation is made of the total number of rendered and referred services per 100 patients. The statistics are ranked from highest to lowest within each bloc. The MRC reviews the patterns of practice of the top 16% physicians in each bloc.
- (2) **Cost of deviation:** This process identifies physicians for audit based on a deviation from the bloc cost per patient. Physicians whose deviation is \$60,000 or greater are reviewed by the MRC. The cumulative deviation is calculated by subtracting the bloc cost per patient (adjusted for age and sex of patients) from the physician's adjusted cost per patient, and multiplying the difference by the total number of patients treated by the physician.

(3) **Special request runs:** Every second year, physicians with a sub-specialty are manually grouped and reviewed.

(4) **Top Ten Review:** The ten physicians who have submitted the highest number of fee claims for selected high volume tariffs are identified for verification.

MRC powers to investigate: The MRC may investigate when it appears that a physician's pattern of practice deviates from that of physicians who, in the opinion of the MRC, practice in comparable circumstances. The MRC may request additional information, review patient charts, ask the physician to provide a written explanation or request a meeting with the physician. If the physician refuses to produce material, the MRC may summarily apply *ex parte* to the Court of Queen's bench for their production.

MRC powers following an investigation: The MRC may

- (1) determine that the physician's practice does not deviate unjustifiably from the peer group and that no further action is required;
- (2) determine that the physician's practice does deviate unjustifiably from the peer group, in which event, the physician may enter into a settlement with MH, or, if no settlement is reached, the matter is referred to the Formal Inquiry Committee ("FIC").

The MRC's reasons for decision are provided to the physician and to MH.

Formal Inquiry Committee ("FIC")

Composition: The FIC is composed of three physician members, one appointed by MH, one appointed by the College and one appointed by the MMA. The appointments are for a term of three years, which may be renewed for one further term. Government pays the members' compensation. No member of the MRC (past or present) can be a member of the FIC. The quorum of FIC consists of all three members.

Notice and Disclosure: The FIC may determine its own practice and procedure. It must issue notice of a hearing to the physician, the Minister and the MRC, thirty days prior to the hearing date. Notice must include the date, time and place of the hearing, and specify the matters for hearing. MRC must provide any information or material in its possession that the FIC requests and the FIC must provide the Minister and the physician with an opportunity to examine any information or material it receives.

Parties: The MRC, the physician and the Minister are parties to the FIC hearing.

Procedure: At the formal hearing, each party may be represented by counsel. The FIC may compel witnesses to testify and produce records. Witnesses are examined and cross-examined and submissions are made. The proceedings are recorded and a transcript is produced.

Findings and orders: The FIC may find that the pattern of practice either does or does not depart unjustifiably from the average pattern of practice to which the physician's billing pattern has been compared. The FIC may dismiss MH's claim or order the physician to repay a specified amount to MH.

Recovery of amounts owing: Any amounts determined to be owing to MH by the physician are considered a debt owing by the physician to the government. MH may recover these amounts by action, or by set off against other payments due to the physician.

Interest: If the physician does not pay the amount owing within thirty days, interest accrues at the rates defined by the legislation.

Costs: The FIC may order the physician to pay all or part of the costs of the investigation and of the hearing.

Referral to the College: Any matter that poses a potential risk to members of the public is referred to the College of Physicians and Surgeons of Manitoba.

Confidentiality: All audit proceedings are confidential, but the MRC, FIC or MH may communicate information to the MMA and College.

Appeals: Either MH or the physician may appeal the decision of the FIC to the Court of Appeal. The appeal is based on the record of proceedings before the FIC. The Court may make any decision that it considers should have been made. It may quash, vary or confirm the FIC order, or refer the matter back to the FIC for reconsideration. An appeal does not operate as a stay of the FIC order.

Education: MMA publishes newsletters every second month and devotes two pages of each issue to billing matters. All MRC decisions are disclosed to physicians. MMA regularly presents seminars on billing matters.

4. Summary of Medical Audit Practice in New Brunswick¹⁶⁶

The New Brunswick Department of Health and Wellness (Medicare) governs the medical services payment plan and audit process, and has created a Medicare Practitioner Unit to monitor and review physicians' billing patterns. A physician must submit a fee claim within three months of providing the service. At the time a claim is received, Medicare assesses it and determines whether to issue payment. A fee claim may also be reassessed after it has been paid. A physician who submits accounts for payment must agree to retain documents relating to a fee claim for seven years and to permit an audit of his or her books and records.

Grounds for assessment of fee claims: Physician's fee claims are assessed to determine whether the quality of service provided met a minimum acceptable level, whether the service was medically required, and whether the physician properly applied the fee schedule in billing for the service.

Basis for initiating an audit: Information that raises concerns leading to initiation of an audit may be obtained from:

- (1) physician inquiries to Medicare;
- (2) medicare checks to ensure compliance with revised billing guidelines;
- (3) complaints from other physicians, patients, staff members or others;
- (4) regular reviews of billing patterns of physicians in certain specialty groups;
- (5) failure to produce patient records verifying that a service was provided;
- (6) responses from patients to letters requesting verification that services were provided; or
- (7) irregularities in a physician's billing patterns.

Physician Profiles: Each year, the Audit Department undertakes comprehensive profiling of a specialty group that is sent to members of the group. Each physician receives an annual profile of his or her previous year's billings.

¹⁶⁶ *Medical Services Payment Act*, S.N.B., c.M-7; Regulations, N.B Reg. 84-20; New Brunswick Department of Health and Wellness, Physician Manual, Audit Section, 2003; New Brunswick Department of Health and Wellness, Summary of Medicare Practitioner Audit, undated.

Investigation: “Practitioner auditors,” who are employed by government, review and approve accounts, respond to billing inquiries from physicians, perform audits, adjust payments where the findings warrant it, and recover payments. Medicare may also appoint Inspectors who are authorized to enter a physician’s office to inspect and audit books, accounts, reports and medical records relating to services rendered to patients. Confidentiality is protected for the physician and patients, including a patient who has made a complaint.

Notice and Physician Consultation: The physician is notified of the findings of the investigation and invited to respond within three weeks. A Medical Consultant reviews the case and the physician’s response.

Investigation Referral Options: If the case cannot be closed following receipt of the physician’s response, the following options are available:

- (1) The physician is requested to repay fees. The repayment amount is based on extrapolation from a random sample of fee claims to the total number of billings.
- (2) If further review is required, the matter is referred to the Professional Review Committee.
- (3) If fraud is suspected, the matter is referred to the police.
- (4) If breach of professional standards is suspected, the matter is referred to the College.
- (5) If the errors result from misinterpretation of the fee schedule, a government Field Representative is instructed to visit the physician to provide the necessary information and assistance.

Professional Review Committee (“PRC”):

Mandate: The PRC functions in an advisory capacity, and may make recommendations to the Director of Medicare, and in some instances to the College or the New Brunswick Medical Society. Its role is to enhance standards of medical service, protect the interests of the public, government and the medical profession in the operation of the medical services plan and to provide experienced professional counsel to physicians whose pattern of practice under the medical services plan does not appear to be in the best interests of the public or the medical profession.

The PRC assesses whether the quality of service provided by the physician met a minimum acceptable level, whether it was medically required, and whether the physician properly

applied the fee schedule in billing for the service. If the PRC finds that the physician provided services that were not medically necessary or misapplied the fee schedule, it must make a recommendation to Medicare regarding the amount of fees to be recovered. The amount is determined by extrapolating from a random sample of cases examined to the population of fee claims.

Composition: The PRC is composed of five physician members nominated by the New Brunswick Medical Society and appointed by the Minister. They are appointed for terms of one to three years at the discretion of the Minister. Members may be reappointed for an unlimited number of further terms of three years.

Procedure: The physician has an opportunity to make submissions to the PRC. The legislation is silent as to whether the submission is in writing or in person. Nor is there any provision for examination and cross-examining witnesses.

Powers: The PRC may engage consultants or experts to assist in a review. In addition, with the approval of Medicare, it may add members to the PRC from the particular branch of medical practice of the physician under review. It may also invite members of the medical profession to provide information and explanations. With the approval of Medicare, it may establish and appoint such sub-committees as it considers necessary.

Medicare Response to PRC Recommendation: Medicare may decide to recover an amount greater or less than the amount recommended by the PRC, or on different terms and conditions than those recommended by the PRC.

Recovery of Amounts Owed, Interest and Costs: If the physician refuses to repay any overpayment, the matter is referred to the Financial Services Branch, which is authorized under the *Financial Services Act* to recover any monies owed to the Province.

After the matter is referred to the Financial Services Branch, interest may be charged as of the date of notice of the audit investigation.

The Physician is not subject to any application fees or awards of costs.

Appeals: No right of appeal is specified in the governing legislation.

Education Initiatives: Government provides to the Medical Society, for dissemination, copies of significant decisions made by the PRC. Medicare operates a “Liaison” service, which, at the request of the physician, arranges for a staff member to visit and respond to any billing questions

following an audit. In addition, newly licensed physicians receive instruction regarding the use of billing codes.

5. Summary of Medical Audit Practice in Newfoundland and Labrador¹⁶⁷

The Medical Care Plan (“MCP”) processes millions of claims each year, submitted by approximately 1,000 physicians. Payment of claims is made in accordance with the MCP Payment Schedule, established under the *Medical Care Insurance Physicians and Fees Regulations*. The MCP is under the jurisdiction of the Department of Health and Social Services.

Grounds for assessment of fee claims: Fees may be recovered on the grounds that the service was not medically necessary or the physician’s records do not support the fee claimed.

Basis for initiating an audit: An audit may be initiated on the basis of

- (1) complaints received from patients, physicians, staff members or others;
- (2) substantial variances between the physician’s practice patterns and provincial averages;
- (3) audits of specific fee codes that generate information leading to individual physician audits;
- (4) responses by patients to verification inquiries that do not support the physician’s fee claims; or
- (5) audits of patient utilization of medical services.

Audit Period: The audit period is generally two years.

Preliminary Audits: The Audit and Claims Integrity Division (“ACID”) randomly selects a small sample of claims and requests the physician to provide photocopies of the patient records,

¹⁶⁷ *Medical Care Insurance Act*, 1999, S.N.L. 1999, c. M-51; *Physicians and Fee Regulations*, C.N.L.R. 69/03; Government of Newfoundland and Labrador Medical Care Plan: “Information for Providers”, “Medical Care Plan”, “Provider Audits” all retrieved from <<http://www.gov.nf.ca/mcp/html/paudit.htm>> on September 3, 2004, and Government of Newfoundland and Labrador, Department of Health and Community Services, “Provider Medical Audit Program”, presentation, 2003 (available at <<http://www.gov.nf.ca/mcp/news/Charts.pdf>>).

which are reviewed by a Medical Claims Auditor. If the Auditor finds indications of inappropriate billing, or if additional information is required, ACID may initiate a Comprehensive Audit.

Claims Monitoring System: The ACID has recently developed a new claims monitoring system (“CMS”) that involves regular monitoring of all physicians, incorporates physician education, and adopts a progressive and proportional approach to monitoring activities and response. The CMS builds on the ACID’s beneficiary verification program. It is based on the ACID’s four governing principles: proaction, prevention, education and feedback. The CMS will be implemented in the Fall of 2005.

Comprehensive Audit: Where there are indications of serious billing problems, the ACID will randomly select a much larger sample of fee claims for verification. ACID staff either review patient records provided by the physician or attend at the physician’s office to conduct an on-site audit. In an on-site audit, the audit team retrieves and copies records of service from patient charts. The staff may interview selected patients and members of the physician’s staff. The results of the investigation are reviewed by ACID with the assistance of the Medical Consultant to Audit.

If the evidence substantiates the physician’s fee claims, the audit is closed and the physician is notified. If a small number of inappropriate billings is found, a fee claim adjustment is made and the physician is instructed on proper billing procedures either by letter or in person.

If significant problems are discovered, either the case proceeds to the Medical Consultant’s Committee, or the ACID calculates a total amount to be recovered from the physician.

Physician Interview: A physician who is subject to an audit may be given an opportunity to attend an interview before the report on information obtained in the Comprehensive Audit is finalized. The Medical Audit Manager and the Medical Consultant to Audit meet with the physician. The issues identified are discussed and the physician may respond by providing explanations and additional information. If the case is then referred to the Medical Consultants’ Committee (“MCC”), the physician is informed of his or her right to make a written submission to the MCC.

Provider Claims Intervention Program (PCIP): A physician may be entered into the Provider Claims Intervention Program (“PCIP”) if the physician is subject to an audit recovery, has been referred for Comprehensive Audit, or if his or her records do not comply with requirements of the MPS. When a physician is in the PCIP, his or her claims for selected services are checked for compliance with MPS requirements before they are paid. The physician must submit copies of patient records to establish that the service provided substantiates the fee claim. As a means of minimizing disruption to the physician’s cash flow, payment advances can be arranged. Physicians remain in the program until it is determined that their billings for two successive pay periods conform to the requirements of the MPS. When a physician leaves the program, the ACID continues to monitor fee claims for a period of one year. A physician who continues to demonstrate patterns or practices that do not comply with the MPS will be re-entered into the Program.

A physician who does not comply with billing requirements may be subject to further action as determined to be appropriate by the MCC, including continuation in the PCIP, referral to Comprehensive Audit, suspension or dismissal from the Medical Care Plan, reduction of billings in accordance with a specified formula, or legal proceedings.

Medical Consultants’ Committee (“MCC”): Cases are referred to the MCC where the physician’s service patterns deviate significantly from the norm, or where records do not support a substantial number of claims.

Composition: The MCC is composed of ten members including the Medical Consultant to Audit, the Medical Director, the Dental Director, the Medical Consultant to the Department of Health and Community Services, a chartered accountant in private practice, and five physicians nominated by the Newfoundland and Labrador Medical Association.

Mandate: The MCC assesses and makes recommendations in cases of alleged over-utilization, inappropriate billing or abuse of the Medical Care Plan (“MCP”) by either physicians or beneficiaries of the plan. Cases are referred to the MCC when ACID and the Medical Consultant to Audit consider that its input would be useful. Referral are generally made in relation to new, complex or contentious billing issues.

Recommendation to Minister: With the assistance of any advice from the MCC, ACID makes a recommendation to the Minister of Health and Community Services regarding the results of the

audit. If the Minister decides that the physician has improperly billed certain services, that the fee claims cannot be substantiated, or that the physician has engaged in an inappropriate pattern of practice, the Minister may issue a Ministerial Order. The Order, supported by reasons, is delivered to the physician. It provides notice of the Department's intention to undertake a recovery of funds. Within thirty days, the physician may make written representations to the Minister, may request a hearing by the Audit Review Board, or may request a process of alternative dispute resolution.

Alternative Dispute Resolution: The purpose of the ADR process is to encourage a co-operative climate, achieve fair and appropriate settlements, and avoid the financial and psychological costs associated with formal proceedings. The process must be completed within ninety days of the Minister's notification to the physician. ACID staff and a lawyer from the Department of Justice work with the physician and his or her lawyer to resolve the billing dispute. If an agreement is reached, the physician waives the right to appeal to the Audit Review Board, and the audit proceeds to the recovery stage.

Appeal to the Audit Review Board ("ARB"): The physician may appeal the Minister's finding to the Audit Review Board ("ARB").

Composition: The members of the ARB are selected from a Review Panel of up to fifteen members who are appointed by the Lieutenant-Governor-in-Council. Five of the members are physicians and two are dentists, selected from lists of nominees provided by the provincial medical and dental associations. Three members are selected to serve on the hearing panel. The Minister selects one member, the physician selects another, and the Minister and physician together select the third member.

Procedure: The ARB has authority to determine its own procedure. The Minister, the physician and the Medical Association each have the right to representation, to lead evidence from witnesses, and to produce documents. Each member of the ARB has the powers of a commissioner appointed under the *Public Inquiries Act*.

Recommendation: The ARB considers the evidence and submissions, prepares a written report setting out its findings and recommendations, and delivers it to the Minister.

Ministerial Order, Extrapolation and Remedies: The Minister considers the representations made by the physician and/or the Medical Association, the report of the Audit Review Board, if any, the recommendations made by the MCC, if any, and the recommendations of the ACID. The total amount to be recovered from the physician is calculated by extrapolating from the results of a sample of claims to the total number of claims under review. The Minister may, by order, withhold all or part of the money claimed, impose a penalty not to exceed the amount of the loss sustained by the Crown plus 10%, suspend or dismiss the physician from participating in the Plan, reduce the amount payable to the physician for insured services by a specified percentage for a period specified in the order, or revoke the allegations. The Order is delivered to the physician, with a copy to the Medical Association.

Appeal to Supreme Court (Trial Division): A physician may appeal from the Ministerial Order, within sixty days from its date, to the Supreme Court (Trial Division). The judge may uphold, amend or revoke the Ministerial Order and make any other decision appropriate in the circumstances. The judge may order costs for or against the appellant or the Crown.

Confidentiality of patient records: In order to protect the confidentiality of information relating to patients, a physician must make available only the information necessary to verify fee claims. Where notes of sensitive information form an integral part of a necessary record, it may be withheld or sent directly to the Medical Consultant for review. Patient records are held under secure conditions until an audit is completed. The information is not otherwise disclosed, except as necessary in a report to Medical Audit Management, the Medical Consultant to Audit, or the MCC. Following completion of an audit process, the records are shredded.

Referrals to Newfoundland Medical Board or the Department of Justice: If the audit investigation discloses practices that might endanger the public, the ACID makes a report to the Newfoundland Medical Board. If the audit investigation discloses actions that may be fraudulent, the ACID refers the matter to the Department of Justice.

Education: The Provider Claims Intervention Program assists physicians to comprehend and comply with billing requirements. The Claims Monitoring System will continue to do so. The ACID conducts orientation sessions for all new physicians in the province and works with

individual physicians and physician groups on an *ad hoc* basis to inform them regarding billing requirements. The ACID also issues bulletins and memoranda on a variety of billing matters. In addition, the Newfoundland and Labrador Medical Association issues bulletins to members identifying common billing errors.

6. Summary of Medical Audit Practice in Nova Scotia¹⁶⁸

Nova Scotia's health insurance plan, Medical Services Insurance ("MSI"), insures eligible residents of Nova Scotia for physicians' services covered by the plan. Atlantic Blue Cross Care ("ABCC"), a private company, administers MSI programs, including physician audits, on behalf of the Department of Health.

Grounds for assessment of fee claims: The purpose of the audit process is to determine that an insured service was performed, that it was medically necessary, and that it was properly represented in the fee claim.

Basis for initiating an audit: Physicians are identified for audit on the basis of information obtained from complaints, review of the physician's billing profile, analysis of various peer comparison reports, post-payment analyses of claims submissions, and responses to service verification letters that were sent to patients.

Screening claims: Where straightforward billing errors are identified in the internal claims review, MSI contacts the physician to make the correction, and a site audit is not required.

Audit Investigation Procedure:

Sample selection process: A sample of approximately one hundred (100) paid claims is selected randomly for each service or fee code under review.

Time period under review in an audit: The period under review is generally the two years preceding notification of the audit investigation. The period may be extended.

Notice: MSI notifies the physician of the need to conduct an onsite audit, which is scheduled at a mutually agreed time.

¹⁶⁸ *Health Services and Insurance Act*, R.S.N.S. 1989, c. 197; *M.S.I. Regulations*, N.S. Reg. 41/69; N.S. Reg. 87/2001.

Production: The physician must produce to the Health Services Examiner documents relevant to the investigation. Copies are made.

Review of Audit Findings: The Examiner prepares a report on the investigation, which is submitted to the Medical Consultant. The Consultant reviews the report and the documents to determine whether services have been billed appropriately. The Consultant may meet with the physician to discuss the audit findings, and to obtain clarification.

The Medical Review Committee (“MRC”): The Medical Review Committee (“MRC”) provides advice in relation to an investigation when requested to do so. I am advised that the MRC is no longer operating.

Amount of repayment based on extrapolation: The amount of a repayment is calculated by extrapolating from the results of the audit on the random sample of services, and applying that result to all similar claims paid during the period from which the sample was drawn.

Notification of audit findings and recoveries: MSI delivers the results of the completed audit to the physician. Where MSI has determined that a recovery of funds is required, the notice includes the amount of the overpayment to be recovered by MSI from the physician and the basis of the recovery. The physician has three weeks to respond to the audit findings prior to the commencement of the recovery by way of set-off against future payments to the physician.

MSI may enter into a settlement with the physician. It may also commence civil proceedings in the Supreme Court of Nova Scotia for recovery of any overpayment.

Appeals: The physician may appeal through the courts. The physician may also follow a complaints procedure set out in s. 3 of the MSI Regulations. I am advised that very few cases are appealed; most matters are resolved directly between MSI and the audited physician.

Education and support initiatives: The Medical Consultant to Audit and other audit staff assist individual physicians and groups of physicians regarding selected billing issues, as necessary.

7. Summary of Medical Audit Practice in Prince Edward Island¹⁶⁹

There are approximately 145 fee-for-service physicians in Prince Edward Island, and members of the audit staff are able to conduct routine audits with respect to all of them. In most cases, billing issues are resolved informally between the physician and the audit staff.

Grounds for assessment of fee claims: The Minister may deny a physician's claim for payment on the basis that the service was not medically required, was beyond the training of the physician, or was less than was medically required. The Minister may refer any claims to the Medical Advisory Committee for assessment.

Basis for initiating an audit: Members of the Ministry audit staff conduct a random computer audit every six weeks, including cost and fee code analysis. The random sample generates approximately 200 claims for audit. Approximately 2,000 audits are completed annually. Audits are performed at physicians' offices and nursing homes a minimum of once annually. Audits are performed at the hospitals approximately three to four times each month.

Investigation: The Minister has broad authority to conduct inquiries and interviews in order to investigate, verify or question any claim submitted for payment, both before and after payment has been made. There are no statutory time limits and no written policies that restrict the audit period, but I am advised that the period of investigation generally does not exceed twelve months.

Review by Medical Advisory Committee ("MAC"): If the Ministry denies a claim in whole or in part, the physician can request an information review by the Medical Director. In most cases, billing issues are resolved informally, but the physician has the right to review by the Medical Advisory Committee ("MAC").

Composition: The MAC is comprised of five members of the Prince Edward Island Medical Society and two representatives of government.

Mandate: The MAC reviews relevant facts, which have been provided by the Ministry without identifying the physician involved. It determines whether there has been a misuse or

¹⁶⁹ *Health Services Payment Act*, R.S.P.E.I 1988, c. H-2; *Health Services Payment Act Regulations*.

abuse of the Plan or whether a fee claimed is commensurate with the service rendered. The MAC also makes recommendations to the Minister regarding interpretation of the tariff.

Procedure: The MAC has the powers of a commissioner under the *Public Inquiries Act*. It does not hold oral hearings, but makes its decisions on the basis of written documentation. The MAC decides the appeal on the day that it is considered and provides its findings to the Minister and the physician within three weeks.

Decision by Minister: If the MAC determines that there has been misuse or abuse of the plan, or that the fee claimed is not commensurate with the service rendered, the Minister may refuse or decrease payment. Recoveries are based upon actual billing errors. The Minister may also impose conditions upon the physician's participation in the Plan. If the physician has willfully made a false representation with respect to any claim under the Plan, the Minister may suspend or cancel the physician's participation in the Plan.

Appeals: A physician has no statutory right of appeal from the Minister's decision, and no attempt has been made to appeal from a Minister's decision.

Offences and penalties: It is an offence for a physician or another person willfully to make a false statement in any report, form or return submitted to the Ministry. A person guilty of such an offence is liable on summary conviction to a fine of not less than \$250 and not more than \$2,000.

Education: There is no formal education program regarding fee billing in Prince Edward Island. If billing concerns arise, the focus is on resolving the matter and working with the physician to ensure future compliance with billing requirements. The Physician Claims Auditor conducts orientation sessions with new physicians.

8. Summary of Medical Audit Practice in Quebec¹⁷⁰

In Quebec, physicians are paid in accordance with agreements between the Ministry of Health and Social Services and the professional associations, namely the Federation of Medical Specialists of Quebec (FMSQ) and the Federation of General Practitioners of Quebec (FMOQ).

¹⁷⁰ *Health Insurance Act*, R.S.Q., c.A-29; *An Act Respecting Administrative Justice*, R.S.Q., c.J-3.

The collective agreements provide for billing codes and fees, and the total amount of government funding allotted to each specialty.

The Régis de l'assurance-maladie du Québec (RAMQ) is a provincially owned insurance company and claims adjudicator. It performs all audit investigations and in many instances performs the roles of both investigator and final adjudicator. RAMQ reports to the Ministry of Health and Social Services.

Grounds for assessment of fee claims: Fees may be recovered from physicians if they have been paid in error or without justification, or the physician did not bill in accordance with the agreement or the defined billing codes.

Basis for initiating an audit: An audit of a physician's fee claims may be initiated in response to complaints, statistical analysis revealing billing anomalies or deviations in relation to a comparator group, or reviews of specific billing codes or specific groups of physicians.

Review Period: The period routinely under review is three years.

Investigation: The RAMQ reviews each benefit claim and also reviews physician billing profiles in comparison with those of physicians in similar practices. Physicians who are found to be billing at higher rates than their colleagues are singled out for more in-depth review.

Investigators and/or physicians will visit a physician who is under review, review charts for the three-year-period and provide an opportunity for the physician to explain disputed claims.

In the absence of quality of care issues, RAMQ may come to a decision that the physician did not bill in accordance with the agreement or the definition of billing codes. Any quality of care issues are referred to the peer review Revisory Committee, and RAMQ postpones its decision until it has received and reviewed the Revisory Committee's opinion.

Revisory Committee:

Composition: There are separate Revisory Committees for general practitioners and specialists. Each committee consists of seven members: five members are physicians, one is a lawyer and, one is a non-voting staff member of the RAMQ. The quorum of the Committee is three voting members, including the Chair.

For both committees, two of the five physicians are selected from a list of at least four names provided by the Ordre professionnel des medecins du Quebec (the regulatory college). The other three physician members are selected from a list of at least six names provided, in the case of the Specialists Committee, by the Federation of Medical Specialists of Quebec, and, for the General Practitioners Committee, by the Federation of General Practitioners of Quebec.

Members are appointed by government and serve for a term of two years, which can be renewed consecutively for two additional terms, or in other words, a maximum of six years. Their compensation is fixed by government and paid by RAMQ.

Mandate: After reviewing any quality of care issues, the Revisory Committee recommends to RAMQ either to pay, in whole or in part, the amount claimed by the physician, refuse to pay any amount, or require reimbursement of any overpayment.

Procedure: Most of the information received by the Revisory Committee is by way of letter from the RAMQ. Before making its recommendations, the Committee must permit the physician to present observations. The physician is required to provide the Committee with any relevant document or information requested. The physician must demonstrate that RAMQ's decision was ill founded. The Committee may base its recommendation on the fact that there is an appreciable deviation between the practice profile of the physician and the profiles of other physicians practicing in the same discipline or carrying out the same activities under similar conditions or in similar regions. No recommendation made by a Revisory Committee may be interpreted as determining the competence of a physician or the quality of service provided.

Appeal of Revisory Committee Decision: Within sixty days of notification of the Revisory decision, an appeal can be taken to the Administrative Tribunal of Quebec.

RAMQ's Process after Revisory Recommendation: Within thirty days of receiving the recommendation of the Revisory Committee, the RAMQ must render its decision, supported by reasons. It must forthwith notify the physician, the College and the relevant professional federation. The notice to the physician must include a copy of the Revisory Committee Recommendation.

Remedies: RAMQ may refuse payment or demand reimbursement in relation to any services in the 36 preceding months that were not furnished, were not furnished in person, have been falsely described, or are not insured services.

The RAMQ can recover payment by withholding fees owing to the physician for other services. Recovery is not stayed pending any appeal, unless it is established that the physician is impoverished. RAMQ can agree to extend the repayment period, upon request, for two to three years, during which interest accrues.

Challenges to RAMQ Decisions: If RAMQ seeks repayment on the basis that the services were not rendered, its decision can be challenged only by way of civil action. If RAMQ seeks reimbursement on the basis that the physician misinterpreted the agreement, the physician can file a grievance in arbitration. The arbitrator's decision is final but is subject to judicial review if it is patently unreasonable. If RAMQ seeks reimbursement on the basis of the recommendation of the Revisory Committee, the physician can appeal to the Administrative Tribunal of Quebec, Social Affairs Division (composed of one lawyer and one physician). The appeal is by hearing *de novo*, and subject to requirements of fairness.

Appeals from RAMQ Decisions: All other RAMQ decisions may be appealed to the Superior Court or the Court of Quebec within six months of receiving notice of the RAMQ decision. The burden of proof that the decision of RAMQ is ill founded is on the physician, except where the decision of RAMQ does not conform to the recommendation of the Revisory Committee, in which case the burden of proof is on RAMQ.

Recovery of Amounts Owning, Interest and Offence: The Act imposes a recovery charge equivalent to ten percent of the outstanding amount owing on the date on which RAMQ proceeds to recovery. The recovery charge can be no less than \$50 and no more than \$10,000. Interest applies at the rate determined pursuant to statute, accruing from the 45th day following the date on which RAMQ notifies the physician. A physician who knowingly contravenes the *Health Insurance Act* is guilty of an offence and liable to pay a fine.

Education: No formal initiatives or programs are reported.

Reporting Links: Every Revisory Committee must report to the Minister annually on its activities.

9. Summary of Medical Audit Practice in Saskatchewan¹⁷¹

I am advised that Saskatchewan is in the process of exploring more informal approaches to medical audit practices and procedures. This summary outlines the medical audit process in effect as of September 2004.

Grounds for assessment of fee claims: A physician's fee claims may be reassessed on grounds of overpayment or on the basis of billing patterns that depart from a pattern of medical practice acceptable to the Joint Medical Professional Review Committee.

Basis for initiating an audit: The Director of Professional Practice at Saskatchewan Health (a Ministerial appointment) determines which claims are investigated, taking into account complaints, errors that have been detected, abnormal billing patterns, responses by patients to service verification letters and other indications of inappropriate billing in the physician's profile.

Physician Profiles: Physicians' billing profiles are analyzed on the basis of various factors, including numbers of Complete Assessments, Partial Assessments and Surcharges, numbers of these claims per 100 patients, standardized cost per patients, and number of patient contacts. Other areas routinely reviewed are the number of consultations per 100 patients, medical advice to allied health professionals, routine calls to special care homes, operative procedures per 100 patients and diagnostic procedures per 100 patients.

Some of the factors taken into account to override or negate referrals based on profile flags include: practices restricted to the physician's specialty which would explain an anomaly, practices related to a specific practice setting (for example, an emergency room or nursing home), or practice circumstances creating abnormal patterns for short periods (for example, a partner's absence generating high demand practice.)

¹⁷¹ *The Saskatchewan Medical Care Insurance Act*, R.S.S. 1978, c. S-29. *The Medical Care Insurance Peer Review Regulations*, c.S-29, Reg. 18.

Investigations: The Medical Services Branch of the Saskatchewan Ministry of Health is responsible for audit investigations.

Ministerial Decision regarding Reassessment: If the Minister has paid an incorrect amount by reason of error, defect or omission in an account submitted, or error in the assessment of an account, the Minister may order that the account be reassessed.

The Joint Medical Professional Review Committee (“JMPRC”): The Director of Professional Practice at Saskatchewan Health may refer a physician to the JMPRC for audit review.

Composition: All members of the JMPRC must be duly qualified medical practitioners, two members appointed by the College of Physicians and Surgeons of Saskatchewan (“the College”) and currently practicing, two members appointed by the Saskatchewan Medical Association (“SMA”) and currently practicing, and two members appointed by the Ministry, at least one being an employee of the Department. The Government of Saskatchewan must not employ the majority of the members of the Committee.

Terms of Office: Members are appointed for a term of up to three years, and are limited to serving two consecutive terms, unless all parties agree to a further twelve-month extension. There is to be at least twelve months between the retirements of two members appointed by the same body.

Temporary Members: The Committee may appoint temporary members by unanimous vote for the purpose of investigating a matter referred to the Committee. A temporary member has the same rights as other members of the Committee.

Quorum: A quorum is constituted by a majority of members. In most instances, decisions are made by majority vote, but unanimity is required for a decision based on a departure from normal patterns of medical practice. If there is a dissenting vote on this issue, it is held back for further discussion and reconsideration.

Compensation: Committee members are remunerated at a rate determined by the Minister. The Chair receives additional remuneration. Special payments may be made at the request of the Chair to a member who has done extraordinary work.

Notice and Disclosure: If the JMPRC considers that a referred matter warrants investigation by the Committee, it serves the physician with notice of its intention to investigate. The Committee can request any information that it considers relevant to the investigation.

Procedure: The JMPRC must observe the rules of natural justice. Its members have the powers of commissioners under *The Public Inquiries Act*.

Scope of Review: In exercising its jurisdiction, the Committee may take into account anything it considers relevant, including a statistical or other comparison between the provision of insured services by the physician whose services are being considered and the provision of insured services by other physicians or groups of physicians. The Committee is not required to examine the provision of any individual service provided by the physician.

Remedies: The JMPRC may order direct recovery from the physician or reduction of payments to the physician. The Committee has discretion to order the physician to make an additional payment not exceeding \$50,000.

Interest: Interest accrues from the date the service was made.

Recovery: The repayment is considered a debt owing to the Minister and may be recovered by suit or counterclaim or by set-off against payments for insured services. There are special provisions for professional corporations.

Period under Review: Orders made by the JMPRC are restricted to a period of not more than 19 consecutive months beginning not earlier than 25 months prior to the day notice was served to the physician of the Committee's decision to investigate.

Report: The Chair of the JMPRC delivers a report of the decision and the information on which it is based to the Director of Professional Review. The Director delivers a copy of the report to the physician, the SMA.

Appeal: The physician may appeal an order of the JMPRC to a judge of the Court of Queen's Bench.

Referrals to the College and to the Attorney General: In an appropriate case, the JMPRC may refer a matter to the College (where it concerns professional misconduct or lack of competence that poses a serious risk of harm to patients) or to the Attorney General (where it may involve fraud). Despite such a referral, the JMPRC retains jurisdiction to conduct its own billing investigation.

JPRC Report to the Council of the College and the Board of the Association: The Committee may provide information "of interest" to the Council of the College and to the Board of the SMA.

Educational Initiatives: The SMA produces a bulletin with a section entitled "Correct Billing Corner."

10. Summary of Medical Audit Practice in Australia¹⁷²

In Australia, the national Health Insurance Commission ("HIC") is responsible for assessing and paying Medicare benefits and preventing, detecting and investigating fraud and abuse.¹⁷³ In 2002-03, the HIC processed over 220 million claims totaling more than \$8 billion.¹⁷⁴

Grounds for assessment of fee claims: Grounds for reassessment of fees include the following: the services were not medically necessary, the physician's medical records were inadequate, and the fee code claimed did not meet the requirements of the Benefits Schedule.

¹⁷² *Health Insurance Act*, 1973; Australian National Audit Commission, *Medifraud and excessive servicing: Health Insurance Commission*, 1993; Health Insurance Commission, *Annual Report*, 2002-03, "Part 4: Medicare"; Health Insurance Commission, "About HIC," at: <http://www.hic.gov.au/abouthic/our_organization/index.htm>; Ministry of Health and Aged Care, "Health Insurance (Professional Services Review – Sampling Methodology) Determination" 2000 (No.1); Professional Services Review, *Annual Report 2002-03*, "Determining Authority", "History" both at <<http://www.psr.gov.au/history.html>>; "Legal" at: <<http://www.psr.gov.au/legal.html>>

¹⁷³ Health Insurance Commission, *Annual Report 2002-03*, Part 4, *loc. cit.* note at 172.

¹⁷⁴ *Ibid.*, at 56.

Basis for initiating an audit: The HIC conducts “purpose-based audits,” which are specific, in-depth reviews to test compliance with the legislation and the benefits schedule. In addition, it conducts “source-based audits,” which are post-payment reviews for the purpose of identifying high-risk areas within the Medicare program.¹⁷⁵ The HIC investigates physicians whose statistics with respect to rendering or initiating services appear to deviate from those of their peers.

In particular, investigations are undertaken where a physician has a high volume of services (and particularly certain classes of services), a high number of services per patient, or orders high numbers of pathology and diagnostic imaging tests.¹⁷⁶ As well, a physician with a “prescribed pattern of service” will be investigated. The “prescribed pattern of service” also known as the “80-20 rule,” applies where a physician renders eighty or more professional services on each of twenty or more days in a twelve month period.

Investigation: An HIC medical adviser may interview the physician to obtain further information, including the physician’s explanation for an aberrant pattern of practice. The HIC adviser reports on the interview to the State Case Management Committee, and in the majority of cases no further action is taken.

Where there are concerns about the physician’s fee claims, the HIC requests the Director of Professional Services Review to investigate further. The HIC must notify the physician of the request. The Director may dismiss the request or provide the physician with a written report and invite a submission on any further action.

After considering the physician’s response, if any, the Director may decide to take no further action, enter into an agreement with the physician to repay benefits, or refer the matter to a Professional Services Review Committee to determine whether the physician has engaged in inappropriate billing practice.¹⁷⁷

The Professional Services Review Committee: The Professional Services Review Committee (PSRC) was established in 1994 to replace a system of review that had been criticized as being an

¹⁷⁵ *Ibid.*, at 67.

¹⁷⁶ Professional Services Review, *Annual Report 2002-03*, at 18.

¹⁷⁷ Health Insurance Commission, *Annual Report 2002-03*, *loc. cit.* note 172, Part 4. Professional Services Review, *Annual Report 2002-03*, *loc. cit.* note 172, at 18.

ineffective means of discouraging the provision of excessive medical services.¹⁷⁸ The Committee is composed of a Chair and two other panel members, all appointed by the Director. The statute requires that the two panel members be drawn from the same specialty as the physician under review.¹⁷⁹

The PSRC must give the physician fourteen days notice that there will be a hearing, including particulars of the services to which the hearing relates. The notice may require the physician to appear at the hearing and give evidence to the Committee.¹⁸⁰ The Committee has the power to require the production of documents and the disclosure of information.¹⁸¹ It is not bound by the rules of evidence.¹⁸²

The physician has the right to attend the hearing, to be accompanied by a lawyer or another adviser, to call witnesses (to give evidence other than character evidence), to produce written statements as to the physician's character, to question a person giving evidence at the hearing, to address the Committee on questions of law arising during the hearing, and to make a final address to the Committee on questions of law, the conduct of the hearing and the merits of the matters to which the hearing relates.¹⁸³ The lawyer's role is limited to providing advice to the physician under review, addressing the Committee on questions of law and making a final address on the merits of the matter.

In investigating the provision of services, the PSRC considers only a sample of the services that are included in the class of services under review. The content and form of sampling methodology that may be used by the PSRC is set out in a Ministerial document titled, "Professional Services Review Scheme – Sampling Methodology Determination 2000 (No.1)."¹⁸⁴

After considering all of the evidence and submissions, the Committee produces a draft report containing findings regarding the conduct of the person under review. After the person under review has been given time to comment on the draft report, a final report is delivered to the Determining Authority.

¹⁷⁸ Australian National Audit Office, *Medifraud and Excessive Servicing: Health Insurance Commission, 2003; Professional Services Review, "History"* at <<http://www.psr.gov.au/history.html>>.

¹⁷⁹ *Health Insurance Act, supra* note 172, at s. 95.

¹⁸⁰ *Ibid.*, s. 102

¹⁸¹ *Ibid.*, s. 105A.

¹⁸² *Ibid.*, s. 106(2).

¹⁸³ *Ibid.*, s. 103.

¹⁸⁴ See Professional Services Review, "Legal", at: <http://www.psr.gov.au/legal.html>.

The Determining Authority (“DA”): The Determining Authority (“DA”) is an independent body within the Professional Services Review system. It has two main roles. The first is to decide whether or not to ratify agreements reached between the Director of PSR and the physician on the sanctions to apply where both parties agree that inappropriate billing practice has occurred. The second is to determine the sanctions to apply whenever a PSRC has found that a physician engaged in inappropriate billing practice.

The DA is comprised of a permanent chair (a medical practitioner), a permanent layperson, and a member from the same profession as the individual under review.¹⁸⁵ In a case where the PRSC has found that a physician has engaged in inappropriate practice, the DA must invite written submissions on any sanctions that may be applied, issue a draft determination, seek comments from the physician, and issue a final determination setting out sanctions.¹⁸⁶ The DA generally deals with matters by teleconference.¹⁸⁷

The statutory time limits require that the DA issue a draft determination within one month and a final determination within 28 days (including 14 days for the physician to make submissions).¹⁸⁸ In fact, in 2002-03, the DA took an average of 58 days to issue draft determinations and another 57 days to issue final determinations. Extensions of time are authorized pursuant to the statute.¹⁸⁹

Remedies and sanctions: The DA may ratify or impose the following sanctions: a reprimand, counseling, repayment of all or part of any Medicare benefit in respect of which the physician has been found to have engaged in inappropriate practice, and full or partial disqualification from Medicare for periods of up to five years.¹⁹⁰

Statistics on Matters settled by Agreements: The 21 agreements made between the Director and physicians were ratified by the DA within an average of sixteen days, well within the statutory time frame of one month. All 21 practitioners were reprimanded, and one was

¹⁸⁵ *Health Insurance Act*, *supra* note 172, at s. 106 ZPA.

¹⁸⁶ *Ibid.*, s. 106SA to 106U.

¹⁸⁷ Professional Services Review, *Annual Report*, 2002-03, at 16.

¹⁸⁸ *Health Insurance Act*, *supra* note 172, at s. 106SA, s. 106T(3), s. 106T(a)(1).

¹⁸⁹ *Ibid.*, s. 106TA(2).

¹⁹⁰ *Ibid.*, s. 106U.

suspended from Medicare for a period of three months. The average amount of repayment ordered was \$12,436, for a total of \$261,165 for all 21 practitioners.¹⁹¹

Statistics on Final Determinations: All eight of the final determinations issued by the DA in 2002-03 involved prescribed patterns of services. The physicians – all general practitioners – were found to have provided eighty or more services on twenty or more days. The range was from 92 days in 5.5 months (with the physician regularly rendering over 100 services in a day) to 22 days in 11 months with 150 services.

Sanctions imposed included reprimand and counseling, serving a period of disqualification from Medicare (the average period being 7.44 months, with a total for all eight practitioners of 59.5 months), and making repayments. The practitioners were required to repay an average amount of \$76,342, for a total of \$610,738 for all eight practitioners. Only two of the eight final determinations issued by the DA were enforced, with six appeals going to the Federal Court.¹⁹²

Extrapolation: The use of extrapolation in calculating the amount of repayment is permitted.

Medicare Participation Review Committee: Physicians convicted of offences against Medicare must be referred to the Medicare Participation Review Committee (“MPRC”) for review of their future participation in the Medicare program. In addition, where the PRSC has twice found that a physician has engaged in inappropriate practice, it refers them to the MPRC.¹⁹³

Panel Composition: The Chair of the MPRC panel must be a lawyer and, depending on the matter being considered, the panel must include two to four members drawn from a pool of practitioners. The MPRC is supported administratively by HIC but is an independent statutory body. Its hearings are in public unless there are special circumstances requiring that they be closed to the public.

Powers: The MPRC may determine that no action should be taken, that the physician should be counseled, that the physician should be reprimanded, that the physician should be partially disqualified from the Medicare system (in respect of providing a specified service,

¹⁹¹ Professional Services Review, Annual Report, 2002-03, *loc. cit.* note 172, at 16.

¹⁹² *Ibid.*, at 17.

¹⁹³ *Health Insurance Act*, *supra* note 172, at s. 124E.

services to a specified class of persons, or services in a specified location), or fully disqualified for a period not exceeding five years.

Review by Administrative Appeals Tribunal: Where an MRPC has made a determination, the physician may apply to the Administrative Appeals Tribunal for a review of the determination.

Publication: The Director is authorized to publish the names of physicians who have had a final determination issued against them (including names and addresses, profession or specialty, the nature of the unacceptable conduct and the sanctions imposed).

Independence: The Director of Professional Services Review, the Professional Services Review Committees, and the Determining authority are independent of the HIC.

Referral to Medical Boards: A PSR Committee is obliged to refer a physician to the appropriate state medical board if it identifies a significant threat to the life or health of a patient. Further, a Committee must refer a physician to the appropriate professional body if the physician has failed to comply with professional standards. The Committee must disregard any opinion it forms with respect to these issues for purposes of making its draft report or final report.¹⁹⁴

Education: Education and information activities for medical practitioners and practice staff include: (1) quarterly newsletters, (2) “Mediguide,” a guide to the Medicare fee claim system and other HIC programs, (3) “HIC Online,” which includes information kits for physicians and practice managers; and (4) articles, media releases, presentations at conferences and at workshops for physicians and practice managers.

I am advised that the introduction of the PSR system has been controversial and that a number of PSR Committee decisions have been appealed to the courts. The Federal Court decision in one case led to statutory amendments. I understand that government is working with relevant health care associations, including national and state medical associations, in an attempt to foster a more open, co-operative and collaborative relationship.

¹⁹⁴ *Ibid.*, s. 106M3.

11. Summary of Medical Audit Practice in New Zealand¹⁹⁵

New Zealand's physician payment system has recently undergone significant reform, transforming it from a primarily fee-for-service system to a funding system based on "capitation." In other words, funding is based on the number of patients enrolled by a physician. Primary Healthcare Organizations ("PHOs"), 75 in number, operate the new funding system under the supervision of 21 District Health Boards ("DHBs").

A PHO typically contracts with a number of medical practices. Each quarter, it submits for payment a register of patients for all of its members. This is described as a "bulk billing" system. PHO physicians can also claim fee-for-service for "casual" patients who are not enrolled with the PHO.¹⁹⁶ The vast majority of New Zealand's population (approximately 4 million) is now enrolled with PHOs. New Zealand pays, annually, approximately \$420 million to PHOs and approximately \$70 million to non-PHO physicians.

Audit and Compliance: The Health Payments, Agreements and Compliance Unit ('HealthPAC'), a stand-alone unit of the Ministry of Health, is responsible for, among other things, the administration of agreements with PHOs and other health providers, payment of claims in accordance with the agreements, clinical data collection from health provider claims, and systems to ensure that health funds are properly expended.

The Audit and Compliance Unit of HealthPAC ("ACU") is responsible for encouraging appropriate claims, preventing fraudulent or inappropriate claims and maintaining a general climate of accountability. The ACU's investigation and audit programs are governed by various Audit Protocols, which set out the purpose and principles of the audit program, describe the

¹⁹⁵ *Health Act* 1956 (N.Z.), 1956/65. *Health Information Privacy Code* 1994 (N.Z.), 1994. *Official Information Act*, 1982 (N.Z.), 1982/156. *Privacy Act* 1993 (N.Z.), 1993/28. Ministry of Health, "Audit and Monitoring: Guidance for DHBs, 2003; "Primary Health Care Audit Protocol: Financial, Claiming and Referred Services," April 2004; "HealthPAC Audit Protocol – Medical Practitioners" (undated); "National Public Health Compliance Audit Protocol," June 2002; "HealthPAC" at <<http://www.nzgovtdirectory.com/directory/section2/healthpac.htm>>; "HealthPAC Functions – Audit and Compliance," at <<http://www.moh.govt.nz/moh.nsf>>; "New Zealand's Health System: what is publicly-funded healthcare and how does New Zealand's health system work?" at: <<http://www.moh.govt.nz>>; Prof. Colleen Flood, Faculty of Law, University of Toronto, e-mail June 2004; Interview with Manager, Risk Assessment and Intelligence, Audit and Compliance, HealthPAC, December 2004.

¹⁹⁶ See Ministry of Health, "New Zealand's Health System: What is publicly-funded healthcare and how does New Zealand's health system work?" *ibid.*; at: <<http://www.moh.govt.nz>>; other information derived from Interview with Manager, Risk Assessment and Intelligence, *ibid.*

process in detail and articulate the rights and responsibilities of the parties. Principles established in the Audit Protocols are also included in the Agreements with PHOs.

I am advised that, when the new audit system was introduced, it met with resistance from physicians, but that the development and implementation of these protocols has been instrumental in improving relations between the Ministry of Health and the New Zealand Medical Association.

Principles governing the audit process: The “relationship principles” governing the audit process are directed at fostering a long-term co-operative and collaborative relationship that enables all parties to the PHO agreement to achieve their objectives efficiently and effectively. These principles include:

- observing the requirements of natural justice,
- respecting patient confidentiality,
- valuing the parties’ skills, expertise and high quality performance,
- providing open and timely communication,
- providing continuing quality improvement and innovative service development to the extent possible within available funding,
- ensuring that risks are borne by the party in the best position to manage them, and
- emphasizing the need for consistency.

In addition, the National Public Health Compliance Audit Protocol provides that a good audit:

- identifies levels of compliance and good performance as well as areas needing improvement (fact finding not fault finding),
- supports the compliance function by emphasizing the developmental and educational potential of the audit,
- evaluates and tests the physician’s operational systems,
- applies the perspectives of risk and change management,
- provides an opportunity for physicians to improve their compliance, and
- allows for feedback from the physician to the Ministry on policies and practices associated with the audit.

Audit Principles: “Audit Framework Guiding Principles” have also been adopted and are reflected in the audit procedures that have been put in place. The audit principles include: observing the requirements of natural justice; conducting audits promptly; providing appropriate

notice of an audit and its anticipated scope; ensuring that auditors are qualified and carry out their work in a professional manner; arranging the audit at a reasonably convenient time; permitting the audited physician to have a person present during an on-site visit; permitting auditors to make copies of records; requiring both parties to provide accurate information and prompt responses; requiring that audit reports be timely, state findings of fact, be provided in draft form for comment by the physician, incorporate the response from the physician, and provide recommendations identifying the actions necessary for either party to bridge the gap between the audit criteria and the level of performance found in the audit; requiring that either or both parties take reasonable steps to implement the recommendations.

Types of Audits: Audits may be directed at a PHO or at a physician, but for present purposes it is necessary to consider the audit process only as it applies to physicians. Two types of audits are established. “Programmed audits” are part of a DHB’s program to audit all PHO’s over a period of time. “Selected audits” are undertaken in response to specific concerns. Audits are distinguished from investigations, which are undertaken in cases of suspected fraud and are referred to the justice system. Audits are also distinguished from informal practice visits, which are informal and focused on assisting physicians to understand billing requirements.

Initiating a “Selected Audit”: HealthPAC may initiate a selected audit where there are billing irregularities, unusual claiming patterns or other issues that suggest inappropriate or fraudulent claiming. Information that leads to an audit is derived from patient surveys, statistical analysis, monitoring of capitation registers and reports or complaints (including complaints to the ACU’s Fraud Hotline).

Time period under review: There are no statutory time limits on the period of claims under review in an audit, but in practice audits generally cover claims submitted within the two years preceding the initiation of the audit.

Patient surveys: If auditors undertake a survey of patients as part of the audit review, they are required to consult with the PHO regarding the survey process and the form of questionnaire to be sent to patients. The DHB facilitates this process if required. The physician is notified that a survey is being conducted. The results of the survey are provided to the PHO. The auditors may

also confirm with patients that specific enrolments or services match those claimed. The Protocols adopt measures to protect the patient's wishes, interests and rights, and they confirm the importance of preserving the physician's confidentiality and integrity.

On-Site Audits:

Notice: HealthPAC must provide thirty business days' notice of its intention to conduct an audit. Where HealthPAC has reasonable grounds to believe that there has been a material breach of an agreement, or that delay would unreasonably prejudice the integrity of the audit or the interests of any eligible person, the notice period may be abridged to the extent that it is reasonably necessary. Where HealthPAC reasonably suspects that fraud has occurred, auditors may enter a physician's premises and conduct an audit without notice. The notice must include the name of the person(s) appointed as auditor(s), their qualifications and a declaration from any auditor as to conflicts of interest. If the physician has reasonable concerns about the focus of any audit or any person appointed as an auditor, he or she must bring those concerns to the attention of HealthPAC within ten business days of receiving the notice.

Auditors: Auditors must be qualified and authorized. They must carry an identification card authorizing them to inspect, copy or take notes of records in accordance with the Health Act, and show it to the physician. Where clinical records will be reviewed, the auditor must be a physician.

Audit Plan: Every audit must have an audit plan specifying the scope and issues to be examined, and specifying a date for completion of the report. A copy of the plan must be provided to the physician.

Limits to disruption of practice: Audits are to be structured in such a way that the physician is normally not kept from work for more than one hour. In cases where the auditors will require more time with the physician, prior notice must be given and the longer period must not exceed three hours. Where further time is required to complete the audit, it is arranged by agreement between the auditors and the physician.

Interview and Inspection of Records: The auditors visit the physician to interview the physician and inspect relevant records. The physician is entitled to have another person present. The records to be inspected may include the capitation register, enrolment forms, clinical records and appointment registers.

Patient records are copied only where it is reasonably considered to be necessary, and is performed only under the supervision of a physician. Non-clinical records may be inspected and copied by other auditors. If clinical records are copied, the auditing physician must advise the patients in question, and is responsible for the security and confidentiality of the records. If the records are required for use as evidence in any Advisory Committee or court, there are provisions for the suppression of any sensitive information. At the end of an audit or investigation, after all parties have agreed that no further action is contemplated, copies of the physician's records are returned or destroyed

Other inquiries: The auditors may also speak to staff members in the physician's practice to discuss systems, practices, and procedures.

Complaint about breach of protocol by auditor: A physician may complain to the CEO of the DHB concerning any breaches of protocols on the part of auditors.

Reporting on progress of fraud investigation: Where an investigation is carried out into suspicions of fraud, the physician must be informed of progress at regular intervals and, in any event, at least monthly.

Audit Results: Auditors must provide a Draft Finding Audit Report as soon as practicable, and in any event not later than four weeks after completion of the audit. If the auditors cannot complete the Report within this time frame, they must provide a progress report.

The physician has the opportunity to respond in writing to the Draft Report, and the response is included in the final audit report. The final report, including the auditors' recommendations is delivered to the DHB and the PHO.

Audit recommendations may include notification of no further action, recovery for invalid payments, referral of the matter to an Advisory Committee or other complaints body, advice to the physician on compliance with billing requirements, or notification that the audit has been re-characterized as an investigation into fraud or serious non-compliance.

Formal Audit Hearing: Medical Advisory Committee ("MAC")

Composition: The Medical Advisory Committee ("MAC") is composed of nominees of the professional association and the Ministry. The majority must be peers of the physician who is being audited. There are MAC's for various areas of practice.

Role: In general, the MAC's functions are to advise the Ministry on the terms and conditions for payment of benefits, fees and subsidies, on disputes and complaints over such payments, and other related issues.

Powers: After an investigation, the MAC may recommend: recovery of invalid payments, referral to another complaints body, advice to the physician on compliance, notification of no further action, or prosecution in cases of fraud or serious non-compliance.

Publication: Audit findings and recommendations may be publicly released, but any information that might identify the physician is excised. All information held by the Ministry of Health is subject to the *Official Information Act 1982*, including information collected and held as a result of a physician audit.

Education and Support Initiatives: The new approach to physician audits in New Zealand emphasizes education and collaboration to support compliance with billing requirements. The Ministry provides a number of documents and guides for physicians and other health care providers. Many of these documents are listed in the Ministry's "Audit and Monitoring: Guidance for DHBs".¹⁹⁷

¹⁹⁷ *Supra*, note 195.

12. Summary of Medical Audit Practice in Medicare in the United States of America¹⁹⁸

Medicare in the United States is administered by the Centers for Medicare and Medicaid Services (“CMS”), a division of the U.S. Department of Health and Human Services. CMS contracts with private insurance companies, referred to as “carriers” or “contractors,” to review and adjudicate physician claims for services. Medical reviews (or audits) are conducted pursuant to the *Social Security Act* or the *Medicare Prescription Drug, Improvement and Modernization Act* (“*Medicare Modernization Act*”). The CMS has issued a Program Integrity Manual to guide the work of the contractors, but they have significant discretion in implementing their own state medical audit review procedures.

Fee-for-service payments under Medicare in the United States total approximately \$192 billion annually. For fiscal year 2001, the Office of Inspector General for the Department of Health and Human Services reported that \$12.1 billion, or about 6.3 per cent, of payments were improperly paid.¹⁹⁹

General Principles and Goals of the Medical Review Program: The Medical Review Program aims to reduce payment error by identifying and addressing billing errors concerning coverage

¹⁹⁸ *Social Security Act* (1935) Public Law 74-271 (49 Stat. 620); *Medicare Prescription Drug, Improvement and Modernization Act* (2003) Public Law H.R. 1 108th Congress; American Medical Association, “Policy Finder, Definitions of ‘Screening’ and ‘Medical Necessity’,” “Medicare Prepayment and Post payment Audits” at <http://www.ama-assn.org/apps/pf_online?f_n=browse&doc=policyfiles?HnE/H-3>; American Medical Association, Council on Medical Service, “Principles of Managed Care 2004,” 5th ed.; B. Baker, “A look at Medicare’s kinder, gentler auditing process,” *American College of Physicians Observer*, July-August 2004, at <<http://www.acponline.org/journal/news/jul-aug04/medicare.htm>>; Centers for Medicare & Medicaid Medical Review Program website at <<http://www.cms.hhs.gov/providers/mr/>>; Health Care Financing Administration, Department of Health and Human Services, Program Memorandum Carriers, “Use of Statistical Sampling Overpayment Estimation when Performing Administrative Reviews of Part B. Claims,” January 8, 2001; Joan Szabo, “New U.S. Medicare Law Offers Doctors Audit Relief,” *Medical Post*, volume 40, Issue 35, September 21, 2004 at <http://www.medicalpost.com/mpcontent/article.jsp?content'20040919_182056_1048>; Texas Medical Association “HCFA Revises Audit Process,” at <http://www.texmed.org/pmt/pay/mmd/medicare_hcfarevisesauditproc.asp>, July 12, 2004; interviews with staff at Centers for Medicare and Medicaid Services Medicare Financial Management and American Medical Association.

¹⁹⁹ Department of Health and Human Services/Office of Inspector General, “Improper Fiscal Year 2001 Medicare Fee-for-Service Payments,” A-17-00-02000, Washington, D.C., February 15, 2002.

and codes, and to do so in a fair and consistent manner.²⁰⁰ The aim is to minimize loss, to use resources efficiently and to treat providers and beneficiaries fairly. Accordingly, medical reviews are directed to the most significant errors (that is, physicians with high volumes of services, high cost, dramatic changes in practices, adverse impacts on beneficiaries, and problems which may escalate if not addressed).²⁰¹

Recent Reforms:²⁰² In the last two years there have been two significant reforms to the review process: (1) adoption of the Progressive Corrective Action program (“PCA”), which establishes that the nature of the review process must be proportionate to the severity of the perceived billing problem, and (2) establishment of new due process requirements for audit reviews, pursuant to the *Medicare Modernization Act*.

Progressive Corrective Action Program (“PCA”): The CMS implemented the PCA in 2002 to improve various aspects of the fairness of the medical review process. In particular, it established that the process must in each case be proportionate to the severity of the billing problem. In determining the appropriate process, carriers must consider the extent of the billing problem, the past history of the physician’s billing errors, and the physician’s willingness to comply. They must evaluate the situation at least every three months and remove a physician from medical review as soon as the physician demonstrates compliance with billing requirements.

In addition, the PCA emphasizes that physician education is essential in addressing specific billing problems with individual physicians or in addressing widespread billing problems among groups of physicians in particular specialties or locations.

The Medicare Modernization Act (“MMA”): The *Medicare Modernization Act*, which enacted amendments to the *Social Security Act* in 2003, established new fairness and due process requirements for medical audits, including establishing standard methodology for sampling a physician’s claims, testing new billing requirements before implementing them, limiting the use of random prepayment reviews, establishing notice and disclosure requirements, providing the physician with an opportunity to respond to allegations of billing irregularities, protecting a

²⁰⁰ CMS Medicare Program Integrity Manual, Chapter 1, section s.1.2, at <<http://www.cms.hhs.gov/providers/mr>>.

²⁰¹ *Ibid.*, Chapter 3, section 3.1.

²⁰² See B. Baker, *supra* note 198.

physician who has relied on billing advice provided by the carrier, explaining findings in a way that assists a physician to correct billing problems, limiting the use of extrapolation, staying recovery pending review and appeal, and providing for extended payment terms in case of financial hardship.

Peer Review Organization (“PRO”): Under the direction of the CMS, the Peer Review Organization (PRO) serves as a quality improvement organization for Medicare, and assists in the medical review process to ensure that payment is made only for medically necessary services and to investigate complaints about quality of care. It operates as a national network with programs in each state, territory and the District of Columbia.

The PRO Manual requires that physicians who are reviewers must be in active practice, which is defined as practicing a minimum of twenty hours per week. In addition, the goal is to ensure that a review is conducted by a reviewer with the same licence, specialty, and practice setting as the physician under review.

Prepayment reviews: CMS attempts to review most claims before payment in order to avoid “chasing” overpayments and in response to the concerns of physicians about repaying monies already received. Physicians who have been identified as having billing problems may be placed on “prepayment review” until they establish a pattern of correct billing. A percentage of their claims must be reviewed before payment can be authorized.

Post-payment reviews: A carrier may undertake a post-payment review regarding either an individual claim or randomly selected samples of claims.

Grounds for assessment of fee claims: Grounds for review are identified in the *Social Security Act*, namely, that claims must be supported by information,²⁰³ and that funded services must be reasonable and necessary for diagnosis and treatment.²⁰⁴ Potential issues relating to quality of care are excluded from the review and are referred to another appropriate agency. According to the Chief Financial Officer’s audit of Medicare in 2000, the vast majority of improper payments made by Medicare were for services that appeared appropriate on the claim

²⁰³ *Social Security Act*, supra note 198, at s. 1833(e).

²⁰⁴ *Ibid.*, s. 1862(a)(1).

form, but did not meet the requirement of “medically necessary” when the clinical record was reviewed. CMS states, “most errors are not acts that were committed knowingly, willfully, and intentionally.”²⁰⁵

Grounds for initiating an audit: Audits may be initiated on the basis of complaints, but most are initiated on the basis of analysis of billing patterns and other data. If a physician’s billing appears to deviate from the norm, the carrier will generally contact the physician to determine whether there is a plausible explanation. If the discussions do not resolve the matter, an audit is conducted.

Differentiating billing errors as minor, moderate or major: Carriers must conduct a “probe” medical review in order to ascertain the scope of a billing problem before deploying significant medical review resources to examine claims that have been identified as a potential problem. The probe review involves examining a small sample of claims, typically 20 to 40 claims. The physician must be notified in writing of the review. At its conclusion, carrier staff members classify the billing problems. A “minor concern” might, for example, involve a small dollar amount billed in error by a physician with no history of filing problem claims. A “moderate concern” might involve a physician who has not responded to educational efforts to correct previous billing problems. A “major concern” might include cases where the percentage of claims billed in error is high.

In accordance with the PCA, the CMS has instructed Medicare carriers to consider a physician’s past history of billing errors and his or her willingness to correct billing errors in determining the scope of an audit, how to proceed with an audit and whether the carrier will withhold payments while the audit is conducted.²⁰⁶ In addition, Medicare carriers must terminate a medical review of physician’s billings as soon as possible when a physician demonstrates compliance with Medicare billing requirements.

Data Analysis: CMS provides extensive direction to carriers on processes and systems required for data analysis of a physician’s claims.²⁰⁷ A carrier must determine whether a problem is specific to an individual physician or more widespread. If the error is widespread among

²⁰⁵ *Ibid.*, Chapter 1, section 1.2.

²⁰⁶ CMS Medicare Program Integrity Manual, Chapter 1, section s.1.2, at <https://www.cms.hhs.gov/providers/mr>.

²⁰⁷ *Ibid.*, see Chapter 2, section 2.2.2.

physicians, the carrier should validate the concern by reviewing 100 potential problem claims from a representative sample of providers. If the error is limited to a small number of providers, the contractor should validate the concern by reviewing 20-40 potential problem claims for each provider in question. If the error is widespread, the contractor must implement appropriate educational initiatives.²⁰⁸

Initial Investigation:

Notification: When initiating prepayment or post payment reviews, the contractor must notify the physician in writing, advising (1) that the physician has been selected for review, (2) whether it is a pre or post payment review, (3) the specific reason for the selection, (4) that the PCA program may apply, (5) that the physician must produce specified medical records, and (6) that the physician has the right to provide additional information.

Document review: If the review is limited to documents, the physician must produce any documents requested within the specified time limit (typically 30-45 days). The carrier must complete the document review and notify the physician of the findings within sixty days of receiving the documents from the physician.

Onsite review: If necessary, the review may be conducted at the physician's office. The carrier provides advance notice of the site review, the reason for the review and a list of medical records for production and copying. The carrier must advise the physician of the scope and purpose of the review, discuss any preliminary findings, and notify the physician of his or her rights. A clinical expert from the same specialty as the physician is involved in the site review.

Notification of review results: The carrier notifies the physician of the results of the review, in writing, and within sixty days of the exit conference at the site review. Whether the review was conducted on the basis of documents only or at the physician's office, the notification letter must provide specific findings and reasons for each denied claim. It must also advise of any corrective actions the physician must take, including educational programs, and any continuing monitoring or review to which the physician's claims will be subject, including referral for prepayment review.

The results letter may include a demand for repayment. The letter must advise the physician of his or her right to submit a rebuttal statement prior to enforcement of the demand. It must also advise the physician of rights to appeal.

²⁰⁸ *Ibid.*, see Chapter 3, section 3.2.1.

Physician rebuttal statement: The physician is entitled to submit a rebuttal statement within fifteen calendar days of the date of the results notification letter. The only issue to be addressed is the date on which recovery should be enforced. Substantive evidence outlined in the rebuttal will be considered only if it clearly demonstrates that the findings, in whole or in part, are incorrect.

Carrier's determination: The carrier's determination may require the repayment of funds. As well, it may include directions regarding education and monitoring. If the matter involved fraud, the physician may be required to repay three times the amount of money fraudulently taken plus a mandatory civil penalty of at least \$5,500.

Recovery and interest: Medicare has the right to recover overpayments and charge interest on debts that are not repaid within thirty days after receipt of a demand letter. In cases of financial hardship, the carrier may accept a plan of repayment over a period of not less than six months and not longer than three years (or five years in the case of extreme hardship).²⁰⁹

Extrapolation: Since 2004, extrapolation can no longer be used to determine recovery amounts except where the carrier establishes that a physician has engaged in a sustained or high level of payment error or that the physician has not corrected payment errors despite documented educational intervention.²¹⁰

Confidentiality: Carriers must maintain the confidentiality of all medical records before, during and after the medical review process.²¹¹

Appeals: The first level of appeal from a carrier's determination is to a Hearing Officer or an Administrative Law Judge, who reviews the record, hears submissions from the physician and comes to a decision based on a "preponderance of evidence." In some jurisdictions, the physician has a choice of a review based on the record, a telephone hearing or an in-person hearing.

²⁰⁹ *Medicare Prescription Drug, Improvement Act ("Medicare Modernization Act")*, s. 935(a)(f)(1)(A).

²¹⁰ *Ibid.*, s. 935(a)(f)(3).

²¹¹ CMS Medicare Program Integrity Manual, *supra* note 206, at Chapter 1, section 1.6.

A physician may also seek judicial review of the carrier's determination by an Administrative Law Judge of the Social Security Administration. This decision is reviewable by the Medicare Appeals Council.

Finally, there is a right of appeal to the Federal Court.

Education: In the United States, education is a primary focus of the medical audit system, with the goal of educating physicians on Medicare rules, on how to comply with the rules and state review policies, and how to avoid common billing mistakes. In any medical review in which a billing error is detected, the carrier must specify an appropriate educational program for the physician and one-on-one discussion is almost always required.

Carriers work with state and specialty medical societies in Local Provider Education and Training Programs ("LPET Programs") to provide education on billing policies and procedures,²¹² and on the PCA program. The focus on education appears to be effective in that it is reported that the national claims payment error rate is continually dropping.²¹³

Educational programs are provided not only for physicians but also for members of carrier staff and for Administrative Law Judges.

The programs for physicians include one-on-one education to address billing errors. The carrier must provide materials relevant to the physician's specific billing issues and comparative data on how the physician's billing varies from others in the same specialty and locality. Comparative billing analysis may also be made available on web sites when widespread problems have been identified. Physicians may also obtain (at their own cost) a copy of their own billing profile.

Comprehensive educational interventions are undertaken when there are pervasive billing issues within specific specialties. At the local level, seminars, workshops and web seminars are provided.

Carriers are required to develop a web-based response document in a Question and Answer format, setting out frequently asked questions regarding local medical review policies. This document must be updated quarterly. Carriers must also provide bulletins regarding local medical review issues. As part of recent reforms pursuant to the *Medicare Modernization Act*,

²¹² *Ibid.*, Chapter 1, section s.1.1.

²¹³ *Ibid.*, Chapter 1, section s.1.4.

carriers are required to establish toll-free numbers and websites where physicians may obtain billing information.²¹⁴

New physicians are monitored (to the extent of reviewing 20-40 claims) to ensure that they establish good billing practices. In addition, physicians can conduct self-audits using the Officer of Inspector General Compliance Program Guidelines.²¹⁵

²¹⁴ *Medicare Prescription Drug, Improvement and Modernization Act*, *supra* note 198, at s. 921.

²¹⁵ The Guidelines can be accessed at < <http://www.os.dhhs.gov/oig/modcomp/index.htm> >.

PART VI. PHYSICIANS' CONCERNS WITH THE MEDICAL AUDIT PROCESS, RESPONSES, CONCLUSIONS AND RECOMMENDATIONS

1. Introduction

There can be no doubt that the medical audit system in Ontario was and is a source of very serious concern, anger, frustration and hardship for physicians. Indeed, at the time the oral submissions were made, physicians considered the audit system to be the prime concern in their relations with the Ministry. They have stated that significant changes must be made before they can have confidence in a new audit system. It is clear from the submissions both written and oral that, if the fee-for-service system is to continue to serve the needs of patients in Ontario, then the complaints and concerns of the physicians pertaining to the audit system must be carefully considered. In this section of the Report, I will address the major concerns of the physicians with the audit system, the responses that have been made to those concerns, and my conclusions and recommendations for establishing in Ontario a fair and effective audit process.

2. No jurisdiction to consider past claims

In considering physician concerns and complaints, it is important to recognize that my Terms of Reference exclude any investigation of past claims. Some physicians, and members of their families, have given compelling accounts of their unfortunate experiences with the audit process. However, those accounts have not been tested by cross-examination, nor have I had the benefit of submissions on behalf of OHIP and the College in regard to individual cases.

Conclusions:

It would not only exceed my jurisdiction but also constitute a denial of natural justice if I were to make findings of fact regarding individual cases.²¹⁶ Nonetheless, I am instructed by the Terms of Reference to consult with "stakeholders," and it is important that I consider their concerns in my efforts to identify the elements of a new audit process that will gain and maintain their confidence.

²¹⁶ See the heading "Redress" in the text *infra*, at 162.

3. Jurisdiction and structure of the medical audit process

Physicians have expressed their concern regarding the role of the College of Physicians and Surgeons of Ontario in the medical audit process. Some have expressed their view in stark terms, asserting that the College should not be acting as “the bill collector for OHIP.”

The mandate of the College is to regulate the medical profession in the public interest, ensuring that physicians adhere to high professional standards of competence and conduct. Matters relating to the negotiation, payment and recovery of fees are outside the mandate of the College and are settled in negotiations between the OMA and the Ministry. It is significant that in no other system I have reviewed is the College the body that conducts audits of physicians' fee claims.

Nonetheless, for more than thirty years, the College has accepted statutory jurisdiction over the medical audit process, which is lodged with its Medical Review Committee (“MRC”). The College leadership takes responsibility, along with the Chair of the MRC, for the operations of the MRC, and has made extensive efforts to address some of the concerns that have arisen regarding MRC processes. The College is prepared to continue to operate the medical audit process, and to work with government and the profession to implement a new audit process, provided that significant changes are made to the principles and processes governing audits.

In the College's view, its involvement in the audit process serves important objectives.²¹⁷ First, the College is independent of the negotiations between OHIP and the OMA regarding fees and insured services. Second, and more importantly, the College is at arm's length from OHIP and can assure the independence of the audit process. Third, the College's expertise enables audit decisions to be based on a full understanding of the nature of the practice of medicine and to be responsive to changes in the medical environment. Fourth, the College can provide important administrative supports to the audit process, including identifying individuals with appropriate expertise to serve as inspectors, experts, and panel members. Fifth, because of its experience, the

²¹⁷ College of Physicians and Surgeons of Ontario, The Medical Review Committee: An Overview (September 10, 2004), at slides 122-124.

College is in the best position to establish a new audit process and have it operational as quickly as possible.

OHIP has reported that there have been discussions in the past concerning the appropriateness of the College's role in the audit process, but that no consensus had emerged to support a change. In the submissions made to me, no one other than the College took the position that the College should continue to be responsible for medical audits, and the College's willingness to do so was conditional on significant reform of the process.

The MRC, acting under the auspices of the College, has attracted serious criticism and complaint. To some extent the MRC was only the messenger within a system whose features are defined by statute. Moreover, the MRC has developed policies and practices to improve the audit review process and has demonstrated its commitment to continue with those efforts.²¹⁸ Nonetheless, the MRC has been perceived by physicians as inflexible in its interpretations, unfair in its processes, inefficient in processing its workload and complicit in a system that has operated unjustly against them.

Conclusions:

I recognize the value of the College's expertise and experience in the regulation of the medical profession. Several of the physicians who appeared before me spoke well of the College, particularly in relation to its peer review program and the guidance the College provides through its standards for record keeping. I also acknowledge that there is no evidence that establishes that the MRC has failed in its responsibility to act independently of OHIP, even though it may have accepted too readily the limits and constraints of the audit process. Moreover, I recognize the College's efforts to address concerns about the audit process in so far as they related to matters within the jurisdiction of the MRC. Finally, I welcome the College's support for a new audit process and its willingness to make a contribution to that process. The College and the MRC have co-operated with this study in an exemplary manner. I found the College to be composed of very able professional people dedicated to the service of physicians, their patients and the people

²¹⁸ College of Physicians and Surgeons of Ontario, Submission (July 2004), at 5; The Medical Review Committee; an Overview (September 10, 2004), at slides 125-128.

of Ontario. Nonetheless, I have concluded that the medical audit process must be the responsibility of a new and completely independent body.

As a result of the criticisms directed at the MRC and the audit system, physicians cannot support an audit process operated by the College. Quite simply, there is no alternative to removing the audit process from the College and assigning it to a new and independent body. It is no longer appropriate for the College to continue in the role of the “enforcer” auditor. If the audit system is to have, as it must, the confidence of the medical profession, the College must relinquish control of the auditing of physicians’ accounts.

The responsibility for conducting audits should be conferred on a new body that I will call the “Physician Audit Board.” This body must, to the extent possible, be completely separate from and independent of the Ministry, OHIP, the OMA and the College. It must have its own premises and staff, and a budget sufficient to cover its reasonable expenses. The budget should not be within the sole control of the Ministry, but should be prepared by the Board and submitted for approval to the College and the OMA. The budget, together with the approvals or comments, should then be submitted to the Minister.

The establishment of the independent Physician Audit Board and its procedures will be the major jurisdictional or structural change in my recommendations. I conclude that OHIP should continue to screen physician fee claims and billing patterns. As I will propose in this report, OHIP should enhance its capability to compare billing patterns on the basis of relevant criteria, enhance its early identification programs, provide physicians with opportunities to explain apparent aberrations in their billing patterns, and focus on encouraging compliance with clearer billing and record-keeping requirements.

When OHIP refers a physician to the Physician Audit Board, an independent Inspector should investigate, and the matter should then either be settled or heard by an Audit Hearing Panel. The Hearing Panel should hold a hearing that provides all the procedural protections afforded by the *Statutory Powers Procedure Act*. At the hearing, OHIP should be responsible for proving the case for the recovery of funds paid as fees to physicians. The Hearing Panel should make a finding and, as appropriate, select from a broader range of possible remedies than is now

possible. In those special cases where extrapolation is still found to be an appropriate remedy, the Panel should refer the matter back to OHIP to calculate the amount owing. The limited use that should be made of extrapolation will be addressed later in this report.

The College of Physicians and Surgeons of Ontario and the Ontario Medical Association should continue to have a role in the audit system through the nomination of members of the Physician Audit Board and Inspectors. As well, they should each have a continuing role in shifting the emphasis from audits to education and in establishing record-keeping systems that meet clinical and billing requirements.

This summary, which anticipates some of my substantive recommendations, is intended only to highlight my recommendations regarding the division of jurisdiction over aspects of the medical audit process. My detailed recommendations relating to each aspect of the audit process will be discussed in later sections of this report.

RECOMMENDATIONS:

- (1) The responsibility for conducting audits of physicians' fee claims should be conferred on a new body, which is separate from and independent of the Ministry, OHIP, the OMA, and the College.**
- (2) The new body, which I will refer to as the "Physician Audit Board," must have its own premises and staff, and a budget to cover its reasonable expenses. The budget should be prepared by the Board and submitted for approval or comment to the College and the OMA. The budget, together with the approvals or comments, should then be submitted to the Minister.**
- (3) OHIP should continue to screen physician fee claims and billing patterns, should be responsible for proving the case for the recovery of funds in any matter before the Audit Hearing Panel, and should make any calculations required in those rare occasions when extrapolation can be used.**
- (4) The College and the OMA should continue to have a role in nominating members of the Physician Audit Board and its Inspectors and addressing policy issues in the billing and audit system.**

Before addressing the investigation and audit process, and the composition and procedures of the Physician Audit Board, it might be helpful to set out what I believe should be the aims and objectives of the audit system.

4. The purpose of the audit process

There is consensus among the parties regarding the need for an effective and fair audit process that ensures accountability in the expenditure of public funds, supports compliance by physicians, and earns their confidence. There is a considerable gap to bridge in achieving that goal, yet some steps have already been taken that indicate willingness by all concerned parties to change. This augurs well for attaining a satisfactory solution to the serious problems that have arisen.

Individual physicians, and some of their associations, have voiced their suspicion that, after 1996, OHIP began to target physicians in particular specialties and to subject them to audits in order to recover revenue. They are concerned that audits were undertaken with the intention to “claw-back” part of the fees the Ministry had agreed to pay to physicians.

OHIP rejects these allegations, and states that an audit is simply a means for recovering monies that a physician was never entitled to receive.²¹⁹ The Provincial Auditor had identified the need to strengthen procedures for screening physicians' fee claims and for enforcing statutory billing requirements.²²⁰ New computer systems enhanced OHIP's capacity to track and compare physicians' billing patterns. OHIP was thus better able to review the 150 million fee claims filed annually by physicians. As a result, a higher proportion of fee claims was reviewed by OHIP. In addition, since a major component of the investigation strategy was to compare a physician's billing patterns with average billing practices for physicians in the specialty, it was necessary to focus on particular specialties. OHIP thus denies that it was targeting physicians, or groups of physicians, for any improper purpose. At the hearings, representatives of OHIP explicitly denied that OHIP had quotas for the recovery of fees, and cited statistics to demonstrate that the number

²¹⁹ The Ministry of Health and Long-Term Care, Submission (July 2004), at 92 (Appendix 11, item 9).

²²⁰ *Ibid.*, Appendix 12.

of referrals to the MRC had not increased.²²¹ The College has also stated that the decisions of the MRC were neither motivated nor influenced by financial considerations.²²²

Conclusions:

All parties are agreed and I confirm that it is essential to physician confidence in the audit system that the audit processes be employed solely for the purpose of determining the accuracy and appropriateness of physician fee claims. It would be scandalous if the audit system were in fact used to “claw back” fee payments negotiated in good faith by the OMA and the Ministry. The nature of the allegations by physicians and the suspicion that has developed in relation to the audit system emphasizes that the audit system must itself be accountable. The system must be based on clear criteria and operate through processes perceived to be fair. Any perception that the audit system is arbitrary will create mistrust and ultimately undermine the delivery of services essential to our health care system. Accordingly, a biennial stakeholders’ forum should be established to consider the operation of the new audit process, to respond to concerns and address mistaken perceptions, and to consider proposals for improvement of the process.

RECOMMENDATIONS:

- (5) It is essential to physician confidence in the audit system that audit processes be employed only for the purpose of determining the accuracy and appropriateness of physician fee claims.**
- (6) The audit system itself must be accountable.**
- (7) A biennial stakeholders’ forum should be established to receive reports on the operation of the new audit process, and to receive and consider proposals for improvement of the process.**

²²¹ Transcript, November 2, 2004, Submissions (Ministry of Health and Long-Term Care), at 149, (line 8) to 150 (line 2) and at 156 (lines 1-25). See the statistics in the text at note 8.

²²² College of Physicians and Surgeons of Ontario, The Medical Review Committee: an Overview (September 2004), at slide 109.

5. A new approach to the audit system: facilitating compliance with billing requirements

Conclusions:

I agree with all parties, who on this issue were unanimous, that it is essential to shift the focus of the audit system in Ontario. The primary goal of a reformed audit system should be to educate and assist physicians in complying with the billing requirements of OHIP. The second but equally important goal should be to identify and eliminate false, fraudulent and egregiously erroneous billing. In support of both of these goals, it will be important to ensure that billing requirements are clear and functional. OHIP has stated that its goal is to educate physicians effectively so that they do not get into difficulties with their billings.²²³ Some initiatives have recently been undertaken to improve the information that is available to physicians concerning the billing and audit process,²²⁴ but much more remains to be done.²²⁵

RECOMMENDATIONS:

- (8) The primary goal of the new approach to the audit system should be to educate and assist physicians in complying with the billing requirements pursuant to the *Health Insurance Act*.**
- (9) The second but equally important goal of the new approach to the audit system should be to identify and eliminate false, fraudulent and egregiously erroneous billing, in a fair and effective manner.**

6. The role of the Schedule of Benefits

The terms of the Schedule of Benefits, which are negotiated between the Ministry and the OMA, are explicitly excluded from my Terms of Reference. Nevertheless, the role played by the Schedule is highly relevant to the matters I was asked to consider and it is important to understand physicians' concerns about its impact.

²²³ Transcript, November 2, 2004, at 157 (lines 10-19).

²²⁴ See the text at note 123.

²²⁵ See recommendations 108 to 115.

a. Interpretation of fee codes in the Schedule of Benefits

Physicians have asserted that the billing requirements in the Schedule of Benefits are complicated, vague, out-of-date, inadequate for use other than as a guideline, and should not be interpreted literally. They complained that OHIP and the MRC insisted on interpreting provisions of the Schedule literally even if the result was to deprive physicians of payment for services that had been rendered and were appropriate to the needs of their patients. They alleged that the Schedule is so inadequate and unfit for its purpose that, if a physician is identified for audit investigation, it is highly likely that investigators, as a result of their interpretation of the Schedule, will readily be able to uncover “breaches” of the billing requirements leading to recovery of fees. In response, the College points out that in 12.75% of audits the MRC ordered no repayment.²²⁶ Nonetheless, all parties are agreed that the Schedule of Benefits is a significant root cause of problems with Ontario’s medical audit process.

Several of those who made submissions referred to the troubling case of Dr. Lyttle, a pediatric respirologist who successfully appealed from a decision of the MRC that had denied his fee claim. Dr. Lyttle had billed a General Assessment code for his examination of the patient. OHIP challenged the fee claim on the basis that a General Assessment code can be billed only when the patient’s circumstances require that the physician conduct an examination of all body parts and systems. In this instance, the young patient did not require, nor did the physician conduct, a vaginal examination. The MRC, applying a literal interpretation to the General Assessment code, reduced his fee claim. The HSARB allowed the appeal. A further appeal by OHIP to the Divisional Court was dismissed.

The HSARB and the Court properly agreed that the General Assessment code was warranted and that the physician had properly exercised his expertise and professional judgment in determining the nature of the investigation that would be sufficient and appropriate for diagnosing and treating the patient. Indeed, it would have been not only inappropriate but also improper to conduct a complete examination of all body systems in the circumstances. Thus the Board and the Court adopted a practical rather than a legalistic approach to interpretation of the General Assessment code in the Schedule of Benefits. Their unanimous reasons are attached to this report as Appendix 11.

²²⁶ See the text, *supra*, at note 9.

OHIP acknowledges that the Schedule of Benefits is a complex document.²²⁷ This I find to be a highly flattering description of the Schedule. I was told that most physicians use only a few codes, but that, even so, it is not always clear which code is the appropriate one to apply. In the fall of 2004, OHIP had agreed with the OMA to review the general preamble to the Schedule of Benefits, simplify it and revise it, and also to establish a committee to make recommendations for improvements to the Schedule.²²⁸ This is truly a very important initiative. The clarity of the Schedule of Benefits is essential to the effective operation of the medical audit system. The establishment of the Joint Committee will fill a gap identified by the College. The College has noted that there was no body to which, or mechanism by which, the MRC could communicate its concerns and experience regarding the difficulties in interpreting and applying provisions of the Schedule of Benefits that do not accurately reflect the realities of medical practice.²²⁹

Conclusions:

The importance of the initiative to review and recommend improvements to the Schedule of Benefits cannot be over emphasized. The Schedule must keep pace with rapid changes in the practice of medicine. Further, it must clearly specify the services to which billing codes relate so that physicians know what codes to use and auditors can assess fee billings on the basis of objective criteria. Until this important work is completed, it is necessary for the audit process to compensate for the deficiencies of the Schedule of Benefits. In particular, the Schedule must not be interpreted in a literal and legalistic manner so as to deprive a physician of payment (or part payment) for a service that is medically appropriate in the circumstances, and complies substantially with the requirements of that fee code.

A permanent joint committee should be formed by OHIP and the OMA to review and recommend revisions to the Schedule of Benefits, in accordance with a time schedule to be specified. If, as a result of an audit, the Physician Audit Board considers that a fee code requires

²²⁷ Transcript, November 2, 2004, at 153 (line 8).

²²⁸ Transcript, November 2, 2004, at 154 (lines 5-20).

²²⁹ College of Physicians and Surgeons of Ontario, Submission (July 2004), at 8.

clarification or amendment, it should refer the decision and reasons of the Hearing Panel to the joint committee, for consideration.

RECOMMENDATIONS:

- (10) **Fee codes in the Schedule of Benefits should not be interpreted in a literal and legalistic manner, so as to deprive a physician of payment for a service that is medically appropriate in the circumstances and complies substantially with the requirements of the fee code.**
- (11) **It is important that OHIP and the OMA review the Schedule of Benefits, simplify it, revise it, clarify it and adapt it to the circumstances of various specialties of medical practice. I recommend that a permanent Joint Committee be established to review the Schedule of Benefits in accordance with a time schedule to be specified.**
- (12) **If, as a result of an audit review, the Physician Audit Board considers that a fee code requires clarification or amendment, it should refer the decision and reasons of the Hearing Panel to the Joint Committee of OHIP and the OMA. The decision should be edited to protect the anonymity of the physician and any patient. Consideration should be given to requiring the Joint Committee to issue a report responding to the referral.**

b. Retroactive application of amended fee codes

There have been instances in which an agreement has been reached to amend the Schedule in order to relieve against problematic fee codes. Physicians have argued that such amendments to correct an inadequacy in the Schedule of Benefits should apply to all pending audit investigations. However, OHIP and the MRC have taken the position that the amended code applies only to services rendered after the amendment was made, unless special provision is made for retroactive application pursuant to the *Health Insurance Act*.

Conclusion:

For the purpose of determining whether an amendment to the Schedule of Benefits should apply to all pending audit investigations, it would seem reasonable to distinguish between substantive and remedial amendments. A remedial amendment, that is to say, an amendment for the purpose of correcting a problem that has emerged in the audit investigation process, should be applied for the benefit of all physicians who find themselves confronted with that problem. On

the other hand, an amendment that is intended to establish a new policy direction should be applied only prospectively.

RECOMMENDATIONS:

- (13) When an amendment is made to the Schedule of Benefits to remedy an inadequacy in the Schedule, the benefit of that amendment should be made available and be binding in all pending audit investigations.**
- (14) When an amendment is made to establish a new policy direction in the Schedule of Benefits, it should apply only prospectively.**

7. Record-keeping requirements for clinical purposes and billing purposes

Physicians complained to me that, even when their clinical records had been assessed by the College and rated as excellent, the MRC might conclude that the records were not sufficient to justify the fee code claimed and, accordingly, deny or reduce the fee.

A physician explained that the records required for billing purposes are sometimes inconsistent with the way in which physicians exercise judgment in arriving at a diagnosis. He advised that a physician runs through a notional checklist of matters to investigate, but keeps a record only of the matters that are material, and does not record matters that, while potentially relevant, have been ruled out. He also played a video of typical conditions in a busy pediatrician's office. The video established that the daily realities of pediatrics are such that the physician's ability to maintain meticulous records must frequently take second place to attending to the immediate needs of very young, frightened, restless, and volatile patients.

Physicians properly submitted in a very convincing manner that their prime aim is always to treat the illnesses and injuries of their patients and that record keeping, while important, should be secondary.

In their written submissions, OHIP and the College emphasized that there are differences in record-keeping requirements for medical purposes and for billing purposes. Thus, for example, for billing purposes it is necessary to record the stop and start time for the provision of time-based

services such as psychotherapy. For medical record purposes, information about timing may not be relevant.²³⁰ OHIP and the MRC took the position that fee codes require certain examinations and procedures, and if they are not recorded in the patient record, the fee code is not justified.

Regardless of the logic of the rationale, physicians lose confidence in a billing system that rejects as inadequate the very records that have been assessed as complying with the high professional standards established by the College. Accordingly, it is a positive development that OHIP has agreed with the OMA to recommend changes to record-keeping standards for billing purposes, assisted by appropriate clinical Sections of the OMA and other interested groups.²³¹

I trust that record templates will also be developed that will enable physicians to meet clinical standards and billing requirements quickly, effectively and efficiently. One family physician took me through slides showing his careful attempts, over the course of several years, to develop and adapt templates for patient record keeping which would meet the needs of patient care and the requirements for billing. It seems wasteful to require that individual physicians create their own record keeping systems when templates could be prepared centrally and adapted to the needs of different types of practice. OHIP has indicated its willingness to work with the major stakeholders to develop templates, make them available to physicians, and encourage physicians to contribute to ongoing improvements.²³² I am advised by OHIP and the College that considerable progress has already been made.

Conclusions:

It is essential that OHIP and the OMA review and recommend amendments to record-keeping standards for billing purposes. This initiative must involve the appropriate clinical Sections of the OMA and other interested groups. In addition, it must involve the College, which has already produced standards for clinical record keeping that are approved by physicians. The goal should be to develop one set of record-keeping requirements that will suffice for both clinical and billing purposes. As a general rule, records that meet medical clinical standards

²³⁰ Ministry of Health and Long-Term Care, Submission (July 2004), at 92-3 (Appendix 11, item 12); Supplementary Submission (November 2004), at 10.

²³¹ *Ibid.*, (July 2004) at 25 (Appendix 1, item 8).

²³² Ministry of Health and Long-Term Care, Supplementary Submission (November 24) at 12.

should suffice for billing purposes. If, however, there is a clear indication that further records are needed in order to claim a particular fee pursuant to the Schedule of Benefits then the required records must be kept. In those situations, the Schedule of Benefits should make it clear that additional records are required.

Record keeping requirements for billing purposes should take into account the realities of medical practice. Care must be taken to ensure that the standards are simple and clear so that they do not become so time-consuming that they take priority over patient care. Record keeping templates and systems should be developed to enable physicians to keep the required records as quickly, easily, and efficiently as possible.

RECOMMENDATIONS:

- (15) It is essential that OHIP and the OMA review and recommend amendments to record-keeping standards for billing purposes. This initiative must involve the appropriate clinical Sections of the OMA and other interested groups. In addition, it should involve the College, with a view to developing one set of record-keeping requirements that will suffice for clinical and billing purposes.**
- (16) As a general rule, records that meet medical clinical standards should suffice for billing purposes. Additional records for fee billing should be required only in those clear cases where the Schedule of Benefits for good reason requires the additional record and this has been brought to the attention of physicians.**
- (17) OHIP, the College, the OMA, its Sections and other interested groups should develop templates to assist physicians in effective and efficient record-keeping.**
- (18) Record keeping requirements for billing purposes should take account of the realities of medical practice and should not require physicians to give priority to record-keeping to the detriment of patient care.**

8. The Physician Audit Board

Physicians and their associations have made recommendations concerning the composition and procedures of the Physician Audit Board and its Hearing Panels. The two

recommendations that are most urgent relate to the need for full and fair hearings, which is discussed later in this Report, and the importance of peer representation on Hearing Panels.

a. Peer representation on the Physician Audit Board, the Hearing Panel, and the roster of Inspectors

Physicians complained that their fee claims ought to be investigated and assessed by true peers, who understand both the fee claim and the nature of the practice that provides the context for consideration of the claim. In particular they submitted that the Inspector and one member of the Audit Hearing Panel should be from the same practice field and setting as the physician or as close to it as possible. To achieve this objective, it would be necessary to appoint to the Physician Audit Board and the roster of Inspectors a representative group of physicians.

In its written submission, OHIP argued that peer representation of this specific sort was not necessary. OHIP referred to court decisions that had described the MRC process as constituting peer review, independent of government. OHIP submitted that all physicians learn how to keep records in a similar fashion and are capable of interpreting a record and comparing it to the requirements of the Schedule of Benefits. In OHIP's view, it is sufficient, in cases where medical necessity or professional standards are at issue, that the Hearing Panel obtain an opinion from a physician of the same specialty as the physician under review.²³³

At the hearings, however, representatives of OHIP agreed that an Inspector who reviews the physician's records should be a peer, and that the Hearing Panel reviewing the matter should, if possible, have at least one peer, or, if that is not possible, should hear from a peer as an expert witness.²³⁴

Conclusion:

All parties now agree, and I conclude, that the membership of the Physician Audit Board should reflect the various disciplines of the profession, that the Inspector assigned to investigate

²³³ Ministry of Health and Long-Term Care, Submission (July 2004), at 25 (Appendix 1, item 6).

²³⁴ Transcript, November 2, 2004, at 140 (lines 14-16) and 178 (line 19) to 179 (line 1).

and report should be from the same practice field and setting as the physician or as close to it as possible, and that one member of the Audit Hearing Panel should also meet that criterion.

RECOMMENDATIONS:

- (19) The membership of the Physician Audit Board should reflect the various disciplines of the medical profession.**
- (20) The Inspector assigned to investigate and report on a physician's fee claims should be a true peer of the physician, that is, from the same practice field and setting as the physician or as close to it as possible.**
- (21) One member of the Audit Hearing Panel should be a true peer of the physician who is before the Panel.**

b. Composition, Qualifications, and Appointment

Conclusions:

On the basis of submissions made to me, and my assessment of the numbers of members necessary to enable the Physician Audit Board to meet its responsibilities, I conclude that the Board should be made up of thirty physicians and ten members of the public, each appointed for a three to five year term, and eligible for reappointment to one additional term. Appointments should be staggered to provide continuity.

To ensure the requisite peer review, the physicians should be selected from as wide a range of practice settings and specialties as possible. Only physicians who are engaged in active practice should be eligible for appointment.

Both the OMA and the College have a significant interest in ensuring that the hearing process is fair. The OMA represents physicians, and the College regulates them in the public interest. Each of them has means of identifying candidates with appropriate expertise and experience. They should both work to ensure that the members of the Hearing Panels are independent, knowledgeable, and fair-minded. In consultation with the Chair of the Physician Audit Board, they should each nominate fifteen of the thirty practicing physicians who will comprise the thirty physician members of the Physician Audit Board. It may be necessary to establish a joint nominating committee in order to ensure the necessary breadth of experience

among the physician members of the Board. Breadth of representation on the Board is necessary in order that one member of each Hearing Panel have experience and expertise that is as close as possible to that of the physician under review.

All physician nominees must be in good standing with the College and have no conflict of interest in relation to issues within the jurisdiction of the Board. Accordingly, the College and OHIP should review and report on their eligibility for appointment.

Physician members of the Board will be expected to undertake difficult and important work that will take them away from their practice. Accordingly, they must be reasonably compensated, on a *per diem* basis. It is, of course, understood that there is an element of public service in an appointment such as this, but it should not require too great a sacrifice. I am advised that physicians sitting on hearing panels for the College are paid a *per diem* stipend of \$750, but that former members of the MRC received a *per diem* stipend of \$347 in accordance with rates for government appointments. This discrepancy is too great. It is important that the significance and complexity of the service performed by Board members be recognized and valued. I am advised that members of the Transitional Physician Audit Board are paid a *per diem* stipend of \$550. Other jurisdictions have also recognized the importance of the work of medical audit board members by providing higher rates of compensation. I recommend that members of the Physician Audit Board be paid a *per diem* stipend of at least \$500. On this subject, see the table attached as Appendix 10, which sets out the rates of compensation paid by other jurisdictions to members of medical audit boards.

The ten public members should be appointed by the Ministry for a term of three to five years and be eligible for reappointment for a second term. The Ministry should consult with the Chair of the Physician Audit Board, the OMA and the College in identifying nominees who are qualified to contribute to the processes and deliberations of the Panel. In particular, members of other professions would bring a broad and helpful perspective to the deliberations, and lawyers might contribute their expertise in procedure and statutory interpretation. Well-qualified public members are required and they should be compensated at the same rate as physician members.

The Chair of the Physician Audit Board should be selected from and by its members and should serve for a term of two years, renewable for two additional years. This selection procedure is significant and necessary to demonstrate to all parties the independence of the Board.

The larger number of physician members (thirty) will enable the Physician Audit Board to be broadly representative of the profession and help to ensure the goal of peer representation on each Hearing Panel. The larger number of both physician and public members will serve three additional purposes. It will permit Hearing Panels to be quickly constituted as they are needed. It will enable the Board as a whole to identify issues of general concern that should be referred to appropriate bodies for consideration. Finally, it will ensure that there are sufficient members available to assist, as needed, in the education of physicians with regard to good billing practices. Since members will be paid on a *per diem* basis, the larger number of members on the Physician Audit Board should have little impact on the total cost of its operations.

RECOMMENDATIONS:

- (22) The Physician Audit Board should be composed of thirty physicians and ten members of the public, each appointed for a three to five year term and eligible for reappointment to one additional term. Appointments should be staggered to ensure continuity and renewal.**
- (23) The OMA and the College, in consultation with the Chair of the Physicians Audit Board, should each nominate fifteen of the thirty physician members. It may be necessary to establish a joint nominating committee to ensure the necessary breadth of experience among physician members.**
- (24) Physician members should be selected from as wide a range of practice settings and specialties as possible.**
- (25) Only physicians who are engaged in active practice should be eligible for appointment.**
- (26) All physician nominees must be in good standing with the College and must have no conflict of interest in relation to issues within the jurisdiction of the Board. The College and OHIP should review and report on their eligibility for appointment.**

- (27) **Ten public members should be appointed by the Ministry. The Ministry should consult with the OMA, the College, and the Chair of the Physician Audit Board in identifying qualified nominees.**
- (28) **Members of the Board should be compensated at a *per diem* rate of at least \$500.**
- (29) **The Chair should be selected from and by the members of the Board and should serve for a term of two years, renewable for two additional years.**

c. Orientation and instruction

Conclusions:

All members of the Board should be instructed in their duties and responsibilities as members of the Physician Audit Board and as members of a Hearing Panel. They should understand billing requirements, investigation procedures, and the audit process. In particular, they should be instructed in the requirements of procedural fairness. They should be taught to always strive to maintain their impartiality; to conduct their hearings with fairness, patience and respect; and to deliver clear, concise, and reasoned decisions.

RECOMMENDATIONS:

- (30) **Members of the Physician Audit Board should be instructed in billing requirements, investigation procedures and the audit process. In particular, members should be instructed in the requirements of procedural fairness; maintaining impartiality; conducting hearings with fairness, patience and respect; and delivering clear, concise, and reasoned decisions.**

d. Annual Report and Meetings

Conclusion:

The full Physician Audit Board should meet at least once a year. It should prepare and approve an annual report on its work. The Board should review, annually or more often if required, issues of procedure or policy, consider any referrals to the Joint Committee on the Schedule of Benefits, and address any needs of Board members for training relevant to their responsibilities.

RECOMMENDATION:

- (31) **The full Physician Audit Board should meet at least once a year. It should prepare and approve an annual report on its work. The Board should review, annually or more often as required, issues of procedure or policy, consider any referrals to the Joint Committee on the Schedule of Benefits, and address any needs of Board members for training relevant to their responsibilities.**

e. Audit Hearing Panels

Pursuant to the *HIA*, either OHIP or the physician may ask that an audit be conducted by a one-member hearing panel. There was considerable concern as to whether a panel of one, sitting informally and thus without procedural requirements, could be fair and appear to be fair. In any event, since the decision of a one-member panel could be reconsidered by a three-member panel, there was little benefit in a one-member process. I was advised that one-member hearing panels are no longer used.

I received various proposals regarding the appropriate composition of Audit Hearing Panels, but there was broad consensus as to the desirability of having a public member, a peer physician, and some flexibility to proceed in the event that a member is not able to continue after a hearing has commenced.

Conclusions:

From the forty members of the Board, the Chair should select Audit Hearing Panels composed of three physicians and one public member. The Chair should designate the member who will serve as Chair of the Panel. It is important that the physician being audited can expect to be reviewed by his or her true peers. Accordingly, at least one of the physician members should practice in the same, or as close as reasonably possible to the same, specialized field and practice setting as the physician whose fee claims are to be reviewed. The provisions of the *HIA* authorizing an audit to be heard by a single-member panel and reconsidered by a three-member panel should be repealed.

RECOMMENDATIONS:

- (32) **The Chair of the Physician Audit Board should select, from members of the Board, three physician members and one public member to sit as an Audit Hearing Panel.**
- (33) **At least one of the physician members should practice in the same, or as close as reasonably possible to the same, specialized field and practice setting as the physician whose fee claims are to be reviewed.**
- (34) **The Chair of the Physician Audit Board should designate a member of the Audit Hearing Panel to serve as Chair.**
- (35) **The provisions of the *HIA* authorizing appointment of a one-member panel and reconsideration of that panel's decision by a three-member panel should be repealed.**

9. Inspectors

Some physicians complained vigorously about their treatment at the hands of Inspectors sent by the MRC to investigate their fee claims. They decried the Inspector's cavalier behaviour, lack of familiarity with the physician's field of practice, disrespect, rudeness, and an attitude reflecting a predetermination that the physician was guilty of improper billing. That is certainly not to say that all Inspectors acted in this manner, but it is unacceptable if any of them did.

It is important that Inspectors be carefully selected and trained and that there be sufficient Inspectors to undertake the work expeditiously. I heard from the College that a lack of Inspectors with appropriate qualifications has created delays in the audit process in the past.²³⁵

Conclusions:

Based on the submissions and my review of other jurisdictions, I conclude that Inspectors have an important role to play in the audit process. The role of an Inspector should be to investigate and report on the facts in relation to the audit, but also, as will be seen below, to make a determination as to whether the physician has a satisfactory explanation for disparities between his or her billing patterns and the norm among the physician's peers.²³⁶

²³⁵ College of Physicians and Surgeons, The Medical Review Committee: An Overview (September 10, 2004), at slide 59.

²³⁶ See section 14 of Part VI of this Report, Recommendations 68-70.

There should be twenty Inspectors, appointed by the Minister, on the joint recommendation of the Chair of the Physician Audit Board, the OMA and the College. The Inspectors must be independent and report only to the Chair of the Physician Audit Panel. They should be appointed for a term of three to five years, and be eligible for reappointment to one additional term. The appointments should be staggered to ensure continuity. The Inspectors should be engaged in active practice and should be selected to represent a broad range of practice specialties and settings.

Openings for Inspectors should be widely advertised to the profession. Candidates for appointment should be reviewed by OHIP and the College to ensure that they are in good standing and have no conflict of interest. In addition, care should be taken to appoint individuals whose disposition will enable them to conduct an inspection appropriately.

The Inspectors must be aware, by experience and training, of the record-keeping requirements for both clinical and billing purposes. They should be required to complete a course of instruction regarding their responsibilities in conducting an inspection and reporting to the Chair of the Board. In particular, they must be made aware of the obligation to treat the physicians they inspect with respect and courtesy and to listen to any explanations they may present with patience and careful attention. The Physician Audit Board should develop a Code of Conduct and procedures for Inspectors.

Inspectors should be remunerated at a *per diem* rate sufficient to attract able candidates and compensate them appropriately for the time they must take away from their practice.

The Chair of the Physician Audit Board should assign an Inspector to undertake a particular investigation. The Inspector should be in active practice in a specialty and practice setting that is the same or reasonably similar to that of the physician whose billings are being considered.

RECOMMENDATIONS:

- (36) The Minister should appoint twenty Inspectors, on the joint nomination of the Chair of the Physician Audit Board, the OMA and the College. Inspectors should be appointed for a term of three to five years and be eligible for reappointment to one additional term. Appointments should be staggered to ensure continuity.
- (37) Inspectors will report only to the Chair of the Physician Audit Board.
- (38) Inspectors should be physicians selected from as wide a range of practice specialties and settings as possible.
- (39) Only physicians who are engaged in active practice should be eligible for appointment as Inspectors.
- (40) Openings for Inspectors should be widely advertised to the profession.
- (41) The College and OHIP should review all candidates for appointment as Inspectors to ensure that they are in good standing and have no conflict of interest in relation to billing issues.
- (42) In addition, care should be taken to appoint individuals as Inspectors whose disposition will enable them to conduct an inspection appropriately.
- (43) Inspectors should be required to complete a course of instruction regarding record-keeping requirements for both clinical and billing purposes, the conduct of an inspection, and reporting requirements. In particular, they must be made aware of their obligation to treat physicians who are being inspected with respect and courtesy, and to listen with patience and careful attention to any explanations they may present.
- (44) The Physician Audit Board should establish a Code of Conduct and procedures for Inspectors.
- (45) Inspectors should be remunerated at a *per diem* rate sufficient to attract qualified candidates and compensate them appropriately for the time they must take away from their practice.
- (46) The Chair of the Physician Audit Board should assign an Inspector to undertake a particular investigation. The Inspector should be in active practice in a specialty and practice setting that is the same or reasonably similar to that of the physician whose billings are being considered.

10. Initiating an audit investigation by OHIP

There appears to be consensus that the process of identifying physicians for audit should remain with OHIP. No concern has been expressed about the initiation of audits in response to complaints received, or in response to issues arising from letters sent to patients to verify whether services were in fact performed. Physicians did, however, express concern about the manner in which physicians are identified for audit in reliance upon an analysis of billing statistics.

a. The fairness of OHIP processes identifying physicians for audit investigation

Physicians insist that they cannot assess the fairness of methods used by OHIP to analyze billing patterns unless those methods are disclosed. The College notes that lack of understanding of the processes by which physicians are identified for audit has led to a perception that some specialties are being targeted for audits.²³⁷ Physicians have also expressed concern that OHIP's approach to identifying physicians for audit does not take sufficient account of material differences among physicians' practices. This concern has two implications. The first implication is that the statistical programs are not sufficiently refined. The second implication is that the efforts of the Medical Consultants²³⁸ do not ensure that a physician is compared with his or her true peers.

Those who made submissions to me provided some compelling examples of situations in which the special circumstances of a physician's practice may justify a billing profile that is different from the profile of the average physician in the same field. For example,

- (1) Consulting pediatricians, with hospital-based practices, treating seriously ill children, are likely to claim a different distribution of fee codes than pediatricians in primary care, who see a great many children who are not ill;
- (2) Family physicians who serve as medical directors of nursing homes are likely to do more frequent and detailed assessments of patients than their colleagues because of the age of their patients and the requirements of the institutions;

²³⁷ College of Physicians and Surgeons of Ontario, Submission (July 2004), at 11.

²³⁸ See the text, *supra*, at note 24.

- (3) Family physicians who provide services to local hockey teams will undoubtedly have more than the average number of evening attendances which are required to suture cuts and treat knee and shoulder injuries;
- (4) Physicians covering a colleague's practice for a few days are likely to see more patients during that period, and, since routine visits are likely to be deferred until the colleague's return, the physician is likely to see a higher proportion of patients with more serious health issues; or
- (5) Physicians practicing in under-serviced areas may work longer hours and see many more patients than the average physician.

It was strongly emphasized on behalf of physicians that the nature of a physician's practice must always be considered in determining whether a physician's billing patterns can be justified.

OHIP has recently developed new software programs to identify variances in billing patterns. I understand that, in British Columbia, more highly refined data is produced through a "case-mix adjustment" software program, which is able to take account of differential illness levels of patients.²³⁹ The program helps to reduce the likelihood of flagging high-billing physicians for investigation simply because their patients are sicker than average. OHIP acknowledges that the ACG software may "avoid unnecessary audit cases,"²⁴⁰ but discounts its usefulness in Ontario since Medical Consultants make individualized assessments of physicians to assess whether they should be referred for audit.

OHIP indicates that the Consultants can make inquiries and exercise judgment in light of all the circumstances of the physician's situation. Nonetheless, physicians have complained that Consultants identify physicians for audit without obtaining access to all of the relevant information. They submit that it is important that physicians have an opportunity to draw to the Consultants' attention, in the initial stages of the investigation, relevant circumstances that might explain any deviation of their billing pattern from the average.

²³⁹ See the text, *supra*, at note 154.

²⁴⁰ Ministry of Health and Long-Term Care, Supplementary Submission to The Hon. Peter Cory (November 2004) at 3.

OHIP reports that progress has been made in addressing this concern. The Joint OMA/Ministry Review of the MRC in 2001 recommended, and OHIP has implemented, the OHIP Payment Review Program (OPRP),²⁴¹ which provides an opportunity for the physician to explain and resolve a billing matter with OHIP before the physician is referred for audit.

Conclusions:

If an investigation and audit flows from a statistical analysis, that analysis itself must be fair and transparent. Physicians who are audited suffer considerable anxiety and dislocation to their practices. Accordingly, the information on which a referral for audit is made must be clear, cogent, and reliable. Physicians should know the basis upon which their billing patterns are compared with those of other physicians. Thus the basis on which a physician is compared with other physicians, and the manner in which the comparison group is selected, must be disclosed. Without full disclosure, physicians rightly feel hampered in assessing the statistical validity of the programs, and their confidence in them is undermined.

Programs like the ACG software, which can produce a more finely tuned analysis of physician billing patterns, will provide more accurate comparative information about physician billing, enabling physicians to be compared with true peers. Accordingly, these programs can assist in protecting physicians from unnecessary and disruptive billing audits. Medical Consultants may also perform this gate-keeping function if they have access to relevant information. However, the work of the Consultants does not address the other purpose of the ACG software, which is to produce billing profiles that are relevant and useful to guide physicians in assessing the reasonableness of their own billing patterns. Accordingly, I do not accept the position of OHIP that the ACG software, or other more refined software, is rendered redundant by the work of the Medical Consultants. Although more refined software programs are costly to develop and implement, it appears, from the experience of other jurisdictions, that they generate real benefits.

The role of the Medical Consultants ensures that the decision to initiate an audit is informed by medical judgment. Yet, if this process is to work effectively, the Medical

²⁴¹ See the text at note 39-41. See Ministry of Health and Long-Term Care, Submission (July 2004), at 23 (Appendix 1, item 5). See Transcript, November 2, 2004, at 158 (lines 2-25).

Consultants must have access to all of the relevant data, including any explanations that physicians may provide for an apparent aberration in their billing pattern.

The referral to audit is a serious matter, and should be undertaken with great care. If OHIP rejects an explanation of billing patterns that is subsequently accepted by the Audit Hearing Panel, the physician should ordinarily be compensated for any costs incurred in the medical audit process. Moreover, in cases where the Panel determines that OHIP's rejection of the explanation was unreasonable, the Panel should have authority to award to the physician up to \$10,000 as compensation for the unjustified disruption an audit has created in the physician's practice and family life.

RECOMMENDATIONS:

- (47) OHIP should disclose the methods used in its statistical analysis of billing patterns and should use only those that take account of the nature of the practice of the physician under review.**
- (48) OHIP should continue to develop its programs for analyzing billing patterns so as to generate more relevant and useful comparative data. More refined data will be more useful in the audit investigation process and more useful in guiding physicians' billing practices. In particular, OHIP should continue to investigate the case-mix adjustment software program used in British Columbia and the feasibility of incorporating the features of that program into the Ontario audit system.**
- (49) OHIP should continue to operate the OHIP Payment Review Program (OPRP). The program must operate in a manner that respects the fact that a physician may have a perfectly acceptable explanation for an apparent deviation from average billing patterns. The General Manager should not make a decision to refer a physician for audit until any such explanation has been sought, given and carefully assessed.**
- (50) If OHIP rejects an explanation of billing patterns that is subsequently accepted by the Audit Hearing Panel (or on appeal from the Panel's decision), the physician should ordinarily be compensated for any costs incurred in the medical audit process. In addition, in cases where the Panel determines that OHIP's rejection of the explanation was unreasonable, the Panel should have authority to award to the physician up to \$10,000 as compensation for**

the unjustified disruption an audit has created in the physician's practice and family life.

b. The need for prior notification of billing deficiencies, the unfairness of retrospective recovery, and the importance of programs to encourage compliance

Physicians told me that it often comes as a surprise to them that their fee claims do not meet the requirements of the *HIA* and the Schedule of Benefits. Accordingly, they submit that there should be an onus on OHIP to alert the physician to any billing problem. In addition, they submit that there should be no recovery of fees already paid to the physician except in cases where the physician persists in billing in the same manner after receiving a warning.

In response, OHIP states that, if physicians were allowed to keep all payments received for incorrect claims prior to detection and notice, there would be no deterrent to inappropriate billing.²⁴² OHIP submits that physicians must ultimately remain responsible for their billings, particularly in light of the difficulty of screening 150 million claims a year from more than 20,000 physicians.²⁴³

Nonetheless, OHIP acknowledges that early notification of billing problems is desirable. OHIP has established the Provider Education Program (PEP) to identify physicians whose claims patterns differ substantially from those of their peers and to provide them with information to encourage compliance with billing requirements.²⁴⁴

In addition, annual profiles²⁴⁵ that provide relevant and accessible comparative information would alert a physician to potential problems that could lead to an audit investigation.

These initiatives, together with clarification of the Schedule of Benefits and record-keeping requirements referred to earlier, would provide sufficient notice to physicians that they

²⁴² *Ibid.*, at 90 (Appendix 11, item 1).

²⁴³ Ministry of Health and Long Term Care, Submission (July 2004), at 15.

²⁴⁴ *Ibid.*, at 23 (Appendix 1, item 7).

²⁴⁵ See Recommendation 108.

are at risk of audit and potentially liable to recovery of fee payments. In the transition period, prior to full implementation of these recommendations, it should be open to a physician to argue that, in the circumstances, no reasonably informed physician could have known that the impugned fee claims did not comply with billing requirements. Further, my recommendations regarding the application of extrapolation²⁴⁶ respond to the concerns raised by physicians about retroactive imposition of ambiguous billing requirements.

RECOMMENDATIONS:

- (51) Physicians should be responsible for complying with clear billing requirements, as set out in the Schedule of Benefits and the standards for record-keeping for billing purposes, and as explained in information published under the authority of the Education and Prevention Committee, a joint committee of OHIP and the OMA.**
- (52) The Provider Education Program should be continued and enhanced to identify and correct billing problems at an early stage.**
- (53) Where the physician can establish that, in the circumstances, no reasonably informed physician could have known that the impugned fee claims did not comply with billing requirements, the claims should not be subject to repayment.**
- (54) In cases where the physician has not had clear and sufficient notice that his or her fee claims may be deficient, recovery should be based only on actual deficiencies without applying extrapolation.**

c. Length of billing period that is under review in an audit

Physicians assert that there should be an onus on OHIP to be prompt in challenging fee claims that OHIP disputes. A delay in challenging claims may expose a physician to significant liability.

In response, OHIP states that, typically, it applies a 24-month review period. It asserts that the 24-month period is appropriate, taking into account OHIP's limited investigative resources, the volume of fee claims, the need to recover public funds where they have been

²⁴⁶ See Recommendations 91 and 92.

advanced on the basis of inaccurate information, and the importance of deterring physicians from making improper fee claims. OHIP did not take the position that it requires 24 months to review fee claims.²⁴⁷ In other jurisdictions examined, review periods range from twelve to 36 months.

OHIP argues against any formal limitation period against the review of claims. It submits that, if information about incorrect claims comes to its attention later than 24 months following the submission of the claim, it should be able to investigate and, in appropriate circumstances, recover the payment. In particular, OHIP submits that it should retain discretion to extend the review period in respect of a physician who persists in incorrect billing of the same fee codes but is not discovered until an audit is undertaken several years later.²⁴⁸ OHIP relies on the fact that physicians are required to keep their medical records for ten years.

Conclusions:

Physicians are entitled to reasonable certainty in their financial planning. They are required to submit their fee claims within six months of rendering the service,²⁴⁹ and they should be entitled to know whether a fee claim is challenged within twelve months of submitting it. If a “best practices” standard is adapted to Ontario, an argument can be made for reducing the review period to twelve months when the new audit system is operational.

In my view, OHIP should be entitled to apply to the Health Services Appeal and Review Board to extend the review period only where it can establish that there are reasonable grounds to believe that a physician has deliberately engaged in a misleading or fraudulent pattern of billing. If it is established that billing by a physician has been fraudulent, then, as in all other cases of fraud, there should be no time limitation on the prosecution of the fraudulent billing. This, however, must be the exception to the general time limitation and would be applicable only in cases of fraud.

²⁴⁷ Transcript, November 2, 2004, at 174 (line 6) to 175 (line 2).

²⁴⁸ Ministry of Health and Long-Term Care, Submission (July 2004), at 91 (Appendix 1, item 3).

²⁴⁹ *Supra*, note 18.

RECOMMENDATIONS:

- (55) The *HIA*, or regulations passed pursuant to that Act, should specify that OHIP may not claim repayment of fees from a physician unless it notifies the physician that the fee claims are subject to audit within twelve months after the physician submits the claim.
- (56) As a transitional provision, until a new audit system is in place, the time limit for OHIP to notify a physician that fee claims are subject to an audit should be 24 months.
- (57) The limitation period for reviewing accounts should be extended only if OHIP establishes, on application to the Health Services Appeal and Review Board, that there are reasonable grounds to believe that a physician has deliberately engaged in a misleading or fraudulent pattern of billing fee claims.

11. OHIP referral of physician to the Physician Audit Board

Conclusion:

If OHIP concludes, after considering any explanation provided by the physician, that a complaint, a negative response to a verification letter or a variance in billing pattern warrants an audit of the physician's billings, it should refer the matter to the Physician Audit Board. The referral should be made only after attempts have been made to correct the problem and settle any repayment owed by the physician.

If the referral is one of the relatively rare cases in which extrapolation could apply (as to which issue see the discussion at page 141 of this report), it will be necessary that OHIP identify a statistically significant sample of patients who have been selected randomly from a list of claims for fee codes that are in dispute. The physician will be asked to produce the records of these patients for review and photocopying.

RECOMMENDATIONS:

- (58) If OHIP concludes, after considering any explanation provided by the physician, that a complaint, a negative response to a verification letter or a deviation in billing patterns warrants an audit of the physician's billing, it may refer the matter to the Physician Audit Board. The referral should be made only after attempts have been

made to correct the problem and settle any repayment owed by the physician.

- (59) If the referral is one of the relatively rare cases in which extrapolation could apply, it will be necessary that OHIP identify a statistically significant sample of patients, who have been selected randomly from a list of claims for each fee code that is in dispute. The physician will be required to produce the records of these patients for review and photocopying.

12. Direct Recovery

Physicians have complained about the authority of the General Manager of OHIP to make a direct recovery and enforce it against the physician despite the fact that the physician disputes the claim or that a review or appeal is pending.

Pursuant to the current statutory provisions, when the General Manager determines that a physician has submitted fee claims that do not meet billing requirements, he may calculate the amount owing and withhold that amount from future fee payments owing to the physician.²⁵⁰ Even though the physician can request a review of the General Manager's decision by the MRC, and appeal further to the HSARB and the Divisional Court, the General Manager is entitled to recover the funds pending the final disposition.²⁵¹ Physicians indicate that this set-off pending review is not only unfair but can lead to very serious financial hardship.

OHIP takes the position that, if recovery is delayed, there is a risk that the debt may never be collected.²⁵² In the past ten years, more than \$3.5 million in recoveries has been lost because of physician bankruptcies, and more than \$6.5 million has been lost because physicians have left Ontario or moved assets beyond the jurisdiction.²⁵³

²⁵⁰ *Health Insurance Act*, *supra* note 5, at s. 27.2(1), and see text at note 30, *supra*.

²⁵¹ *Health Insurance Act*, s. 27.2(2).

²⁵² Ministry of Health and Long-Term Care, Submission (July 2004), at 91 (Appendix 11, item 10) and 93 (item 15).

²⁵³ *Ibid.*, at 93 (item 15).

OHIP acknowledges that, at common law, the collection of a debt is generally stayed pending appeal, but asserts that the public interest justifies overriding the usual legal approach in this instance.²⁵⁴ OHIP notes that information relevant to an assessment of the risk factors regarding incipient bankruptcy or departure from the jurisdiction is not within the knowledge of OHIP, and accordingly, the onus should not be on OHIP to establish that immediate enforcement is justified or to seek security for the payment of the debt.²⁵⁵

Nonetheless, OHIP reports that, pursuant to the 2003 Agreement between the Ministry and the OMA, the General Manager has agreed to exercise discretion, in accordance with established criteria, on the requirement of recovery pending appeal, including an option for the OMA to provide security as an alternative to the physician paying the debt.²⁵⁶

Conclusions:

In light of the serious consequences that may result to a physician who is subject to a direct recovery order, OHIP should be able to exercise direct recovery only where it establishes that there are reasonable grounds to believe that the physician is liable to OHIP for the repayment of fees and that the physician is on the verge of insolvency, departing the jurisdiction, or moving assets out of the jurisdiction. Apart from that, the public interest in OHIP's ability to recover payments should not outweigh the public interest in fairness to the physician pending a review by the Physician Audit Board, an appeal to the Health Services Appeal and Review Board, or a further appeal to the Divisional Court. OHIP should be entitled to make application to any of these bodies for an order of direct recovery or set-off on the grounds that I have specified.

RECOMMENDATIONS:

- (60) Section 27.2(2) of the *HIA*, authorizing OHIP to exercise direct recovery of fee payments without a determination having been made by the MRC (Physician Audit Board) that they are due and owing, should be repealed.**
- (61) OHIP should be authorized to apply to the Physician Audit Board, the Health Services Appeal and Review**

²⁵⁴ *Ibid.*, see, also, Transcript, November 2, 2004, at 162 (line 12) to 163 (line 3).

²⁵⁵ Transcript, November 2, 2004, at 160 (line 9) to 163 (line 3).

²⁵⁶ Ministry of Health and Long Term Care, Submission (July 2004), at 25 (Appendix 1, item 7).

Board or the Divisional Court as the case may be for an order authorizing direct recovery of fee payments and any applicable interest. The direct recovery may be by way of set-off or other claim. An order for direct recovery should be made only where OHIP establishes reasonable grounds to believe that the physician concerned is on the verge of insolvency, departing the jurisdiction or moving assets out of the jurisdiction.

13. Notifying a physician of an audit

Conclusion:

The audit of any fee claim by the Physician Audit Board must begin with a letter from the Chair of the Board, advising the physician of the grounds for concern, enclosing information about the audit process and disclosing the material referred to the Board by OHIP. The letter should ask for any additional explanation the physician would like to put forward in writing within thirty days of receipt of the letter. The letter should also invite the physician to select, from among three dates, a time for the visit of an Inspector. The letter should be restrained and polite and acknowledge that, in many cases, a physician can provide a satisfactory explanation to a billing complaint or concern.

RECOMMENDATIONS:

- (62) The letter from the Chair of the Physician Audit Board notifying a physician of an investigation and audit should specify the grounds for concern, disclose the material provided by OHIP, enclose information about the audit process, solicit any explanation from the physician, to be forwarded in writing within thirty days of receipt of the letter, and invite the physician to select, from among three dates, a time for the visit of the Inspector assigned to the matter.**
- (63) The letter should be restrained and polite and acknowledge that in many cases, a physician can provide a satisfactory explanation to a billing complaint or concern.**

14. Inspection

Conclusions:

When a referral is received from OHIP, the Chair of the Physician Audit Board should assign an Inspector to the case as well as a staff member with responsibility for processing the

case. The Inspector selected should be in the same practice field and setting as the physician, or as close to it as reasonably possible.

The Inspector will attend at the physician's office, on a date determined in consultation with the physician, to speak to the physician, and to examine and copy records. A clerk should accompany the Inspector to assist with the photocopying of records as it is needed. Patient records should be reviewed only by the Inspector.

The physician should have the right to be represented by an agent or lawyer during the inspection. In addition, the physician should be permitted to present the evidence of patients, provided they consent to speak with the Inspector, and the evidence of any medical expert who has been invited to attend by the physician.

After examining the patient records, speaking to the physician and perhaps to patients and any medical expert in attendance, the Inspector will prepare a full report on the information obtained through the inspection, and provide his or her assessment as to whether the fee claims substantially comply with billing requirements.

The Inspector may well have access to information that would not have been available to OHIP when the referral to audit was made. If the Inspector concludes that this is a situation that very clearly calls for a termination of the audit process, the Inspector will make a recommendation to that effect to the Chair of the Physician Audit Board. The Chair may either accept the recommendation and terminate the audit or direct that the audit proceed. In either event, a copy of the Inspector's report, and the Chair's decision, will be sent to the physician and to OHIP.

If the Inspector is not satisfied that the fee claims are correct but determines that the errors are clerical in nature, or made in good faith, or based upon an erroneous interpretation of the Schedule of Benefits, then the Inspector may make other recommendations. For example, in those circumstances, the Inspector may recommend that the errors in billing should be rectified with education. The Inspector will consider what education is required and how long the doctor's fee claims should continue to be reviewed, which should not in any event exceed six months.

The Inspector's written report will set out the findings from the inspection, and the reasons supporting the Inspector's recommendation.

A copy of the Inspector's report will be provided, within fifteen days of completion of the inspection, to OHIP, the physician and the Chair of the Physician Audit Board. The physician will then have fifteen days from receipt of the Inspector's report to deliver any reply.

RECOMMENDATIONS:

- (64) When an audit referral is received from OHIP, the Chair of the Physician Audit Board should assign an Inspector who is in the same practice field and setting as the physician, or as close to it as reasonably possible.**
- (65) A staff member should be assigned to co-ordinate the processing of the investigation and audit throughout the proceeding.**
- (66) The Inspector will attend at the physician's office, on a date to be determined in consultation with the physician, to speak with the physician and to examine and copy records. A clerk should accompany the Inspector to assist with photocopying records as it is needed. Only the Inspector should review patient records.**
- (67) The physician should have the right to be represented by an agent or lawyer during the inspection. In addition, the physician should be permitted to present the evidence of patients, provided they consent to speak with the Inspector, and the evidence of any medical expert who has been invited to attend by the physician.**
- (68) After examining the patient records, speaking to the physician and perhaps to patients and any medical expert in attendance, the Inspector will prepare a full report on the information obtained through the inspection, and provide his or her assessment as to whether the fee claims substantially comply with billing requirements.**
- (69) At the conclusion of the inspection, the Inspector may, in situations that would warrant, recommend immediate termination of the audit process. Alternatively, the Inspector may recommend that the audit process should proceed. In either event, the Inspector will set out brief reasons for the decision. The Chair of the Physician Audit**

Board may, on receipt of the Inspector's report, either terminate the audit or direct the audit to proceed.

- (70) If the Inspector is not satisfied that the bills are correct but determines that the errors are clerical in nature, or made in good faith, or based upon an erroneous interpretation of the Schedule of Benefits, or trivial in nature and not warranting an audit of the physician's accounts, then the Inspector may recommend to the Chair of the Physician Audit Board other remedies, including education in billing requirements and monitoring of billings for a period not to exceed six months. The Chair of the Physician Audit Board may, on receipt of the Inspector's report, order that the Inspector's recommendation be adopted and put into effect or direct that the matter proceed to an audit before the Physician Audit Board.
- (71) Within fifteen days of completing the inspection, the Inspector will deliver to the physician, to the Chair of the Physician Audit Board, and to OHIP a report on the findings of the inspection, together with reasons to support his or her assessments and recommendations.
- (72) The physician will then have fifteen days from receipt of the Inspector's report to deliver any reply.

15. Procedure before the Audit Hearing Panel

a. Composition of the Audit Hearing Panel

Conclusion:

There is general agreement that the Hearing Panel for each audit review should be composed of four members: one public member and three physicians, including one who practices in the same or as close as reasonably possible to the same specialized field and practice setting as the physician whose fee claims are to be reviewed. If one of the assigned members, other than the member who is considered to be a peer and who must be present, is unable to participate in the hearing, any three members of the Hearing Panel will suffice to reach a decision on the matter before them.

RECOMMENDATIONS:

- (73) The Audit Hearing Panel for each audit review should be composed of four members: one public member and three physicians, including one who practices in the same or as close as reasonably possible to the same specialized field and

practice setting as the physician whose fee claims are to be reviewed.

- (74) If one of the assigned members, other than the member who is considered to be a peer, is unable to participate in the hearing, any three members of the Hearing Panel will suffice to reach a decision on the matter before them.**

b. Procedure: Most jurisdictions have established informal procedures in their audit processes, emphasizing dispute resolution. In Ontario, however, the lack of procedural protections in the MRC review process has become a major focus for concern. While there should be opportunities to settle disputes, free from the pressure of excessive costs provisions, it is also important to provide, at an early stage in the proceedings, a fair and full review by an independent tribunal.

Several physicians have submitted that a combination of factors made them feel that, in the eyes of OHIP and the MRC, they were “guilty” until proven “innocent.” It is understandable that many physicians view a challenge to their fee claims as impugning their professional integrity. They feel as stigmatized by an audit of their fee-for-service records as they would by allegations of professional incompetence or misconduct. Physicians have recounted to me that their anxiety was exacerbated by the manner in which they were treated by Inspectors and by members of the MRC.

OHIP’s response to this concern reflects little appreciation that physicians perceive an audit as a serious risk to professional reputation. OHIP appears to dismiss the physicians’ concern:

“There is no question of guilt or innocence – there is no conviction, no fine, no incarceration, and no criminal or public record. This is an audit of paid accounts. If the audit finds that the services for which the physician is paid have not been rendered, have been misrepresented, were not medically necessary, or were not performed within professional standards, then the General Manager is directed to recover the monies paid.”²⁵⁷

²⁵⁷ Ministry of Health and Long-Term Care, Submission, (July 2004), at 92 (Appendix 11, item 8).

Physicians criticize the MRC process in which there is no presentation of the evidence that can be challenged on cross-examination, members of panels take on the role of questioning the physician, and panels come to preliminary determinations before hearing from the physician.

In its submissions, OHIP initially asserted that the MRC procedures met the requirements of “natural justice” or procedural fairness. In OHIP’s view, natural justice required only that the accuser should not be the judge and that the accused has the right to be heard. OHIP noted that the MRC is independent of the Ministry, that a physician has the opportunity to be heard and to be represented by legal counsel in MRC processes, that a lawyer is usually provided for the MRC hearing, and paid for, by the Canadian Medical Protective Association, and that the physician has a right of appeal to the Health Services Appeal and Review Board (HSARB) and subsequently to the Divisional Court.²⁵⁸

A representative of OHIP expressed satisfaction that the process had worked in the case of Dr. Lyttle.²⁵⁹ In my view, one would not want the process to “work” in that fashion too often. It would be preferable to provide a full and fair hearing process, applying appropriate criteria, at the first instance of tribunal review. Instead, the MRC had developed a complex process of consideration and reconsideration, in which its panels first came to a decision and only then heard from the physician, thus casting a burden on the physician to dissuade the panel from the decision it had already made. Not until a case reached the HSARB on appeal would the physician get a full and fair hearing.

At the conclusion of oral submissions, representatives of OHIP indicated that it would have no objection to adopting, for the new audit process, procedures that comply with the requirements of natural justice and the *Statutory Powers Procedure Act*.²⁶⁰ I confirm the wisdom of that decision.

²⁵⁸ Ministry of Health and Long Term Care, Submission, (July 2004), at 91 (Appendix 11, item 4).

²⁵⁹ Transcript, November 2, 2004, at 164 (line 10) to 166 (line 17).

²⁶⁰ R.S.O. 1990, c. S-22 (attached to the Report as Appendix 8); Transcript, November 2, 2004, at 179 (lines 8-23).

Conclusions:

The Physician Audit Board will always have challenging decisions to make. It must interpret and apply that difficult and complex document, the Schedule of Benefits. It must assess diverse medical services. Because its work is challenging, and can have a very significant impact on physicians, the Board must, in all its procedures, operate fairly. In order to have the confidence of physicians and the public, it must be, and appear to be, an independent and unbiased body. Its procedures must, to the extent possible, be clear and transparent, and its work must proceed expeditiously. Above all, the Physician Audit Board must deal fairly with the physicians who appear before it.

It is very clear that the investigation of physician fee claims is not a routine audit, that physicians are justified in feeling that their professional reputations are at risk, and that it is essential that they be afforded the protections of fair procedures. The grounds on which fees may be recovered include misrepresentation, rendering services that are not medically necessary, and failing to comply with professional standards. Physicians quite properly take these matters very seriously. Professional reputations are at stake and the potential financial exposure can be crippling.

The potentially serious consequences of an audit decision demand that the decision of the Audit Hearing Panel be reached fairly. The physician who is subject to an audit must be treated in a manner that is respectful, patient, courteous and sensitive to his or her situation.

The case against the physician should be presented by or on behalf of OHIP. The onus of proof should be on OHIP throughout to establish, on a balance of probabilities, that there are significant errors in the physician's fee claims. I am aware that the standard of proof for the MRC in a review based on patterns of practice, is "reasonable grounds to believe."²⁶¹ In effect, this standard shifts the burden of proof to the physician. In my view, this standard is insufficient and unfair. I say this in light of the grave and serious consequences of an audit to the physician. Fairness requires that the onus be upon OHIP to establish the physician's liability to repayment on a balance of probabilities.

²⁶¹ *Health Insurance Act*, *supra* note 5, at s. 39.

There cannot be a fair hearing without appropriate statutory safeguards. The audit hearing must be subject to the *Statutory Powers Procedure Act*.²⁶² The Act will go far to ensure the fairness of the hearing. The physician under review is certainly entitled to notice, to production of all material upon which the referral for audit is based, to cross-examine the witnesses alleging billing errors, to call witnesses (including experts), to make representations and submissions, and to be represented by counsel throughout the proceeding. The physician should be provided with legal counsel, preferably through the Canadian Medical Protective Association. In addition, the physician is entitled to the delivery of written reasons by the Hearing Panel. The reasons must explain the basis of the decision and must include the Panel's assessment of any expert evidence that has been called. The reasons must be delivered within thirty days of the close of submissions. Ordinarily, the Panel will proceed on the basis of consensus, but a member of the Panel who dissents should file dissenting reasons.

My recommendations concerning the procedures of the Audit Hearing Panel are crucial in ensuring an audit system in which physicians will have confidence. A physician subject to audit must be entitled to a full hearing before an independent and unbiased Hearing Panel, which, through fair procedures, receives and assesses the evidence, listens to submissions, and applies its judgment. The Hearing Panel must determine the extent to which the physician's fee claims are substantiated and the extent to which they substantially comply with the requirements of the Schedule of Benefits. The Hearing Panel must interpret the Schedule of Benefits in a practical manner, taking into account the realities of medical practice. In addition, the Hearing Panel must determine the appropriate remedy.

In exercising this important and challenging jurisdiction, the Hearing Panel should have the benefit of evidence that has been tested by examination and cross-examination and submissions from both parties. These recommendations are crucial to ensuring that the audit system will have the confidence and respect of the physicians. It will always be vitally important that an independent tribunal, fully informed through fair procedures and hearings, exercise its judgment on the validity of physician fee claims. This will be of particular importance until such

²⁶² *Supra*, note 260.

time as the Schedule of Benefits and the requirements of record-keeping are revised and adapted to current conditions.

RECOMMENDATIONS:

- (75) In the audit process, a physician is entitled to be treated with respect, patience and courtesy. Any explanations the physician provides should be carefully considered.**
- (76) A code of conduct should be developed for those dealing with physicians in the audit process and should form part of the orientation programs provided to members of the Audit Hearing Panel.**
- (77) Because of the serious implications of an audit for the physician it is essential that the audit hearing process be fair. An independent and unbiased Hearing Panel must base its decision on evidence that may be tested on cross-examination and after hearing submissions from both sides of the matter. Members of the Panel must not take the lead in questioning the physician. Rather, any questions they put to the physician should be directed solely to clarifying the issues or the evidence.**
- (78) The case against the physician should be presented by or on behalf of OHIP. The onus should be on OHIP to establish, on a balance of probabilities, that a fee claim is not justified.**
- (79) The audit hearing must be subject to the *Statutory Powers Procedure Act*. The physician must be entitled to receive notice, receive production of all material upon which the referral for audit and the Inspector's report is based, to cross-examine the witnesses alleging billing errors, to call witnesses (including patients and experts), to make representations and submissions, and to be represented by counsel throughout the proceeding. Counsel should be provided, preferably through the Canadian Medical Protective Association.**
- (80) In addition, the physician is entitled to the delivery of written reasons by the Hearing Panel, within thirty days of the close of submissions. The reasons must explain the basis of the decision and must include the Panel's assessment of any expert evidence that has been called. Ordinarily, the Panel will proceed on the basis of consensus, but a member of the Panel who dissents should file dissenting reasons.**

c. Marginal increase in cost of a full hearing process

I have been told that the MRC avoided meeting with physicians whose fee claims were being audited because of a concern for incurring costs that would be charged to the physicians. I have dealt with costs elsewhere, but I acknowledge that a hearing under the *Statutory Powers Procedure Act* is likely to be more expensive than a less formal proceeding. I note that the expenses may be reduced in those instances where OHIP and the physician can settle upon the provisions of an Agreed Statement of Facts for submission to the Hearing Panel. In addition, it should be open to the parties to enter into a settlement at any stage of the proceedings. In combination with the educational and early identification programs discussed above, it appears that there will be a marked reduction in the number of audits. This will, of course, reduce the overall expenses of physician audits.

In addition, a full hearing will be efficient in that it will avoid the multiplicity of panels engaged in considerations, reconsiderations, reviews by panels differently constituted, calculations, and recalculations that characterized the MRC process and added to its inefficiency. Furthermore, by providing a full hearing before the Physician Audit Board, any review by the HSARB can be based on the record below and will not require an appeal in the nature of a new hearing. In my view, it is completely unacceptable to require that the physician wait to appeal to HSARB before he or she obtains a full and fair hearing.

In any event, the marginal increase in the cost of the hearing process is justified by the importance of the issues and the necessity to provide a fair hearing process.

d. Proof of compliance with billing requirements

Physicians have submitted that it should be possible to establish compliance with billing requirements not only by reference to the physician's chart, but also on the basis of other evidence from the physician or a patient that the insured service defined in the Schedule of Benefits was substantially rendered. By contrast, it appears that the only concern of OHIP and the MRC has been whether the physician's records contain the documentation required to support the fee claim. I was told that some dedicated physicians, who worked seventy-hours a week to provide patient care in under-serviced areas, were denied fees for the services they had rendered because their patient charts did not establish that all inquiries required by the Schedule of

Benefits had, in fact, been undertaken. It was said that, despite physicians sacrificing their own family life to work long hours responding to patient needs, and despite the fact that they did not submit claims for all the services they actually performed, they were directed to repay the fees they had claimed as compensation for their service.

OHIP's response is that the audit process established by the *HIA* focuses on patient records as the basis for determining whether a fee claim is justified, and that part of the fee is awarded for recording the services provided. As I observed earlier, s. 37.1 of the *HIA*, provides (in paraphrased form) that,

- a. no fee is payable unless the record contains the necessary information to establish
 - i. that the physician provided the service and
 - ii. that it was medically necessary, and
- b. if a fee is payable, its amount depends on the description of the service provided in the record.

As provided in the legislation, a physician's fee claim can be rejected in whole or in part solely on the basis of inadequacy of the doctor's records. Application of this rule appears to be inflexible, no matter how appropriate, useful and important the service may actually have been to the patient. In its written submission, OHIP supported this approach to auditing, asserting that, by focusing on the record, audits can be objective and consistent.²⁶³ Physicians have responded that they became doctors, not to keep records, but to treat patients. They assert that it is grossly unfair to put hard-working physicians at risk by requiring them to repay very substantial sums for services that they did, in fact, render, but did not adequately document.

In oral submissions, representatives of OHIP indicated some willingness to look beyond the physician's records and to consider other evidence that could support a fee claimed. The OHIP representative stated that

“[T]he record should be the *primary source* for the review of the audit body, because that record is created at the time of service, as soon as possible as the service is created, and that should be the principal starting point for reviewing the records. *It doesn't mean that*

²⁶³ The Ministry of Health and Long-Term Care, Submission (July 2004), at 94 (Appendix 11, item 16).

*other information cannot be ... presented by the physician or OHIP during the course of the review... ”*²⁶⁴

Conclusion:

It is essential that OHIP and the audit process have the flexibility to look beyond the records to other proof that a particular service was rendered. Anything less can be grossly unfair. Moreover, it provides incentives for physicians to attend to record-keeping in priority to the treatment of patients. Fairness and the welfare of patients require that flexibility and good judgment be exercised in investigating sources of evidence in addition to the physician's records in determining whether a fee claim accurately reflects the service performed by the physician.

RECOMMENDATIONS:

- (81) **Section 37.1 of the *HIA* should be amended to provide that a physician's records are the primary focus of an audit investigation, but a physician may also introduce other evidence to establish that an insured service defined in the Schedule of Benefits was substantially rendered and therefore eligible for payment. Other evidence might include evidence from patients, professional colleagues or staff members.**
- (82) **Record-keeping requirements for billing purposes should be applied in a manner that takes account of the realities of medical practice and ensures that incentives do not give priority to record-keeping to the detriment of patient care.**

16. Time for completion of review

Physicians spoke of instances where an audit investigation had been started and an inspector had called, but the physician then heard nothing further about the audit for months, indeed, on some occasions, for years. They submitted that audit proceedings, and delays in completing the process, seriously disrupted their practices and their lives. They contended that there should be clear time limits for the holding of the hearing and for the delivery of the reasons by the Hearing Panel.

²⁶⁴ Transcript, November 2, 2004, at 159 (line 24) to 160 (line 9), emphasis added.

All participants agreed that it is important to expedite the process. OHIP has established a benchmark of 100 days for completion of its OHIP Payment Review Program (OPRP), and considers that the full audit process should be completed within a year.²⁶⁵ The MRC had also established benchmarks and guidelines for its processes,²⁶⁶ but was concerned that it could not get timely responses from OHIP regarding the calculation of the amounts of fee payment recoveries.

Conclusions:

It is important that the investigation and audit process be completed expeditiously. The audit process is likely to disrupt not only the physician's practice and family life but also the physician's peace of mind and financial security. It needs to be brought to a conclusion as soon as possible. The staff member assigned to co-ordinate the audit should prepare a time line for that audit and encourage Inspectors and Hearing Panels to keep to the schedule. The time line should be calculated on the following basis (in each instance the number of days refers to working days):

Day 1	Physician Audit Board (PAB) receives referral from OHIP File is opened and staff coordinator is assigned. Chair appoints Inspector who provides three possible dates for conducting the inspection.
Day 10	Notification letter, with supporting documents, is prepared and sent to the physician and to the Inspector.
Day 30	Physician may deliver a response (within 15 days of receipt of letter). Response is transmitted to the Inspector.
Day 60	Visit by Inspector to physician's office. Inspector interviews physician and photocopies records; at request of physician, Inspector speaks with patients, colleagues and/or expert witnesses; possible delays as result of availability of physician, physician's advisor/lawyer and witnesses. The inspection is completed.
Day 75	The Inspector then prepares reasons for his or her decision to terminate the process or proceed with the audit and delivers the report to the Chair of PAB, the General Manager of OHIP and the physician. The report must be delivered within fifteen days of completion of the inspection.
Day 80	Chair of PAB either accepts the Inspector's recommendation to terminate the audit process or appoints a Hearing Panel and sets a date for Hearing.
Day 90	The physician delivers his or her response.

²⁶⁵ Transcript, November 2, 2004, at 173 (line 8), to 174 (line 5).

²⁶⁶ College of Physicians and Surgeons of Ontario, Additional Material requested by The Hon. Mr. Cory (October 2004) at 18 ff.

Day 130	The Hearing is completed (subject to any necessary adjournments).
Day 160	The Hearing Panel delivers its reasons.

I recognize that, in complex cases, the time required to complete an investigation may need to be extended. In addition, the circumstances of the physician, the availability of his or her counsel, and the availability of witnesses for the physician may make it difficult to comply with the proposed timeline. To the extent that circumstances warrant, the Inspector and the Hearing Panel should be responsive and flexible in accommodating the physician, but they should use their best efforts to proceed with the audit investigation and review in a timely manner. The staff co-ordinators should report regularly to the Chair of the Physician Audit Board regarding the status of audit investigations and reviews.

RECOMMENDATIONS:

- (83) The staff member assigned to co-ordinate the audit should prepare a time line for that audit and encourage Inspectors and Hearing Panels to adhere to the schedule.**
- (84) The following time limits should be specified:**
 - **PAB sends notification letter to physician within 10 days of receiving referral from OHIP.**
 - **Physician delivers response, if any, within 15 days of receiving the letter.**
 - **Inspector completes inspection within 30 days of receiving physician's letter.**
 - **Inspector delivers report within 15 days of completing inspection.**
 - **Physician delivers response, if any, within 15 days of receiving Inspector's report.**
 - **A hearing is scheduled to commence within 30 days of receiving the physician's response.**
 - **The Hearing Panel delivers its decision and written reasons within 30 days of close of submissions.**
- (85) To the extent that circumstances warrant, the Inspector and the Hearing Panel should be responsive and flexible in accommodating the physician, but should use their best efforts to ensure that the Inspector and the Hearing Panel comply with their obligations to process the audit investigation and review in a timely manner.**

- (86) Staff co-ordinators should report regularly to the Chair of the Physician Audit Board regarding the status of audit investigations and reviews.

17. Remedies

a. Remedial flexibility and fairness

The potentially ruinous impact of recovering substantial payments from physicians for services they did in fact provide is at the core of the outrage expressed to me by some physicians and their families. It is essential that this concern be addressed. All the fair and independent procedures count for little if the end result is that physicians are not compensated for services that they did in fact provide.

Moreover, the best practice remedial standards, recently adopted in New Zealand²⁶⁷ and the United States,²⁶⁸ recognize that “progressive corrective action” is appropriate in remedying physician fee-billing problems. In other words, the nature of the review process and the severity of the remedy should be proportionate to the seriousness of the billing problem. In addition, several jurisdictions, including the United States, provide for flexibility in the terms of a repayment order, taking into account the financial circumstances of the physician.

Conclusions:

I acknowledge that physicians who do not properly document their services must suffer a penalty. I also acknowledge that, in the absence of proper records, the onus is on the physician to establish through other means that he or she has provided services that warrant payment. In such cases, OHIP and the Physician Audit Board should have the authority to reduce the amount of a recovery where the result would unfairly deprive the physician of basic compensation for services the physician has rendered to patients.

My recommendations concerning the use of extrapolation are relevant to this issue.²⁶⁹ Apart from the extrapolation remedy, in situations where there is no evidence of bad faith or

²⁶⁷ See the text, *supra*, at note 195.

²⁶⁸ See the text, *supra*, at note 198.

²⁶⁹ See Recommendations 91 and 92.

fraudulent misconduct on the part of the physician, and the physician can establish by other evidence the nature and extent of patient care and service provided, the Audit Hearing Panel should be authorized to reduce the amount required to be repaid in order to ensure that the physician is fairly compensated for the services he or she has provided to patients. In making this determination, the Hearing Panel should also take into account the extent to which a physician may have provided insured services for which no fee claims were submitted or the services were under-billed.

The Hearing Panel should have a reasonable amount of flexibility to fashion remedies that are appropriate and applicable to the seriousness of the billing error that has been identified and to the circumstances of the physician who has made that error. For example, a Hearing Panel might determine that the billing problem would be corrected if the physician undertook a course or participated in one-on-one instruction. As well, it might determine that the physician's fee claims should be monitored for a period not to exceed six months, or until OHIP is satisfied that the billing problem has been corrected.

In addition, if an amount is found owing by a physician, the Hearing Panel should have authority to be flexible as to the terms of repayment. Those terms should reflect not only the nature or amount of the billing error but the financial circumstances of the physician.

In the most serious cases, when there has been a repetitive pattern of inappropriate billing or a flagrant disregard of the educational assistance provided to the physician, the Panel should also have authority to suspend or remove the physician's right to submit fee claims to OHIP.

RECOMMENDATIONS:

- (87) Section 37.1 of the HIA should be amended to provide that the General Manager of OHIP or the Audit Hearing Panel is authorized to reduce the amount of a recovery order where the result would unfairly deprive the physician of basic and fair compensation for the service the physician has rendered to patients.**
- (88) The Audit Hearing Panel should have discretion to fashion flexible remedies that take into account the nature and amount of the billing errors and the experience and circumstances of the physician.**

- (89) **The Hearing Panel should have authority to be flexible as to the terms of repayment, taking into account the nature and amount of the billing error and the financial circumstances of the physician.**
- (90) **In serious cases, when there has been a repetitive pattern of inappropriate billing or a flagrant disregard of the educational assistance provided to the physician, the Panel should also have authority to suspend or remove the physician's right to submit fee claims to OHIP.**

b. Extrapolation

Physicians have questioned the validity and fairness of random sampling and extrapolation as a method of determining the amount of a repayment owing for the review period when it is determined that some fee claims were billed at too high a rate. Extrapolation is based upon the assumption that, if a certain proportion of the physician's randomly selected patient records do not support a particular fee code under investigation, then the auditor can simply assume that a similar proportion of all those fee codes was improperly billed during the review period. It means that a physician could be found responsible for improper billing on a much greater scale based upon findings of improper billings on a much smaller scale. When extrapolation is used, most of the billing errors are never proven, they are simply assumed to have occurred.

One physician drew a comparison to making a finding that a driver is guilty of speeding and then making a determination by extrapolation as to the number of times he has exceeded the speed limit in the past two years. Of course, one instance of wrongdoing would not provide a statistically sound basis for extrapolation, but even a statistically sound sample would not meet the standard of proof in a criminal, or probably even in a civil, court proceeding. OHIP notes, however, that extrapolation (i.e. the method of inferring from statistical sampling) has been validated by the courts in review of MRC processes, and has been confirmed by recent reports on

the statistical methods used by OHIP and by the MRC.²⁷⁰ OHIP asserts that the statistical method used in sampling provides the “best estimate” for the proportion of incorrect claims.²⁷¹

The problem, though, is that all it provides is an estimate, and an estimate does not constitute proof of the amount actually owing. OHIP’s answer to concerns about the accuracy of the “estimate” is that a physician can seek review of a larger sample.²⁷² Unfortunately, the results of the larger sample continue to be nothing more than an “estimate”.

In any event, OHIP confirms that confidence intervals can improve with the number of records sampled, and indicates that it is willing to consider any process that would improve confidence intervals.²⁷³ It appears that the unit sampling approach used in medical audits in British Columbia examines a significantly larger sample of claims.²⁷⁴ The College has retained an expert who has made recommendations for improving the statistical validity of extrapolation, but the College also indicated that it supports more limited use of extrapolation.²⁷⁵ In the U.S. Medicare Program,²⁷⁶ extrapolation can no longer be used to determine recovery amounts except where the carrier establishes that a physician has engaged in a sustained or high level of payment error or has failed to correct payment errors despite documented educational intervention.

OHIP has submitted that the U.S. Medicare experience with extrapolation is not relevant in Ontario. In particular, it notes that U.S. carriers had been using samples that were not statistically valid, and that the federal Medicare agency had directed them to use valid samples.²⁷⁷

²⁷⁰ See Ministry of Health and Long-Term Care, Submission (July 2004), Appendix 2, Explanatory Notes at 26-27; Supplementary Submission (November 2004) at 5. Malcolm Griffin and Marshall Godwin, *supra* note 108; see also Susan Bondy, *supra* note 109.

²⁷¹ Ministry of Health and Long-Term Care, Supplementary Submission (November 2004) at 5.

²⁷² *Ibid.*, at 6.

²⁷³ Transcript, November 2, 2004, at 150-52.

²⁷⁴ See the text, *supra*, at note 160.

²⁷⁵ Transcript, November 2, 2004, at 131 (line 18) to 133 (line 8).

²⁷⁶ See the text, *supra*, at note 211.

²⁷⁷ *Ibid.*, at 7.

In response, OHIP asserts that its sampling process “does not require correction.”²⁷⁸ However, the U.S. Medicare agency went further than requiring valid samples. It also provided for the discounting of “estimates” produced by valid sampling²⁷⁹ and restricted the use of extrapolation regardless of the validity of the samples used. As discussed above, U.S. Medicare now restricts the use of extrapolation to those cases in which a physician has engaged in a sustained or high level of payment error or has not corrected payment errors despite documented educational intervention.²⁸⁰

Conclusion:

It may be that extrapolation is appropriate in some rare cases. Yet it is difficult to think of any situation in civil cases where statistics are used not to establish liability but to arrive at the amount of the recovery. It is to me significant that in the United States the use of extrapolation in physician audits, no matter how valid the sample, has been criticized and greatly limited. Certainly extrapolation has no place in the first auditing of a physician’s accounts. It is important that OHIP monitor fee claims as carefully as possible, identify problems as early as possible and address them with the physician, through the OHIP Payment Review Program and, if necessary, the investigation and audit process. The audit should address as many of the claims as OHIP decides to refer to the Physician Audit Board and the Board should review them as expeditiously as possible. I do not accept that the use of extrapolation is a fair substitute for effective and timely post-payment review of physician for claims. It is in most instances, unfair and unnecessary.

Extrapolation should be used to calculate the physician’s liability only on a second or subsequent audit where the physician has an established history of serious billing errors, or where the physician has continued to make billing errors despite documented efforts to educate the physician regarding billing requirements. The onus should rest upon OHIP to demonstrate that this is a case where it is appropriate to use extrapolation in light of the past history of the physician.

²⁷⁸ Ministry of Health and Long-Term Care, Supplementary Submission (November 2004) at 8.

²⁷⁹ *Ibid.*

²⁸⁰ See the text, *supra*, at note 210.

RECOMMENDATIONS:

- (91) The technique of extrapolation should not be applied in a physician's first audit. It should be used to calculate the extent of the physician's liability to repay fees only on a second or subsequent audit where the physician has previously been found liable to repay fees to OHIP or where the physician has continued to make billing errors despite documented efforts to educate the physician regarding billing requirements.**
- (92) In cases where extrapolation is applied, the random samples must have reasonable and convincing confidence intervals.**

c. Costs:

Physicians complained to me that they should not be required to pay the costs incurred by OHIP and the Physician Audit Board in investigating and auditing fee claims, that the costs are substantial, and that costs liability is used unfairly to pressure physicians into making settlements.

Physicians noted that the costs of conducting an income tax audit are not visited upon the taxpayer and that neither should physicians have to pay the costs of a medical audit. The onerous cost provisions enacted in 1996 and implemented in 1998 have been adjusted three times as a result of negotiations between OHIP and the OMA. Since the most recent changes, made in February 2004, there has been no charge to the physician for the investigation or for the first two days that the MRC commits to the physician's case, but the College reported that most MRC matters went beyond two days and thus costs were still a factor compelling physicians to settle and give up the right to appeal.²⁸¹ Moreover, the existing costs provisions led the MRC to adopt processes that have appeared to be arbitrary.²⁸² No representative who appeared at the hearings, including the representatives of the Ministry, was prepared to argue in support of the onerous cost

²⁸¹ College of Physicians and Surgeons of Ontario, Submission (July 2004), at 10; The Medical Review Committee: An Overview (September 10, 2004), at slide 132.

²⁸² College of Physicians and Surgeons on Ontario, The Medical Review Committee: An Overview (September 10, 2004), at slide 12.

provisions.²⁸³ In several jurisdictions I reviewed, physicians are not required to pay the cost of audit process.²⁸⁴

Conclusion:

Generally, the physician should not be ordered to pay the costs of the investigation, inspection or hearing. The only exceptions should be in the case of a physician who has been found by the Hearing Panel to have unreasonably failed to produce records, otherwise failed to co-operate, or been responsible for unnecessary, lengthy or frequent time-consuming delays. In that event, the costs should relate to the expense of the delay. If there is an appeal, the award of costs will be determined in the ordinary course by the HSARB or by the Divisional Court.

RECOMMENDATION:

- (93) **The *Health Insurance Act* should be amended to provide that costs of the audit process will be awarded against the physician only if, and to the extent that, the physician has unreasonably failed to produce documents and records or otherwise unreasonably failed to co-operate with the audit investigation and review, or has been responsible for unnecessary delays, either lengthy or frequent. Reference is also made to Recommendation 50, *supra*.**

d. Interest

Physicians complained that interest on repayment of fees should not run from the end of the payment period in which the fee claim was submitted by the physician but rather should run from the time that the physician was notified of a problem with his or her billings.

OHIP argued in favour of the existing statutory requirement that, where a physician is ordered to repay fees that were paid to him or her in error, OHIP should recover interest for the period the physician has had the use of the funds. The College recommended that interest should not accrue during any substantial delays that are the responsibility of OHIP.²⁸⁵

²⁸³ See e.g., Transcript, November 2, 2004, at 180 (line 17) to 181 (line 4). See, also, Ministry of Health and Long-Term Care, Submission (July 2004), Appendix 11, at 91 (item 5), and at 94 (item 17).

²⁸⁴ See Alberta, *supra* at 42; British Columbia, *supra* at note 162; New Brunswick, *supra* at 56, but see Manitoba, *supra* at 53.

²⁸⁵ College of Physicians and Surgeons of Ontario, Submission, July 2004, at 13.

Conclusion:

If the Hearing Panel determines that the physician has made errors in billing that warrant a recovery of fees, then the interest may run on the amount found to be improperly paid to the physician from the date the notice is sent to the physician of the audit investigation. For example, if on January 14, 2006, a letter is sent to the physician advising that a matter has been referred to the Physician Audit Board, then the interest will run from January 14, 2006. To fix the interest in that way will encourage both OHIP and the physician to process the matter as quickly as possible. This is certainly in the interest of all the parties involved. However, if it can be shown that the physician had notice, at an earlier date, that the matter would be referred to the Physician Audit Board, interest should run from the earlier date.

Further, in the case of a second or subsequent audit of a physician's fee claims, or if the physician has flagrantly ignored the educational material and instruction provided to him or her, then the Hearing Panel should have authority to direct that interest be paid on the amount found owing from the date it was paid to the physician. The Hearing Panel should also have authority to relieve against the accrual of interest during any substantial delay that is the responsibility of OHIP.

RECOMMENDATION:

- (94) **If the Hearing Panel determines that the physician has made errors in billing that warrant a recovery of fees, then interest should accrue on the amount found to be improperly paid to the physician from the date the notice is sent to the physician of the audit review hearing, or from whatever earlier date it is shown that the physician was made aware of the proposed referral to the Physician Audit Board.**
- (95) **The Hearing Panel should have authority to relieve against the accrual of interest during any substantial delays that are the responsibility of OHIP.**
- (96) **In the case of a second or subsequent audit of the physician's fee claims, or if the physician has flagrantly ignored the educational material and instruction provided to him or her, then the Hearing Panel may direct that interest be paid on the amount found owing from the date it was paid to the physician.**

e. Publication

Although OHIP has thus far refrained from publishing the identity of physicians who are ordered to repay fees, it retains the statutory authority to do so.²⁸⁶ Indeed, there are reports that OHIP had been urged by the Provincial Auditor to make use of that authority.²⁸⁷ Physicians unanimously decry the unfairness of publishing the identity of physicians who are ordered to repay fees. In their view, members of the public generally would not distinguish between a decision that a physician has improperly billed fees and a decision that the physician has been found guilty of professional misconduct.

Conclusion:

There is unanimous agreement that it would be inappropriate to publish information about audit decisions that would identify, or lead to the identification of, the physician or any of the physician's patients. In my view, the statutory authority to publish, which has never been used, constitutes an inchoate threat that increases, unnecessarily, the anxiety level of physicians who are facing an audit. It should be repealed.

RECOMMENDATION:

- (97) **Section 18.1(18) of the *Health Insurance Act*, which authorizes the publication of the identities of those physicians who have been ordered to repay fees, should be repealed. It should be replaced with a requirement that any information that identifies, or could lead to the identification of, a physician who has been audited or the physician's patients, is confidential and protected from disclosure.**

18. Appeals

Conclusion:

A physician should have a right of appeal from a decision of the Physician Audit Board ("PAB") to the Health Services Appeal and Review Board ("HSARB"). Since there will have been a full hearing before the PAB, the appeal can be argued on the record and should thus be

²⁸⁶ *HIA*, *supra* note 5, at s. 18.1(18); see the text, *supra*, at note 118.

²⁸⁷ Ministry of Health and Long-Term Care, Submission (July 2004), at 97 (Appendix 12).

simpler and less time-consuming than the appeal process in effect before the transition period. The physician and OHIP should be the parties to the appeal.

There should be a further right of appeal, by either party, from a decision of the HSARB to the Divisional Court.

RECOMMENDATIONS:

- (98) A physician should have a right of appeal from a decision of the Physician Audit Board to the Health Services Appeal and Review Board.**
- (99) The physician and OHIP should be the parties to the appeal.**
- (100) There should be a further right of appeal, by either party, from a decision of the Health Services Appeal and Review Board to the Divisional Court.**

19. Privacy of patient records

Several physicians expressed concern about protecting the privacy of patient records in the audit review process. Section 38 of the *Health Insurance Act* establishes a duty of confidentiality on committee and board members, employees, and each person engaged in the administration of the Act to preserve the secrecy of information pertaining to an insured. However, the Act also provides for exceptions to the duty, permitting disclosure in proceedings under the Act and in proceedings concerning the competence, capacity or conduct of a physician.

Pursuant to the *Transitional Physician Payment Review Act, 2004*, the Transitional Physician Audit Panel²⁸⁸ and the Divisional Court²⁸⁹ are obliged to protect the confidentiality of personal health information and are authorized to edit any documents they release to the public to remove any personal health information.

²⁸⁸ *Transitional Physician Payment Review Act, 2004*, s. 2 (amending the *Ministry of Health Appeal and Review Boards Act, 1998*, s. 7.1(6),6.).

²⁸⁹ *Transitional Physician Payment Review Act, 2004*, s. 1 (amending the *Health Insurance Act*, s. 18.0.1(10)).

On November 1, 2004, the *Personal Health Information Protection Act*²⁹⁰ (“*PHIPA*”) came into force in Ontario. The Act authorizes disclosure of patient records to the Ministry of Health “to determine or provide funding or payment to the custodian for the provision of health care.”²⁹¹ It also authorizes the Ministry to disclose the information within the Ministry for the purpose of monitoring or verifying claims for payment. Since the audit process I recommend is independent of the Ministry, it appears that the Investigators and Audit Hearing Panels would not have access to patient records in the absence of an amendment to *PHIPA*.

The provisions for protecting the confidentiality of patient records in Newfoundland and Labrador provide a best practices standard. A physician should be required to make available only the information that is necessary to verify fee claims. Where notes of sensitive information form an integral part of a necessary record, it should be examined only by the Inspector, who is a physician, OHIP, or by the Audit Hearing Panel. Patient records should be held under secure conditions until an audit is completed. Following completion of the audit process, the records should be shredded or returned to the physician for safe keeping.

Conclusion:

It is essential to ensure the privacy of personal health information, and to do so in a manner that still permits the investigation and audit of physician fee claims by Inspectors and the Physician Audit Board who are independent of the Ministry. In my view, it would be appropriate to create a further exception in *PHIPA* to achieve this purpose.

In addition, it is important to continue in effect the transition requirements protecting the confidentiality of personal health information in reviews by the Audit Hearing Panel, the Health Services Appeal and Review Board, and the Divisional Court. Confidentiality practices and procedures must be developed for those involved in the investigation and audit process, and should include provision (1) that only as much patient information as is necessary for the audit function is produced, (2) that only OHIP, the Inspector, and Audit Hearing Panel members have access to patient records, and (3) that copies of, or notes relating to, personal health information

²⁹⁰ S.O. 2004, c. 3, Schedule A, s. 85.

²⁹¹ *Personal Health Information Protection Act*, ss. 38(1)(b) and s. 46(1).

be destroyed as soon as reasonably possible after completion of the audit. These practices and policies should be reviewed with Inspectors, panel Members and staff as part of their training programs.

RECOMMENDATIONS:

- (101) **The *Personal Health Information Protection Act* should be amended to authorize the disclosure of patient information to Inspectors and members of the Physician Audit Board to the extent necessary in order to permit an effective investigation and audit of a physician's fee claims.**
- (102) **The protections for confidentiality of personal health information in hearings before the Transitional Physician Audit Panel and the Divisional Court should be continued.**
- (103) **Confidentiality policies and procedures must be developed for those involved in the investigation and audit process. Such procedures should include provisions (1) that no more patient information than necessary be produced in an audit, (2) that only OHIP, the Inspector, and members of the Audit Hearing Panel have access to patient records, and (3) that copies of, or notes relating to, personal health information be destroyed as soon as reasonably possible after completion of an audit or returned to the patient's physician for safe keeping.**
- (104) **Confidentiality policies and procedures should be reviewed with members of the Physician Audit Board, Inspectors, and staff as part of their training programs.**

20. Educational programs, materials and supports that should be provided to physicians to facilitate compliance with billing requirements

The shift in focus of the audit system requires the preparation and dissemination of educational programs and materials to physicians. Several physicians told me that they had not received any formal instruction preparing them to submit fee claims to OHIP for their services. It appears that most physicians entering fee-for-service practice learn about billing from cursory discussions with a mentor, a colleague, or a member of their office staff. I was advised that family physicians receive a course of instruction on office management, including billing procedures, but that physicians in other fields of practice receive no such instruction.

a. Long-standing methods of providing information to physicians

For more than thirty years, OHIP has provided a comprehensive document describing its operations to each physician registering with OHIP. In addition, Ministry Bulletins have been mailed regularly to physicians explaining changes to fee codes and billing policies. Since 1999, OHIP has provided a Resource Manual for Physicians, which is also available on the Ministry's Web site. Since 1976, physicians have been able to obtain annual profiles of their billing patterns. In 1986, OHIP began providing a Mini-Profile to family physicians, summarizing the six fee codes most commonly claimed by family physicians and providing comparative data. The Mini-Profiles were discontinued in 1994 because it was thought that there had been no measurable impact on the billing practices of those who received them.²⁹²

b. More recent initiatives

OHIP, the OMA, and the College have recently taken steps to improve the amount and caliber of the information that is available to physicians concerning the audit system. In particular:

- (1) **Education and Prevention Committee:** OHIP and the OMA have established a joint committee, the Education and Prevention Committee ("EPC"), whose primary goal is "to educate physicians about submitting OHIP claims that accurately reflect the service provided so that the need for recovery of inappropriately submitted claims is reduced."²⁹³ The EPC has reviewed and commented on educational Bulletins prepared by OHIP, and the Bulletins have been published and made available to OMA members. The Bulletins provide clear and useful information on the following topics: Post-Payment Review and Auditing of OHIP Claims, The Claims Review Process, OHIP Claim Submissions: Pre and Post-Payment Review Process, OHIP Billing Numbers, Billing Special Visit Premiums, Billing for Delegated Services, and Billing the Sole Delivery Premium.²⁹⁴ In addition, the EPC is developing a course on how to submit appropriate claims to OHIP.²⁹⁵

²⁹² Ministry of Health and Long-Term Care, Submission (July 2004), at 14.

²⁹³ Education and Prevention Committee Interpretive Bulletin, volume 1, no. 1, in Ministry of Health and Long-Term Care, Submission (July 2004), Appendix 8, at 69.

²⁹⁴ Ministry of Health and Long-Term Care, Submission (July 2004), Appendix 8, at 61-98.

²⁹⁵ Ministry of Health and Long-Term Care, Submission (July 2004), Appendix 1, at 24 (item 8).

The EPC, acting on behalf of a physician who remains anonymous, will seek responses from the Ministry to questions arising from educational bulletins.

- (2) **Explanatory Materials:** The MRC recently developed materials, and posted them on a Web page, to explain the various steps in the audit review process.²⁹⁶
- (3) **Provider Education Program:** In 2001, OHIP established the Provider Education Program ("PEP") with the goal of identifying physicians who appear to be billing specified fee codes incorrectly or whose claims patterns differ significantly from those of their peers. These physicians are provided with information to facilitate their compliance with billing requirements before they become liable for a substantial overpayment of fees.²⁹⁷
- (4) **Physician profiles:** In 2004, the price of annual physician profiles was reduced from \$80.00 to \$16.00.
- (5) **Review of new physicians:** In addition, OHIP plans to review the billing practices of newly registered physicians within three to five years and provide feedback where it is needed.

Conclusions:

Each of the programs referred to serves a useful purpose and should be continued and enhanced except to the extent that they duplicate each other. Programs should be developed to meet, not only the needs of physicians, but also the needs of their medical office staff. On-line, self-directed learning programs should be offered, as they are in British Columbia. These programs should have various modules applicable to different types of practice. A self-evaluation test could be included at the end of each module.

Physician billing profiles are particularly useful and they should be provided annually without charge to each fee-for-service physician in the province. The mini-profiles distributed without charge in British Columbia provide information regarding the physician's patterns of practice and billing in comparison with those of other physicians in a similar practice. Full profiles are also available and a guide to interpretation is provided that assists readers to

²⁹⁶ *Supra*, note 123.

²⁹⁷ Ministry of Health and Long-Term Care, Submission (July 2004), at 23 (Appendix 1, item 7).

understand the data. The profile is considered to be a powerful educational tool. It makes physicians aware that their billing patterns are monitored. In addition, it generates inquiries, which provide opportunities to educate physicians about billing requirements. The experience in British Columbia²⁹⁸ and in the United States²⁹⁹ appears to establish that education enhances compliance, and reduces the need for audits.

RECOMMENDATIONS:

- (105) The Education and Prevention Committee established by OHIP and the OMA should be continued. The EPC should encourage and enhance initiatives to provide effective information to physicians and their staff about the billing and audit processes. The EPC should continue to publish bulletins, and develop a course on compliance with billing requirements. The EPC should consider developing on-line, self-directed learning programs for physicians and their staff. Programs of instruction should be adapted to different types of practices.**
- (106) The Physician Audit Board should establish a website and post information about its policies and procedures for inspections and audits, as well as its decisions, edited to protect the privacy of physicians and patients.**
- (107) OHIP should continue to develop the Provider Education Program (PEP) to facilitate physician compliance with billing requirements and to avoid audit investigations in cases where physicians can provide explanations that justify deviations in their billing patterns.**
- (108) OHIP should provide to each fee-for-service physician, without charge, an annual mini billing profile, which will, in a timely manner, provide physicians with useful information about their billing patterns in comparison with those of other similarly-situated physicians. A guide to interpretation should accompany the profile. More detailed profiles should be provided on request and on payment of a reasonable fee.**

c. Physician Billing Advisory Service

OHIP should establish a Physician Billing Advisory Service, which might be operated by the Provider Education Program. A somewhat similar service is operated in British Columbia

²⁹⁸ See the text, *supra*, at 48-50.

²⁹⁹ See the text, *supra*, at 90-91.

and in the United States to assist physicians with billing issues. An advisory service is sorely needed in Ontario. I was advised by OHIP that inquiries may now be directed to District Offices of OHIP or to Medical Consultants. However, I also heard on several occasions that physicians who seek to establish a patient record system that complies with billing requirements, cannot get definitive responses (or, in some cases, any response). I also heard that physicians have not been able to obtain responses when they seek direction with regard to billing problems.

A well-regarded specialist, who had successfully defended an audit of his fee claims, recounted to me, and produced for my review, the correspondence that documented his futile efforts to secure clarifications that would assist him in developing a record-keeping system for himself and the colleagues in his office. He was determined to develop a system that would meet all billing requirements and thus avoid a further audit. Since no instruction was available regarding the records needed for billing purposes, he took a course on record keeping for clinical purposes, offered by the College. The instructor, who reviewed the physician's records system, said it was excellent. The physician sought confirmation that the records were sufficient for billing purposes. His telephone calls and correspondence with OHIP were to no avail. In spite of all his efforts to develop a record system for himself and his colleagues that would be appropriate for billing purposes, one of his colleagues was subsequently investigated. The MRC held that his records were insufficient to substantiate his fee claims. This state of affairs the physicians rightly find to be intolerable.

Conclusion:

A physician who has a question about billing should be able to get a definitive answer in a timely fashion. First, it should be possible for a physician to obtain summary advice on routine inquiries through a toll-free telephone service or email. Second, it should be possible for a physician to seek an "advance ruling" that will be given expeditiously and will be binding on OHIP until further notice to the profession. The physician must be able to make the second type of inquiry anonymously, perhaps through the offices of the OMA. Questions and answers of the second type should be published immediately, without identifying either physicians or their patients, for the guidance of other physicians. The Billing Advisory Service should track the nature of both types of inquiries in order to identify matters that require clarification for the benefit of other physicians. The Billing Advisory Service should report on a quarterly basis to

the Joint OHIP-OMA Committee on the Schedule of Benefits and to the Education and Prevention Committee.

RECOMMENDATIONS:

- (109) OHIP should establish a Physician Billing Advisory Service to provide timely responses to physician inquiries about billing. Two types of services should be provided: (a) summary advice on routine inquiries by e-mail or by telephone to a toll-free number, and (b) advance rulings that will be binding on OHIP until further notice. A physician must be able to make the second type of inquiry anonymously, perhaps through the offices of the OMA. Responses to the second type of inquiry should be posted on the web page.**
- (110) All queries should be tracked to identify matters that require clarification for the benefit of other physicians. The Advisory Service should report quarterly to an OHIP-OMA Committee on the Schedule of Benefits and to the Education and Prevention Committee.**

d. Educational programs prior to entering clinical practice

The submissions of physicians and their organizations indicate that very little if any training or instruction is provided to physicians with regard to billing before they enter into practice. From 1999 to 2003, OHIP representatives met with new medical graduates to introduce the billing system, but the meetings were discontinued because they did not generate sufficient interest.³⁰⁰

Conclusions:

There is general agreement, and I conclude, that physicians should be required to complete an effective course of instruction in billing before they register with OHIP. The programs should be targeted to the needs of the various specialties. Instruction should include billing requirements, the audit system, and record-keeping for clinical and billing purposes.

Physicians should be provided with appropriate reference materials and instructed on the means by which they will keep current with billing requirements and the sources of guidance.

³⁰⁰ Ministry of Health and Long Term Care, Submission (July 2004), at 14.

The programs could be designed and delivered through the combined efforts of OHIP, the Physician Audit Board, the College and the OMA (and its Sections).

Learning programs designed for new fee-for-service physicians could also cover other relevant aspects of practice management. I understand that physicians entering family practice receive such instruction. I have been advised that physicians entering other types of practice would benefit from similar programs.

RECOMMENDATIONS:

- (111) OHIP and the Physician Audit Board, working with the College and the OMA (and its Sections) should design and offer programs for physicians who are about to enter practices in which they will bill OHIP for their services.**
- (112) Physicians should be required to complete the program relevant to their practice specialty prior to entering practices in which they will bill OHIP for their services.**
- (113) The programs should provide instruction in billing requirements and the audit system, as well as instruction in record-keeping for clinical and billing purposes.**

e. Publication of audit decisions on an anonymous basis

Conclusions:

Decisions rendered by the Physician Audit Board should be published on a web page established and maintained by the Board. Links to the web page should be provided on web pages maintained by OHIP and by the OMA. The decisions must be edited to remove any information that might identify the physician or any patient. A note should be provided synthesizing and annotating Board decisions so that interested persons can easily gain access to relevant information.

RECOMMENDATION:

- (114) Decisions of the Physician Audit Board should be published on a web page established and maintained by the Board. The decisions must be edited to remove any information that might identify the physician or any patient. A note should be provided synthesizing and**

annotating Board decisions so that interested persons can easily gain access to relevant information.

f. Other modes of providing information and education

Physicians in other provinces receive information about billing processes through a variety of programs and publications. It is costly to produce this information, and busy physicians have limited time to study it. I thus suggest that the EPC review the types of materials that have been developed elsewhere, particularly in British Columbia, and seek ways of providing this information to Ontario physicians as efficiently as possible.

21. Communications and Co-operation

It is apparent that there is a need for continuing and enhanced communication and co-operation between the principal actors concerned with the requirements for, and audit of, physician billing. Fortunately, it appears that co-operation is already underway. In particular I note the work of OHIP and the OMA in their Education and Prevention Committee,³⁰¹ and the establishment of a joint committee to review and revise the Schedule of Benefits.³⁰²

Conclusions:

Reference has been made in the recommendations to the need for co-operation and joint action among, particularly, OHIP and the OMA, and, to a lesser extent, the College and the proposed Physician Audit Board. I refer, in particular, to the following recommendations:

- The College and the OMA should continue to have a role in nominating members of the Physician Audit Board and its Inspectors and addressing policy issues in the billing and audit system. (Recommendations 4, 23, 26, 27, 40, 44)
- The audit system itself must be accountable. A biennial stakeholders' forum should be established to receive reports on the operation of the new audit process, and to receive and consider proposals for improvement of the process. (Recommendations 6 and 7)

³⁰¹ See the text at note 126.

³⁰² See the text at note 228.

- OHIP and the OMA should establish a permanent joint committee to review, revise, clarify, and simplify the Schedule of Benefits and adapt it to the circumstances of various specialties of medical practice. (Recommendation 11)
- If, as a result of an audit review, the Physician Audit Board considers that a fee code requires clarification or amendment, it should refer the decision and reasons of the Hearing Panel to the joint committee of OHIP and the OMA on the Schedule of Benefits. (Recommendation 12)
- OHIP and the OMA should review, revise and establish record-keeping standards for billing purposes. This initiative should involve the appropriate clinical Sections of the OMA and other interested groups. In particular, it should involve the College, with a view to developing one set of record-keeping requirements that will suffice for clinical and billing purposes. In addition, templates should be developed to assist physicians in effective and efficient record-keeping. (Recommendations 15 and 17)
- OHIP, the OMA, the College and the Physician Audit Board should co-operate in developing instructional materials and programs to inform and educate physicians, equipping them to comply with record-keeping and billing requirements. (Recommendations 109-116)

It is obvious that both OHIP and the OMA need to give high priority to working together to reform the Schedule of Benefits. They must also work together, and with the College, to develop comprehensive and cost-effective standards for record-keeping. They must co-operate with the College and the Physician Audit Board to develop materials and educational programs in regard to billing, record-keeping, and the audit process, and to establish and operate the physician advisory service regarding billing and billing problems. Each has a significant role to play. Their co-operation will help the health care system and all physicians who work in it. There may be significant difference of opinion on some issues between OHIP and the OMA. Yet, it is common ground among all the principal actors that the problems with the medical audit process must be addressed, and that they must work together to shift its focus from a punitive process to an educational one which will assist physicians to understand and comply with billing requirements, and then call them to account if they do not.

In my review of other jurisdictions, I have found that there is often uneasiness in the relationships of government agencies and medical associations with respect to physician audit processes. In a few jurisdictions, it has been possible to build a climate of co-operation and joint action. That should be the goal in Ontario. The process should start by co-operating in building a

fair and effective audit process, supported by education and assistance to facilitate compliance with billing requirements.

RECOMMENDATIONS:

- (115) OHIP, the College, the OMA and the Physician Audit Board should co-operate in implementing the following Recommendations:**
- a. Recommendations (4), (23), (26), (27), (40), (44): nomination and vetting of Inspectors and members of the Physician Audit Board;**
 - b. Recommendations (6) and (7): accountability of audit system; biennial stakeholders' forum;**
 - c. Recommendation (11): permanent OHIP – OMA Joint Committee on the Schedule of Benefits;**
 - d. Recommendation (12): references from the Physician Audit Board to the OHIP – OMA Joint Committee on the Schedule of Benefits;**
 - e. Recommendations (15) and (17): developing requirements for record-keeping that meet both clinical and billing standards and templates to assist physicians with efficient record-keeping;**
 - f. Recommendations (108) to (115): developing instructional materials and programs to assist physicians to comply with record-keeping and billing requirements and to understand the audit process.**

22. Assessing the cost-effectiveness of recommendations

The Terms of Reference require me to take into account, as one criteria, that the medical audit process should be “cost effective to administer.”

Conclusion:

In my review I have emphasized the necessity of having full and fair hearings of audit disputes. In doing so, I have discussed some of the costs that might be incurred.³⁰³ I had considered retaining professional advisors to assist me, in the final stages of my study, in making a more detailed assessment of the cost implications of my recommendations. However, the

³⁰³ See the text, *supra* at note 133.

Ministry advised me that such an assessment is not required and, contrary to appearances, is not part of my Terms of Reference.

All residents of Ontario are aware that there are tremendous pressures on the funding of the health care system. It follows that it is important to ensure that proposals for new procedures are cost effective. I would have liked to put my own recommendations to that test. Nonetheless, I derive some confidence in their cost-effectiveness from the fact that each of the recommendations has counterparts in other jurisdictions.

Although there may be additional costs in implementing my recommendations, these costs may be offset by fewer audits. In any event, the recommendations are essential to providing an audit process that is fair, from its commencement to the final moment of the hearing. It is apparent that physicians will not have confidence in an audit process that is not fair. Indeed the potential consequences of an audit to a physician are such that fairness must be the governing rule. In a free and democratic society, nothing less is acceptable. If, in the end result, costs do rise, they must be accepted as the price of fairness and of rebuilding physician confidence in the audit process.

Other jurisdictions have provided for less expensive, informal hearings as part of their solution to audit problems. They consider that informal processes are less costly, financially and psychologically, than formal hearings. I have considered these models and note that the Provider Education Program and the OHIP Payment Review Program provide opportunities for informal resolution of billing issues in Ontario. However, at this time there is not the requisite atmosphere of trust between the parties that would enable an informal audit process to work effectively or to be acceptable. Only a more formal process with procedural protections can achieve a result in Ontario that is both fair to all the parties and will assist in rebuilding and maintaining the trust and confidence of physicians.

23. Transitional Provisions

The Terms of Reference invite me to “identify transition and implementation considerations.” I did not receive any submissions recommending that changes should be made to the transition provisions already in place.

Conclusion:

The transition period should be as brief as possible. If my recommendations are to be implemented, it should be done expeditiously. The medical audit system has been in transition for some months pursuant to the *Transitional Physician Payment Review Act, 2004*. The Medical Review Committee has been suspended and the Transitional Physician Audit Panel established in its place.

During the remaining transition period, the current transitional arrangements should remain in place, subject to three essential changes. First, any hearings before the Transitional Physician Audit Panel should be conducted in accordance with the *Statutory Powers Procedure Act*, adapted to take into account the specific recommendations I have made regarding procedure and hearing. Applying the requirements of the Act will ensure the minimal requisite procedural protections necessary to achieve fairness, and the appearance of fairness, in the transitional audit hearings. The hearing process can be shortened in cases where there are agreed statements of fact, but matters in dispute should be determined through a formal hearing process.

Second, in determining whether a physician has submitted inappropriate fee claims, it should be understood that, in accordance with the decisions of the HSARB and the Divisional Court in *Lyttle v. Ontario*, the Transitional Physician Audit Panel should interpret fee codes in the Schedule of Benefits in a realistic and flexible manner so as not to deprive a physician of payment for a service that is medically appropriate in the circumstances and complies substantially with the requirements of the fee code (Recommendation 10). In addition, the Transitional Panel should be authorized to take into account evidence tendered by the physician to establish that an insured service defined in the Schedule of Benefits was substantially rendered and therefore eligible for payment (Recommendation 81).

Third, when the Transitional Physician Audit Panel determines that a physician has submitted inappropriate fee claims, it should be authorized to apply the following principles in determining the amount of any reduction in or repayment of fees:

- (1) Where a physician can establish that, in the circumstances, no reasonably informed physician could have known that the impugned fee claims did not comply with billing requirements, the claims should not be subject to reduction or repayment in whole or in part (Recommendation 53);
- (2) In cases where a physician has not had previous notice that his or her fee claims may be deficient, recovery should be based only on actual deficiencies without applying extrapolation (Recommendation 90); and
- (3) A recovery order should be reduced where the result would unfairly deprive the physician of basic and fair compensation for the services the physician has rendered to patients (Recommendation 87).

RECOMMENDATIONS:

- (116) **The transition arrangements already in place pursuant to the Transitional Physician Payment Review Act, 2004, should be continued.**
- (117) **The following recommendations should be implemented during the transition period and govern the process and decisions of the Transitional Physician Audit Panel:**
 - a. **Recommendation (79): application of the *Statutory Powers Procedure Act*;**
 - b. **Recommendation (10): interpretation of the Schedule of Benefits;**
 - c. **Recommendation (81): relying on records and other evidence to establish that services were substantially rendered;**
 - d. **Recommendation (53): no reduction where a reasonably informed physician could not have known that the impugned fee claims did not comply with billing requirements;**
 - e. **Recommendation (91): no extrapolation in the absence of previous notice of deficiencies;**

- f. **Recommendation (87): reduction or recovery limited so as not to unfairly deprive the physician of basic and fair compensation for services rendered.**

- (118) **As provided in Recommendations 55 and 56, in the transition period, the time limit for OHIP to notify a physician that fee claims are subject to audit should be 24 months.**

24. Considering the provision of redress

In considering the concerns raised by physicians, I must also refer to the submissions that were well and comprehensively made by the Specialist Coalition of Ontario (SCO). The SCO has urged me to recommend that an inquiry be undertaken to review the cases of physicians who have been “wrongly penalized” by the medical audit system and to recommend appropriate compensation. The SCO maintains that there are three essential requirements for restoring physician confidence in the medical audit system. First, the systemic causes for the loss of confidence in the former audit process must be fully understood. Second, those who were penalized must receive redress. And third, a new process that is fair, just, and transparent must be established. I am advised that the submissions of the SCO have been adopted and supported by medical associations representing more than 17,000 Ontario physicians.

The case for redress, as it was put to me, can be summarized in this way. Prior to 1996, even though the Schedule of Benefits was out of date, it did not pose a problem because it was used as a general guide. Following the enactment of the *Savings and Restructuring Act, 1996* (SRA), it appeared that referrals to the MRC increased, particularly in relation to “General Assessment” and “General Re-Assessment” codes. The MRC interpreted these codes literally, resulting in substantial recoveries from physicians. Finally, in 2000, the Schedule of Benefits was revised to address the problem by establishing codes for “Specialty Specific Assessment” and “Reassessment.” Nonetheless, the MRC continued to apply the old definitions in audits of fee claims that had been submitted prior to adoption of the revisions. The SCO characterized this approach as reflecting “mean-spiritedness and cynicism.” When the Health Services Appeal and Review Board allowed an appeal and overturned the literal interpretation, OHIP appealed to the Divisional Court, which upheld the decision of HSARB.

The SCO submits that the approach of the MRC to interpretation of the Schedule of Benefits was exacerbated by onerous provisions introduced by the *Savings and Restructuring Act*. Audit recoveries increased substantially when the amounts owing were calculated by extrapolation, that is by investigating a sample of services and applying the result to all the services performed within the review period. Onerous costs provisions forced many physicians to settle rather than incur the costs of a hearing. Some physicians were ruined financially. Many suffered from grave anxiety, serious depression, and family difficulties. Several physicians, and in some cases, members of their families, who appeared before me or filed written submissions, confirmed these devastating effects on the basis of their own experience.

Conclusion:

As I indicated earlier,³⁰⁴ it is beyond my terms of reference to address past cases. Further, to do so would offend the rules of natural justice since the cases have not been addressed by both sides. What I am asked to do by the SCO and the other associations that support its position, is to recommend that those physicians who were penalized by a literal interpretation of the Schedule of Benefits should have the right to have their cases reviewed, to have all money, interest and costs returned with interest, to have an amount assessed for loss of economic opportunity, and to be completely indemnified for costs of the process.

I am unable to make findings in individual cases. Further, I am not able to make what amounts to a collective finding that physicians suffered in a manner that should now be compensated by government. The issue was not included in my terms of reference and accordingly it has not been addressed by other participants whose interests would be affected and who would have submissions to make. Further, I note that the SCO identifies actions on the part of organizations other than government that it indicates may have contributed to delays in exercising rights of appeal. It is in the appeal process that other significant aspects of the problem were ultimately addressed and considered. In the circumstances, I cannot come to any conclusions in respect of these allegations. In any event, it is clear that I have neither the authority, nor the necessary evidentiary base to reach an opinion or make a recommendation as to the need for a process to consider compensation.

³⁰⁴ See the text, *supra*, at note 216.

Part VII. Conclusion

In many cases, the cumulative effect of the billing and audit requirements now under review was to subject physicians to recoveries of more than \$100,000, with devastating effects on those physicians, their patients and their families. The negative consequences reach even deeper into the medical system on which all Ontarians rely. Many physicians, who view the results of the audit system as arbitrary and unfair, have determined to avoid the process at all costs. I have thus heard from some physicians that, despite the unmet need for medical services, and their desire to provide dedicated service to their patients, they have concluded that it is necessary, for the protection of their families, or at the very least preferable, to curtail their practices so as to stay within average billing patterns. In that manner, they hope to avoid being singled out for investigation and audit, with the resulting devastation that can ensue. Accordingly, an audit system that is perceived as inflexible, arbitrary and unfair has a negative impact on the availability of medical services in Ontario. Not only have I heard that some physicians are grudgingly limiting their practices, but I have also heard that the audit system is a factor in the decisions of some physicians to leave the jurisdiction. It is essential, for our health care system, that we have a fee billing system that is based on clear criteria and a medical audit process that is itself fair and is fairly administered.

Furthermore, it is essential that we have an audit system that works effectively to establish physician accountability for fee billings. The Ontario health system operates on public funds. There is then a trust concept that is applicable to those funds. Since physicians bill their fees on the honour system, it follows that there must be in place a system of accountability. The public trust funds must only be paid out to physicians to compensate them for services they have properly rendered and which come within the provisions of the Ontario Health Insurance Program to patients who are covered by that program. Nothing less can be accepted.

My aim has been to design a medical audit system that is fair to all the parties to the Ontario Health Insurance Plan, and that commands the confidence and respect of the physicians. The recommendations I have made are aimed at shifting the focus toward encouraging compliance with clearly defined billing requirements. They are also aimed at achieving peer review and fairness in each and every one of the procedures of the audit process from its

commencement through to the conclusion of the hearing. I believe that, if the recommendations I have made are implemented, the goal will be achieved. There would then be in place in Ontario a medical audit system that will attain the often elusive goal of fairness and effectiveness for all parties and, in particular, enjoy the respect and confidence of the medical profession.

All of which is respectfully submitted,

21 April 2005

The Hon. Peter de C. Cory, C.C., C.D.

List of Recommendations

Jurisdiction and structure of the medical audit process (at 96)

- (1) The responsibility for conducting audits of physicians' fee claims should be conferred on a new body, which is separate from and independent of the Ministry, OHIP, the OMA and the College.
- (2) The new body, which I will refer to as the "Physician Audit Board", must have its own premises and staff, and a budget to cover its reasonable expenses. The budget should be prepared by the Board and submitted for approval or comment to the College and the OMA. The budget, together with the approvals or comments, should then be submitted to the Minister.
- (3) OHIP should continue to screen physician fee claims and billing patterns, should be responsible for proving the case for the recovery of funds in any matter before the Audit Hearing Panel, and should make any calculations required in those rare occasions when extrapolation can be used.
- (4) The College and the OMA should continue to have a role in nominating members of the Physician Audit Board and its Inspectors and addressing policy issues in the billing and audit system.

The purpose of the audit process (at 98)

- (5) It is essential to physician confidence in the audit system that audit processes be employed only for the purpose of determining the accuracy and appropriateness of physician fee claims.
- (6) The audit system itself must be accountable.
- (7) A biennial stakeholders' forum should be established to receive reports on the operation of the new audit process, and to receive and consider proposals for improvement of the process.

A new approach to the audit system: facilitating compliance with billing requirements (at 99)

- (8) The primary goal of the new approach to the audit system should be to educate and assist physicians in complying with the billing requirements pursuant to the *Health Insurance Act*.
- (9) The second but equally important goal of the new approach to the audit system should be to identify and eliminate false, fraudulent and egregiously erroneous billing, in a fair and effective manner.

The role of the Schedule of Benefits

Interpretation of fee codes in the Schedule of Benefits (at 102)

- (10) Fee codes in the Schedule of Benefits should not be interpreted in a literal and legalistic manner, so as to deprive a physician of payment for a service that is medically appropriate in the circumstances and complies substantially with the requirements of the fee code.
- (11) It is important that OHIP and the OMA review the Schedule of Benefits, simplify it, revise it, clarify it and adapt it to the circumstances of various specialties of medical practice. I recommend that a permanent joint committee be established to review the Schedule of Benefits in accordance with a time schedule to be specified.
- (12) If, as a result of an audit review, the Physician Audit Board considers that a fee code requires clarification or amendment, it should refer the decision and reasons of the Hearing Panel to the Joint Committee of OHIP and the OMA. The decision should be edited to protect the anonymity of the physician and any patient. Consideration should be given to requiring the Joint Committee to issue a report responding to the referral.

Retroactive application of amended fee codes (at 103)

- (13) When an amendment is made to the Schedule of Benefits to remedy an inadequacy in the Schedule, the benefit of that amendment should be made available and be binding in all pending audit investigations.
- (14) When an amendment is made to establish a new policy direction in the Schedule of Benefits, it should apply only prospectively.

Record-keeping requirements for clinical purposes and billing purposes (at 105)

- (15) It is essential that OHIP and the OMA review and recommend amendments to record-keeping standards for billing purposes. This initiative must involve the appropriate clinical Sections of the OMA and other interested groups. In addition, it should involve the College, with a view to developing one set of record-keeping requirements that will suffice for clinical and billing purposes.
- (16) As a general rule, records that meet medical clinical standards should suffice for billing purposes. Additional records for fee billing should be required only in those clear cases where the Schedule of Benefits for good reason requires the additional record and this has been brought to the attention of physicians.
- (17) OHIP, the College, the OMA, its Sections and other interested groups should develop templates to assist physicians in effective and efficient record-keeping.

- (18) Record keeping requirements for billing purposes should take account of the realities of medical practice and should not require physicians to give priority to record-keeping to the detriment of patient care.

The Physician Audit Board

Peer representation on the Physician Audit Board, the Hearing Panel, and the roster of Inspectors (at 107)

- (19) The membership of the Physician Audit Board should reflect the various disciplines of the medical profession.
- (20) The Inspector assigned to investigate and report on a physician's fee claims should be a true peer of the physician, that is, from the same practice field and setting as the physician or as close to it as possible.
- (21) One member of the Audit Hearing Panel should be a true peer of the physician who is before the Panel.

Composition, Qualifications, and Appointment (at 109)

- (22) The Physician Audit Board should be composed of thirty physicians and ten members of the public, each appointed for a three to five year term and eligible for reappointment to one additional term. Appointments should be staggered to ensure continuity and renewal.
- (23) The OMA and the College, in consultation with the Chair of the Physician Audit Board, should each nominate fifteen of the thirty physician members. It may be necessary to establish a joint nominating committee to ensure the necessary breadth of experience among physician members.
- (24) Physician members should be selected from as wide a range of practice settings and specialties as possible.
- (25) Only physicians who are engaged in active practice should be eligible for appointment.
- (26) All physician nominees must be in good standing with the College and must have no conflict of interest in relation to issues within the jurisdiction of the Board. The College and OHIP should review and report on their eligibility for appointment.
- (27) Ten public members should be appointed by the Ministry. The Ministry should consult with the OMA, the College, and the Chair of the Physician Audit Board in identifying qualified nominees.
- (28) Members of the Board should be compensated at a *per diem* rate of at least \$500.
- (29) The Chair should be selected from and by the members of the Board and should serve for a term of two years, renewable for two additional years.

Orientation and instruction (at 110)

- (30) Members of the Physician Audit Board should be instructed in billing requirements, investigation procedures and the audit process. In particular, members should be instructed in the requirements of procedural fairness; maintaining impartiality; conducting hearings with fairness, patience and respect; and delivering clear, concise, and reasoned decisions.

Annual report and meetings (at 111)

- (31) The full Physician Audit Board should meet at least once a year. It should prepare and approve an annual report on its work. The Board should review, annually or more often as required, issues of procedure or policy, consider any referrals to the Joint Committee on the Schedule of Benefits, and address any needs of Board members for training relevant to their responsibilities.

Audit Hearing Panels (at 112)

- (32) The Chair of the Physician Audit Board should select, from members of the Board, three physician members and one public member to sit as an Audit Hearing Panel.
- (33) At least one of the physician members should practice in the same, or as close as reasonably possible to the same, specialized field and practice setting as the physician whose fee claims are to be reviewed.
- (34) The Chair of the Physician Audit Board should designate a member of the Audit Hearing Panel to serve as Chair.
- (35) The provisions of the *Health Insurance Act* authorizing appointment of a one-member panel and reconsideration of that panel's decision by a three-member panel should be repealed.

Inspectors (at 114)

- (36) The Minister should appoint twenty inspectors, on the joint nomination of the Chair of the Physician Audit Board, the OMA and the College. Inspectors should be appointed for a term of three to five years and be eligible for reappointment to one additional term. Appointments should be staggered to ensure continuity.
- (37) Inspectors will report only to the Chair of the Physician Audit Board.
- (38) Inspectors should be physicians selected from as wide a range of practice specialties and settings as possible.
- (39) Only physicians who are engaged in active practice should be eligible for appointment.

- (40) Openings for inspectors should be widely advertised to the profession.
- (41) The College and OHIP should review all candidates for appointment as Inspectors to ensure that they are in good standing and have no conflict of interest in relation to billing issues.
- (42) In addition, care should be taken to appoint individuals as Inspectors whose disposition will enable them to conduct an inspection appropriately.
- (43) Inspectors should be required to complete a course of instruction regarding record-keeping requirements for both clinical and billing purposes, the conduct of an inspection, and reporting requirements. In particular, they must be made aware of their obligation to treat physicians who are being inspected with respect and courtesy, and to listen with patience and careful attention to any explanations they may present.
- (44) The Physician Audit Board should establish a Code of Conduct and procedures for Inspectors.
- (45) Inspectors should be remunerated at a *per diem* rate sufficient to attract qualified candidates and compensate them appropriately for the time they must take away from their practice.
- (46) The Chair of the Physician Audit Board should assign an Inspector to undertake a particular investigation. The Inspector should be in active practice in a specialty and practice setting that is the same or reasonably similar to that of the physician whose billings are being considered.

Initiating an audit investigation by OHIP

The fairness of OHIP processes identifying physicians for audit investigation (at 118)

- (47) OHIP should disclose the methods used in its statistical analysis of billing patterns and should use only those that take account of the nature of the practice of the physician under review.
- (48) OHIP should continue to develop its programs for analyzing billing patterns so as to generate more relevant and useful comparative data. More refined data will be more useful in the audit investigation process and more useful in guiding physicians' billing practices. In particular, OHIP should continue to investigate the case-mix adjustment software program used in British Columbia and the feasibility of incorporating the features of that program into the Ontario audit system.
- (49) OHIP should continue to operate the OHIP Payment Review Program (OPRP). The program must operate in a manner that respects the fact that a physician may have a perfectly acceptable explanation for an apparent variance from average billing patterns.

The General Manager should not make a decision to refer a physician for audit until any such explanation has been sought, given and carefully assessed.

- (50) If OHIP rejects an explanation of billing patterns that is subsequently accepted by the Audit Hearing Panel (or on appeal from the Panel's decision), the physician should ordinarily be compensated for any costs incurred in the medical audit process. In addition, in cases where the Panel determines that OHIP's rejection of the explanation was unreasonable, the Panel should have authority to award to the physician up to \$10,000 as compensation for the unjustified disruption an audit has created in the physician's practice and family life.

The need for prior notification of billing deficiencies, the unfairness of retrospective recovery, and the importance of programs to encourage compliance (at 120)

- (51) Physicians should be responsible for complying with clear billing requirements, as set out in the Schedule of Benefits and the standards for record-keeping for billing purposes, and as explained in information published for their guidance under the authority of the Education and Prevention Committee, a joint committee of OHIP and the OMA
- (52) The Provider Education Program should be continued and enhanced to identify and correct billing problems at an early stage.
- (53) Where the physician can establish that, in the circumstances, no reasonably informed physician could have known that the impugned fee claims did not comply with billing requirements, the claims should not be subject to repayment.
- (54) In cases where the physician has not had previous notice that his or her fee claims may be deficient, recovery should be based only on actual deficiencies without applying extrapolation.

Length of billing period that is under review in an audit (at 122)

- (55) The *Health Insurance Act*, or regulations passed pursuant to that Act, should specify that OHIP may not claim repayment of fees from a physician unless it notifies the physician that the fee claims are subject to audit within twelve months after the physician submits the claim.
- (56) As a transitional provision, until a new audit system is in place, the time limit for OHIP to notify a physician that fee claims are subject to an audit should be 24 months.
- (57) The limitation period for reviewing accounts should be extended only if OHIP establishes, on application to the Health Services Appeal and Review Board, that there are reasonable grounds to believe that a physician has deliberately engaged in a misleading or fraudulent pattern of billing fee claims.

OHIP referral of physician to the Physician Audit Board (at 122)

- (58) If OHIP concludes, after considering any explanation provided by the physician, that a complaint, a negative response to a verification letter or a deviation in billing patterns warrants an audit of the physician's billing, it may refer the matter to the Physician Audit Board. The referral should be made only after attempts have been made to correct the problem and settle any repayment owed by the physician.
- (59) If the referral is one of the relatively rare cases in which extrapolation could apply, it will be necessary that OHIP identify a statistically significant sample of patients, who have been selected randomly from a list of claims for each fee code that is in dispute. The physician will be required to produce the records of these patients for review and photocopying.

Direct recovery (at 124)

- (60) Section 27.2(2) of the *Health Insurance Act*, authorizing OHIP to exercise direct recovery of fee payments without a determination having been made by the MRC (Physician Audit Board) that they are due and owing, should be repealed.
- (61) OHIP should be authorized to apply to the Physician Audit Board, the Health Services Appeal and Review Board or the Divisional Court as the case may be for an order authorizing direct recovery of fee payments and any applicable interest. The direct recovery may be by way of set off or other claim. An order for direct recovery should be made only where OHIP establishes reasonable grounds to believe that the physician concerned is on the verge of insolvency, departing the jurisdiction or moving assets out of the jurisdiction.

Notifying a physician of an audit (at 125)

- (62) The letter from the Chair of the Physician Audit Board notifying a physician of an investigation and audit should specify the grounds for concern, disclose the material provided by OHIP, enclose information about the audit process, solicit any explanation from the physician, to be forwarded in writing within thirty days of receipt of the letter, and invite the physician to select, from among three dates, a time for the visit of the Inspector assigned to the matter.
- (63) The letter should be restrained and polite and acknowledge that in many cases, a physician can provide a satisfactory explanation to a billing complaint or concern.

Inspection (at 127)

- (64) When an audit referral is received from OHIP, the Chair of the Physician Audit Board should assign an Inspector who is in the same practice field and setting as the physician, or as close to it as reasonably possible.

- (65) A staff member should be assigned to co-ordinate the processing of the investigation and audit throughout the proceeding.
- (66) The Inspector will attend at the physician's office, on a date to be determined in consultation with the physician, to speak with the physician and to examine and copy records. A clerk should accompany the Inspector to assist with the photocopying of records as it is needed. Only the Inspector should review patient records.
- (67) The physician should have the right to be represented by an agent or lawyer during the inspection. In addition, the physician should be permitted to present the evidence of patients, provided they consent to speak with the Inspector, and the evidence of any medical expert who has been invited to attend by the physician.
- (68) After examining the patient records, speaking to the physician and perhaps to patients and any medical expert in attendance, the Inspector will prepare a full report on the information obtained through the inspection, and provide his or her assessment as to whether the fee claims substantially comply with billing requirements.
- (69) At the conclusion of the inspection, the Inspector may, in situations that would warrant, recommend immediate termination of the audit process. Alternatively, the Inspector may recommend that the audit process should proceed. In either event, the Inspector will set out brief reasons for the decision. The Chair of the Physician Audit Board may, on receipt of the Inspector's report, either terminate the audit or direct the audit to proceed.
- (70) If the Inspector is not satisfied that the bills are correct but determines that the errors are clerical in nature, or made in good faith, or based upon an erroneous interpretation of the Schedule of Benefits, or trivial in nature and not warranting an audit of the physician's accounts, then the Inspector may recommend to the Chair of the Physician Audit Board other remedies, including education in billing requirements and monitoring of billings for a period not to exceed six months. The Chair of the Physician Audit Board may, on receipt of the Inspector's report, order that the Inspector's recommendation be adopted and put into effect or direct that the matter proceed to an audit before the Physician Audit Board.
- (71) Within fifteen days of completing the inspection, the Inspector will deliver to the physician, to the Chair of the Physician Audit Board, and to OHIP a report on the findings of the inspection, together with reasons to support his or her assessments and recommendations.
- (72) The physician will then have fifteen days from receipt of the Inspector's report to deliver any reply.

Procedure before the Audit Hearing Panel

Composition of the Audit Hearing Panel (at 128)

- (73) The Audit Hearing Panel for each audit review should be composed of four members: one public member and three physicians, including one who practices in the same or as close as reasonably possible to the same specialized field and practice setting as the physician whose fee claims are to be reviewed.
- (74) If one of the assigned members, other than the member who is considered to be a peer, is unable to participate in the hearing, any three members of the Hearing Panel will suffice to reach a decision on the matter before them.

Procedure (at 133)

- (75) In the audit process, a physician is entitled to be treated with respect, patience and courtesy. Any explanations the physician provides should be carefully considered.
- (76) A code of conduct should be developed for those dealing with physicians in the audit process and should form part of the orientation programs provided to members of the Audit Hearing Panel.
- (77) Because of the serious implications of an audit for the physician it is essential that the audit hearing process be fair. An independent and unbiased Hearing Panel must base its decision on evidence that may be tested on cross-examination and after hearing submissions from both sides of the matter. Members of the Panel must not take the lead in questioning the physician. Rather, any questions they put to the physician should be directed solely to clarifying the issues or the evidence.
- (78) The case against the physician should be presented by or on behalf of OHIP. The onus should be on OHIP to establish, on a balance of probabilities, that a fee claim is not justified.
- (79) The audit hearing must be subject to the *Statutory Powers Procedure Act*. The physician must be entitled to receive notice, receive production of all material upon which the referral for audit and the Inspector's report is based, to cross-examine the witnesses alleging billing errors, to call witnesses (including patients and experts), to make representations and submissions, and to be represented by counsel throughout the proceeding. Counsel should be provided, preferably through the Canadian Medical Protection Association.
- (80) In addition, the physician is entitled to the delivery of written reasons by the Hearing Panel, within thirty days of the close of submissions. The reasons must explain the basis of the decision and must include the Panel's assessment of any expert evidence that has been called. Ordinarily, the Panel will proceed on the basis of consensus, but a member of the Panel who dissents may file dissenting reasons.

Proof of compliance with billing requirements (at 136)

- (81) Section 37.1 of the *Health Insurance Act* should be amended to provide that a physician's records are the primary focus of an audit investigation, but a physician may also introduce other evidence to establish that an insured service defined in the Schedule of Benefits was substantially rendered and therefore eligible for payment. Other evidence might include evidence from patients, professional colleagues or staff members.
- (82) Record-keeping requirements for billing purposes should be applied in a manner that takes account of the realities of medical practice and ensures that incentives do not give priority to record-keeping to the detriment of patient care.

Time for completion of review (at 138)

- (83) The staff member assigned to co-ordinate the audit should prepare a time line for that audit and encourage Inspectors and Hearing Panels to adhere to the schedule.
- (84) The following time limits should be specified:
- PAB sends notification letter to physician within 10 days of receiving referral from OHIP.
 - Physician delivers response, if any, within 15 days of receiving the letter.
 - Inspector completes inspection within 30 days of receiving physician's letter.
 - Inspector delivers report within 15 days of completing inspection.
 - Physician delivers response, if any, within 15 days of receiving Inspector's report.
 - A hearing is scheduled to commence within 30 days of receiving the physician's response.
 - The Hearing Panel delivers its decision and written reasons within 30 days of close of submissions.
- (85) To the extent that circumstances warrant, the Inspector and the Hearing Panel should be responsive and flexible in accommodating the physician, but should use their best efforts to ensure that the Inspector and the Hearing Panel comply with their obligations to process the audit investigation and review in a timely manner.
- (86) Staff co-ordinators should report regularly to the Chair of the Physician Audit Board regarding the status of audit investigations and reviews.

Remedies

Remedial flexibility and fairness (at 140)

- (87) Section 37.1 of the *Health Insurance Act* should be amended to provide that the General Manager of OHIP or the Audit Hearing Panel is authorized to reduce the amount of a

recovery order where the result would unfairly deprive the physician of basic and fair compensation for the service the physician has rendered to patients.

- (88) The Audit Hearing Panel should have discretion to fashion flexible remedies that take into account the nature and amount of the billing errors and the experience and circumstances of the physician.
- (89) The Hearing Panel should have authority to be flexible as to the terms of repayment, taking into account the nature and amount of the billing error and the financial circumstances of the physician.
- (90) In serious cases, when there has been a repetitive pattern of inappropriate billing or a flagrant disregard of the educational assistance provided to the physician, the Panel should also have the authority to suspend or remove the physician's right to submit fee claims to OHIP.

Extrapolation (at 144)

- (91) The technique of extrapolation should not be applied in a physician's first audit. It should be used to calculate the extent of the physician's liability to repay fees only on a second or subsequent audit where the physician has previously been found liable to repay fees to OHIP or where the physician has continued to make billing errors despite documented efforts to educate the physician regarding billing requirements.
- (92) In cases where extrapolation is utilized, the random samples must have reasonable and convincing confidence intervals.

Costs (at 145)

- (93) The *Health Insurance Act* should be amended to provide that costs of the audit process will be awarded against the physician only if, and to the extent that, the physician has unreasonably failed to produce documents and records or otherwise unreasonably failed to co-operate with the audit investigation and review, or has been responsible for unnecessary delays, either lengthy or frequent. Reference is also made to Recommendation 50, *supra*.

Interest (at 146)

- (94) If the Hearing Panel determines that the physician has made errors in billing that warrant a recovery of fees, then interest should accrue on the amount found to be improperly paid to the physician from the date the notice is sent to the physician of the audit review hearing, or from whatever earlier date it is shown that the physician was made aware of the proposed referral to the Physician Audit Board.
- (95) The Hearing Panel should have authority to relieve against the accrual of interest during any substantial delays that are the responsibility of OHIP.

- (96) In the case of a second or subsequent audit of the physician's fee claims, or if the physician has flagrantly ignored the educational material and instruction provided to him or her, then the Hearing Panel may direct that interest be paid on the amount found owing from the date it was paid to the physician.

Publication (at 147)

- (97) Section 18.1(18) of the *Health Insurance Act*, which authorizes the publication of the identities of those physicians who have been ordered to repay fees, should be repealed. It should be replaced with a requirement that any information that identifies, or could lead to the identification of, a physician who has been audited or the physician's patients, is confidential and protected from disclosure.

Appeals (at 148)

- (98) A physician should have a right of appeal from a decision of the Physician Audit Board to the Health Services Appeal and Review Board.
- (99) The physician and OHIP should be the parties to the appeal.
- (100) There should be a further right of appeal, by either party, from a decision of the Health Services Appeal and Review board to the Divisional Court.

Privacy of patient records (at 150)

- (101) The *Personal Health Information Protection Act* should be amended to authorize the disclosure of patient information to Inspectors and members of the Physician Audit Board to the extent necessary in order to permit an effective investigation and audit of a physician's fee claims.
- (102) The protections for confidentiality of personal health information in hearings before the Transitional Physician Audit Panel and the Divisional Court should be continued.
- (103) Confidentiality policies and procedures must be developed for those involved in the investigation and audit process. Such procedures should include provisions (1) that no more patient information than necessary be produced in an audit, (2) that only OHIP, the Inspector, and members of the Audit Hearing Panel have access to patient records, and (3) that copies of, or notes relating to, personal health information be destroyed as soon as reasonably possible after completion of an audit or returned to the patient's physician for safe keeping.
- (104) Confidentiality policies and procedures should be reviewed with members of the Physician Audit Board, Inspectors, and staff as part of their training programs.

Educational programs, materials and supports that should be provided to physicians to facilitate compliance with billing requirements (at 153)

- (105) The Education and Prevention Committee established by OHIP and the OMA should be continued. The EPC should encourage and enhance initiatives to provide effective information to physicians and their staff about the billing and audit processes. The EPC should continue to publish bulletins, and develop a course on compliance with billing requirements. The EPC should consider developing on-line, self-directed learning programs for physicians and their staff. Programs of instruction should be adapted to different types of practices.
- (106) The Physician Audit Board should establish a website and post information about its policies and procedures for inspections and audits, as well as its decisions, edited to protect the privacy of physicians and patients.
- (107) OHIP should continue to develop the Provider Education Program (PEP) to facilitate physician compliance with billing requirements and to avoid audit investigations where physicians can provide explanations that justify variances in their billing patterns.
- (108) OHIP should provide to each fee-for-service physician, without charge, an annual mini billing profile, which will, in a timely manner, provide physicians with useful information about their billing patterns in comparison with those of other similarly-situated physicians. A guide to interpretation should accompany the profile. More detailed profiles should be provided on request and on payment of a reasonable fee.
- (109) OHIP should establish a Physician Billing Advisory Service to provide timely responses to physician inquiries about billing. Two types of services should be provided: a) summary advice on routine inquiries by e-mail or by telephone to a toll-free number, and b) advance rulings that will be binding on OHIP until further notice. A physician must be able to make the second type of inquiry anonymously, perhaps through the offices of the OMA. Responses to the second type of inquiry should be posted on the web page.
- (110) All queries should be tracked to identify matters that require clarification for the benefit of other physicians. The Advisory Service should report quarterly to an OHIP-OMA Committee on the Schedule of Benefits and to the Education and Prevention Committee.
- (111) OHIP and the Physician Audit Board, working with the College and the OMA (and its Sections) should design and offer programs for physicians who are about to enter practices in which they will bill OHIP for their services.
- (112) Physicians should be required to complete the program relevant to their practice specialty prior to entering practices in which they will bill OHIP for their services.
- (113) The programs should provide instruction in billing requirements and the audit system, as well as instruction in record-keeping for clinical and billing purposes.

- (114) Decisions of the Physician Audit Board should be published on a web page established and maintained by the Board. The decisions must be edited to remove any information that might identify the physician or any patient. A note should be provided synthesizing and annotating Board decisions so that interested persons can easily access relevant information.

Communications and Co-operation (at 159)

- (115) OHIP, the College, the OMA and the Physician Audit Board should co-operate in implementing the following Recommendations:
- a. Recommendations (4), (23), (26), (27), (40), (44): nomination and vetting of Inspectors and members of the Physician Audit Board;
 - b. Recommendations (6) and (7): accountability of audit system; biennial stakeholders' forum;
 - c. Recommendation (11): permanent OHIP – OMA Joint Committee on the Schedule of Benefits;
 - d. Recommendation (12): references from the Physician Audit Board to the OHIP – OMA Joint Committee on the Schedule of Benefits;
 - e. Recommendations (15) and (17): developing requirements for record-keeping that meet both clinical and billing standards and templates to assist physicians with efficient record-keeping;
 - f. Recommendations (109) to (116): developing instructional materials and programs to assist physicians to comply with record-keeping and billing requirements and to understand the audit process.

Transitional Provisions (at 162)

- (116) The transition arrangements already in place pursuant to the *Transitional Physician Payment Review Act*, 2004, should be continued.
- (117) The following recommendations should be implemented during the transition period and govern the process and decisions of the Transitional Physician Audit Panel:
- a. Recommendation (79): application of the *Statutory Powers Procedure Act*;
 - b. Recommendation (10): interpretation of the Schedule of Benefits;
 - c. Recommendation (81): relying on records and other evidence to establish that services were substantially rendered;

- d. Recommendation (53): no reduction where a reasonably informed physician could not have known that the impugned fee claims did not comply with billing requirements;
 - g. Recommendation (91): no extrapolation in the absence of previous notice of deficiencies;
 - h. Recommendation (87): reduction or recovery limited so as not to unfairly deprive the physician of basic and fair compensation for services rendered.
- (118) As provided in Recommendations 55 and 56, in the transition period, the time limit for OHIP to notify a physician that fee claims are subject to audit should be 24 months.

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REQUEST FOR SUBMISSIONS

Review of the Medical Audit Practice in Ontario

The Minister of Health and Long-Term Care, the Honourable George Smitherman, has appointed Peter Cory, C.C., C.D., to review the Medical Audit Practice in Ontario.

The purpose of this review is to find and develop the best-practice method to audit fee-for-service claims that is accountable to the people, physicians and government of Ontario and that rebuilds the confidence of the profession in the audit process.

Interested organizations of physicians or individual physicians may make submissions or recommendations. They should be sent by **July 14th, 2004** to the following address – **Department of Justice, Ontario Regional Office, 130 King Street West, 34th Floor, Toronto, Ontario M5X 1K6.**

Oral hearings for those wishing to make them will be held the week of October 25th, 2004 and if need be continuing thereafter.

Notice should be given by all those desiring to make oral submissions and indicating the estimated time they will take, they should be sent to the above address on or before **September 15, 2004.**

The Terms of Reference for this review are available from the Department of Justice at the above address. Please contact **Vittoria Alcamo** at **416-973-0956.**

The Globe and Mail, June 21, 2004

**LISTS OF ORGANIZATIONS AND INDIVIDUALS
WHO MADE WRITTEN AND ORAL SUBMISSIONS
TO THE HON. PETER CORY**

Written Submissions – Organizations

Ministry of Health and Long-Term Care (OHIP): July 2004, November 2004

College of Physicians and Surgeons of Ontario: July 2004, September 10, 2004, September 14, 2004, October 2004

Ontario Medical Association: July 2004

Canadian Medical Protective Association: July 2004, October 2004

Health Services Appeal and Review Board: September 2004

Ontario Medical Association, Section on Pediatrics: July 2004

Association of Ontario Neurologists: July 2004, October 2004

Coalition of Family Physicians: August 2004

Specialist Coalition of Ontario: August 2004, November 2004

Greater Niagara Medical Society: July 2004

Hamilton Academy of Medicine: October 2004

Ontario Bar Association, Health Law Section: October 2004

Written Submissions – Individuals

Dr. Peter Ashby

Dr. Vlad I. Avram

Dr. Kim A. Barnett

Dr. Alice E. Briggs

Dr. Joseph R.K. Butchey

Dr. Albert Cannitelli

Dr. Paul Cary

Dr. Howard R. Cohen

Dr. Till Davy

Dr. Farouk Dindar

Dr. Earl F. Dobkin

Dr. C.R. Fischer, Dr. H.J. Weber, Dr. L. Tanious, Dr. E. Potter, Dr. F. Shekh

Dr. Bob Frankford
 Dr. Alexander Franklin
 Dr. Jerry Green
 Dr. Michael D. Hefferon
 Mrs. Irene Hsu (widow of Dr. Anthony C. Hsu)
 Dr. M.A.R. Khan
 Dr. Jeffrey Lipsitz
 Dr. Fionnuala O’Kelly
 Dr. Cesar Garcia Pan
 Dr. Nicholas Prins
 Dr. Wayne Rankin
 Dr. Gabriel J. Slowey
 Dr. Errol A. Sue-A-Quan
 Dr. Allan G. Swayze
 Dr. Roland Wong
 Dr. Robert S. Yufe

Eight submissions made in private

Oral Submissions – Organizations

Ministry of Health and Long-Term Care (OHIP): October 25 and November 2, 2004

Dr. Garry D. Salisbury
 Ms Jo-Ann Connolly
 Ms Laurel Montrose
 Mr. James Smith

College of Physicians and Surgeons of Ontario: October 26 and November 2, 2004

Dr. Barrett R. Adams
 Dr. Rachel Edney
 Dr. Rocco Gerace
 Ms Lisa Brownstone

Ontario Medical Association: October 27 and November 2, 2004

Dr. John Rapin
 Dr. Alan Studniberg
 Dr. Deborah Hellyer
 Mr. Jim Simpson
 Mr. Adam Farber
 Mr. Paul De Zara

Canadian Medical Protective Association: October 28, 2004

Dr. Peter Fraser
 Dr. John Gray
 Ms Margaret Ross

Ontario Medical Association, Section on Pediatrics: November 1, 2004

Dr. Hirotaka Yamashiro
 Dr. U. Cellupica
 Dr. Fionnuala O'Kelly
 Dr. Manjit Walia

Association of Ontario Neurologists: October 27, 2004

Dr. Edwin Klimek
 Mr. Joseph Colangelo

Coalition of Family Physicians: November 1, 2004

Dr. Douglas Mark
 Mr. Brian Shell
 Dr. Michael Goodwin
 Dr. Jan Lussis
 Dr. Chris Pinto
 Mr. Stephen Skyvington

Specialist Coalition of Ontario: November 1, 2004

Dr. William Hughes
 Mr. Paul French

Hamilton Academy of Medicine: October 25, 2004

Dr. R. Guscott
 Dr. Hadcock

Ontario Bar Association, Health Law Section: November 2, 2004

Mr. Lonny Rosen
 Ms Erin Fitzpatrick
 Mr. Michael Fraleigh
 Mr. Lad Kucis
 Mr. Gordon Slemko
 Mr. Gary Srebolow

Oral Submissions – Individuals

Dr. Alice E. Briggs	October 26, 2004
Dr. Albert Cannitelli	October 26, 2004
Dr. Paul Cary	October 25, 2004
Dr. Howard Cohen	October 29, 2004
Dr. Till Davy	October 27, 2004
Dr. Farouk Dindar	October 28, 2004
Dr. Robert Frankford	October 27, 2004
Dr. Alexander Franklin	October 26, 2004
Dr. Jerry Green	October 26, 2004
Dr. Michael Hawke	October 29, 2004
Dr. Patrick Hewlett	October 28, 2004

Mrs. Irene Hsu (widow of Dr. Anthony Hsu)	October 28, 2004
Dr. Jeffrey Lipsitz	November 1, 2004
Dr. Nicholas Prins	October 29, 2004
Dr. Wayne Rankin	October 29, 2004
Dr. Allan Swayze	October 25, 2004
Ms Tracey Tremayne Lloyd	November 2, 2004
Dr. Roland Wong	October 29, 2004

Two oral submissions made in private.

POLICY ON CONFIDENTIAL SUBMISSIONS

July 2004

Individual physicians, or those acting on their behalf, may request that their submissions to The Hon. Peter Cory concerning Medical Audit Practice in Ontario be treated as confidential. Confidential submissions may be made in writing and also in person.

Issues identified in confidential submissions will be summarized in a manner that protects the confidentiality of their source. Those making submissions are invited to propose suitable language for this purpose. The summaries will be included in the record of submissions. If it is not possible to summarize a confidential submission in a manner that protects the confidentiality of its source, the submission will form no part of the record and will not be referred to in Mr. Cory's report.

HEALTH INSURANCE ACT R.S.O. 1990, CHAPTER H.6

Amended by: 1992, c. 32, s. 15; 1993, c. 2, s. 12; 1993, c. 10, s. 53; 1993, c. 32, s. 2; 1994, c. 17, ss. 68-74; 1996, c. 1, Sched. H, ss. 1-35; 1996, c. 21, s. 51; 1997, c. 16, s. 7; 1998, c. 18, Sched. G, s. 54; 1999, c. 10, ss. 1, 2; 2000, c. 26, Sched. H, s. 1; 2000, c. 42, Sched., ss. 17-19; 2001, c. 8, ss. 32, 33; 2002, c. 18, Sched. I, s. 8; 2004, c. 3, Sched. A, s. 85; 2004, c. 5, ss. 36-43; 2004, c. 13, s. 1.

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Definitions

1. In this Act,

“Appeal Board” means the Health Services Appeal and Review Board under the *Ministry of Health Appeal and Review Boards Act, 1998*; (“Commission d’appel”)

“Deputy Minister” means the Deputy Minister of Health; (“sous-ministre”)

Note: On a day to be named by proclamation of the Lieutenant Governor, section 1 is amended by the Statutes of Ontario, 1996, chapter 1, Schedule H, subsection 1 (1) by adding the following definition:

“eligible physician” means, other than in section 19.1, a physician who is determined under sections 29.2 to 29.6 to be an eligible physician; (“médecin admissible”)

See: 1996, c. 1, Sched. H, ss. 1 (1), 40.

“future cost of insured services” means the estimated total cost of the future insured services made necessary as the result of an injury that will probably be required by a patient after the date of settlement or, where there is no settlement, the first day of trial; (“coût futur des services assurés”)

“General Manager” means the General Manager appointed under section 4; (“directeur général”)

“health card” means a document in a prescribed form issued by the General Manager; (“carte Santé”)

“health facility” means an ambulance service, a medical laboratory and any other facility prescribed by the regulations as a health facility for the purposes of this Act; (“établissement de santé”)

“insured person” means a person who is entitled to insured services under this Act and the regulations; (“assuré”)

“insured services” means services that are determined under section 11.2 to be insured services; (“services assurés”)

“Minister” means the Minister of Health; (“ministre”)

“past cost of insured services” means the total cost of the insured services made necessary as the result of an injury and provided to a patient up to and including the date of settlement or, where there is no settlement, the first day of trial; (“coût antérieur des services assurés”)

“physician” means a legally qualified medical practitioner lawfully entitled to practise medicine in the place where medical services are rendered by the physician; (“médecin”)

“Plan” means the Ontario Health Insurance Plan referred to in section 10; (“Régime”)

“practitioner” means a person other than a physician who is lawfully entitled to render insured services in the place where they are rendered; (“praticien”)

“prescribed” means prescribed by the regulations; (“prescrit”)

“regulations” means the regulations made under this Act; (“règlements”)

“resident” means a resident as defined in the regulations and the verb “reside” has a corresponding meaning. (“résident”) R.S.O. 1990, c. H.6, s. 1; 1993, c. 2, s. 12; 1993, c. 32, s. 2 (1); 1994, c. 17, s. 68; 1996, c. 1, Sched. H, s. 1 (2); 1998, c. 18, Sched. G, s. 54 (1).

ADMINISTRATION

Administration of Plan by Minister

[2. \(1\)](#) The Minister is responsible in respect of the administration and operation of the Plan and is the public authority for Ontario for the purposes of the *Canada Health Act*.

Duties of Minister

[\(2\)](#) The Minister may,

- (a) enter into arrangements for the payment of remuneration to physicians and practitioners rendering insured services to insured persons on a basis other than fee for service;
- (b) enter into agreements with persons, organizations and government agencies outside Ontario for the provision of insured services to insured persons;
- (c) limit the hospital and health care services outside Canada for which payment may be made under the Plan;
- (d) establish one or more advisory committees to advise or assist in the operation of the Plan;
- (e) authorize surveys and research programs and obtain statistics for purposes related to the Plan. R.S.O. 1990, c. H.6, s. 2.

Collection of personal information

[\(3\)](#) The Minister may collect, directly or indirectly,

- (a) personal information that relates to the eligibility of a person to become or to continue to be an insured person; or
- (b) the prescribed personal information, which may include a photograph and signature, that relates to the form or content of the health card.

Agreements concerning personal information

[\(4\)](#) The Minister may enter into agreements to collect, use or disclose the personal information referred to in clause (3) (a) and to collect and use the personal information referred to in clause (3) (b). 1994, c. 17, s. 69.

Agreements concerning payment information

[\(4.1\)](#) The Minister may enter into agreements to collect, use and disclose,

- (a) personal information concerning insured services provided by physicians, practitioners or health facilities; and
- (b) such other personal information as may be prescribed. 1996, c. 1, Sched. H, s. 2 (1).

Limitation

[\(5\)](#) An agreement shall provide that personal information collected or disclosed under the agreement will be used only,

- (a) to verify the accuracy of information held or exchanged by a party to the agreement;
- (b) to administer or enforce a law administered by a party to the agreement; or
- (c) for such other purposes as may be prescribed. 1994, c. 17, s. 69; 1996, c. 1, Sched. H, s. 2 (2).

Confidentiality

[\(6\)](#) An agreement shall provide that personal information collected, used or disclosed under it is confidential and shall establish mechanisms for maintaining the confidentiality of the information. 1996, c. 1, Sched. H, s. 2 (3).

Ontario-Canada agreement

[3. \(1\)](#) The Government of Ontario, represented by the Treasurer of Ontario, may enter into and amend from time to time an agreement with the Government of Canada under which Canada will contribute to the cost of that part of the Plan related to the provision of any insured services in or by hospitals and health facilities in accordance with such terms and conditions as the agreement provides.

Idem

[\(2\)](#) The Government of Ontario, represented by the Minister, may enter into and amend from time to time an agreement with the Government of Canada under which Canada will contribute to the cost of that part of the Plan related to insured services other than insured services provided in or by a hospital or health facility, in accordance with such terms and conditions as the agreement provides. R.S.O. 1990, c. H.6, s. 3.

General Manager

[4. \(1\)](#) A General Manager for the Plan shall be appointed by the Lieutenant Governor in Council.

Duties

[\(2\)](#) Subject to this Act and the regulations, it is the function of the General Manager and he or she has the power,

- (a) to administer the Plan as the chief executive officer of the Plan;
- (b) to carry out enrolments in the Plan including the determination of eligibility;
- (c) to make payments by the Plan for insured services, including the determination of eligibility and amounts;
- (d) to establish and maintain branch offices for the administration of the Plan;

- (e) to conduct actions and negotiate settlements on behalf of the Plan under the subrogation of the Plan under this Act to the rights of insured persons;
- (f) to require any information required or permitted to be provided to the General Manager under this Act or the regulations to be provided in such form as he or she specifies;
- (g) to perform such other function and discharge such other duties as are assigned to the General Manager by this Act and the regulations or by the Minister. R.S.O. 1990, c. H.6, s. 4.

Collection of personal information

[4.1 \(1\)](#) The Minister and the General Manager may directly or indirectly collect personal information, subject to such conditions as may be prescribed, for purposes related to the administration of this Act, the *Health Care Accessibility Act* or the *Independent Health Facilities Act* or for such other purposes as may be prescribed. 1996, c. 1, Sched. H, s. 3.

Use of personal information

[\(2\)](#) The Minister and the General Manager may use personal information, subject to such conditions as may be prescribed, for purposes related to the administration of this Act, the *Health Care Accessibility Act* or the *Independent Health Facilities Act* or for such other purposes as may be prescribed. 1996, c. 1, Sched. H, s. 3.

Disclosure

[\(3\)](#) The Minister and the General Manager shall disclose personal information if all prescribed conditions have been met and if the disclosure is necessary for purposes related to the administration of this Act, the *Health Care Accessibility Act* or the *Independent Health Facilities Act* or for such other purposes as may be prescribed. However, the Minister or the General Manager shall not disclose the information if, in his or her opinion, the disclosure is not necessary for those purposes. 1996, c. 1, Sched. H, s. 3.

Obligation

[\(4\)](#) Before disclosing personal information obtained under the Act or under an agreement, the person who obtained it shall delete from it all names and identifying numbers, symbols or other particulars assigned to individuals unless,

- (a) disclosure of the names or other identifying information is necessary for the purposes described in subsection (3), 2 (5) or 38 (4); or
- (b) disclosure of the names or other identifying information is otherwise authorized under the *Freedom of Information and Protection of Privacy Act* or the *Personal Health Information Protection Act*, 2004. 1996, c. 1, Sched. H, s. 3; 2004, c. 3, Sched. A, s. 85 (1).

MEDICAL REVIEW COMMITTEE

Medical Review Committee

[5. \(1\)](#) The committee known in English as the Medical Review Committee and in French as comité d'étude de la médecine is continued as a committee of the College of Physicians and Surgeons of Ontario. R.S.O. 1990, c. H.6, s. 5 (1); 2000, c. 26, Sched. H, s. 1 (1).

Members

- [\(2\)](#) The Medical Review Committee shall consist of,
- (a) the prescribed number of members appointed by the Minister from among the persons nominated for the purpose by the College of Physicians and Surgeons of Ontario; and
 - (b) the prescribed number of members who are not physicians or practitioners, appointed by the Minister. 1993, c. 32, s. 2 (2); 2000, c. 26, Sched. H, s. 1 (2).

Same

[\(2.1\)](#) The number of members under clause (2) (a) shall be not less than three times the number under clause (2) (b). 1993, c. 32, s. 2 (2).

Quorum

[\(3\)](#) Three members of the Medical Review Committee, one of whom shall be a member who is not a physician or practitioner, constitute a quorum of the Committee. However, one member who is a physician constitutes a quorum for the purposes of a review requested under subsection 18.1 (2) or 39.1 (3). 1996, c. 1, Sched. H, s. 4 (1).

Divisions of Committee

[\(3.1\)](#) The Medical Review Committee may sit in several divisions simultaneously, if a quorum of the Committee is present in each division. 1996, c. 1, Sched. H, s. 4 (1).

Remuneration

[\(4\)](#) The members of the Medical Review Committee shall be paid such remuneration for their services, on an hourly basis, a daily basis or otherwise, as the Lieutenant Governor in Council determines. R.S.O. 1990, c. H.6, s. 5 (4).

Administration expenses

[\(5\)](#) The Medical Review Committee shall be paid such amounts for the administration expenses of the Committee and the engaging of assistance for the Committee as may be approved by the Minister. R.S.O. 1990, c. H.6, s. 5 (5).

Qualifications of members

(6) No member of the Medical Review Committee shall be employed in the service of Ontario or any agency of the Crown. R.S.O. 1990, c. H.6, s. 5 (6).

Duties

(7) The Medical Review Committee shall perform such duties as are assigned to it under the Act and shall make reports and recommendations respecting any matter referred to it by the Minister, the Appeal Board or the College of Physicians and Surgeons of Ontario. 1996, c. 1, Sched. H, s. 4 (2); 2000, c. 26, Sched. H, s. 1 (3).

Powers

(8) Members of the Medical Review Committee have the powers of an inspector appointed under subsection 40 (1). 1996, c. 1, Sched. H, s. 4 (2).

PRACTITIONER REVIEW COMMITTEES

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MEDICAL ELIGIBILITY COMMITTEE

...

REPORT TO ASSEMBLY

8. Repealed: 1998, c. 18, Sched. G, s. 54 (4).

Report to Assembly

9. The Minister shall make a report annually to the Lieutenant Governor in Council upon the affairs of the Plan and the Minister shall lay the report before the Assembly if it is in session or, if not, at the next session. R.S.O. 1990, c. H.6, s. 9.

ONTARIO HEALTH INSURANCE PLAN

Ontario Health Insurance Plan continued

10. The Ontario Health Insurance Plan is continued for the purpose of providing for insurance against the costs of insured services on a non-profit basis on uniform terms and conditions available to all residents of Ontario, in accordance with this Act, and providing other health benefits related thereto. R.S.O. 1990, c. H.6, s. 10.

Right to insurance

[11. \(1\)](#) Every person who is a resident of Ontario is entitled to become an insured person upon application therefor to the General Manager in accordance with this Act and the regulations. R.S.O. 1990, c. H.6, s. 11 (1).

Establishing entitlement

[\(2\)](#) It is the responsibility of every person to establish his or her entitlement to be, or to continue to be, an insured person. 1994, c. 17, s. 70.

[\(3\)](#) Repealed: 2000, c. 26, Sched. H, s. 1 (4).

Health card

[11.1 \(1\)](#) A health card remains the property of the Minister at all times.

Taking possession of card

[\(2\)](#) A prescribed person may take possession of a health card that is surrendered to him or her voluntarily.

Return to General Manager

[\(3\)](#) On taking possession of a health card under subsection (2), the person shall return it to the General Manager as soon as possible.

Protection from liability

[\(4\)](#) No proceeding for taking possession of a health card shall be commenced against a person who does so in accordance with subsection (2). 1993, c. 32, s. 2 (4).

Insured services

[11.2 \(1\)](#) The following services are insured services for the purposes of the Act:

1. Prescribed services of hospitals and health facilities rendered under such conditions and limitations as may be prescribed.
2. Prescribed medically necessary services rendered by physicians under such conditions and limitations as may be prescribed.
3. Prescribed health care services rendered by prescribed practitioners under such conditions and limitations as may be prescribed. 1996, c. 1, Sched. H, s. 8.

Exceptions

[\(2\)](#) Despite subsection (1), services that a person is entitled to under the insurance plan established under the *Workplace Safety and Insurance Act, 1997* or under the *Homes for Special Care Act* or under any

Act of the Parliament of Canada except the *Canada Health Act* are not insured services. 1996, c. 1, Sched. H, s. 8; 1997, c. 16, s. 7.

Restrictions

(3) Such services as may be prescribed are insured services only if they are provided in or by designated hospitals or health facilities.

Same

(4) Such services as may be prescribed are insured services only if they are provided to insured persons in prescribed age groups.

Same

(5) Such services as may be prescribed are not insured services when they are provided to insured persons in prescribed age groups. 1996, c. 1, Sched. H, s. 8.

Entitlement to insured services

12. (1) Every insured person is entitled to payment to himself or herself or on his or her behalf for, or to be otherwise provided with, insured services in the amounts and subject to such conditions and co-payments, if any, as are prescribed. R.S.O. 1990, c. H.6, s. 12.

Note: On a day to be named by proclamation of the Lieutenant Governor, section 12 is amended by the Statutes of Ontario, 1996, chapter 1, Schedule H, section 9 by adding the following subsections:

Exception

(2) Subsection (1) does not apply if the insured service is provided in Ontario by a physician who is not an eligible physician.

Commencement

(3) Subsection (2) comes into force on a day to be named by proclamation of the Lieutenant Governor.

See: 1996, c. 1, Sched. H, ss. 9, 40.

Choice of physician or practitioner

13. This Act shall not be administered or construed to affect the right of an insured person to choose his or her own physician or practitioner, and does not impose any obligation upon any physician or practitioner to treat an insured person. R.S.O. 1990, c. H.6, s. 13.

Other insurance prohibited

14. (1) Every contract of insurance, other than insurance provided under section 268 of the *Insurance Act*, for the payment of or reimbursement or indemnification for all or any part of the cost of any insured services other than,

- (a) any part of the cost of hospital, ambulance and nursing home services that is not paid by the Plan;
- (b) compensation for loss of time from usual or normal activities because of disability requiring insured services;
- (c) any part of the cost that is not paid by the Plan for such other services as may be prescribed when they are performed by such classes of persons or in such classes of facilities as may be prescribed,

performed in Ontario for any person eligible to become an insured person under this Act, is void and of no effect in so far as it makes provision for insuring against the costs payable by the Plan and no person shall enter into or renew such a contract. R.S.O. 1990, c. H.6, s. 14 (1); 1996, c. 1, Sched. H, s. 10.

Resident not to benefit from prohibited insurance

(2) A resident shall not accept or receive any benefit under any contract of insurance prohibited under subsection (1) whereby the resident or his or her dependants may be provided with or reimbursed or indemnified for all or any part of the costs of, or costs directly related to the provision of any insured service. R.S.O. 1990, c. H.6, s. 14 (2).

Exceptions

(3) Subsections (1) and (2) do not apply to a contract of insurance entered into by a resident whose principal employment is in the United States of America and who is entitled to enter into the contract by virtue of his or her employment. R.S.O. 1990, c. H.6, s. 14 (3).

Idem

(4) Where payment is made to or on behalf of an insured person under a contract or agreement referred to in subsection (3) and such payment is less than would have been made under this Act and the regulations for the same insured services, the General Manager may pay to or on behalf of the insured person the difference between the amount paid under the contract or agreement and the amount established by the regulations for the insured services for which payment was made under the contract or agreement. R.S.O. 1990, c. H.6, s. 14 (4).

Exception

(5) Subsections (1) and (2) do not apply during the period that a person who is a resident must wait to be enrolled as an insured person. 2000, c. 26, Sched. H, s. 1 (5).

Billing – physicians

15. (1) A physician shall submit all of his or her accounts for the performance of insured services rendered to an insured person directly to the Plan in accordance with and subject to the requirements of this Act and the regulations, unless an agreement under subsection 2 (2) provides otherwise. 2004, c. 5, s. 36.

Requirements where Plan billed

(2) Where a physician submits his or her accounts directly to the Plan under this section,

- (a) payment shall be made,
 - (i) directly to the physician, or
 - (ii) as the physician directs in accordance with section 16.1; and
- (b) the payment by the Plan for the insured services rendered to an insured person constitutes payment in full of the account. 2004, c. 5, s. 36.

Where s. 2 (2) applies

[\(3\)](#) Where an account is submitted to the Plan in accordance with subsection 2 (2) with respect to insured services rendered to an insured person, the payment by the Plan constitutes payment in full of the account. 2004, c. 5, s. 36.

Billing – practitioners

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Transitional

[15.2 \(1\)](#) The following rules apply with respect to a physician or designated practitioner to whom subsection 11 (7) of the *Commitment to the Future of Medicare Act*, 2004 applies:

1. Sections 15 and 15.1 do not apply to him or her.
2. Subsections 15 (5), 16 (5), 16.1 (2), 17 (2), 25 (2) to (9), and 27.2 (3) and (4), as applicable, as they existed immediately before their repeal by the *Commitment to the Future of Medicare Act*, 2004 continue to apply to the physician or designated practitioner, as the case may be, as if they had not been repealed, except in respect of any prescribed accounts or classes of accounts, and subject to any prescribed circumstances or conditions.
3. Where, under subsection 27.2 (3), the physician or designated practitioner is required to temporarily submit his or her accounts directly to the Plan, the submission of the accounts is not a deemed election for the purposes of subsection 11 (6) of the *Commitment to the Future of Medicare Act*, 2004, but subsection 10 (3) of that Act applies to him or her during the time that he or she is temporarily required to submit accounts directly to the Plan.
4. All other applicable provisions of this Act apply to the physician or designated practitioner. 2004, c. 5, s. 36.

Same

[\(2\)](#) Where a physician or designated practitioner to whom section 11 of the *Commitment to the Future of Medicare Act*, 2004 applies submits his or her accounts for the rendering of insured services to insured persons directly to the Plan, subsections 25 (2) to (9) of this Act, as they existed before their repeal, apply to him or her with respect to accounts submitted before he or she commenced submitting his or her accounts directly to the Plan. 2004, c. 5, s. 36.

Interpretation

[\(3\)](#) In this section,

“physician” and “designated practitioner” mean a physician or designated practitioner within the meaning of Part II of the *Commitment to the Future of Medicare Act*, 2004. 2004, c. 5, s. 36.

Billing numbers

[16. \(1\)](#) An account or claim submitted in the name of a physician or practitioner in conjunction with the billing number issued to the physician or practitioner, and any payment made pursuant to the account or claim is deemed to have been,

- (a) submitted personally by the physician or practitioner;
- (b) paid to the physician or practitioner personally;
- (c) received by the physician or practitioner personally; and
- (d) made by and submitted with the consent and knowledge of the physician or practitioner. 2004, c. 5, s. 36.

Health facilities

[\(2\)](#) Subsection (1) applies with necessary modifications to health facilities. 2004, c. 5, s. 36.

Applies despite direction

[\(3\)](#) This section applies despite a direction given pursuant to section 16.1. 2004, c. 5, s. 36.

Exception

[\(4\)](#) This section does not apply to an account, claim or payment in the circumstances and on the conditions prescribed in the regulations. 2004, c. 5, s. 36.

Definition

[\(5\)](#) In this section,

“billing number” means the unique identifying number issued by the General Manager to a physician, practitioner or health facility for the purpose of identifying the accounts or claims for insured services rendered by that physician, practitioner or health facility. 2004, c. 5, s. 36.

Direction to make payments to entity

[16.1 \(1\)](#) A physician or a practitioner may direct that payments for services performed by the physician or practitioner and to which the physician or practitioner is lawfully entitled may be directed to such person or entity as may be prescribed and in such circumstances and on such conditions as may be prescribed, including such requirements and other matters with respect to directions as may be prescribed. 2000, c. 42, Sched., s. 19.

[\(2\)](#) Repealed: 2004, c. 5, s. 37.

Person or entity not entitled

(3) The entitlement to payment for services performed by a physician or a practitioner is that of the physician or practitioner and not that of the person or entity to which the physician or practitioner has directed that such a payment be made. 2000, c. 42, Sched., s. 19.

Repayment to Plan

(4) Where payment is made by the Plan to a person or entity pursuant to subsection (1), any money owing to the Plan by the physician or the practitioner may be recovered from the physician or practitioner personally. 2000, c. 42, Sched., s. 19.

Interpretation

(5) A reference in this Act or the regulations to a payment to a physician or a practitioner where the reference relates to a payment for services performed by the physician or practitioner shall be deemed to include a payment made to a person or entity pursuant to a direction made under this section. 2000, c. 42, Sched., s. 19.

Keeping and inspection of records

(6) Section 37.1 (record-keeping) applies with necessary modifications to a person or entity to whom payment is made pursuant to a direction and sections 40, 40.1 and 40.2 apply with necessary modifications to an inspection of the records to be kept. 2000, c. 42, Sched., s. 19.

Accounts for insured services

17. (1) Physicians, practitioners and health facilities shall prepare accounts for their insured services in such form as the General Manager may require. The accounts must meet the prescribed requirements. 1996, c. 1, Sched. H, s. 11.

(2) Repealed: 2004, c. 5, s. 38.

Time for submitting

(3) The physician, practitioner, health facility or, in the case of a patient who is billed directly, the patient must submit an account for an insured service to the General Manager within such time after the service is performed as may be prescribed. When submitted, the account must be in the required form and meet the prescribed requirements. 1996, c. 1, Sched. H, s. 11; 2000, c. 26, Sched. H, s. 1 (6).

Fees payable for insured services

17.1 (1) A physician, practitioner or insured person who submits an account to the General Manager in accordance with the Act for insured services provided by a physician or a practitioner is entitled to be paid the fee determined under this section.

Ineligible physician

(2) The fee payable for an insured service provided in Ontario by a physician who is not an eligible physician is nil. This subsection does not apply if the service is rendered on a basis other than fee for service.

Amount

(3) The basic fee payable for an insured service is the amount set out in the regulations. The amount may differ for different classes of physician or practitioner.

Same

(4) The regulations may provide that the basic fee for an insured service is nil.

Adjustment of amount

(5) The basic fee payable for an insured service performed by a physician or practitioner may be increased or decreased as provided in the regulations based upon one or more of the following factors:

1. The professional specialization of the physician or practitioner.
2. The relevant professional experience of the physician or practitioner.
3. The frequency with which the physician or practitioner provides the insured service.
4. The geographic area in which the insured service is provided.
5. The setting in which the insured service is provided.
6. The period of time when the insured service is provided.
7. Such other factors as may be prescribed.

Threshold amount

(6) If the total amount payable for one or more prescribed insured services provided by a physician or practitioner during a prescribed period equals or exceeds a prescribed amount, the fee payable for an insured service may be increased or decreased in accordance with the regulations. The fee payable may be reduced to nil.

Same

(7) A change made under subsection (6) in the fee payable for an insured service is imposed in addition to any change made under subsection (5) in the basic fee payable.

Commencement

(8) Subsection (2) comes into force on a day to be named by proclamation of the Lieutenant Governor. 1996, c. 1, Sched. H, s. 12.

Fees payable, health facilities

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Payment of accounts

[18.](#) (1) The General Manager shall determine all issues relating to accounts for insured services and shall make the payments from the Plan that are authorized under the Act.

Same

[2](#) The General Manager may refuse to pay for a service provided by a physician, practitioner or health facility or may pay a reduced amount in the following circumstances:

1. If the General Manager is of the opinion that all or part of the insured service was not in fact rendered.
2. If the General Manager is of the opinion that the nature of the service is misrepresented, whether deliberately or inadvertently.
3. For a service provided by a physician, if the General Manager is of the opinion, after consulting with a physician, that all or part of the service was not medically necessary.
4. For a service provided by a practitioner, if the General Manager is of the opinion, after consulting with a practitioner who is qualified to provide the same service, that all or part of the service was not therapeutically necessary.
5. For a service provided by a health facility, if the General Manager is of the opinion, after consulting with a physician or practitioner, that all or part of the service was not medically or therapeutically necessary.
6. If the General Manager is of the opinion that all or part of the service was not provided in accordance with accepted professional standards and practice.
7. In such other circumstances as may be prescribed.

Note: Subsection (3) comes into force on a day to be named by proclamation of the Lieutenant Governor.

Same

[3](#) The General Manager may refuse to pay for a service provided by a physician if the General Manager is of the opinion that the physician is not an eligible physician.

See: 1996, c. 1, Sched. H, s. 40 and *The Ontario Gazette* dated March 9, 1996.

Same

[4](#) The General Manager shall refuse to pay for an insured service if the account for the service is not prepared in the required form, does not meet the prescribed requirements or is not submitted to him or her within the prescribed time. However, the General Manager may pay for the service if there are extenuating circumstances.

Reimbursement

(5) The General Manager may require a physician, practitioner or health facility to reimburse the Plan for an amount paid for a service if, after the payment is made, the General Manager is of the opinion that a circumstance described in subsection (2) exists.

Exception, physician

(6) Despite subsection (5), the General Manager shall not require a physician to reimburse the Plan if the sole reason for requiring the reimbursement is that a circumstance described in paragraph 3 or 6 of subsection (2) exists.

Exception, practitioner

(7) Despite subsection (5), the General Manager shall not require a practitioner to reimburse the Plan if the sole reason for requiring the reimbursement is that a circumstance described in paragraph 4 or 6 of subsection (2) exists.

Note: Subsection (8) comes into force on a day to be named by proclamation of the Lieutenant Governor.

Ineligible physician

(8) The General Manager may require a physician to reimburse the Plan for an amount paid for a service if, after the payment is made, the General Manager is of the opinion that the physician is not an eligible physician.

See: 1996, c. 1, Sched. H, s. 40 and *The Ontario Gazette* dated March 9, 1996.

Notice

(9) The General Manager shall notify the physician, practitioner or health facility of a decision to refuse to pay for a service, to pay a reduced amount or to require the reimbursement of the Plan. 1996, c. 1, Sched. H, s. 13.

Physicians

18.0.1 (1) Subject to subsection (2), during the period that commences when this section comes into force, and ends when this section is repealed under section 18.0.4, sections 18.1 and 39.1 do not apply to a physician, and this section applies instead. 2004, c. 13, s. 1.

Saving

(2) Subsection (1) does not affect,

- (a) a right to request a review by the Medical Eligibility Committee under clause 18.1 (1) (a); or
- (b) any rights, responsibilities or obligations under subsections 18.1 (14) to (19) with regard to a review in which a final direction was given before this section came into force. 2004, c. 13, s. 1.

Panel Review

(3) Upon the request of a physician, the Transitional Physician Audit Panel is authorized to review the following matters in relation to that physician:

1. A decision of the General Manager to refuse to pay for a service, or to pay a reduced amount for a service under subsection 18 (2).
2. A decision of the General Manager to require reimbursement of an amount paid for a service under subsection 18 (5). 2004, c. 13, s. 1.

If review requested

(4) If a physician requests a review under subsection (3), the chair of the Appeal Board shall designate members of the Transitional Physician Audit Panel to deal with the review and set a time for the review and the panel shall conduct the review and render its direction as expeditiously as may be reasonably possible, and in any case shall render its direction no more than 45 days after the last day on which evidence in the review was adduced before the panel, unless the General Manager and the physician consent to an extension. 2004, c. 13, s. 1.

Parties

(5) Only the General Manager and the physician are parties to a review by the Transitional Physician Audit Panel. 2004, c. 13, s. 1.

Directions

(6) Following the review, the Transitional Physician Audit Panel may give any direction that could have been given by the Medical Review Committee under subsection 18.1 (10). 2004, c. 13, s. 1.

Interest, payable by physician

(7) If, as a result of a direction by the Transitional Physician Audit Panel, an amount is payable by a physician, interest calculated in the prescribed manner is payable on the amount, payable from the date the account was paid by the Plan. 2004, c. 13, s. 1.

Interest, payable to physician

(8) If, as a result of a direction by the Transitional Physician Audit Panel, an amount is payable by the General Manager, interest calculated in the prescribed manner is payable on the amount, payable from the date the amount was recovered from the physician by the Plan. 2004, c. 13, s. 1.

Applicability of certain provisions

(9) The following provisions apply, with necessary modifications, to a review by the Transitional Physician Audit Panel:

1. Subsections 21 (1.1) and (2).
2. Subsections 23 (1) to (4) and (6).
3. Section 27.2. 2004, c. 13, s. 1.

Appeal to Divisional Court

(10) Any party to a review before the Transitional Physician Audit Panel may appeal from the panel's direction to the Divisional Court in accordance with the rules of court, but,

- (a) personal health information contained in any document or evidence filed or adduced with regard to the appeal, or in any order or decision of the Court shall not be made accessible to the public; and
- (b) the Divisional Court may edit any documents it releases to the public to remove any personal health information. 2004, c. 13, s. 1.

Transitional Suspension

18.0.2 (1) Unless the physician elects otherwise under subsection (2), a review or reconsideration by the Medical Review Committee with regard to the physician is suspended for the period that this section is in force where, prior to its coming into force,

- (a) the physician requested the review under subsection 18.1 (1) or the reconsideration of that review under subsection 18.1 (7); and
- (b) the Medical Review Committee had not given a final direction from the review, or in the case of a reconsideration, a final direction from the reconsideration. 2004, c. 13, s. 1.

Election

(2) A physician may elect, instead of a suspension under subsection (1), to request a review by the Transitional Physician Audit Panel under section 18.0.1 as if he or she had never requested that the Medical Review Committee perform a review or a reconsideration of a review. 2004, c. 13, s. 1.

Suspension, section 39.1

(3) Unless the physician elects otherwise under subsection (4), a review or reconsideration by the Medical Review Committee with regard to the physician is suspended for the period that this section is in force where, prior to its coming into force,

- (a) the General Manager had, in respect of the physician, requested the review under subsection 39.1 (1) or the physician had made a request for the reconsideration in accordance with subsection 39.1 (4); and
- (b) the Medical Review Committee had not given a final direction from the review, or in the case of a reconsideration, a final direction from the reconsideration. 2004, c. 13, s. 1.

If no suspension

(4) If a physician is the subject of a request by the General Manager for a review under subsection 39.1 (1) or a request by the physician for a reconsideration in accordance with subsection 39.1 (4), the physician may elect that the General Manager, acting under subsection 18 (1), determine all issues relating to those accounts of the physician that formed the subject-matter of the request as if no request had ever been made. 2004, c. 13, s. 1.

Other issues if no suspension

(5) Where a physician elects under subsection (2) or (4) not to suspend a review or reconsideration, in respect of a review or reconsideration being conducted by the Medical Review Committee, no conclusion, decision or deliberation of the Medical Review Committee, whether of a preliminary, draft or final nature, is admissible in any subsequent review, proceeding or appeal, despite any other Act or law to the contrary. 2004, c. 13, s. 1.

Additional election

(6) Where, on the day this section came into force, a physician had received notice of a direction, and had not yet requested a reconsideration within the time provided under subsection 18.1 (8) or 39.1 (4),

- (a) the physician may elect to request a reconsideration, and have it suspended under this section;
- (b) the physician may elect a review under subsection (2) or (4), as the case may be; or
- (c) the physician may elect to treat the direction as final, in which case any provisions of this Act that would have applied to the direction if it had become final before the coming into force of this section apply. 2004, c. 13, s. 1.

Rules re election

(7) An election under subsection (2), (4) or (6) must be made within 30 days from the day this section comes into force. 2004, c. 13, s. 1.

Notice

(8) Notice of election not to suspend under subsection (2) or (4) must be served on the General Manager. 2004, c. 13, s. 1.

Interest

(9) If a suspension applies under subsection (1) or (3) in respect of a request for a reconsideration, no interest is payable during the time that this section is in force on any amount payable by the physician as a result of the direction of the Medical Review Committee subject to the reconsideration. 2004, c. 13, s. 1.

Appeals

(10) In any appeal to the Appeal Board or the Divisional Court concerning a decision of the Medical Review Committee made before the coming into force of this section, the General Manager may elect to stand in the place of the Medical Review Committee, and if the General Manager so elects, he or she has all the rights and responsibilities of the Medical Review Committee for the purposes of the appeal. 2004, c. 13, s. 1.

Transitional

[\(11\)](#) Where on June 21, 2004 payments to a physician are suspended under subsection 40.2 (6), the suspension shall remain in effect until the physician has complied with subsections 37 (1) and (3) to the satisfaction of the General Manager. 2004, c. 13, s. 1.

Definition

[18.0.3](#) In sections 18.0.1 and 18.0.2,

“Transitional Physician Audit Panel” means the Transitional Physician Audit Panel established under section 7.1 of the Ministry of Health Appeal and Review Boards Act, 1998. 2004, c. 13, s. 1.

Repeal

[18.0.4](#) Sections 18.0.1, 18.0.2 and 18.0.3 are repealed on a day to be named by proclamation of the Lieutenant Governor. 2004, c. 13, s. 1.

Review by committee, physician

[18.1 \(1\)](#) A physician may request that a decision of the General Manager under subsection 18 (2) or (5) be reviewed,

- (a) by the Medical Eligibility Committee in the circumstances described in subsection 19 (1); or
- (b) by the Medical Review Committee in any other circumstance. 1996, c. 1, Sched. H, s. 13.

Same

[\(2\)](#) A physician may request that a review by the Medical Review Committee be performed by a single member of the Committee,

- (a) if the amount of money in dispute is less than such amount as may be prescribed; or
- (b) if the General Manager consents to a review by a single committee member. 1996, c. 1, Sched. H, s. 13.

Review by committee, practitioner

[\(3\)](#) A practitioner may request that a decision of the General Manager under subsection 18 (2) or (5) be reviewed by the applicable practitioner review committee. 1996, c. 1, Sched. H, s. 13.

Same

[\(4\)](#) The practitioner may request that the review be performed by a single member of the practitioner review committee,

- (a) if the amount of money in dispute is less than such amount as may be prescribed; or
- (b) if the General Manager consents to a review by a single committee member. 1996, c. 1, Sched. H, s. 13.

Time for request

(5) A request for a review must be made within 60 days after the physician or practitioner receives notice of the decision of the General Manager and must be accompanied by the prescribed application fee for the type of review requested. 1996, c. 1, Sched. H, s. 13.

Expedited review

(6) The following rules apply with respect to a review by a single committee member:

1. The review must begin promptly after the request is made and must be conducted expeditiously.
2. The committee member may give any direction that the applicable committee is authorized under subsection (10) to give. If the review results from a request made under clause (2) (a) or (4) (a), the direction may provide for payment or reimbursement of an amount greater than the prescribed amount referred to in those clauses.
3. In such circumstances as the committee member considers appropriate, he or she may recommend that the General Manager consider requesting a review under section 39.1 and may give the General Manager such information as the committee member considers appropriate.
4. Following the review, the committee member shall promptly give notice to the physician or practitioner of his or her direction under paragraph 2. The committee member is not required to give written reasons for the direction. 1996, c. 1, Sched. H, s. 13; 2002, c. 18, Sched. I, s. 8 (1, 2).

Same, reconsideration

(7) A person aggrieved by the direction given by the single committee member may request the Medical Review Committee or the applicable practitioner review committee, as the case may be, to reconsider the matter. 1996, c. 1, Sched. H, s. 13; 2002, c. 18, Sched. I, s. 8 (3).

Request for reconsideration

(8) A request for reconsideration must be made within 30 days after the physician or practitioner receives notice of the single committee member's direction, and must be accompanied by the prescribed application fee. 2002, c. 18, Sched. I, s. 8 (4).

Procedural directions

(9) During a review or reconsideration, the applicable committee or a single committee member, as the case may be, may require the physician or practitioner to take such steps by such time as the committee or member may determine. 1996, c. 1, Sched. H, s. 13.

Direction by committee

(10) Following the review or following its reconsideration of a review by a single committee member, the Medical Review Committee or the practitioner review committee may give a direction,

- (a) that the decision of the General Manager be confirmed;
- (b) that the General Manager make a payment in accordance with the submitted account;

(c) that the General Manager pay a reduced amount, as calculated by the General Manager in accordance with the direction; or

(d) that the physician or practitioner reimburse the Plan in the amount calculated by the General Manager in accordance with the direction. 2002, c. 18, Sched. I, s. 8 (5).

Recommendation of further review

(11) Following the review or following its reconsideration of a review by a single committee member, the Medical Review Committee or the practitioner review committee may recommend in such circumstances as it considers appropriate that the General Manager consider requesting a review under section 39.1 and may give the General Manager such information as it considers appropriate. 1996, c. 1, Sched. H, s. 13.

Notice

(12) The applicable committee shall serve the persons affected by a direction given under subsection (10) with a notice stating that the physician or practitioner may appeal it to the Appeal Board. 1996, c. 1, Sched. H, s. 13.

Reasons for direction

(13) Upon request, the applicable committee shall give the persons affected by its direction written reasons for it. 1996, c. 1, Sched. H, s. 13.

Interest

(14) If, as a result of a direction, an amount is payable by or to a physician or practitioner, interest is also payable on the amount. Interest is calculated in the prescribed manner and is payable from the date determined in the prescribed manner. 1996, c. 1, Sched. H, s. 13.

Additional payment

(15) The physician or practitioner shall pay an additional amount for the cost of the review and for the cost of any reconsideration of a review,

- (a) if a decision of the General Manager refusing to pay an account for services provided by the physician or practitioner is confirmed;
- (b) if, as a result of a direction, the physician or practitioner is required to reimburse the Plan; or
- (c) if the General Manager is required to pay him or her less than the amount of the account submitted for the insured services. 1996, c. 1, Sched. H, s. 13.

Same

(16) The additional amount under subsection (15) shall be determined in the prescribed manner. 1996, c. 1, Sched. H, s. 13.

Refund of fee

(17) The General Manager shall refund any portion of the application fee paid by the physician or practitioner that remains after the additional amount, if any, under subsection (15) is paid. 1996, c. 1, Sched. H, s. 13.

Publication of details

(18) The General Manager may make public the following information relating to the matter under review:

1. The name and specialty, if any, of the physician or practitioner.
2. The municipality or geographic area in which the physician or practitioner practised his or her profession when the services giving rise to the direction of the applicable committee were provided.
3. The municipality or geographic area in which the physician or practitioner practises his or her profession when the information is made public.
4. A description of the situation under review. The description must not identify, or enable a person to identify, a patient.
5. The amount, if any, that the physician or practitioner is required to pay to the Plan.
6. Such other information as may be prescribed. 1996, c. 1, Sched. H, s. 13; 2002, c. 18, Sched. I, s. 8 (6).

No appeal

(19) The decision of the General Manager to make information public under subsection (18) is final and shall not be appealed to the Appeal Board or the Divisional Court. 1996, c. 1, Sched. H, s. 13.

Restriction

(20) The General Manager shall not make the information public until any appeal of a related direction given under subsection (10) is finally determined. 1996, c. 1, Sched. H, s. 13.

Same

(21) The General Manager shall not make the information public if the matter is reviewed by a single committee member and no reconsideration of the review is requested under subsection (7). 1996, c. 1, Sched. H, s. 13.

Review

18.2 (1) The General Manager may request the Medical Review Committee to review the provision of a service by a physician, practitioner or health facility when the service was provided at the request of another physician and the General Manager is of the opinion that the service was not medically necessary. 2002, c. 18, Sched. I, s. 8 (7).

Direction to repay

(2) If directed to do so by the Medical Review Committee, the physician who requested the provision of the service shall reimburse the Plan,

- (a) in the amount paid by the Plan to the physician or practitioner for the service;
- (b) in the amount paid by the Plan to the health facility, if the health facility submitted an account to the General Manager for the service;
- (c) in the amount of the facility fee paid to the health facility under the *Independent Health Facilities Act*; or
- (d) in the case of a health facility other than one referred to in clause (b) or (c), in the amount otherwise payable by the Plan to a health facility that submits accounts to the General Manager for such services. 1996, c. 1, Sched. H, s. 13; 2002, c. 18, Sched. I, s. 8 (8).

Same

(3) Subsections 18.1 (14) to (16) and (18) to (20) apply following a direction. 1996, c. 1, Sched. H, s. 13; 2002, c. 18, Sched. I, s. 8 (9).

Notice

(4) The Committee shall serve the physician with a notice stating that he or she may appeal the direction to the Appeal Board. 1996, c. 1, Sched. H, s. 13.

Reasons for direction

(5) Upon request, the Committee shall give the physician written reasons for the direction. 1996, c. 1, Sched. H, s. 13.

Appeal

(6) Section 20 applies, with necessary modifications, with respect to an appeal to the Appeal Board. 1996, c. 1, Sched. H, s. 13.

When services not medically necessary

19. (1) Where there is a dispute regarding a decision by the General Manager that an insured person is not entitled to an insured service in a hospital or health facility because such service is not medically necessary, the General Manager, upon receiving notice of such dispute, shall refer the matter to the Medical Eligibility Committee.

Medical Eligibility Committee to consider

(2) The Medical Eligibility Committee shall consider the facts relevant to the disputed decision, including any medical records and reports about the insured person and, when considered necessary by the Committee, interviewing the insured person and discussing the matter with the person and his or her physician.

Recommendations

(3) After giving consideration to the matter, the Medical Eligibility Committee shall recommend to the General Manager either that he or she pay or refuse to pay, according to the findings of the Committee, the sum or sums claimed by the insured person to be payable to the person or on his or her behalf, as the case may be, and that the General Manager approve or refuse to approve, in accordance with the recommendations of the Committee, the provision of the insured service or services that are in dispute and, subject to sections 20 to 24, the General Manager shall carry out the recommendations of the Committee. R.S.O. 1990, c. H.6, s. 19.

19.1 Repealed: 2004, c. 5, s. 39.

Refusal of claims, entitlement

19.2 (1) The General Manager may refuse a claim for payment for insured services if, in the opinion of the General Manager, the person who received the services was not an insured person at the time the services were rendered.

Direction by Appeal Board to pay

(2) The Appeal Board may direct the General Manager to pay any claims he or she refused to pay under subsection (1) if, after a hearing, the Appeal Board determines that the person to whom the insured services were rendered was an insured person at the time the services were rendered. 1994, c. 17, s. 71.

Appeal to Appeal Board

20. (1) The following persons may appeal the following matters to the Appeal Board:

1. A person who has applied to become or continue to be an insured person may appeal a decision of the General Manager refusing the application.
2. An insured person who has made a claim for payment for insured services may appeal a decision of the General Manager refusing the claim or reducing the amount so claimed to an amount less than the amount payable by the Plan.
3. The affected physician may appeal a direction of the Medical Review Committee under subsection 18.1 (10) but not a direction of a single committee member under paragraph 2 of subsection 18.1 (6).
4. The affected practitioner may appeal a direction of a practitioner review committee under subsection 18.1 (10) but not a direction of a single committee member under paragraph 2 of subsection 18.1 (6). 1996, c. 1, Sched. H, s. 15; 2002, c. 18, Sched. I, s. 8 (10, 11).

Notice of appeal

(2) The appellant shall file a notice of appeal within 15 days after receiving notice of the decision of the General Manager or the direction of the applicable committee. 1996, c. 1, Sched. H, s. 15.

Powers of Appeal Board

[21. \(1\)](#) If a person requires a hearing, the Appeal Board shall appoint a time for and hold the hearing and may, by order, direct the General Manager to take such action as the Appeal Board considers the General Manager should take in accordance with this Act and the regulations. 2002, c. 18, Sched. I, s. 8 (12).

Same

[\(1.0.1\)](#) For the purposes of making an order under subsection (1), the Appeal Board may amend a direction of the General Manager, the Medical Review Committee or a practice review committee and shall do so in accordance with this Act and the regulations. 2002, c. 18, Sched. I, s. 8 (12).

Security for payment

[\(1.1\)](#) The Appeal Board may make an order at any time directing a physician or practitioner to provide security for payment of all or part of an amount determined by the General Manager, the Medical Review Committee or a practitioner review committee to be owing to the Plan and may impose such conditions as the Appeal Board considers appropriate. 1996, c. 1, Sched. H, s. 16.

Same

[\(1.2\)](#) The Appeal Board shall make an order for security for payment in such circumstances as may be prescribed. The security must meet such requirements as may be prescribed. 1996, c. 1, Sched. H, s. 16.

Extension of time for hearing

[\(2\)](#) The Appeal Board may extend the time for the giving of notice by a person requiring a hearing under this section, either before or after expiration of such time, where it is satisfied that there are apparent grounds for granting relief to the claimant pursuant to a hearing and that there are reasonable grounds for applying for the extension, and the Appeal Board may give such directions as it considers proper consequent upon the extension. R.S.O. 1990, c. H.6, s. 21 (2).

Parties

[22. \(1\)](#) The General Manager is a party to all proceedings before the Appeal Board.

Same

[\(2\)](#) The Medical Review Committee and the physician are parties to an appeal from a direction of the Committee.

Same

[\(3\)](#) The practitioner review committee and the practitioner are parties to an appeal from a direction of the committee.

Same

(4) The Appeal Board may add such other parties to a proceeding as it considers appropriate. 1996, c. 1, Sched. H, s. 17.

Evidence

Examination of documentary evidence

23. (1) A person who is a party to proceedings before the Appeal Board shall be afforded an opportunity to examine before the hearing any written or documentary evidence that will be produced or any report the contents of which will be given in evidence at the hearing.

Board members not to have investigated prior to hearing

(2) Members of the Appeal Board holding a hearing shall not have taken part, before the hearing, in any investigation or consideration of the subject-matter of the hearing and shall not communicate directly or indirectly in relation to the subject-matter of the hearing with any person or with any party or representative of the party except upon notice to and with opportunity for all parties to participate, but the Appeal Board may seek legal advice from an adviser independent from the parties and in such case the nature of the advice should be made known to the parties in order that they may make submissions as to the law.

Recording evidence

(3) The oral evidence taken before the Appeal Board at a hearing shall be recorded and, if so required, copies of a transcript thereof shall be furnished upon the same terms as in the Ontario Court (General Division).

Findings of fact

(4) The findings of fact of the Appeal Board pursuant to a hearing shall be based exclusively on evidence admissible or matters that may be noticed under section 15 or 16 of the *Statutory Powers Procedure Act*. R.S.O. 1990, c. H.6, s. 23 (1-4).

(5) Repealed: 1998, c. 18, Sched. G, s. 54 (5).

Release of documents, etc.

(6) Documents and things put in evidence at the hearing shall, upon the request of the person who produced them, be released to the person by the Appeal Board within a reasonable time after the matter in issue has been finally determined. R.S.O. 1990, c. H.6, s. 23 (6).

Appeal to Divisional Court

24. (1) Any party to the proceedings before the Appeal Board under this Act may appeal from its decision or order to the Divisional Court in accordance with the rules of court. R.S.O. 1990, c. H.6, s. 24 (1); 1998, c. 18, Sched. G, s. 54 (6).

Record to be filed in court

(2) Where any party appeals from a decision or order of the Appeal Board, the Appeal Board shall forthwith file in the Divisional Court the record of the proceedings before it in which the decision was made, which, together with the transcript of evidence if it is not part of the Appeal Board's record, shall constitute the record in the appeal.

Minister to be heard

(3) The Minister is entitled to be heard by counsel or otherwise upon the argument of an appeal under this section.

Powers of court on appeal

(4) An appeal under this section may be made on questions of law or fact or both and the court may affirm or may rescind the decision of the Appeal Board and may exercise all powers of the Appeal Board to direct the General Manager to take any action which the Appeal Board may direct the General Manager to take and as the court considers proper and for such purposes the court may substitute its opinion for that of the General Manager or of the Appeal Board, or the court may refer the matter back to the Appeal Board for rehearing, in whole or in part, in accordance with such directions as the court considers proper. R.S.O. 1990, c. H.6, s. 24 (2-4).

Security for payment

(5) Subsections 21 (1.1) and (1.2) apply, with necessary modifications, with respect to the court. 1996, c. 1, Sched. H, s. 18.

Furnishing reasons to professional governing body

25. (1) Where a decision of the General Manager to refuse or reduce a payment or to require and recover reimbursement of any overpayment of any amount paid by the Plan on any of the grounds referred to in paragraphs 1 to 7 of subsection 18 (2) has become final, the General Manager shall furnish the Minister and the governing body of the profession of which the physician or practitioner rendering the services is a member with a copy of the decision and the reasons therefor, and in all other cases the General Manager may furnish such governing body with a copy of the decision and the reasons therefor. R.S.O. 1990, c. H.6, s. 25 (1); 2002, c. 18, Sched. I, s. 8 (13).

(2) Repealed: 2004, c. 5, s. 40 (1).

(3) Repealed: 2004, c. 5, s. 40 (2).

(4)-(7) Repealed: 2004, c. 5, s. 40 (3).

(8), (9) Repealed: 2004, c. 5, s. 40 (4).

Service of notice

26. Except where otherwise provided, any notice required by this Act to be served may be served personally or by registered mail addressed to the person to whom the notice is being given at the person's latest known address and, where notice is served by registered mail, the service shall be considered to have been made on the seventh day after the day of mailing unless the person to whom notice

is given establishes that the person did not, acting in good faith, through absence, accident, illness or other cause beyond the person's control receive the notice until a later date. R.S.O. 1990, c. H.6, s. 26.

26.1 Repealed: 1996, c. 1, Sched. H, s. 19.

Proposed revision of O.M.A. schedule of fees

27. At least six months before any proposed revision of the schedule of fees of the Ontario Medical Association, the Ontario Medical Association shall notify the Minister of the proposed revision and the Minister shall arrange and implement discussions with representatives of the said Association respecting the details and extent of any proposed changes in the schedule of fees. R.S.O. 1990, c. H.6, s. 27.

Contributions to the Plan

27.1 (1) Every physician, practitioner and health facility who provides insured services shall make such contribution to the Plan as may be prescribed relating to the amount of fees payable to him, her or it under the Plan during such prior period as may be prescribed.

Amount

(2) The amount of the basic contribution from each physician, practitioner or health facility shall be determined in accordance with the regulations.

Adjustment

(3) The basic contribution from a physician, practitioner or health facility may be increased or decreased as provided in the regulations based upon such factors as may be prescribed.

Exemption

(4) Such classes of physicians, practitioners or health facilities as may be prescribed are exempt from making a contribution to the Plan. 1996, c. 1, Sched. H, s. 20.

Payments, etc., to the Plan

27.2 (1) The General Manager may obtain or recover money that a physician, practitioner or health facility owes to the Plan by set off against any money payable to him, her or it under the Plan. 1996, c. 1, Sched. H, s. 21.

Same

(2) The General Manager may obtain or recover money by set off despite a review by the Medical Eligibility Committee, the Medical Review Committee or a practitioner review committee or an appeal to the Appeal Board or Divisional Court concerning whether the money is owed to the Plan. 1996, c. 1, Sched. H, s. 21.

(3), (4) Repealed: 2004, c. 5, s. 41.

Payment by contribution to annual expenditures

28. Any amounts payable to or on behalf of an insured person under the Plan in respect of insured services provided by or in a hospital or health facility may be paid in the form of the payment by the Province of all or any part of the annual expenditures of such hospital or health facility, where such payment by the Province is authorized under any Act. R.S.O. 1990, c. H.6, s. 28.

Disclosure authorized

29. (1) Every insured person shall be deemed to have authorized his or her physician or practitioner, a hospital or health facility which provided a service to the insured person and any other prescribed person or organization to give the General Manager particulars of services provided to the insured person,

- (a) for the purpose of obtaining payment under the Plan for the services;
- (b) for the purpose of enabling the General Manager to monitor and control the delivery of insured services;
- (c) for the purpose of enabling the General Manager to monitor and control payments made under the Plan or otherwise for insured services; and
- (d) for such other purposes as may be prescribed. 1996, c. 1, Sched. H, s. 22.

Immunity

(2) No action lies against a person or organization for giving information to the General Manager under the Act. 1996, c. 1, Sched. H, s. 22.

Exception

(3) This section does not apply where the *Personal Health Information Protection Act, 2004* applies. 2004, c. 3, Sched. A, s. 85 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, the Act is amended by the Statutes of Ontario, 1996, chapter 1, Schedule H, section 23 by adding the following section:

ELIGIBLE PHYSICIANS

Definitions and practice address

29.1 (1) In sections 29.2 to 29.6,

“affiliated”, in respect of a physician and a facility, means associated in a prescribed relationship; (“affilié”)

“facility” means a hospital within the meaning of the *Public Hospitals Act*, an independent health facility within the meaning of the *Independent Health Facilities Act* or any other prescribed facility or agency; (“établissement”)

“family practitioner” means a physician who holds a certificate of registration with the College of Physicians and Surgeons of Ontario authorizing the independent practice of medicine and who is not a specialist; (“médecin de famille”)

“oversupplied area” means an area that is determined under subsection 29.4 (2) to be oversupplied with physicians; (“région sursaturée”)

“specialist” means a physician who holds,

- (a) a certificate of registration with the College of Physicians and Surgeons of Ontario authorizing the independent practice of medicine, and
- (b) certification in a specialty by the Royal College of Physicians and Surgeons of Canada. (“spécialiste”)

Location of practice

(2) For the purposes of sections 29.2 to 29.6, a physician is presumed to be rendering insured services in each area for which the records of the College of Physicians and Surgeons of Ontario show on such date as may be prescribed an address that is his or her practice address.

Same

(3) Despite subsection (2), the General Manager may determine that a practice address of a physician is different from the address determined under subsection (2). The decision of the General Manager is final.

Same, correction

(4) If the physician’s practice address as shown in the records of the College is incorrect or if the physician also practices at other addresses or practices in such circumstances as may be prescribed, the physician may provide the General Manager with such evidence as the General Manager may require before such date as may be prescribed to establish the physician’s practice address or addresses.

See: 1996, c. 1, Sched. H, ss. 23, 40.

Note: On a day to be named by proclamation of the Lieutenant Governor, the Act is amended by the Statutes of Ontario, 1996, chapter 1, Schedule H, section 24 by adding the following section:

Eligible physicians

29.2 (1) Subject to section 29.4, a physician is an eligible physician if he or she meets the requirements set out in this section.

Same

(2) Subject to subsection (4), the following persons are eligible physicians:

1. A physician who is an eligible physician for the purposes of section 19.1 immediately before this section comes into force.
2. A physician who is granted an appointment that takes effect before the prescribed date to the medical staff of a hospital in Ontario. The appointment must be granted before such date as may be prescribed.
3. A physician who is granted an appointment that takes effect before the prescribed date to the teaching staff of a faculty of medicine in Ontario. The appointment must be granted before such date as may be prescribed.
4. A physician other than one described in paragraph 1 who, on and after the prescribed date, is a family practitioner who does not render insured services in an oversupplied area.
5. A physician other than one described in paragraph 1 who, on and after the prescribed date, is a specialist who is affiliated with a facility.
6. A physician other than one described in paragraphs 1 to 5 who incurs significant financial obligations in connection with the commencement of the practice of medicine in Ontario before the date on which this section comes into force.

7. A physician who is a member of a class of physicians that is prescribed as being eligible physicians.

Exception

(3) A physician is not an eligible physician if he or she is a member of a class of physicians that is prescribed as not being eligible.

Same, conditions

(4) A physician is not an eligible physician unless he or she complies with such additional conditions for becoming an eligible physician as may be prescribed.

See: 1996, c. 1, Sched. H, ss. 24, 40.

Note: On a day to be named by proclamation of the Lieutenant Governor, the Act is amended by the Statutes of Ontario, 1996, chapter 1, Schedule H, section 24 by adding the following section:

Designated eligible physicians

29.3 (1) The Minister may designate as an eligible physician a physician who does not meet the requirements set out in section 29.2 if the Minister considers that,

- (a) the services of the physician are required to meet a need in an academic area, a domain of medical practice or a geographic area;
- (b) the services of the physician are required to fulfil a prescribed purpose; or
- (c) exceptional circumstances exist in respect of the physician.

Conditions

(2) A designation may be made subject to such conditions as are specified.

Delegation

(3) The Minister may delegate his or her authority under this section.

See: 1996, c. 1, Sched. H, ss. 24, 40.

Note: On a day to be named by proclamation of the Lieutenant Governor, the Act is amended by the Statutes of Ontario, 1996, chapter 1, Schedule H, section 25 by adding the following section:

Number of eligible physicians

29.4 (1) The Minister may, by regulation, fix or vary the number of physicians, or the number of physicians in a class of physicians, who may become eligible physicians in an area after the date on which this section comes into force. The Minister may do so without prior notice.

Oversupplied area

(2) The Minister may, by regulation, determine from time to time the areas of Ontario that are oversupplied with physicians.

Same

(3) A determination under subsection (2) may be made by class of physician.

Moratorium

(4) In any of the following circumstances, the Minister may, by regulation, impose a moratorium during which no physician is entitled to become an eligible physician in an area to which the moratorium applies:

1. If the Minister considers that the number of physicians who meet the criteria under section 29.2 and who wish to become eligible physicians under the Act is causing or is likely to cause inequities in the administration of the Act.

2. If the Minister considers that the number of physicians described in paragraph 1 exceeds or is likely to exceed the number of physicians permitted to become eligible physicians in a class or an area as a result of a decision of the Minister.

Time

(5) A moratorium is effective for the period of time declared by the Minister. The Minister may end or extend a moratorium as the Minister in his or her sole discretion considers necessary or advisable in the circumstances.

Notice

(6) The Minister may impose, end or extend a moratorium without prior notice.

Determination of eligibility

(7) If the number of physicians who meet requirements under section 29.2 for an eligible physician and who wish to become eligible physicians under the Act is greater than the number that are permitted to become eligible physicians in a class or an area as a result of a decision of the Minister, the determination of which physicians will become eligible physicians shall be made in accordance with such method and criteria as may be prescribed.

See: 1996, c. 1, Sched. H, ss. 25, 40.

Note: On a day to be named by proclamation of the Lieutenant Governor, the Act is amended by the Statutes of Ontario, 1996, chapter 1, Schedule H, section 26 by adding the following section:

Loss of eligible status

29.5 (1) An eligible physician who fails to comply with such requirements or conditions as may be prescribed for eligible physicians ceases to be an eligible physician.

Specialist

(2) A specialist who becomes an eligible physician after the date this section comes into force and who ceases to be affiliated with a facility ceases to be an eligible physician.

Same

(3) A specialist described in subsection (2) becomes an eligible physician again on the date on which he or she becomes affiliated with a facility.

Change of kind of practice

(4) An eligible physician ceases to be an eligible physician if he or she changes the nature of his or her practice from that of a family practitioner to that of a specialist. This does not apply if the physician is affiliated with a facility as a specialist.

Exemption, ineligible physicians

(5) The Minister may exempt a physician or a class of physicians from subsection (1), (2) or (4) in the following circumstances:

1. If the Minister considers that the services of the physician or class are required to meet a need in an academic area, a domain of medical practice or a geographic area.

2. If the Minister considers that the services of the physician or class are required to fulfil a prescribed purpose.

3. If the Minister considers that exceptional circumstances exist in respect of the physician or class.

Same

(6) An exemption under paragraph 1 or 2 of subsection (5) may be made despite a moratorium under subsection 29.4 (4).

Same

(7) An exemption may be made subject to such conditions as are specified.

Same

(8) The Minister may designate a person to exercise his or her powers and duties under subsection (5).

See: 1996, c. 1, Sched. H, ss. 26, 40.

Note: On a day to be named by proclamation of the Lieutenant Governor, the Act is amended by the Statutes of Ontario, 1996, chapter 1, Schedule H, section 27 by adding the following section:

Declaration of ineligibility

29.6 (1) Subject to subsections (2) to (5), the General Manager may declare that a physician is not an eligible physician in the following circumstances:

1. If the General Manager is of the opinion that the physician is not qualified under the Act to be an eligible physician.
2. If the General Manager is of the opinion that the physician is not an eligible physician, although the physician appears to have acted or to be acting as an eligible physician.
3. If the General Manager is of the opinion that the physician is not in compliance with a condition in respect of continuing to be an eligible physician.

Notice

(2) If the General Manager proposes to make a declaration under subsection (1), he or she shall give notice of the proposal to the physician together with reasons for the proposal.

Written submission

(3) The physician may give the General Manager a written submission about the proposal within 15 days after receiving the notice and the General Manager shall consider it.

Extension

(4) The General Manager may accept a written submission after the time provided under subsection (3) if he or she considers that there are reasonable grounds for so doing.

No declaration

(5) The General Manager may decline to make a declaration under subsection (1) if he or she is satisfied by the written submission that it is in the best interest of the proper management of the health care system or the delivery of health care services in Ontario to do so.

Criteria

(6) The General Manager shall consider such criteria as may be prescribed before declining to make a declaration for the reasons described in subsection (5).

Notice of declaration

[\(7\)](#) The General Manager shall notify the physician of his or her decision and, upon request, shall provide written reasons for it.

Decision final

[\(8\)](#) A declaration by the General Manager under this section is final and binding.

See: 1996, c. 1, Sched. H, ss. 27, 40.

Note: On a day to be named by proclamation of the Lieutenant Governor, the Act is amended by the Statutes of Ontario, 1996, chapter 1, Schedule H, section 28 by adding the following section:

Transition, proceedings

[29.7](#) No proceeding shall be commenced in which compensation is sought for any loss relating to the coming into force of sections 29.1 to 29.6.

See: 1996, c. 1, Sched. H, ss. 28, 40.

Note: On a day to be named by proclamation of the Lieutenant Governor, the Act is amended by the Statutes of Ontario, 1996, chapter 1, Schedule H, section 29 by adding the following section:

Ministerial review

[29.8](#) On or before November 30, 1997, the Minister shall undertake a comprehensive review of the operation of sections 29.1 to 29.6. Following the review, the Minister may make recommendations about those sections to the Lieutenant Governor in Council.

See: 1996, c. 1, Sched. H, ss. 29, 40.

SUBROGATION

...

DIRECT RECOVERY

...

THIRD PARTY SERVICES

...

GENERAL

General information requirement

[37. \(1\)](#) Every physician and practitioner shall give the General Manager such information, including personal information, as may be prescribed for purposes related to the administration of this Act, the *Health Care Accessibility Act* or the *Independent Health Facilities Act* or for such other purposes as may be prescribed.

Same

(2) Such persons or organizations as may be prescribed shall give the General Manager such information, including personal information, as may be prescribed and such information as he or she may require for the purpose of administering the Act.

Time

(3) The information shall be provided in such form and within such time as the General Manager may require.

Application

(4) This section applies despite anything in the *Regulated Health Professions Act, 1991*, an Act listed in Schedule 1 to the *Regulated Health Professions Act, 1991*, the *Drugless Practitioners Act* or any regulations made under those Acts. 1996, c. 1, Sched. H, s. 30.

Record-keeping

37.1 (1) For the purposes of this Act, every physician, practitioner and health facility shall maintain such records as may be necessary to establish whether he, she or it has provided an insured service to a person. 1996, c. 1, Sched. H, s. 31.

Same

(2) For the purposes of this Act, every physician, practitioner and health facility shall maintain such records as may be necessary to demonstrate that a service for which he, she or it prepares or submits an account is the service that he, she or it provided. 1996, c. 1, Sched. H, s. 31.

Same

(3) For the purposes of this Act, every physician and health facility shall maintain such records as may be necessary to establish whether a service he, she or it has provided is medically necessary. 1996, c. 1, Sched. H, s. 31.

Same

(4) For the purposes of this Act, every practitioner and health facility shall maintain such records as may be necessary to establish whether a service he, she or it has provided is therapeutically necessary. 1996, c. 1, Sched. H, s. 31.

Same

(5) The records described in subsections (1), (2), (3) and (4) must be prepared promptly when the service is provided. 1996, c. 1, Sched. H, s. 31.

Obligation

(6) If there is a question about whether an insured service was provided, the physician, practitioner or health facility shall provide the following persons with all relevant information within his, her or its control:

1. The General Manager.
2. An inspector who requests the information.
3. In the case of a physician or health facility, a member of the Medical Review Committee who requests the information.
4. In the case of a practitioner or health facility, a member of the applicable practitioner review committee who requests the information. 1996, c. 1, Sched. H, s. 31.

Presumption

(7) In the absence of a record described in subsection (1), (3) or (4), it is presumed that an insured service was provided and that the basic fee payable is nil. 1996, c. 1, Sched. H, s. 31; 2002, c. 18, Sched. I, s. 8 (18).

Different service provided

(8) In the absence of a record described in subsection (2), the insured service that was provided is presumed to be the insured service, if any, that the General Manager considers to be described in the records as having been provided and not the insured service for which the account was prepared or submitted. 2002, c. 18, Sched. I, s. 8 (19).

Information confidential

38. (1) Each member of the Medical Review Committee, every practitioner review committee, the Medical Eligibility Committee and the Appeal Board and each employee thereof, the General Manager and each person engaged in the administration of this Act and the regulations shall preserve secrecy with respect to all matters that come to his or her knowledge in the course of his or her employment or duties pertaining to insured persons and any insured services rendered and the payments made therefor, and shall not communicate any such matters to any other person except as otherwise provided in this Act. R.S.O. 1990, c. H.6, s. 38 (1).

Exceptions

(2) A person referred to in subsection (1) may furnish information pertaining to the date or dates on which insured services were provided and for whom, the name and address of the hospital and health facility or person who provided the services, the amounts paid or payable by the Plan for such services and the hospital, health facility or person to whom the money was paid or is payable, but such information shall be furnished only,

- (a) in connection with the administration of this Act, the *Regulated Health Professions Act, 1991*, a health profession Act as defined in subsection 1 (1) of that Act, the *Public Hospitals Act*, the *Private Hospitals Act* or the *Ambulance Act* or the *Canada Health Act* or the *Criminal Code* (Canada), or regulations made thereunder;
- (b) in proceedings under this Act or the regulations;

(c) to the person who provided the service, the person's solicitor, other personal representative, executor, administrator, guardian of property, trustee in bankruptcy or other legal representative;

(d) to the person who received the services, his or her solicitor, personal representative or guardian, the committee or guardian of the person's estate or other legal representative of that person; or

(e) pursuant to a summons by a court of competent jurisdiction. R.S.O. 1990, c. H.6, s. 38 (2); 1992, c. 32, s. 15; 1998, c. 18, Sched. G, s. 54 (7).

Statistical purposes

(3) The information referred to in subsection (1) may be published by the Ministry of Health in statistical form if the individual names and identities of persons who received insured services are not thereby revealed. R.S.O. 1990, c. H.6, s. 38 (3).

Exception for professional discipline

(4) If, in the course of the administration of this Act and the regulations, the General Manager, the Medical Review Committee or a practitioner review committee obtains reasonable grounds to believe that a physician or practitioner is incompetent, incapable or has committed professional misconduct, the General Manager, the Medical Review Committee or the practitioner review committee, as the case may be, shall give the following information to the statutory body governing the profession of the physician or practitioner:

1. The information described in subsection (2).
2. Information pertaining to the nature of the insured services provided by the physician or practitioner.
3. Information concerning any diagnosis given by the physician or practitioner.
4. Such other personal information as may be prescribed. 2002, c. 18, Sched. I, s. 8 (20).

Filing with court

38.1 A copy of any of the following may be filed with the Superior Court of Justice after the time in which an appeal may be made has passed, and once filed shall be entered in the same way as a judgment or order of the Superior Court of Justice and is enforceable as an order of that court:

1. A decision of the General Manager made under this Act.
2. A decision of the Appeal Board made under this Act. 2004, c. 5, s. 42.

Protection from liability

39. Members of the Medical Review Committee, practitioner review committees, the Medical Eligibility Committee, employees of such committees, the General Manager and persons engaged in the administration of this Act are not liable for anything done or made in good faith by them in the performance of their duties under this Act and the regulations. 1998, c. 18, Sched. G, s. 54 (8).

General review re insured services

[39.1 \(1\)](#) The General Manager may request the Medical Review Committee to review the provision of insured services by a physician. The request may specify the types of insured services to be reviewed and the period during which the services were provided. 1996, c. 1, Sched. H, s. 33.

Same

[\(2\)](#) The General Manager may request a practitioner review committee to review the provision of insured services by a practitioner. The request may specify the types of insured services to be reviewed and the period during which the services were provided. 1996, c. 1, Sched. H, s. 33.

Expedited review

[\(3\)](#) The General Manager may request that the review be performed by a single member of the applicable committee. 1996, c. 1, Sched. H, s. 33.

Same

[\(4\)](#) Subsections 18.1 (6) to (9) apply with respect to a review by a single committee member. 1996, c. 1, Sched. H, s. 33.

Directions

[\(5\)](#) Following a review or following a reconsideration of a review by a single committee member, the Medical Review Committee or practitioner review committee may direct the General Manager,

- (a) to increase the amount paid to the physician or practitioner for an insured service; or
- (b) to require the physician or practitioner to repay all or part of any payment made under the Plan. 1996, c. 1, Sched. H, s. 33.

Same

[\(6\)](#) A direction under clause (5) (b) may be made only in the following circumstances:

1. If the applicable committee has reasonable grounds to believe that all or part of the insured services were not rendered.
2. If the applicable committee has reasonable grounds to believe that all or part of the services,
 - i. were not medically necessary, if they were provided by a physician, or
 - ii. were not therapeutically necessary, if they were provided by a practitioner.
3. If the applicable committee has reasonable grounds to believe that the nature of the services is misrepresented, whether deliberately or inadvertently.
4. If the applicable committee has reasonable grounds to believe that all or part of the services were not provided in accordance with accepted professional standards and practice.
5. In such other circumstances as may be prescribed. 1996, c. 1, Sched. H, s. 33.

Same

(7) Subsections 18.1 (14) to (16) and (18) to (20) apply following a review. 1996, c. 1, Sched. H, s. 33; 2002, c. 18, Sched. I, s. 8 (21).

Notice

(8) The applicable committee shall serve the persons affected by a direction given under subsection (5) with a notice stating that the physician or practitioner may appeal it to the Appeal Board. 1996, c. 1, Sched. H, s. 33.

Reasons for decision

(9) Upon request, the applicable committee shall give the persons affected by its direction written reasons for it. 1996, c. 1, Sched. H, s. 33.

Appeal

(10) Section 20 applies, with necessary modifications, with respect to an appeal to the Appeal Board. 1996, c. 1, Sched. H, s. 33.

Inspectors, Medical Review Committee

40. (1) The Minister may appoint inspectors from among the persons nominated by the College of Physicians and Surgeons of Ontario. These inspectors shall act only under the direction of the Medical Review Committee.

Powers

(2) The powers and duties of inspectors appointed under subsection (1) relate only to the provision of insured services by physicians.

Inspectors, practitioner review committees

(3) The Minister may appoint inspectors from among the persons nominated by a body referred to in section 6 that nominates persons for appointment to a practitioner review committee. These inspectors shall act only under the direction of the applicable practitioner review committee.

Powers

(4) The powers and duties of inspectors appointed under subsection (3) relate only to the provision of insured services by practitioners engaged in the practice of the applicable health discipline. 1996, c. 1, Sched. H, s. 34.

Powers of inspectors

40.1 (1) An inspector has the following powers:

1. To interview a physician or practitioner and members of his or her staff on matters that relate to the provision of insured services.
2. To interview persons employed in a hospital, health facility or such other type of health care facility as may be prescribed in which insured services are provided, or the operator of one, on matters that relate to the provision of insured services.
3. To question a person on matters that may be relevant to an inspection, review or reconsideration of a review, subject to the person's right to have counsel or some other representative present during the examination.
4. To enter and inspect premises where insured services are provided and to inspect the operations carried out on the premises.
5. To inspect and receive information from health records or from notes, charts and other material relating to patient care, regardless of the form or medium in which such records or material are kept, and to reproduce and retain copies of them.
6. To inspect, at any reasonable time, all books of account, documents, correspondence and records, including payroll and employment records, regardless of the form or medium in which the records are kept, and to reproduce and retain copies of them.
7. To remove material described in paragraph 5 or 6 for the purpose of copying it. The inspector must show the certificate of his or her appointment by the Minister and must give a receipt for the material. The material must be promptly returned to the person apparently in charge of the premises from which the material is removed.
8. To enter premises where material required for the purposes of the Act, and material referred to in paragraphs 5 and 6, is stored for the purpose of inspecting it.

Same

(2) An inspector has the powers of a commission under Part II of the *Public Inquiries Act* and may exercise them only in relation to those persons described in paragraphs 1 and 2 of subsection (1).

Notice

(3) The inspector shall give five days written notice to the physician, practitioner or administrator of the hospital, health facility or other health care facility that the inspector wishes to conduct an interview described in paragraph 1 or 2 of subsection (1).

Same

(4) The notice must, where practicable, state the subject-matter of the interview and the identity or the position, if known, of the person or persons to be interviewed.

Same

(5) The notice must state that the person to be interviewed is entitled to be represented by legal counsel.

Private residence

(6) An inspector shall not enter a private residence without the consent of an occupier except under the authority of a warrant under subsection (7).

Warrant

(7) A provincial judge or justice of the peace may issue a warrant in the prescribed form authorizing an inspector to enter a private residence for the purpose of conducting an inspection if the judge or justice of the peace is satisfied upon application by an inspector, on information upon oath, that there are reasonable grounds for doing so.

Legible records

(8) If a book, document, item of correspondence or record is kept in a form or medium that is not legible, the inspector may require the person apparently in charge of it to provide him or her with a legible physical copy for examination.

Cost

(9) The cost of providing the inspector with a legible copy under subsection (8) shall be borne by the physician, practitioner or health facility, as the case may be. 1996, c. 1, Sched. H, s. 34.

Obstruction

40.2 (1) No person shall obstruct an inspector or withhold or conceal from an inspector any book, document, correspondence, record or thing relevant to an inspection.

Duty to co-operate

(2) Every physician who provides insured services shall co-operate fully with an inspector who is carrying out an inspection under the Act or with a member of the Medical Review Committee who is exercising powers or performing duties under the Act.

Same

(3) Every practitioner who provides insured services shall co-operate fully with an inspector who is carrying out an inspection under the Act or with a member of a practitioner review committee who is exercising powers or performing duties under the Act.

Same

(4) The operator and administrator of every hospital, health facility and other health care facility in which insured services are provided shall co-operate fully with an inspector who is carrying out an inspection under the Act and shall ensure that employees also co-operate fully.

Same

[\(5\)](#) Every person who receives insured services shall co-operate fully with an inspector who is carrying out an inspection under the Act.

Suspension of payments

[\(6\)](#) The General Manager may suspend payments under the Plan to a physician or practitioner during any period when he or she fails to comply with subsection (2) or (3) without just cause, whether or not the physician or practitioner is convicted of an offence.

Same

[\(7\)](#) The General Manager may suspend payments under the Plan to a hospital or health facility during any period when its operator or administrator or its employees fail to comply with subsection (4) without just cause, whether or not the person is convicted of an offence. 1996, c. 1, Sched. H, s. 34.

[41.](#) Repealed: 2000, c. 26, Sched. H, s. 1 (7).

[42.](#) Repealed: 2000, c. 26, Sched. H, s. 1 (7).

Offence, benefits by fraud

[43. \(1\)](#) No person shall knowingly obtain or attempt to obtain payment for or receive or attempt to receive the benefit of any insured service that the person is not entitled to obtain or receive under this Act and the regulations.

Idem

[\(2\)](#) No person shall knowingly aid or abet another person to obtain or attempt to obtain payment for or receive or attempt to receive the benefit of any insured service that such other person is not entitled to obtain or receive under this Act and the regulations.

False information

[\(3\)](#) No person shall knowingly give false information in an application, return or statement made to the Plan or to the General Manager in respect of any matter under this Act or the regulations. R.S.O. 1990, c. H.6, s. 43.

Mandatory reporting

[43.1 \(1\)](#) A prescribed person who, in the course of his or her professional or official duties, has knowledge that an event referred to in subsection (2) has occurred shall promptly report the matter to the General Manager.

Events

[\(2\)](#) Subsection (1) applies to the following events:

1. An ineligible person receives or attempts to receive an insured service as if he or she were an insured person.
2. An ineligible person obtains or attempts to obtain reimbursement by the Plan for money paid for an insured service as if he or she were an insured person.
3. An ineligible person, in an application, return or statement made to the Plan or the General Manager, gives false information about his or her residency.

Definition, “ineligible person”

(3) In subsection (2),

“ineligible person” means a person who is neither an insured person nor entitled to become one.

Defence

(4) It is a defence to a proceeding for failure to make a report required by subsection (1) that the prescribed person delayed making the report because he or she believed, on reasonable grounds, that making the report might be a direct and immediate cause of serious bodily harm to a person, and made the report as soon as he or she was of the opinion that the danger no longer existed.

Voluntary reporting

(5) A prescribed person may report to the General Manager any matter relating to the administration or enforcement of this Act or the regulations.

Subss. (1) and (5) prevail

(6) Subsections (1) and (5) apply even if the information reported is confidential or privileged and despite any Act, regulation or other law prohibiting disclosure of the information.

Protection from liability

(7) No proceeding for making a report under subsection (1) or (5) or for providing information in connection with the report shall be commenced against a person unless he or she acts maliciously and the information on which the report is based is not true.

Exception: solicitor-client privilege

(8) Nothing in this section abrogates any privilege that may exist between a solicitor and his or her client. 1993, c. 32, s. 2 (8).

General penalty, individual

44. (1) Every individual who contravenes any provision of this Act or the regulations for which no penalty is specifically provided is guilty of an offence and is liable,

- (a) for a first offence, to a fine of not more than \$25,000 or to imprisonment for a term of not more than 12 months, or to both;

(b) for a subsequent offence, to a fine of not more than \$50,000 or to imprisonment for a term of not more than 12 months, or to both. 2002, c. 18, Sched. I, s. 8 (22).

Same, corporation

(2) Every corporation that contravenes any provision of this Act or the regulations for which no penalty is specifically provided is guilty of an offence and is liable to a fine of not more than \$50,000 for a first offence and to a fine of not more than \$200,000 for a subsequent offence. 2002, c. 18, Sched. I, s. 8 (22).

Compensation or restitution

(3) The court that convicts a person of an offence under this section may, in addition to any other penalty, order that the person pay compensation or make restitution to any person who suffered a loss as a result of the offence. 2002, c. 18, Sched. I, s. 8 (22).

No limitation

(4) Section 76 of the *Provincial Offences Act* does not apply to a prosecution under this section. 2002, c. 18, Sched. I, s. 8 (22).

Regulations

45. (1) The Lieutenant Governor in Council may make regulations,

- (a) prescribing the form of the health card;
- (a.1) providing for the enrolment of persons as insured persons and prescribing waiting periods therefor;
- (b) defining “resident” for the purposes of this Act;
- (b.1) prescribing the personal information that may be collected, used or disclosed under clause 2 (3) (b);
- (c) providing for the continuation and termination of insurance coverage in respect of insured persons who cease to be eligible;
- (c.1) prescribing numbers of members for the purposes of clauses 5 (2) (a) and (b) and paragraphs 1 to 5 of subsection 6 (1);
- (c.2) enabling the General Manager to require information or evidence relating to eligibility as a condition for a person to become or continue as an insured person and governing the information or evidence that may be required;
- (d) designating disciplines for the purpose of section 16;
- (e) governing insured services, including specifying those services that are not insured services;
- (f) governing fees payable for insured services;
- (g) governing payments for insured services;
- (h) Repealed: 1996, c. 1, Sched. H, s. 35 (1).
- (i) Repealed: 1996, c. 1, Sched. H, s. 35 (1).

- (j) Repealed: 1996, c. 1, Sched. H, s. 35 (1).
- (k) providing for the making of claims for payment of the cost of insured services and prescribing the information that shall be furnished in connection therewith;
- (l) prescribing the co-payments that shall be made by or on behalf of an insured person to qualify the person to receive those insured services specified in the regulations as requiring co-payments;
- (m) providing for the times when and manner in which physicians shall submit accounts directly to the Plan under section 15;
- (n) providing for the times when and manner in which practitioners shall submit accounts directly to the Plan under section 16;
- (o) exempting any class of accounts from the application of section 15 or any provision thereof;
- (p) exempting any class of accounts from the application of section 16 or any provision thereof;
- (q) Repealed: 1996, c. 1, Sched. H, s. 35 (2).
- (r) prescribing facilities that are health facilities for the purposes of this Act in addition to those referred to in the definition of “health facility” in section 1;

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (1) is amended by the Statutes of Ontario, 1996, chapter 1, Schedule H, subsection 35 (3) by adding the following clauses:

(r.1) defining the following terms:

1. for the purposes of subsection 29.1 (2), defining “area”,
2. for the purposes of subsections 29.1 (2) and (4), defining “practice address”,
3. for the purposes of paragraph 6 of subsection 29.2 (2), defining “significant financial obligations”;

(r.2) governing the determination of which physicians from among those who meet the requirements under section 29.2 will become eligible physicians;

See: 1996, c. 1, Sched. H, ss. 35 (3), 40.

- (s) prescribing procedures for the enforcement of and recovery under rights to which the Plan is subrogated and without restricting the generality of the foregoing,
 - (i) requiring the insured person and his or her solicitor to act on behalf of the Plan in any action,
 - (ii) requiring such notices as are prescribed,
 - (iii) providing for the terms and conditions under which an action to enforce such rights may be begun, conducted and settled,
 - (iv) prescribing the portion of the costs of an insured person incurred in an action for the recovery of such rights that shall be borne by the Plan;
- (t) assigning additional duties to the General Manager, the Medical Review Committee, practitioner review committees, the Medical Eligibility Committee and the Appeal Board;
- (u) prescribing forms for the purposes of this Act and providing for their use;
- (v) designating classes for the purpose of subsection 11 (3);

- (w) prescribing persons for the purpose of subsection 11.1 (2);
- (x) prescribing, for the purpose of clause 19.1 (3) (d), what constitutes an application for a provider number or its equivalent;
- (x.1) governing the costs that may be recovered under section 36.0.1, including the determination of those costs, and the evidence that is admissible to prove those costs in an action under that section;
- (y) prescribing persons for the purpose of subsections 43.1 (1) and (5);
- (z) prescribing the co-payments for accommodation referred to in subsection 46 (2); Which constituent elements shall be deemed not to form part of an insured service rendered by a physician or practitioner.
- (z.1) prescribing anything that must or may be prescribed or that must or may be done in accordance with the regulations or as provided in the regulations. R.S.O. 1990, c. H.6, s. 45 (1); 1993, c. 32, s. 2 (9); 1994, c. 17, s. 72 (1, 2); 1996, c. 1, Sched. H, s. 35 (1, 2, 4); 1999, c. 10, s. 2; 2004, c. 5, s. 43 (1, 2).

Regulations

(1.1) The Lieutenant Governor in Council may make regulations,

- (a) prescribing, for the purpose of clause 19.1 (3) (g), classes of physicians that are eligible for the purpose of section 19.1;
- (b) prescribing the classes of physicians that are not eligible under subsection 19.1 (4);
- (c) prescribing, for the purpose of clause 19.1 (7) (b), the purposes for which the Minister may exempt a physician or a class of physicians from the application of subsection 19.1 (1);
- (d) prescribing services that meet the requirements of clauses 36.1 (1) (a) and (b) as third party services, or prescribing them as third party services in specified circumstances, and specifying the circumstances;
- (e) in relation to a specified third party service or in relation to a third party service provided in specified circumstances,
 - (i) prescribing another person or entity as a third party instead of or in addition to the person or entity who makes the request or requirement referred to in clause 36.1 (1) (a),
 - (ii) if more than one person or entity make the request or requirement referred to in clause 36.1 (1) (a), prescribing one or more of them as third parties and providing that the others are not third parties, or
 - (iii) providing that there is no third party;
- (f) designating or establishing a body that shall have power to decide disputes about payment for third party services, including power to summon witnesses and require the production of documents and power to award costs and interest;
- (g) governing the composition of the body referred to in clause (f), the qualifications, appointment, functions and remuneration of its members and their immunity from liability;
- (h) prescribing the parties to a proceeding before the body referred to in clause (f) and the rules governing practice, procedure and evidence in a proceeding before the body, including prescribing whether or not the body is required to hold a hearing;

- (i) prescribing the duties and powers of the body referred to in clause (f) in relation to making decisions and orders;
- (j) providing that a court or body acting under subsection 36.3 (4) shall consider other matters in addition to or instead of the guidelines and schedules of fees referred to in subsections 36.3 (5) and (6), and specifying those other matters. 1993, c. 32, s. 2 (10); 1996, c. 1, Sched. H, s. 35 (5, 6).

Classes

[\(1.2\)](#) A regulation may create different classes of persons, facilities, accounts, fees payable or payments and may establish different entitlements for or relating to each class or impose different requirements, conditions or restrictions on or relating to each class. 1996, c. 1, Sched. H, s. 35 (7).

Adoption of schedules of fees

[\(2\)](#) A regulation may adopt by reference in whole or in part, with such changes as the Lieutenant Governor in Council considers necessary, the fees in any schedule of fees as prescribed amounts payable in whole or in part, by the Plan. R.S.O. 1990, c. H.6, s. 45 (2).

Ministerial order

[\(2.1\)](#) Upon the advice of the General Manager, and where the Minister considers it to be in the public interest to do so, the Minister may make an order amending a schedule of fees or benefits that has been adopted in a regulation in any manner the Minister considers appropriate for the purposes of the regulation. 2004, c. 5, s. 43 (3).

Duration

[\(2.2\)](#) An order made under subsection (2.1) remains in force until the earliest of the following events occurs:

1. The order is cancelled by an order made under subsection (2.3).
2. A regulation is made adopting a schedule of fees or benefits or an amendment to the schedule of fees or benefits in which essentially the same subject-matter is addressed.
3. Twelve months have elapsed from the making of the order. 2004, c. 5, s. 43 (3).

Cancellation

[\(2.3\)](#) Upon the advice of the General Manager, and where the Minister considers it to be in the public interest to do so, the Minister may make an order cancelling an order under subsection (2.1). 2004, c. 5, s. 43 (3).

Not a regulation

[\(2.4\)](#) An order made under subsection (2.1) or (2.3) is not a regulation for the purposes of the *Regulations Act*, but has the same effect as if the schedule of fees or benefits as amended by the order had been adopted by regulation. 2004, c. 5, s. 43 (3).

Publication

[\(2.5\)](#) The Minister shall publish an order made under subsection (2.1) or (2.3) in *The Ontario Gazette*, and in any other manner the Minister considers appropriate, and the order is effective from the publication date of the issue of the *Gazette* in which publication is made, unless paragraph 2 or 3 of subsection (2.2) applies first. 2004, c. 5, s. 43 (3).

Variation

[\(2.6\)](#) An amendment made by an order under subsection (2.1) may be varied at any time by regulation. 2004, c. 5, s. 43 (3).

Restriction

[\(2.7\)](#) An order under subsection (2.1) may not be made more than once with respect to essentially the same subject-matter. 2004, c. 5, s. 43 (3).

When regulation may be effective

[\(3\)](#) A regulation is, if it so provides, effective with reference to a period before it is filed. R.S.O. 1990, c. H.6, s. 45 (3).

Exemptions

[\(3.1\)](#) A regulation may exempt a class of persons or facilities from the application of a specified provision of the Act or regulations. 1996, c. 1, Sched. H, s. 35 (8).

Insured services

[\(3.2\)](#) Without limiting the generality of clause (1) (e), a regulation made under it may provide the following:

1. Which services rendered in or by hospitals and health facilities are insured services.
2. Which constituent elements form part of an insured service rendered by physicians or practitioners.
3. Which constituent elements shall be deemed not to form part of an insured service rendered by a physician or practitioner. 1996, c. 1, Sched. H, s. 35 (8).

Restriction

[\(3.3\)](#) A regulation made under clause (1) (e) or (g) shall not include a provision that would disqualify the Province of Ontario, under the *Canada Health Act*, for contribution by the Government of Canada because the Plan would no longer satisfy the criteria under that Act. 1996, c. 1, Sched. H, s. 35 (8).

Services designated without prescribing amounts payable

[\(4\)](#) The Lieutenant Governor in Council may make regulations under clause (1) (e) prescribing services that are insured services without prescribing any amounts payable by the Plan for those services. R.S.O. 1990, c. H.6, s. 45 (4).

Fees related to independent health facilities

(5) A regulation may prescribe an amount payable by the Plan for an insured service rendered in a hospital that has been approved under the Public Hospitals Act without prescribing an amount payable if the service is rendered in a health facility operated by a person to whom subsection 7 (7) of the *Independent Health Facilities Act* applies. R.S.O. 1990, c. H.6, s. 45 (5).

Circumstances

(6) A regulation made under clause (1) (l) may specify the circumstances in which it applies and may establish different entitlements or impose different requirements, conditions or restrictions in the specified circumstances. 1996, c. 1, Sched. H, s. 35 (9).

(7) Repealed: 1996, c. 1, Sched. H, s. 35 (9).

(8) Repealed: 1996, c. 1, Sched. H, s. 35 (10).

No appeal

45.1 (1) Every decision by a body designated or established under clause 45 (1.1) (f) respecting a dispute about payment for third party services shall be final and binding and shall not be subject to appeal.

Enforcement of decision

(2) The body designated or established under clause 45 (1.1) (f) or a party to a proceeding before the body may file a copy of the decision or order of the body, excluding the reasons, in the Ontario Court (General Division) or, if the amount ordered to be paid does not exceed the monetary jurisdiction of the Small Claims Court, in the Small Claims Court and, when so filed, the decision or order may be enforced as an order of the court in which it is filed. 1993, c. 32, s. 2 (11).

MENTAL ILLNESS

...

HEALTH INSURANCE ACT LOI SUR L'ASSURANCE-SANTÉ

R.R.O. 1990, REGULATION 552

Amended to O. Reg. 172/05

GENERAL

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DEFINITIONS

1. (1) In this Regulation,

“benefit period” means the period of time during which an insured person is entitled to insured services;

...

“schedule of benefits” means the document published by the Ministry of Health and Long-Term Care titled “Schedule of Benefits — Physician Services under the *Health Insurance Act* (July 1, 2003)” and includes the following amendments, but does not include the “[Commentary...]” portions of the document:

1. Amendments dated August 1, 2003.
2. Amendments dated September 1, 2003.
3. Amendments dated November 1, 2004.
4. Amendments dated December 1, 2004;

...

(2) A reference to the schedule of benefits or the schedule of optometry benefits in relation to a service is a reference to the relevant schedule in force at the time the service was rendered. O. Reg. 320/04, s. 1 (3).

(3) Appendices A, B, C and F of the document titled “Schedule of Benefits — Physician Services under the *Health Insurance Act* (July 1, 2000)” do not form part of the schedule of benefits for the purposes of this Regulation. O. Reg. 368/00, s. 1 (2).

(4) Revoked: O. Reg. 265/03, s. 1 (2).

...

PHYSICIAN SERVICES

37.1 (1) A service rendered by a physician in Ontario is an insured service if it is referred to in the schedule of benefits and rendered in such circumstances or under such conditions as may be specified in the schedule of benefits. O. Reg. 111/96, s. 2.

(2) The basic fee payable by the Plan for an insured service prescribed under subsection (1) is the fee payable under the schedule of benefits. O. Reg. 111/96, s. 2.

(3) A laboratory service set out in the schedule of laboratory benefits and rendered by a physician is an insured service if,

(a) it is rendered for the purposes of diagnosing or treating a patient of the physician who sees the physician for purposes other than the sole purpose of receiving the laboratory service; or

(b) it is rendered in a public hospital. O. Reg. 111/96, s. 2; O. Reg. 201/99, s. 5 (1).

(4) The basic fee payable by the Plan for a laboratory service set out in the schedule of laboratory benefits and rendered by a physician in the circumstances referred to in clause (3) (a) is 51.7 cents multiplied by the applicable individual unit value for the service set out opposite the service in the schedule of laboratory benefits. O. Reg. 111/96, s. 2; O. Reg. 201/99, s. 5 (2).

(5) The basic fee payable for a laboratory service set out in the schedule of laboratory benefits and rendered by a physician in a public hospital is nil. O. Reg. 111/96, s. 2; O. Reg. 201/99, s. 5 (3).

(6) If, under this Regulation or under an agreement to which the Government of Ontario is a party, the fee payable for an insured service set out in the schedule of laboratory benefits is nil, the fee payable for an insured service rendered by a physician in relation to that service is nil. O. Reg. 111/96, s. 2; O. Reg. 201/99, s. 5 (4).

(7) Despite subsection (6), if a second physician renders a diagnostic laboratory medicine consultation in relation to a laboratory service set out in the schedule of laboratory benefits at the request of another physician, the fee payable to the second physician is the fee set out in the schedule of benefits. O. Reg. 111/96, s. 2; O. Reg. 201/99, s. 5 (5).

(8) For the purposes of subsection (7), a diagnostic laboratory medicine consultation occurs when a physician who practises laboratory medicine in a hospital gives a written opinion with respect to tissue, slides or specimens that are referred to the physician by a physician practising laboratory medicine in another hospital. O. Reg. 111/96, s. 2.

...

37.3 (1) Subject to subsection (2), the basic fee payable for an insured service rendered by a physician in Ontario, as set out in the schedule of benefits, shall be increased by 1.95 per cent if it is rendered on or after April 1, 2000. O. Reg. 369/00, s. 1.

(2) The increase in the basic fee payable under subsection (1) does not apply to an insured service referred to in Part 2 of Appendix E to the General Preamble to the schedule of benefits, other than a service referred to at the end of that Part of the Appendix under the heading "Other". O. Reg. 369/00, s. 1.

37.4 The basic fee payable for an insured service that is rendered in a hospital and set out in Part 2 of Appendix E to the General Preamble to the schedule of benefits shall be decreased by,

- (a) 6.7 per cent, if it is rendered before April 1, 1999;
- (b) 3 per cent, if it is rendered on or after April 1, 1999 but before October 1, 1999; and
- (c) 7 per cent, if it is rendered on or after October 1, 1999. O. Reg. 177/99, s. 1; O. Reg. 483/99, s. 1.

37.5 (1) The fee payable for an insured service rendered by a physician during a fiscal year referred to in Column 1 of the Table to this section shall be decreased in accordance with subsection (2) if the total amount payable for insured services rendered by the physician between the beginning of the fiscal year and the day the service is rendered exceeds the threshold amount set out opposite the fiscal year in Column 2 of the Table to this section. O. Reg. 50/03, s. 2.

(2) For the purposes of subsection (1), in the case of an insured service rendered during a fiscal year referred to in Column 1 of the Table to this section, if the total amount payable for insured services rendered by the physician between the beginning of the fiscal year and the day the insured service is rendered is equal to or exceeds the threshold amount set out opposite the fiscal year in Column 2 of the Table, the fee payable for the insured service is one-third of the basic fee otherwise payable. O. Reg. 50/03, s. 2.

(3) For the purposes of this section, the total amount payable for insured services shall include the amounts payable for all insured services other than the following:

- 1. A service set out in Appendix E to the General Preamble to the schedule of benefits.
 - 2. A service rendered under the Underserved Area Program of the Ministry of Health.
- O. Reg. 50/03, s. 2.

(4) Despite subsection (1), the fee payable for the following insured services shall not be decreased under this section:

1. A service set out in Appendix E to the General Preamble to the schedule of benefits.
2. A service rendered under the Underserviced Area Program of the Ministry of Health. O. Reg. 50/03, s. 2; O. Reg. 264/03, s. 1.

(5) In this section,

“fiscal year” means the period from April 1 of each year to and including March 31 of the following year. O. Reg. 50/03, s. 2.

(6) This section, as it read immediately before April 1, 2002, continues to apply with respect to payments for services rendered before April 1, 2002. O. Reg. 50/03, s. 2.

TABLE
THRESHOLD AMOUNTS FOR PHYSICIAN PROVIDERS

Column 1	Column 2
Fiscal year	Total amount payable
For the fiscal year beginning April 1, 2002, and any subsequent fiscal year	\$455,000

O. Reg. 50/03, s. 2.

37.6 Revoked: O. Reg. 370/00, s. 3.

Note: Despite its revocation, section 37.6, as it read immediately before January 1, 2000, continues to apply with respect to payments for services rendered before January 1, 2000. See: O. Reg. 370/00, s. 5 (2).

BILLING AND PAYMENT FOR INSURED SERVICES

38. (1) Revoked: O. Reg. 111/96, s. 3.

(2) A physician who does not submit his or her accounts directly to the Plan may commence to bill the Plan by giving written notice to the General Manager that he or she intends to bill the Plan directly and the notification becomes effective the first day of the third month following the month in which the General Manager receives such notification but may become effective on an earlier date as ordered by the General Manager. R.R.O. 1990, Reg. 552, s. 38 (2).

(3) A physician who does not submit his or her accounts directly to the Plan and who becomes a full-time member of a clinic that is registered with the Plan may give written notice to the General Manager that he or she intends to bill the Plan directly and the notification becomes effective the first day of the month following the month in which the General Manager receives such notification. R.R.O. 1990, Reg. 552, s. 38 (3).

(4) Subject to subsection (5), the following classes of accounts are exempt from the application of section 15 of the Act:

1. Accounts for the performance of insured services rendered to an insured person who is a recipient of a war veteran’s allowance under the *War Veterans Allowance Act* (Canada).
2. Accounts for the performance of insured services rendered to an insured Indian who is a member of a band as defined in the *Indian Act* (Canada).

3. Accounts for the performance of insured services rendered to an insured person in an out-patient or any other clinical department of a public hospital.

4. Accounts for the performance of insured services rendered to an insured person in,

- i. a nursing home,
- ii. a home for the aged, established and maintained under the *Homes for the Aged and Rest Homes Act*,
- iii. a children's mental health centre under the *Children's Mental Health Services Act*, being chapter 69 of the Revised Statutes of Ontario, 1980,
- iv. a hospital established or approved under the *Community Psychiatric Hospitals Act*,
- v. a psychiatric facility under the *Mental Health Act*,
- vi. an institution designated as an approved home under the *Mental Hospitals Act*,
- vii. a designated facility to which the *Developmental Services Act* applies,
- viii. a home for special care, established, approved or licensed under the *Homes for Special Care Act*, or
- ix. an approved charitable home for the aged under the *Charitable Institutions Act*.

5. Accounts for the performance of insured services rendered to an insured person in a mobile vision or hearing van operated by a non-profit organization to provide eye or ear care in under-served areas in Ontario.

6. Accounts for the performance of an examination rendered to an insured person and for documentation prepared for the purpose of an investigation or confirmation of an alleged sexual assault. R.R.O. 1990, Reg. 552, s. 38 (4); O. Reg. 375/93, s. 9.

(5) Payment for the classes of accounts exempted by paragraphs 3 and 4 of subsection (4) may only be made where,

- (a) the physician performing the services is a member of an associate medical group that is registered with the Plan;
- (b) the accounts for such services are submitted by the association referred to in clause (a) directly to the Plan; and
- (c) the associate medical group referred to in clause (a) and physician accept the payment as constituting payment in full for the services. R.R.O. 1990, Reg. 552, s. 38 (5).

(6) Revoked: O. Reg. 86/93, s. 2.

(7) Revoked: O. Reg. 363/02, s. 2.

(8)-(10) Revoked: O. Reg. 86/93, s. 2.

(11) The Plan shall pay a designated hospital for insured services provided to an insured person on the day of the person's admission to the hospital but not on the day of the person's discharge from the hospital. R.R.O. 1990, Reg. 552, s. 38 (11).

(12) The Plan shall not make and a hospital shall not accept duplicate payments for any insured services provided by the hospital. R.R.O. 1990, Reg. 552, s. 38 (12).

38.0.0.1 (1) A physician or practitioner may give a direction under subsection 16.1 (1) of the Act (direction to make payments to prescribed person or entity) to the persons or entities and in the circumstances described in this section. O. Reg. 422/01, s. 1.

(2) A physician who ordinarily practises with one or more physicians at a department of a public hospital in Ontario (a “physician hospital group”) may direct that payment for the insured services he or she renders at that department be made,

- (a) to the physician hospital group or to one or more members of that group;
- (b) to the public hospital; or
- (c) to a person or partnership with which the physician hospital group has an agreement concerning the provision of insured services at that department. O. Reg. 422/01, s. 1.

(3) A practitioner who ordinarily practises at a department of a public hospital in Ontario with one or more practitioners who are members of the same regulated health profession (a “practitioner hospital group”) may direct that payment for the insured services he or she renders at that department be made,

- (a) to the practitioner hospital group or to one or more members of that group;
- (b) to the public hospital; or
- (c) to a person or partnership with which the practitioner hospital group has an agreement concerning the provision of insured services at that department. O. Reg. 422/01, s. 1.

(4) Subject to subsection (6), a physician who ordinarily practises with one or more physicians (a “physician group”) at one or more sites in Ontario may direct that payment for the insured services he or she renders at the site or sites be made,

- (a) to the physician group or to one or more members of that group; or
- (b) to a person or partnership with which the physician group has an agreement concerning the provision of insured services at those sites. O. Reg. 422/01, s. 1.

(5) Subject to subsection (6), a practitioner who ordinarily practises at one or more sites in Ontario with one or more practitioners who are members of the same regulated health profession (a “practitioner group”) may direct that payment for the insured services he or she renders at the site or sites be made,

- (a) to the practitioner group or to one or more members of that group; or
- (b) to a person or partnership with which the practitioner group has an agreement concerning the provision of insured services at those sites. O. Reg. 422/01, s. 1.

(6) Subsection (4) or (5) applies only if the General Manager assigned an identification number to the physician group or practitioner group before the day Ontario Regulation 422/01 comes into force. O. Reg. 422/01, s. 1.

(7) A physician who renders insured services to insured persons pursuant to an alternative funding plan arrangement entered into with the Minister (an “AFP physician”) may direct that payment for the insured services he or she renders be made to one of the following or to both of the following as provided for in the direction:

1. The group of AFP physicians that ordinarily renders insured services to insured persons under the same alternative funding plan arrangement as the physician making the direction, or to one or more members of that group.
2. The governance organization responsible for ensuring provision of insured services by AFP physicians under the alternative funding plan arrangement entered into with the Minister. O. Reg. 441/03, s. 1.

38.0.1 (1) The following circumstances are prescribed for the purposes of paragraph 7 of subsection 18 (2) of the Act:

1. The General Manager is of the opinion that the account for the insured service has not been submitted in accordance with the Act and the regulations.
2. The General Manager is of the opinion that the fee code used by a physician or the amount claimed by a practitioner in the account submitted for payment is incorrect in the circumstances.
3. The General Manager is of the opinion that the insured service for which an account has been submitted was provided in circumstances in which no payment or a reduced payment is to be made, according to the Act, the regulations or the schedule of benefits.
4. The General Manager is of the opinion that the account submitted by a physician for payment includes two or more fee codes that reflect, in whole or in part, the provision of a single insured service rendered to an insured person in circumstances in which the service is more accurately described by only one fee code.
5. The General Manager is of the opinion that the account submitted by a practitioner for payment includes two or more claims that reflect, in whole or in part, the provision of a single insured service rendered to an insured person in circumstances in which the service is more accurately described by only one fee code.
6. The General Manager is of the opinion,
 - i. that an account submitted for payment by a physician includes a fee code for a service (the “billed service”) that is described in the schedule of benefits as an element of an insured service (the “insured service”), and
 - ii. that the insured service was rendered by another physician to the same person as the billed service was rendered and with respect to the same medical circumstances. O. Reg. 344/01, s. 1.

(2) The following circumstances are prescribed for the purposes of paragraph 5 of subsection 39.1 (6) of the Act:

1. The applicable committee is of the opinion that the account for the insured service has not been submitted in accordance with the Act and the regulations.
2. The applicable committee is of the opinion that the fee code used by a physician or the amount claimed by a practitioner in the account submitted for payment is incorrect in the circumstances.
3. The applicable committee is of the opinion that the insured service for which an account has been submitted was provided in circumstances in which no payment is to be made, according to the Act, the regulations or the schedule of benefits.
4. The applicable committee is of the opinion that the account submitted by a physician for payment includes two or more fee codes that reflect, in whole or in part, the provision of a single insured service rendered to an insured person in circumstances in which the service is more accurately described by only one fee code.
5. The applicable committee is of the opinion that the account submitted by a practitioner for payment includes two or more claims that reflect, in whole or in part, the provision of a single insured service rendered to an insured person in circumstances in which the service is more accurately described by only one fee code.
6. The applicable committee is of the opinion,

i. that an account submitted for payment by a physician includes a fee code for a service (the “billed service”) that is described in the schedule of benefits as an element of an insured service (the “insured service”), and

ii. that the insured service was rendered by another physician to the same person as the billed service was rendered and with respect to the same medical circumstances. O. Reg. 344/01, s. 1.

(3) In this section,

“fee code” means fee schedule code as listed in the schedule of benefits. O. Reg. 344/01, s. 1.

38.1 (1) For the purposes of clause 18.1 (2) (a) of the Act, a physician may request that a decision of the General Manager under subsection 18 (2) or (5) of the Act be reviewed by a single member of the Medical Review Committee if the amount in dispute is less than \$100,000. O. Reg. 575/98, s. 1; O. Reg. 150/00, s. 1 (1).

(2) For the purposes of clause 18.1 (4) (a) of the Act, a practitioner may request that a decision of the General Manager under subsection 18 (2) or (5) of the Act be reviewed by a single member of the applicable practitioner review committee if the amount in dispute is less than \$100,000. O. Reg. 575/98, s. 1; O. Reg. 150/00, s. 1 (2).

38.2 (1) For the purposes of subsection 18.1 (5) of the Act, the amount that must accompany a request for review shall be equal to 5 per cent of the amount in dispute but in no case shall be more than \$2,500 or less than \$350. O. Reg. 256/03, s. 1.

(2) For the purposes of subsection 18.1 (8) of the Act, the amount that must accompany a request for reconsideration shall be \$350. O. Reg. 256/03, s. 1.

38.2.1 (1) For the purposes of subsection 18.1 (14) of the Act, interest on an amount payable by or to a physician or practitioner, that is payable as a result of a direction under subsection 18.1 (10), 18.2 (2) or 39.1 (5), shall be paid at the rate set by the Ministry of Finance under section 10 of the *Financial Administration Act*. O. Reg. 575/98, s. 1; O. Reg. 149/00, s. 1; O. Reg. 150/00, s. 3 (1).

(2) For the purposes of subsection 18.1 (14) of the Act, interest on an amount payable by or to a physician or practitioner shall be paid from the date determined in accordance with the following rules:

1. If the review committee directs an amount to be paid after reviewing a decision of the General Manager to refuse to pay for a service or to pay a reduced amount under subsection 18 (2) of the Act, interest is payable from the payment day that is or that follows the day the physician or practitioner receives notice of the General Manager’s decision.

2. If the review committee directs the General Manager to return to a physician or practitioner all or part of a reimbursement that he or she paid after being required to reimburse the Plan under subsection 18 (5) of the Act, interest is payable from the day that the physician or practitioner made the reimbursement.

3. If the review committee confirms the General Manager’s decision to require a physician or practitioner to reimburse the Plan under subsection 18 (5), interest is payable from the day the physician or practitioner receives notice of the General Manager’s decision to require the reimbursement.

4. If a review committee directs an amount to be paid under subsection 18.2 (2) or 39.1 (5), interest is payable from the payment day that follows the end of the review period. O. Reg. 575/98, s. 1; O. Reg. 150/00, s. 3 (2).

(3) In subsection (2),

“payment day” means the day the Plan makes payments to physicians and practitioners and is the 15th day of each month;

“review period” means, with respect to a review by the Medical Review Committee or a practitioner review committee of the amount payable for services rendered by a physician or practitioner, the period of time during which those services were rendered. O. Reg. 575/98, s. 1.

38.2.2 (1) For the purposes of subsection 18.1 (15) of the Act, if, as a result of a review or a reconsideration of a review under section 18.1 of the Act, a physician or practitioner is required to reimburse money to the Plan or a direction is made directing the General Manager to pay an amount to a physician or practitioner that is less than the amount of the account submitted, the additional amount for the cost of the review or for the cost of the reconsideration of the review shall be calculated using the following formula:



where,

A is,

(a) where the physician or practitioner is required to reimburse money to the Plan, the amount that is required to be reimbursed, or

(b) where the General Manager is required to pay less than the amount of the account submitted, the portion of the amount the physician or practitioner claimed, in the review or reconsideration, should be paid to him or her that has been refused by the review committee;

B is,

(a) where the physician or practitioner is required to reimburse money to the Plan, the amount that the physician or practitioner claimed he or she should not be required to reimburse in the review or reconsideration, or

(b) where the General Manager is required to pay less than the amount of the account submitted, the amount that the physician or practitioner claimed should be paid to him or her in the review or reconsideration;

C is \$1000, in the case of a review or reconsideration conducted by the Medical Review Committee, or \$500, in the case of a review or reconsideration conducted by a practitioner review committee;

D is the number of review days in the review or reconsideration, as determined under subsection (5).

O. Reg. 149/00, s. 2.

(2) Despite subsection (1), the additional amount determined under that subsection shall not exceed the lesser of,

(a) the amount that is,

(i) where the physician or practitioner is required to reimburse money to the Plan, the amount that is required to be reimbursed, multiplied by 0.35, or

(ii) where the General Manager is required to pay less than the amount of the account submitted, the portion of the amount the physician or practitioner claimed, in the review or reconsideration, should be paid to him or her that has been refused by the review committee, multiplied by 0.35; and

(b) \$1000 for each review day, in the case of a review or reconsideration conducted by the Medical Review Committee, or \$500 for each review day, in the case of a review or a reconsideration conducted by a practitioner review committee. O. Reg. 149/00, s. 2.

(3) For the purposes of subsection 18.1 (15) of the Act, if, as a result of a review or a reconsideration of a review under section 18.1 of the Act, a direction is made confirming the decision of the General Manager to refuse to pay an account for services or if, as a result of a review or a reconsideration of a review under section 18.2 or 39.1 of the Act, a physician or practitioner is required to reimburse money to the Plan, the additional amount for the cost of the review or for the cost of the reconsideration of the review shall be calculated using the following formula:



where,

C is \$1000, in the case of a review or reconsideration conducted by the Medical Review Committee, or \$500, in the case of a review or reconsideration conducted by a practitioner review committee;

D is the number of review days in the review or reconsideration, as determined under subsection (5).

O. Reg. 149/00, s. 2; O. Reg. 150/00, s. 4 (1).

(4) Despite subsection (3), the additional amount determined under that subsection shall not exceed,

(a) where a direction is made confirming the decision of the General Manager to refuse to pay an account for services, the amount that the physician or practitioner claimed should be paid to him or her in the review or reconsideration, multiplied by 0.35; or

(b) where a physician or practitioner is required to reimburse money to the Plan, the amount that is required to be reimbursed, multiplied by 0.35. O. Reg. 149/00, s. 2.

(5) For the purposes of subsections (1), (2) and (3), if the direction of the committee is made on or after April 1, 2003 and if the circumstances set out in subsection (5.2) do not apply, the number of review days in a review or reconsideration is the lesser of 15 and the number determined as follows:

1. For each member of the committee, determine the number of days, including any partial days rounded to the first decimal, the member spent working on the review or reconsideration and on related matters after commencing to hear from the physician or practitioner.

2. If the parties agreed to a settlement of the review or reconsideration, determine, for each member, the number of days, including any partial days rounded to the first decimal, the member spent considering and agreeing to the offer to settle after commencing to hear from the physician or practitioner.

3. For each member of the committee, determine the days that are spent by the committee in hearing from the physician or practitioner, including any partial days rounded to the first decimal, to a maximum of two days.

4. For each member, subtract the number of days determined for the member under paragraphs 2 and 3 from the number of days determined for the member under paragraph 1.

5. Add the numbers determined under paragraph 4 for each member to calculate the total number of days all the members of the committee spent working on the review or reconsideration and on related matters.

6. For the purposes of the calculations in paragraphs 1, 2 and 3, the committee is "hearing from the physician or practitioner" when the physician or practitioner or his or her counsel or

agent is in the presence of the committee for the purpose of making representations. O. Reg. 5/04, s. 1.

(5.1) For the purposes of subsections (1), (2) and (3), if the direction of the committee was made before April 1, 2003 or if the circumstances set out in subsection (5.2) apply, the number of review days in a review or reconsideration shall be determined as follows:

1. For each member of the committee, determine the number of days, including any partial days rounded to the first decimal, the member spent working on the review or reconsideration and on related matters.
2. If the parties agreed to a settlement of the review or reconsideration, determine, for each member, the number of days, including any partial days rounded to the first decimal, the member spent considering and agreeing to the offer to settle.
3. For each member, subtract the number of days determined for the member under paragraph 2 from the number of days determined for the member under paragraph 1.
4. Add the numbers determined under paragraph 3 for each member to calculate the total number of days all the members of the committee spent working on the review or reconsideration and on related matters. O. Reg. 5/04, s. 1.

(5.2) The following are set out as circumstances for the purposes of subsections (5) and (5.1):

1. In the case of a practitioner, if a direction under subsection 18.1 (10) of the Act has previously been made requiring the practitioner to reimburse money to the Plan or directing the General Manager to pay an amount to the practitioner that is less than the amount of the account submitted.
2. In the case of a physician,
 - i. if a direction under subsection 18.1 (10) of the Act has previously been made requiring the physician to reimburse money to the Plan or directing the General Manager to pay an amount to the physician that is less than the amount of the account submitted, and
 - ii. the direction related, in whole or in part, to a claim or claims submitted with regard to one or more of the same schedule of benefits fee codes or classes of fee code as the claim or claims giving rise to the current review or reconsideration. O. Reg. 5/04, s. 1.

(5.3) The following are classes of fee code for the purposes of paragraph 2 of subsection (5.2):

1. Class 1 — all codes which are in respect of diagnostic tests or services, or the interpretation of a diagnostic test or service.
2. Class 2 — all codes in respect of surgical services.
3. Class 3 — all codes in respect of anesthesia services.
4. Class 4 — all codes other than those contained in any of classes 1 to 3. O. Reg. 5/04, s. 1.

(6) Despite subsections (1) and (3), the additional amount for the cost of a review or for the cost of a reconsideration of a review shall be a nil amount if the physician or practitioner who is a party to the review or reconsideration made an offer to settle the matter and the offer was refused and,

- (a) where the issue in the review or reconsideration related to whether the Plan owed money to the physician or practitioner, the settlement offer provided that the physician or practitioner accept payment of an amount that was equal to or less than the amount that the committee or single member directed that the Plan pay; or

(b) where the issue in the review or reconsideration related to whether the physician or practitioner owed money to the Plan, the settlement offer provided that the physician or practitioner reimburse an amount that was equal to or greater than the amount that the committee or single member directed the member to reimburse. O. Reg. 149/00, s. 2.

(6.1) Despite subsections (1) to (3), in the case of a review or a reconsideration of a review that, as of March 3, 2000, is before a review committee and in respect of which no direction has been issued, the additional amount for the cost of the review or reconsideration shall be a nil amount if the physician or practitioner made an offer to settle the matter on or before that date, or makes such an offer within 45 days after that date, and the offer is accepted at any time after it is made. O. Reg. 150/00, s. 4 (2).

(7) Upon the recommendation of the review committee, the General Manager may reduce the additional amount payable for the cost of a review or reconsideration of a review, as determined under subsections (1) to (5), by such amount as is reasonable in the circumstances. O. Reg. 149/00, s. 2.

(8) The review committee may recommend a reduction of the additional amount payable for the cost of a review or reconsideration of a review if, in the course of the review or reconsideration, either of the following circumstances are found to exist:

1. The review or reconsideration relates to accounts that were submitted to the Plan by a physician or practitioner in accordance with advice received from the General Manager.

2. The General Manager or review committee failed to provide the physician or practitioner with information that was likely to affect either his or her decision to proceed with the review or reconsideration or his or her decision to make an offer to settle the matter. O. Reg. 149/00, s. 2.

38.2.3 Sections 38.2.1 and 38.2.2 apply to any review or reconsideration of a review under section 18.1 or 39.1 of the Act that is commenced on or after November 5, 1998 or that was commenced before November 5, 1998 but in respect of which a direction had not been issued before that date. O. Reg. 149/00, s. 2.

38.3 (1) In this section,

“electronic data transfer” means a method approved by the Ministry of Health and Long-Term Care for electronically transferring information. O. Reg. 362/02, s. 1.

(2) It is a condition of payment that the following claims be submitted by electronic data transfer:

1. A claim for the cost of an insured service rendered by a physician, practitioner or health facility, if the physician, practitioner or health facility was first assigned an Ontario Health Insurance Plan identification number on or after January 1, 2003.

2. A claim for the cost of a laboratory service that is an insured service under section 22, if the medical director of the laboratory was first assigned an Ontario Health Insurance Plan identification number on or after January 1, 2003. O. Reg. 362/02, s. 1.

(3) It is a condition of payment that the following claims be submitted in a machine readable form acceptable to the Ministry of Health and Long-Term Care:

1. A claim for the cost of an insured service rendered by a physician, practitioner or health facility, if the physician, practitioner or health facility was assigned an Ontario Health Insurance Plan identification number on or after January 1, 1993 and before January 1, 2003.

2. A claim for the cost of a laboratory service that is an insured service under section 22, if the medical director of the laboratory was assigned an Ontario Health Insurance Plan identification number on or after January 1, 1993 and before January 1, 2003. O. Reg. 362/02, s. 1.

(4) Subsections (2) and (3) do not apply to a claim for the cost of an insured service rendered by a dental surgeon. O. Reg. 362/02, s. 1.

(5) A processing fee is payable under the regulations under the *Interpretation Act* for every claim received after July 13, 1993, unless the claim is submitted by electronic data transfer or in a machine readable form acceptable to the Ministry of Health and Long-Term Care. O. Reg. 362/02, s. 1.

(6) This section does not apply to a claim for a service rendered to an insured person outside of Ontario. O. Reg. 362/02, s. 1.

38.4 (1) It is a condition of payment of a claim for an insured service rendered to an insured person in Ontario that the claim include the following information:

1. The Ontario Health Insurance Plan identification number for,
 - i. the physician or practitioner who rendered the service,
 - ii. the physiotherapy clinic listed in the document published by the Ministry of Health and Long-Term Care titled "Schedule of Designated Physiotherapy Clinics", dated April 1, 2005, that rendered the service, or
 - iii. the medical director of the laboratory in which the service was rendered.
2. If the service was rendered by a physician, practitioner or laboratory,
 - i. the four characters assigned by the Plan that indicate whether the physician or practitioner practices alone or with one or more other physicians or practitioners or whether the service was provided in a laboratory, and
 - ii. the two characters assigned by the Plan that indicate the specialty of the physician, if any, or the specialty or profession of the practitioner or laboratory director, if any.
3. The most recently issued 10 digit health number for the insured person to whom the service was provided and any version code that may appear on the person's health card bearing that number.
4. The date of birth of the insured person to whom the service was rendered.
5. The payment program code "HCP".
6. Any characters assigned by the Ministry of Health and Long-Term Care that identify the payee as a provider or recipient of the insured service.
7. If the service is a diagnostic radiology procedure in accordance with the schedule of benefits, the Ontario Health Insurance Plan identification number of the referring physician or registered nurse in the extended class.
8. If the service is a laboratory or other diagnostic procedure listed under "Nuclear Medicine", "Pulmonary Function Studies" or "Diagnostic Ultrasound" in the schedule of benefits, the Ontario Health Insurance Plan identification number of the referring physician, midwife, registered nurse in the extended class or laboratory.
9. If the service is a consultation in accordance with the schedule of benefits, the Ontario Health Insurance Plan identification number of the referring physician.
10. If the service is an assessment requested by a midwife in accordance with the schedule of benefits, the Ontario Health Insurance Plan identification number of the midwife.
11. If the service was rendered in a mobile independent health facility licensed under the *Independent Health Facilities Act* or if the service consists of the interpretation of the results

of a diagnostic procedure performed in that type of facility, the four character service site indicator assigned by the Plan to identify the location at which the service was rendered.

12. If the service was provided to a person who was an in-patient in a hospital, the date of the person's admission to the hospital.

13. If the service was rendered by a physician who was issued an Ontario Health Insurance Plan identification number after December 16, 1996, the numeric code assigned by the Ministry of Health and Long-Term Care for the location where the service was rendered.

14. The fee code that, in the circumstances in which the service was rendered, correctly describes the service as specified,

- i. in the schedule of benefits, if the service was rendered by a physician,

...

15. In the case of a service other than a laboratory service described in section 22, the amount of the fee being claimed.

16. If it is relevant under the schedule of benefits, the number of times the service was rendered or the number of units claimed for the service.

17. The date the service was rendered.

18. If it is required by the Plan, the diagnostic code specified by the Plan for the service that relates to the insured person's condition.

19. If the service was an X-ray or laboratory or other diagnostic procedure that was provided in a hospital upon the requisition of an oral and maxillofacial surgeon, the Ontario Health Insurance Plan identification number of the referring oral and maxillofacial surgeon. O. Reg. 362/02, s. 1; O. Reg. 129/05, s. 5 (1, 2).

(2) It is a condition of payment of a claim for an insured service rendered in Ontario to a person who is insured by a health insurance scheme provided by another province or territory of Canada applies that the following information be included:

1. The payment program code "RMB", the health number or other identification number issued to the person by the health insurance scheme in the other province or territory, the person's first and last names, the person's sex and the code for the province or territory in which the person is insured, as specified by the Plan.

2. The Ontario Health Insurance Plan identification number for,

- i. the physician who rendered the service, or
- ii. the medical director of the laboratory in which the service was rendered.

3. If the service was rendered by a physician or laboratory,

- i. the four characters assigned by the Plan that indicate whether the physician practices alone or with one or more other physicians or whether the service was provided in a laboratory, and
- ii. the two characters assigned by the Plan that indicate the specialty of the physician, if any, or the specialty of the laboratory director, if any.

4. Any characters assigned by the Ministry of Health and Long-Term Care that identify the payee as a provider or recipient of the insured service.

5. If the service is a diagnostic radiology procedure in accordance with the schedule of benefits, the Ontario Health Insurance Plan identification number of the referring physician.

6. If the service is a laboratory or other diagnostic procedure listed under “Nuclear Medicine”, “Pulmonary Function Studies” or “Diagnostic Ultrasound” in the schedule of benefits, the Ontario Health Insurance Plan identification number of the referring physician.

7. If the service is a consultation in accordance with the schedule of benefits, the Ontario Health Insurance Plan identification number of the referring physician.

8. If the service was rendered in a mobile independent health facility licensed under the *Independent Health Facilities Act* or the service consists of the interpretation of the result of a diagnostic procedure performed in that type of facility, the four character service site indicator assigned by the Plan to identify the location at which the service was rendered.

9. If the service was provided to a person who was an in-patient in a hospital, the date of the person’s admission to the hospital.

10. If the service was rendered by a physician, the fee code that, in the circumstances in which the service was rendered, correctly describes the service as specified in the schedule of benefits.

11. In the case of a service other than a laboratory service described in section 22, the amount of the fee being claimed.

12. If it is relevant under the schedule of benefits, the number of times the service was rendered or the number of units claimed for the service.

13. The date the service was rendered.

14. If it is required by the Plan, the diagnostic code specified by the Plan for the services that relates to the insured person’s condition. O. Reg. 362/02, s. 1.

(3) In the case of a claim submitted in machine readable form, it is a condition of payment that the claim include the following additional information with respect to each service for which payment is claimed:

1. The transaction identifier code “HE”.
2. The appropriate identification code for the record.
3. The identifier code for the technical specification release.
4. The code for the Ministry of Health and Long-Term Care district office where the service provider is registered for the purpose of claims payments.
5. In the case of a claim that is included in a batch of claims, the date on which the batch of claims was created and the sequence number of the batch.
6. The operator number assigned by the Ministry of Health and Long-Term Care to the person authorized to submit the claim by magnetic cartridge or tape.
7. On the last record in each batch of claims, the total number of each of the record identification codes H, R, and T. O. Reg. 362/02, s. 1.

38.5 In sections 38.3 and 38.4,

“Ontario Health Insurance Plan identification number” means the number issued by the Plan to a physician, practitioner, registered nurse in the extended class, midwife, medical director of a laboratory licensed under the *Laboratory and Specimen Collection Centre Licensing Act*, hospital or health facility for the purposes of monitoring, processing and paying claims for payment of insured services and of monitoring and controlling the delivery of insured services. O. Reg. 362/02, s. 1.

38.6 (1) For the purposes of subsection 27.2 (3) of the Act, the General Manager may require a physician or practitioner to submit accounts directly to the Plan if the physician or practitioner owes money to the Plan, has received the notice referred to in subsection (2) and has not paid the amount specified in the notice within 30 days after the day the notice is given. O. Reg. 14/01, s. 2.

(2) The General Manager shall give a physician or practitioner 30 days written notice of,

- (a) the amount owing to the Plan;
- (b) the matter in respect of which the amount is owing; and
- (c) the intention of the General Manager to require the physician or practitioner to submit accounts directly to the Plan. O. Reg. 14/01, s. 2.

...

S.O. 1998, c. 18, Schedule H

MINISTRY OF HEALTH APPEAL AND REVIEW BOARDS ACT, 1998

**Amended by: S.O. 2000, c. 26, Sched. H, s. 2; S.O. 2002, c. 18, Sched. I, s. 16;
 S.O. 2004, c. 13, s. 2.**

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PART I

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

Health Professions Appeal and Review Board

1. The following boards are amalgamated to form the Health Professions Appeal and Review Board, to be known in French as the Commission d'appel et de révision des professions de la santé:

1. The Health Professions Board.

2. The Hospital Appeal Board.

S.O. 1998, c. 18, Sched. H, s. 1, in force February 1, 1999 (O. Gaz. 1999 p. 278).

Duties

2. The Board's duties are to conduct the hearings and reviews and to perform the duties that are assigned to it under the Regulated Health Professions Act, 1991, a health profession act as defined in that Act, the Drug and Pharmacies Regulation Act, the Public Hospitals Act or under any other Act. S.O. 1998, c. 18, Sched. H, s. 2, in force February 1, 1999 (O. Gaz. 1999 p. 278).

Composition

3. (1) The Board shall be composed of at least 12 members who shall be appointed by the Lieutenant Governor in Council on the recommendation of the Minister of Health.

Term of appointment

(2) Members of the Board shall be appointed for terms not exceeding three years.

Chair and vice-chairs

(3) The Lieutenant Governor in Council shall designate one member of the Board to be the chair and two members to be vice-chairs.

Additional vice-chairs

(4) The chair may from time to time designate additional members to be vice-chairs.

Replacement of members

(5) A person appointed to replace a member of the Board before the member's term expires shall hold office for the remainder of the term.

Reappointments

(6) Members of the Board are eligible for reappointment. S.O. 1998, c. 18, Sched. H, s. 3(2-6), in force February 1, 1999 (O. Gaz. 1999 p. 278).

S.O. 1998, c. 18, Sched. H, s. 3; S.O. 2000, c. 26, Sched. H, s. 2.

Qualifications of members

4. A person may not be appointed as a member of the Board if the person,

- (a) is employed in the public service of Ontario or by a Crown agency as defined in the Crown Agency Act;
- (b) is or has been a member of a College as defined in the Regulated Health Professions Act, 1991 or of a Council of such a College; or

- (c) is or has been a member of the College of Veterinarians of Ontario or of the Council of the College.

S.O. 1998, c. 18, Sched. H, s. 4, in force February 1, 1999 (O. Gaz. 1999 p. 278).

PART II

HEALTH SERVICES APPEAL AND REVIEW BOARD

Health Services Appeal and Review Board

5. The following boards are amalgamated to form the Health Services Appeal and Review Board, to be known in French as the Commission d'appel et de révision des services de santé:

1. The Health Services Appeal Board.
2. The Health Facilities Appeal Board.
3. The Health Protection Appeal Board.
4. The Nursing Homes Review Board.
5. The Laboratory Review Board.

S.O. 1998, c. 18, Sched. H, s. 5, in force February 1, 1999 (O. Gaz. 1999 p. 278).

Duties

6. (1) The Board's duties are to conduct the hearings and reviews and to perform the duties that are assigned to it under the following Acts:

1. The Ambulance Act.
2. The Charitable Institutions Act.
3. The Healing Arts Radiation Protection Act.
4. The Health Care Accessibility Act.
5. The Health Facilities Special Orders Act.
6. The Health Insurance Act.
7. The Health Protection and Promotion Act.
8. The Homes for the Aged and Rest Homes Act.
9. The Immunization of School Pupils Act.
10. The Independent Health Facilities Act.
11. The Laboratory and Specimen Collection Centre Licensing Act.
12. The Long-Term Care Act, 1994.
13. The Nursing Homes Act.
14. The Private Hospitals Act.

Same

(2) The Board shall perform its duties under the Acts set out in subsection (1) in accordance with those Acts and the regulations made under them.

Limit on jurisdiction

(3) Despite subsection (2), the Board shall not inquire into or make a decision concerning the constitutional validity of a provision of an Act or a regulation.

Same

(4) Subsection (3) shall be deemed always to have applied to the Board, but its enactment by section 16 of Schedule I to the Government Efficiency Act, 2002 does not affect any proceeding that was finally determined before the date on which that section came into force.

S.O. 1998, c. 18, Sched. H, s. 6, in force February 1, 1999 (O. Gaz. 1999 p. 278); S.O. 2002, c. 18, Sched. I, s. 16.

Composition

7. (1) The Board shall be composed of at least 12 members who shall be appointed by the Lieutenant Governor in Council on the recommendation of the Minister of Health.

Term of appointment

(2) Members of the Board shall be appointed for terms not exceeding three years.

Limitation on number of physicians

(3) No more than three legally qualified medical practitioners may be appointed to the Board.

Chair and vice-chairs

(4) The Lieutenant Governor in Council shall designate one member of the Board to be the chair and two members to be vice-chairs.

Additional vice-chairs

(5) The chair may from time to time designate additional members to be vice-chairs.

Replacement of members

(6) A person appointed to replace a member of the Board before the member's term expires shall hold office for the remainder of the term.

Reappointments

(7) Members of the Board are eligible for reappointment.

S.O. 1998, c. 18, Sched. H, s. 7(2-7), in force February 1, 1999 (O. Gaz. 1999 p. 278).

S.O. 1998, c. 18, Sched. H, s. 7; S.O. 2000, c. 26, Sched. H, s. 2.

Transitional Physician Audit Panel

7.1 (1) There is established a panel of the Board, to be known as the Transitional Physician Audit Panel in English and comité provisoire de vérification des honoraires de médecins in French, to deal with reviews under section 18.0.1 of the Health Insurance Act, consisting of,

- (a) the members of the Board appointed under subsections (2) and (4); and
- (b) the members of the Board who meet the qualifications set out in subsection (2) or (4).

Appointment, medical practitioners

(2) Despite subsection 7 (3), the Lieutenant Governor In Council, on the recommendation of the Minister of Health and Long-Term Care and in consultation with the Ontario Medical Association and the College of Physicians and Surgeons of Ontario, shall appoint no fewer than six legally qualified medical practitioners to the Board to serve as members of the Transitional Physician Audit Panel.

Restriction

(3) A legally qualified medical practitioner who was subject to a review by the Medical Review Committee or who was required to reimburse the Plan under the Health Insurance Act may not be appointed under subsection (2) until at least 10 years have passed since he or she was subject to a review by the Medical Review Committee or was required to reimburse the Plan.

Appointment, lawyers

(4) The Lieutenant Governor In Council, on the recommendation of the Minister of Health and Long-Term Care shall appoint to the Board no fewer than three members of the Law Society of Upper Canada, other than life members, honorary members or student members of the Society, to serve as members of the Transitional Physician Audit Panel.

Restriction

(5) Members appointed under subsections (2) and (4) shall not otherwise sit as members of the Board.

Rules re panel

(6) For the purposes of dealing with a review under section 18.0.1 of the Health Insurance Act, the following rules apply:

1. The review shall be dealt with by three members of the Transitional Physician Audit Panel designated by the chair of the Board.
2. Two of the three members shall be legally qualified medical practitioners, and one shall be a member of the Law Society of Upper Canada.
3. The chair of the Board shall designate a member to serve as chair for the purposes of the review.
4. The panel may not award costs.

5. Reviews by the panel are closed to the public.
6. Personal health information that is contained in any document or evidence filed or adduced with regard to the review, or in any order or decision of the panel, shall not be made accessible to the public, and the panel may edit any documents it releases to the public to remove any personal health information.
7. The parties to a review must exchange witness statements, summaries of evidence and copies of any documents proposed to be adduced in evidence at least 15 days before the day on which the review is scheduled to commence.
8. No evidence is admissible at a review that was not substantially disclosed in accordance with paragraph 7 and no document is admissible in a review that was not disclosed in accordance with paragraph 7.
9. The panel may not review, reconsider or amend a direction, decision or order except to correct a typographical error or error of calculation.
10. A review shall be conducted orally unless the General Manager appointed under the Health Insurance Act and the physician consent to the review being conducted electronically or in writing.
11. Subject to paragraphs 1 to 10, Part III applies.

Repeal

- (7) This section is repealed on a day to be named by proclamation of the Lieutenant Governor.

S.O. 2004, c. 13, s. 2.

Qualifications of members

8. A person may not be appointed as a member of the Board if the person is employed in the public service of Ontario or by a Crown agency as defined in the Crown Agency Act.

S.O. 1998, c. 18, Sched. H, s. 8, in force February 1, 1999 (O. Gaz. 1999 p. 278).

PART III PROVISIONS RELATING TO BOTH BOARDS

Application of part

9. This Part applies with respect to the Health Professions Appeal and Review Board and the Health Services Appeal and Review Board.

S.O. 1998, c. 18, Sched. H, s. 9, in force February 1, 1999 (O. Gaz. 1999 p. 278).

Annual report

10. A Board shall report annually to the Minister of Health on its activities.

S.O. 1998, c. 18, Sched. H, s. 10, in force February 1, 1999 (O. Gaz. 1999 p. 278).

Remuneration and expenses

11. The members of a Board shall be paid the remuneration and expenses the Lieutenant Governor in Council determines.

S.O. 1998, c. 18, Sched. H, s. 11, in force February 1, 1999 (O. Gaz. 1999 p. 278).

Employees

12. A Board may employ, under the Public Service Act, persons it considers necessary to carry out its duties.

S.O. 1998, c. 18, Sched. H, s. 12, in force February 1, 1999 (O. Gaz. 1999 p. 278).

Panels

13. (1) A proceeding before a Board shall be considered and determined by a panel of one or more members of the Board.

Selection of panel

(2) The selection of the members of the Board who sit on a panel shall be at the discretion of the chair.

Number of members

(3) A panel shall have an uneven number of members.

Chair or vice-chair on panel

(4) One of the members of a panel shall be the chair or a vice-chair of the Board.

S.O. 1998, c. 18, Sched. H, s. 13, in force February 1, 1999 (O. Gaz. 1999 p. 278).

Procedural matters, etc.

14. (1) In a proceeding before a panel of three or more members of a Board, a procedural or interlocutory matter may, if the chair so decides, be heard and determined by one of the members of the panel and the member shall be selected by the chair.

Same

(2) Subsection 13(4) does not apply with respect to procedural or interlocutory matters.

S.O. 1998, c. 18, Sched. H, s. 14, in force February 1, 1999 (O. Gaz. 1999 p. 278).

Resignation, expiry of membership

15. If a member of a panel of a Board which has begun proceedings with respect to a particular matter resigns from the Board or if the member's appointment to the Board expires, the member is deemed to continue to be a member of the Board for the purposes of dealing with that matter.

S.O. 1998, c. 18, Sched. H, s. 15, in force February 1, 1999 (O. Gaz. 1999 p. 278).

Death, revocation of membership, etc.

16. If a member of a panel of a Board which has begun proceedings with respect to a particular matter dies, has their appointment to the Board revoked or becomes unable or unwilling to continue as a member before the matter is concluded, the remaining members of the panel may deal with the matter.

S.O. 1998, c. 18, Sched. H, s. 16, in force February 1, 1999 (O. Gaz. 1999 p. 278).

Members of panel who participate

17. Only the members of a panel who were present throughout a proceeding shall participate in the panel's decision.

S.O. 1998, c. 18, Sched. H, s. 17, in force February 1, 1999 (O. Gaz. 1999 p. 278).

Immunity

18. No proceeding for damages shall be commenced against a Board, a member, employee or agent of a Board or anyone acting under the authority of the chair of a Board for any act done in good faith in the performance or intended performance of the person's duty or for any alleged neglect or default in the performance in good faith of the person's duty.

S.O. 1998, c. 18, Sched. H, s. 18, in force February 1, 1999 (O. Gaz. 1999 p. 278).

TRANSITIONAL PHYSICIAN PAYMENT REVIEW ACT, 2004

S.O. 2004, c. 13

[Bill 104, 2004]

Royal Assent: June 24, 2004

Act in force on Royal Assent, except sections 1 and 2 in force September 1, 2004

Preamble

The people of Ontario and their Government:

Believe that accountability is the cornerstone of responsible use of public funds;

Recognize the skill, dedication and integrity demonstrated by the staff and the members of the Medical Review Committee in fulfilling the Committee's vital role in medical audit within Medicare;

Acknowledge that timely payment of physician accounts is necessarily premised upon a Medicare payment system founded on trust;

Recognize that the Government in consultation with the College of Physicians and Surgeons of Ontario have retained Mr. Justice Peter Cory to conduct a "best practices" comparative analysis of medical audit systems and standards, to report back on any conclusions reached, and to make recommendations based upon those conclusions;

Recognize that, pending the outcome of that report, confidence in Ontario's medical audit system may be enhanced by providing a transitional alternative audit process for physician accounts;

Affirm that the preservation of Medicare depends on collaboration between patients, health-care providers and Government;

Therefore, Her Majesty, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:

PART I AMENDMENTS TO THE HEALTH INSURANCE ACT

1. The Health Insurance Act is amended by adding the following sections:

Physicians

18.0.1 (1) Subject to subsection (2), during the period that commences when this section comes into force, and ends when this section is repealed under section 18.0.4, sections 18.1 and 39.1 do not apply to a physician, and this section applies instead.

Saving

- (2) Subsection (1) does not affect,
- (a) a right to request a review by the Medical Eligibility Committee under clause 18.1 (1) (a); or
 - (b) any rights, responsibilities or obligations under subsections 18.1 (14) to (19) with regard to a review in which a final direction was given before this section came into force.

Panel Review

(3) Upon the request of a physician, the Transitional Physician Audit Panel is authorized to review the following matters in relation to that physician:

- 1. A decision of the General Manager to refuse to pay for a service, or to pay a reduced amount for a service under subsection 18 (2).
- 2. A decision of the General Manager to require reimbursement of an amount paid for a service under subsection 18 (5).

If review requested

(4) If a physician requests a review under subsection (3), the chair of the Appeal Board shall designate members of the Transitional Physician Audit Panel to deal with the review and set a time for the review and the panel shall conduct the review and render its direction as expeditiously as may be reasonably possible, and in any case shall render its direction no more than 45 days after the last day on which evidence in the review was adduced before the panel, unless the General Manager and the physician consent to an extension.

Parties

(5) Only the General Manager and the physician are parties to a review by the Transitional Physician Audit Panel.

Directions

(6) Following the review, the Transitional Physician Audit Panel may give any direction that could have been given by the Medical Review Committee under subsection 18.1 (10).

Interest, payable by physician

(7) If, as a result of a direction by the Transitional Physician Audit Panel, an amount is payable by a physician, interest calculated in the prescribed manner is payable on the amount, payable from the date the amount was paid by the Plan.

Interest, payable to physician

(8) If, as a result of a direction by the Transitional Physician Audit Panel, an amount is payable by the General Manager, interest calculated in the prescribed

manner is payable on the amount, payable from the date the amount was recovered from the physician by the Plan.

Applicability of certain provisions

(9) The following provisions apply, with necessary modifications, to a review by the Transitional Physician Audit Panel:

1. Subsections 21 (1.1) and (2).
2. Subsections 23 (1) to (4) and (6).
3. Section 27.2.

Appeal to Divisional Court

(10) Any party to a review before the Transitional Physician Audit Panel may appeal from the panel's direction to the Divisional Court in accordance with the rules of court, but,

- (a) personal health information contained in any document or evidence filed or adduced with regard to the appeal, or in any order or decision of the Court shall not be made accessible to the public; and
- (b) the Divisional Court may edit any documents it releases to the public to remove any personal health information.

Transitional Suspension

18.0.2 (1) Unless the physician elects otherwise under subsection (2), a review or reconsideration by the Medical Review Committee with regard to the physician is suspended for the period that this section is in force where, prior to its coming into force,

- (a) the physician requested the review under subsection 18.1 (1) or the reconsideration of that review under subsection 18.1 (7); and
- (b) the Medical Review Committee had not given a final direction from the review, or in the case of a reconsideration, a final direction from the reconsideration.

Election

(2) A physician may elect, instead of a suspension under subsection (1), to request a review by the Transitional Physician Audit Panel under section 18.0.1 as if he or she had never requested that the Medical Review Committee perform a review or a reconsideration of a review.

Suspension, section 39.1

(3) Unless the physician elects otherwise under subsection (4), a review or reconsideration by the Medical Review Committee with regard to the physician is suspended for the period that this section is in force where, prior to its coming into force,

- (a) the General Manager had, in respect of the physician, requested the review under subsection 39.1 (1) or the physician had made a request for the reconsideration in accordance with subsection 39.1 (4); and

- (b) the Medical Review Committee had not given a final direction from the review, or in the case of a reconsideration, a final direction from the reconsideration.

If no suspension

(4) If a physician is the subject of a request by the General Manager for a review under subsection 39.1 (1) or a request by the physician for a reconsideration in accordance with subsection 39.1 (4), the physician may elect that the General Manager, acting under subsection 18 (1), determine all issues relating to those accounts of the physician that formed the subject-matter of the request as if no request had ever been made.

Other issues if no suspension

(5) Where a physician elects under subsection (2) or (4) not to suspend a review or reconsideration, in respect of a review or reconsideration being conducted by the Medical Review Committee, no conclusion, decision or deliberation of the Medical Review Committee, whether of a preliminary, draft or final nature, is admissible in any subsequent review, proceeding or appeal, despite any other Act or law to the contrary.

Additional election

(6) Where, on the day this section came into force, a physician had received notice of a direction, and had not yet requested a reconsideration within the time provided under subsection 18.1 (8) or 39.1 (4),

- (a) the physician may elect to request a reconsideration, and have it suspended under this section;
- (b) the physician may elect a review under subsection (2) or (4), as the case may be; or
- (c) the physician may elect to treat the direction as final, in which case any provisions of this Act that would have applied to the direction if it had become final before the coming into force of this section apply.

Rules re election

(7) An election under subsection (2), (4) or (6) must be made within 30 days from the day this section comes into force.

Notice

(8) Notice of election not to suspend under subsection (2) or (4) must be served on the General Manager.

Interest

(9) If a suspension applies under subsection (1) or (3) in respect of a request for a reconsideration, no interest is payable during the time that this section is in force on any amount payable by the physician as a result of the direction of the Medical Review Committee subject to the reconsideration.

Appeals

(10) In any appeal to the Appeal Board or the Divisional Court concerning a decision of the Medical Review Committee made before the coming into force of this section, the General Manager may elect to stand in the place of the Medical

Review Committee, and if the General Manager so elects, he or she has all the rights and responsibilities of the Medical Review Committee for the purposes of the appeal.

Transitional

(11) Where on June 21, 2004 payments to a physician are suspended under subsection 40.2 (6), the suspension shall remain in effect until the physician has complied with subsections 37 (1) and (3) to the satisfaction of the General Manager.

Definition

18.0.3 In sections 18.0.1 and 18.0.2,

"Transitional Physician Audit Panel" means the Transitional Physician Audit Panel established under section 7.1 of the Ministry of Health Appeal and Review Boards Act, 1998.

Repeal

18.0.4 Sections 18.0.1, 18.0.2 and 18.0.3 are repealed on a day to be named by proclamation of the Lieutenant Governor.

**PART II
AMENDMENTS TO THE MINISTRY OF HEALTH
APPEAL AND REVIEW BOARDS ACT, 1998**

2. The Ministry of Health Appeal and Review Boards Act, 1998 is amended by adding the following section:

Transitional Physician Audit Panel

7.1 (1) There is established a panel of the Board, to be known as the Transitional Physician Audit Panel in English and comité provisoire de vérification des honoraires de médecins in French, to deal with reviews under section 18.0.1 of the Health Insurance Act, consisting of,

- (a) the members of the Board appointed under subsections (2) and (4);
and
- (b) the members of the Board who meet the qualifications set out in subsection (2) or (4).

Appointment, medical practitioners

(2) Despite subsection 7 (3), the Lieutenant Governor In Council, on the recommendation of the Minister of Health and Long-Term Care and in consultation with the Ontario Medical Association and the College of Physicians and Surgeons of Ontario, shall appoint no fewer than six legally qualified medical practitioners to the Board to serve as members of the Transitional Physician Audit Panel.

Restriction

(3) A legally qualified medical practitioner who was subject to a review by the Medical Review Committee or who was required to reimburse the Plan under the Health Insurance Act may not be appointed under subsection (2) until at least 10 years have passed since he or she was subject to a review by the Medical Review Committee or was required to reimburse the Plan.

Appointment, lawyers

(4) The Lieutenant Governor In Council, on the recommendation of the Minister of Health and Long-Term Care shall appoint to the Board no fewer than three members of the Law Society of Upper Canada, other than life members, honorary members or student members of the Society, to serve as members of the Transitional Physician Audit Panel.

Restriction

(5) Members appointed under subsections (2) and (4) shall not otherwise sit as members of the Board.

Rules re panel

(6) For the purposes of dealing with a review under section 18.0.1 of the Health Insurance Act, the following rules apply:

1. The review shall be dealt with by three members of the Transitional Physician Audit Panel designated by the chair of the Board.
2. Two of the three members shall be legally qualified medical practitioners, and one shall be a member of the Law Society of Upper Canada.
3. The chair of the Board shall designate a member to serve as chair for the purposes of the review.
4. The panel may not award costs.
5. Reviews by the panel are closed to the public.
6. Personal health information that is contained in any document or evidence filed or adduced with regard to the review, or in any order or decision of the panel, shall not be made accessible to the public, and the panel may edit any documents it releases to the public to remove any personal health information.
7. The parties to a review must exchange witness statements, summaries of evidence and copies of any documents proposed to be adduced in evidence at least 15 days before the day on which the review is scheduled to commence.
8. No evidence is admissible at a review that was not substantially disclosed in accordance with paragraph 7 and no document is admissible in a review that was not disclosed in accordance with paragraph 7.
9. The panel may not review, reconsider or amend a direction, decision or order except to correct a typographical error or error of calculation.
10. A review shall be conducted orally unless the General Manager appointed under the Health Insurance Act and the physician consent to the review being conducted electronically or in writing.

11. Subject to paragraphs 1 to 10, Part III applies.

Repeal

(7) This section is repealed on a day to be named by proclamation of the Lieutenant Governor.

Commencement

3. (1) Subject to subsection (2), this Act comes into force on the day it receives Royal Assent.

Same

(2) Sections 1 and 2 come into force on a day to be named by proclamation of the Lieutenant Governor.

Short title

4. The short title of this Act is the Transitional Physician Payment Review Act, 2004.

R.S.O. 1990, c. S.22

STATUTORY POWERS PROCEDURE ACT

Amended by: S.O. 1993, c. 27, Sched.;
S.O. 1994, c. 27, s. 56;
S.O. 1997, c. 23, s. 13; S.O. 1999,
c. 12, Sched. B, s. 16; S.O. 2002, c. 17, Sched. F.

Definitions

1.--(1) In this Act,

"electronic hearing" means a hearing held by conference telephone or some other form of electronic technology allowing persons to hear one another; ("audience électronique")

"hearing" means a hearing in any proceeding; ("audience")

"licence" includes any permit, certificate, approval, registration or similar form of permission required by law; ("autorisation")

"municipality" has the same meaning as in the Municipal Affairs Act; ("municipalité")

"oral hearing" means a hearing at which the parties or their counsel or agents attend before the tribunal in person; ("audience orale")

"proceeding" means a proceeding to which this Act applies. ("instance")

"statutory power of decision" means a power or right, conferred by or under a statute, to make a decision deciding or prescribing,

- (a) the legal rights, powers, privileges, immunities, duties or liabilities of any person or party, or
- (b) the eligibility of any person or party to receive, or to the continuation of, a benefit or licence, whether the person is legally entitled thereto or not; ("compétence légale de décision")

"tribunal" means one or more persons, whether or not incorporated and however described, upon which a statutory power of decision is conferred by or under a statute. ("tribunal")

"written hearing" means a hearing held by means of the exchange of documents, whether in written form or by electronic means. ("audience écrite")

Meaning of "person" extended

(2) A municipality, an unincorporated association of employers, a trade union or council of trade unions who may be a party to a proceeding in the exercise of a statutory power of decision under the statute

conferring the power shall be deemed to be a person for the purpose of any provision of this Act or of any rule made under this Act that applies to parties. R.S.O. 1990, c. S.22, s. 1(2).

R.S.O. 1990, c. S.22, s. 1; S.O. 1994, c. 27, s. 56; S.O. 2002, c. 17, Sched. F.

Interpretation

2. This Act, and any rule made by a tribunal under section 25.1, shall be liberally construed to secure the just, most expeditious and cost-effective determination of every proceeding on its merits. R.S.O. 1990, c. S.22, s. 2; S.O. 1994, c. 27, s. 56; S.O. 1999, c. 12, Sched. B, s. 16.

Application of Part I

3.--(1) Subject to subsection (2), this Act applies to a proceeding by a tribunal in the exercise of a statutory power of decision conferred by or under an Act of the Legislature, where the tribunal is required by or under such Act or otherwise by law to hold or to afford to the parties to the proceeding an opportunity for a hearing before making a decision.

Where Act does not apply

(2) This Act does not apply to a proceeding,

- (a) before the Assembly or any committee of the Assembly;
- (b) in or before,
 - (i) the Court of Appeal,
 - (ii) the Ontario Court (General Division),
 - (iii) the Ontario Court (Provincial Division),
 - (iv) the Unified Family Court,
 - (v) the Small Claims Court, or
 - (vi) a justice of the peace;
- (c) to which the Rules of Civil Procedure apply;
- (d) before an arbitrator to which the Arbitrations Act or the Labour Relations Act applies;
- (e) at a coroner's inquest;
- (f) of a commission appointed under the Public Inquiries Act;
- (g) of one or more persons required to make an investigation and to make a report, with or without recommendations, where the report is for the information or advice of the person to whom it is made and does not in any way legally bind or limit that person in any decision he or she may have power to make; or
- (h) of a tribunal empowered to make regulations, rules or by-laws in so far as its power to make regulations, rules or by-laws is concerned.

R.S.O. 1990, c. S.22, s. 3; S.O. 1994, c. 27, s. 56.

Waiver of procedural requirements

4. (1) Any procedural requirement of this Act, or of another Act or a regulation that applies to a proceeding, may be waived with the consent of the parties and the tribunal.

Same, rules

(2) Any provision of a tribunal's rules made under section 25.1 may be waived in accordance with the rules.

S.O. 1994, c. 27, s. 56; S.O. 1997, c. 23, s. 13.

Disposition without hearing

4.1 If the parties consent, a proceeding may be disposed of by a decision of the tribunal given without a hearing, unless another Act or a regulation that applies to the proceeding provides otherwise.

S.O. 1994, c. 27, s. 56; S.O. 1997, c. 23, s. 13.

Panels, certain matters

4.2 (1) A procedural or interlocutory matter in a proceeding may be heard and determined by a panel consisting of one or more members of the tribunal, as assigned by the chair of the tribunal.

Assignments

(2) In assigning members of the tribunal to a panel, the chair shall take into consideration any requirement imposed by another Act or a regulation that applies to the proceeding that the tribunal be representative of specific interests.

Decision of panel

(3) The decision of a majority of the members of a panel, or their unanimous decision in the case of a two-member panel, is the tribunal's decision.

S.O. 1994, c. 27, s. 56; S.O. 1997, c. 27, s. 56.

Panel of one

4.2.1 (1) The chair of a tribunal may decide that a proceeding be heard by a panel of one person and assign the person to hear the proceeding unless there is a statutory requirement in another Act that the proceeding be heard by a panel of more than one person.

Reduction in number of panel members

(2) Where there is a statutory requirement in another Act that a proceeding be heard by a panel of a specified number of persons, the chair of the tribunal may assign to the panel one person or any lesser number of persons than the number specified in the other Act if all parties to the proceeding consent. S.O. 1999, c. 12, Sched. B, s. 16.

Expiry of term

4.3 If the term of office of a member of a tribunal who has participated in a hearing expires before a decision is given, the term shall be deemed to continue, but only for the purpose of participating in the decision and for no other purpose. S.O. 1994, c. 27, s. 56; S.O. 1997, c. 23, s. 13.

Incapacity of member

4.4 (1) If a member of a tribunal who has participated in a hearing becomes unable, for any reason, to complete the hearing or to participate in the decision, the remaining member or members may complete the hearing and give a decision.

Other Acts and regulations

(2) Subsection (1) does not apply if another Act or a regulation specifically deals with the issue of what takes place in the circumstances described in subsection (1).

S.O. 1994, c. 27, s. 56; S.O. 1997, c. 23, s. 13.

Decision not to process commencement of proceeding

4.5 (1) Subject to subsection (3), upon receiving documents relating to the commencement of a proceeding, a tribunal or its administrative staff may decide not to process the documents relating to the commencement of the proceeding if,

- (a) the documents are incomplete;
- (b) the documents are received after the time required for commencing the proceeding has elapsed;
- (c) the fee required for commencing the proceeding is not paid; or
- (d) there is some other technical defect in the commencement of the proceeding.

Notice

(2) A tribunal or its administrative staff shall give the party who commences a proceeding notice of its decision under subsection (1) and shall set out in the notice the reasons for the decision and the requirements for resuming the processing of the documents.

Rules under s. 25.1

(3) A tribunal or its administrative staff shall not make a decision under subsection (1) unless the tribunal has made rules under section 25.1 respecting the making of such decisions and those rules shall set out,

- (a) any of the grounds referred to in subsection (1) upon which the tribunal or its administrative staff may decide not to process the documents relating to the commencement of a proceeding; and
- (b) the requirements for the processing of the documents to be resumed.

Continuance of provisions in other statutes

(4) Despite section 32, nothing in this section shall prevent a tribunal or its administrative staff from deciding not to process documents relating to the commencement of a proceeding on grounds that differ from those referred to in subsection (1) or without complying with subsection (2) or (3) if the tribunal or its staff does so in accordance with the provisions of an Act that are in force on the day this section comes into force.

S.O. 1999, c. 12, Sched. B, s. 16.

Dismissal of proceeding without hearing

4.6 (1) Subject to subsections (5) and (6), a tribunal may dismiss a proceeding without a hearing if,

- (a) the proceeding is frivolous, vexatious or is commenced in bad faith;
- (b) the proceeding relates to matters that are outside the jurisdiction of the tribunal; or
- (c) some aspect of the statutory requirements for bringing the proceeding has not been met.

Notice

(2) Before dismissing a proceeding under this section, a tribunal shall give notice of its intention to dismiss the proceeding to,

- (a) all parties to the proceeding if the proceeding is being dismissed for reasons referred to in clause (1) (b); or
- (b) the party who commences the proceeding if the proceeding is being dismissed for any other reason.

Same

(3) The notice of intention to dismiss a proceeding shall set out the reasons for the dismissal and inform the parties of their right to make written submissions to the tribunal with respect to the dismissal within the time specified in the notice.

Right to make submissions

(4) A party who receives a notice under subsection (2) may make written submissions to the tribunal with respect to the dismissal within the time specified in the notice.

Dismissal

(5) A tribunal shall not dismiss a proceeding under this section until it has given notice under subsection (2) and considered any submissions made under subsection (4).

Rules

(6) A tribunal shall not dismiss a proceeding under this section unless it has made rules under section 25.1 respecting the early dismissal of proceedings and those rules shall include,

- (a) any of the grounds referred to in subsection (1) upon which a proceeding may be dismissed;
- (b) the right of the parties who are entitled to receive notice under subsection (2) to make submissions with respect to the dismissal; and
- (c) the time within which the submissions must be made.

Continuance of provisions in other statutes

(7) Despite section 32, nothing in this section shall prevent a tribunal from dismissing a proceeding on grounds other than those referred to in subsection (1) or without complying with subsections (2) to (6) if the tribunal dismisses the proceeding in accordance with the provisions of an Act that are in force on the day this section comes into force. S.O. 1999, c. 12, Sched. B, s. 16.

Classifying proceedings

4.7 A tribunal may make rules under section 25.1 classifying the types of proceedings that come before it and setting guidelines as to the procedural steps or processes (such as preliminary motions, pre-hearing conferences, alternative dispute resolution mechanisms, expedited hearings) that apply to each type of proceeding and the circumstances in which other procedures may apply. S.O. 1999, c. 12, Sched. B, s. 16.

Alternative dispute resolution

4.8 (1) A tribunal may direct the parties to a proceeding to participate in an alternative dispute resolution mechanism for the purposes of resolving the proceeding or an issue arising in the proceeding if,

- (a) it has made rules under section 25.1 respecting the use of alternative dispute resolution mechanisms; and
- (b) all parties consent to participating in the alternative dispute resolution mechanism.

Definition

(2) In this section,

"alternative dispute resolution mechanism" includes mediation, conciliation, negotiation or any other means of facilitating the resolution of issues in dispute.

Rules

(3) A rule under section 25.1 respecting the use of alternative dispute resolution mechanisms shall include procedural guidelines to deal with the following:

1. The circumstances in which a settlement achieved by means of an alternative dispute resolution mechanism must be reviewed and approved by the tribunal.
2. Any requirement, statutory or otherwise, that there be an order by the tribunal.

Mandatory alternative dispute resolution

(4) A rule under subsection (3) may provide that participation in an alternative dispute resolution mechanism is mandatory or that it is mandatory in certain specified circumstances.

Person appointed to mediate, etc.

(5) A rule under subsection (3) may provide that a person appointed to mediate, conciliate, negotiate or help resolve a matter by means of an alternative dispute resolution mechanism be a member of the tribunal or a person independent of the tribunal. However, a member of the tribunal who is so appointed with respect to a matter in a proceeding shall not subsequently hear the matter if it comes before the tribunal unless the parties consent.

Continuance of provisions in other statutes

(6) Despite section 32, nothing in this section shall prevent a tribunal from directing parties to a proceeding to participate in an alternative dispute resolution mechanism even though the requirements of subsections (1) to (5) have not been met if the tribunal does so in accordance with the provisions of an Act that are in force on the day this section comes into force.

S.O. 1999, c. 12, Sched. B, s. 16.

Mediators, etc., not compellable

4.9 (1) No person employed as a mediator, conciliator or negotiator or otherwise appointed to facilitate the resolution of a matter before a tribunal by means of an alternative dispute resolution mechanism shall be compelled to give testimony or produce documents in a proceeding before the tribunal or in a civil proceeding with respect to matters that come to his or her knowledge in the course of exercising his or her duties under this or any other Act.

Evidence in civil proceedings

(2) No notes or records kept by a mediator, conciliator or negotiator or by any other person appointed to facilitate the resolution of a matter before a tribunal by means of an alternative dispute resolution mechanism under this or any other Act are admissible in a civil proceeding.

S.O. 1999, c. 12, Sched. B, s. 16.

Parties

5. The parties to a proceeding shall be the persons specified as parties by or under the statute under which the proceeding arises or, if not so specified, persons entitled by law to be parties to the proceeding. R.S.O. 1990, c. S.22, s. 5.

Written hearings

5.1 (1) A tribunal whose rules made under section 25.1 deal with written hearings may hold a written hearing in a proceeding.

Exception

(2) The tribunal shall not hold a written hearing if a party satisfies the tribunal that there is good reason for not doing so.

Same

(2.1) Subsection (2) does not apply if the only purpose of the hearing is to deal with procedural matters.

Documents

(3) In a written hearing, all the parties are entitled to receive every document that the tribunal receives in the proceeding.

S.O. 1994, c. 27, s. 56; S.O. 1997, c. 23, s. 13; S.O. 1999, c. 12, Sched. B, s. 16.

Electronic hearings

5.2 (1) A tribunal whose rules made under section 25.1 deal with electronic hearings may hold an electronic hearing in a proceeding.

Exception

(2) The tribunal shall not hold an electronic hearing if a party satisfies the tribunal that holding an electronic rather than an oral hearing is likely to cause the party significant prejudice.

Same

(3) Subsection (2) does not apply if the only purpose of the hearing is to deal with procedural matters.

Participants to be able to hear one another

(4) In an electronic hearing, all the parties and the members of the tribunal participating in the hearing must be able to hear one another and any witnesses throughout the hearing.

S.O. 1994, c. 27, s. 56; S.O. 1997, c. 23, s. 13.

Different kinds of hearings in one proceeding

5.2.1 A tribunal may, in a proceeding, hold any combination of written, electronic and oral hearings.

S.O. 1997, c. 23, s. 13.

Pre-hearing conferences

5.3 (1) If the tribunal's rules made under section 25.1 deal with pre-hearing conferences, the tribunal may direct the parties to participate in a pre-hearing conference to consider,

- (a) the settlement of any or all of the issues;
- (b) the simplification of the issues;
- (c) facts or evidence that may be agreed upon;
- (d) the dates by which any steps in the proceeding are to be taken or begun;
- (e) the estimated duration of the hearing; and
- (f) any other matter that may assist in the just and most expeditious disposition of the

proceeding.

Other Acts and regulations

(1.1) The tribunal's power to direct the parties to participate in a pre-hearing conference is subject to any other Act or regulation that applies to the proceeding.

Who presides

(2) The chair of the tribunal may designate a member of the tribunal or any other person to preside at the pre-hearing conference.

Orders

(3) A member who presides at a pre-hearing conference may make such orders as he or she considers necessary or advisable with respect to the conduct of the proceeding, including adding parties.

Disqualification

(4) A member who presides at a pre-hearing conference at which the parties attempt to settle issues shall not preside at the hearing of the proceeding unless the parties consent.

Application of s. 5.2

(5) Section 5.2 applies to a pre-hearing conference, with necessary modifications.

S.O. 1994, c. 27, s. 56; S.O. 1997, c. 23, s. 13.

Disclosure

5.4 (1) If the tribunal's rules made under section 25.1 deal with disclosure, the tribunal may, at any stage of the proceeding before all hearings are complete, make orders for,

- (a) the exchange of documents;
- (b) the oral or written examination of a party;
- (c) the exchange of witness statements and reports of expert witnesses;
- (d) the provision of particulars;
- (e) any other form of disclosure.

Other Acts and regulations

(1.1) The tribunal's power to make orders for disclosure is subject to any other Act or regulation that applies to the proceeding.

Exception, privileged information

(2) Subsection (1) does not authorize the making of an order requiring disclosure of privileged information.

S.O. 1994, c. 27, s. 56; S.O. 1997, c. 23, s. 13.

Notice of hearing

6.--(1) The parties to a proceeding shall be given reasonable notice of the hearing by the tribunal. R.S.O. 1990, c. S.22, s. 6(1).

Statutory authority

(2) A notice of a hearing shall include a reference to the statutory authority under which the hearing will be held.

Oral hearing

(3) A notice of an oral hearing shall include,

- (a) a statement of the time, place and purpose of the hearing; and
- (b) a statement that if the party notified does not attend at the hearing, the tribunal may proceed in the party's absence and the party will not be entitled to any further notice in the proceeding.

Written hearing

(4) A notice of a written hearing shall include,

- (a) a statement of the date and purpose of the hearing, and details about the manner in which the hearing will be held;
- (b) a statement that the hearing shall not be held as a written hearing if the party satisfies the tribunal that there is good reason for not holding a written hearing (in which case the tribunal is required to hold it as an electronic or oral hearing) and an indication of the procedure to be followed for that purpose;
- (c) a statement that if the party notified neither acts under clause (b) nor participates in the hearing in accordance with the notice, the tribunal may proceed without the party's participation and the party will not be entitled to any further notice in the proceeding.

Electronic hearing

(5) A notice of an electronic hearing shall include,

- (a) a statement of the time and purpose of the hearing, and details about the manner in which the hearing will be held;
- (b) a statement that the only purpose of the hearing is to deal with procedural matters, if that is the case;
- (c) if clause (b) does not apply, a statement that the party notified may, by satisfying the tribunal that holding the hearing as an electronic hearing is likely to cause the party

- significant prejudice, require the tribunal to hold the hearing as an oral hearing, and an indication of the procedure to be followed for that purpose; and
- (d) a statement that if the party notified neither acts under clause (c), if applicable, nor participates in the hearing in accordance with the notice, the tribunal may proceed without the party's participation and the party will not be entitled to any further notice in the proceeding.

R.S.O. 1990, c. S.22, s. 6; S.O. 1994, c. 27, s. 56; S.O. 1997, c. 23, s. 13; S.O. 1999, c. 12, Sched. B, s. 16.

Effect of non-attendance at hearing after due notice

7. (1) Where notice of an oral hearing has been given to a party to a proceeding in accordance with this Act and the party does not attend at the hearing, the tribunal may proceed in the absence of the party and the party is not entitled to any further notice in the proceeding.

Same, written hearing

(2) Where notice of a written hearing has been given to a party to a proceeding in accordance with this Act and the party neither acts under clause 6 (4) (b) nor participates in the hearing in accordance with the notice, the tribunal may proceed without the party's participation and the party is not entitled to any further notice in the proceeding.

Same, electronic hearings

(3) Where notice of an electronic hearing has been given to a party to a proceeding in accordance with this Act and the party neither acts under clause 6(5) (c), if applicable, nor participates in the hearing in accordance with the notice, the tribunal may proceed without the party's participation and the party is not entitled to any further notice in the proceeding.

R.S.O. 1990, c. S.22, s. 7; S.O. 1994, c. 27, s. 56.

Where character, etc., of a party is in issue

8. Where the good character, propriety of conduct or competence of a party is an issue in a proceeding, the party is entitled to be furnished prior to the hearing with reasonable information of any allegations with respect thereto. R.S.O. 1990, c. S.22, s. 8.

Hearings to be public, exceptions

- 9.--(1) An oral hearing shall be open to the public except where the tribunal is of the opinion that,
- (a) matters involving public security may be disclosed; or
- (b) intimate financial or personal matters or other matters may be disclosed at the hearing of such a nature, having regard to the circumstances, that the desirability of avoiding disclosure thereof in the interests of any person affected or in the public interest outweighs the desirability of adhering to the principle that hearings be open to the public,

in which case the tribunal may hold the hearing in the absence of the public.

Written hearings

(1.1) In a written hearing, members of the public are entitled to reasonable access to the documents submitted, unless the tribunal is of the opinion that clause (1) (a) or (b) applies.

Electronic hearings

(1.2) An electronic hearing shall be open to the public unless the tribunal is of the opinion that,

- (a) it is not practical to hold the hearing in a manner that is open to the public; or
- (b) clause (1)(a) or (b) applies.

Maintenance of order at hearings

(2) A tribunal may make such orders or give such directions at an oral or electronic hearing as it considers necessary for the maintenance of order at the hearing, and, if any person disobeys or fails to comply with any such order or direction, the tribunal or a member thereof may call for the assistance of any peace officer to enforce the order or direction, and every peace officer so called upon shall take such action as is necessary to enforce the order or direction and may use such force as is reasonably required for that purpose.

R.S.O. 1990, c. S.22, s. 9; S.O. 1994, c. 27, s. 56; S.O. 1997, c. 23, s. 13.

Proceedings involving similar questions

9.1 (1) If two or more proceedings before a tribunal involve the same or similar questions of fact, law or policy, the tribunal may,

- (a) combine the proceedings or any part of them, with the consent of the parties;
- (b) hear the proceedings at the same time, with the consent of the parties;
- (c) hear the proceedings one immediately after the other; or
- (d) stay one or more of the proceedings until after the determination of another one of them.

Exception

(2) Subsection (1) does not apply to proceedings to which the Consolidated Hearings Act applies.

Same

(3) Clauses (1) (a) and (b) do not apply to a proceeding if,

- (a) any other Act or regulation that applies to the proceeding requires that it be heard in private;
- (b) the tribunal is of the opinion that clause 9(1) (a) or (b) applies to the proceeding.

Conflict, consent requirements

(4) The consent requirements of clauses (1)(a) and (b) do not apply if another Act or a regulation that applies to the proceedings allows the tribunal to combine them or hear them at the same time without the **consent of the parties**.

Use of same evidence

(5) If the parties to the second-named proceeding consent, the tribunal may treat evidence that is admitted in a proceeding as if it were also admitted in another proceeding that is heard at the same time under clause (1) (b).

S.O. 1994, c. 27, s. 56; S.O. 1997, c. 23, c. 13.

Right to counsel

10. A party to a proceeding may be represented by counsel or an agent.

S.O. 1994, c. 27, s. 56.

Examination of witnesses

10.1 A party to a proceeding may, at an oral or electronic hearing,

- (a) call and examine witnesses and present evidence and submissions; and
- (b) conduct cross-examinations of witnesses at the hearing reasonably required for a full and fair disclosure of all matters relevant to the issues in the proceeding.

S.O. 1994, c. 27, s. 56.

Rights of witnesses to counsel

11.--(1) A witness at an oral or electronic hearing is entitled to be advised by counsel or an agent as to his or her rights but such counsel or agent may take no other part in the hearing without leave of the tribunal.

Idem

(2) Where an oral hearing is closed to the public, the counsel or agent for a witness is not entitled to be present except when that witness is giving evidence.

R.S.O. 1990, c. S.22, s. 11; S.O. 1994, c. 27, s. 56.

Summonses

12.--(1) A tribunal may require any person, including a party, by summons,

- (a) to give evidence on oath or affirmation at an oral or electronic hearing; and

- (b) to produce in evidence at an oral or electronic hearing documents and things specified by the tribunal,

relevant to the subject-matter of the proceeding and admissible at a hearing.

Form and service of summons

(2) A summons issued under subsection (1) shall be in the prescribed form (in English or French) and,

- (a) where the tribunal consists of one person, shall be signed by him or her;
- (b) where the tribunal consists of more than one person, shall be signed by the chair of the tribunal or in such other manner as documents on behalf of the tribunal may be signed under the statute constituting the tribunal.

Same

(3) The summons shall be served personally on the person summoned.

Fees and allowances

(3.1) The person summoned is entitled to receive the same fees or allowances for attending at or otherwise participating in the hearing as are paid to a person summoned to attend before the Ontario Court (General Division).

Bench warrant

(4) A judge of the Ontario Court (General Division) may issue a warrant against a person the judge is satisfied that,

- (a) a summons was served on the person under this section;
- (b) the person has failed to attend or to remain in attendance at the hearing (in the case of an oral hearing) or has failed otherwise to participate in the hearing (in the case of an electronic hearing) in accordance with the summons; and
- (c) the person's attendance or participation is material to the ends of justice.

Same

(4.1) The warrant shall be in the prescribed form (in English or French), directed to any police officer, and shall require the person to be apprehended anywhere within Ontario, brought before the tribunal forthwith and,

- (a) detained in custody as the judge may order until the person's presence as a witness is no longer required; or
- (b) in the judge's discretion, released on a recognizance, with or without sureties, conditioned for attendance or participation to give evidence.

Proof of service

(5) Service of a summons may be proved by affidavit in an application to have a warrant issued under subsection (4).

Certificate of facts

(6) Where an application to have a warrant issued is made on behalf of a tribunal, the person constituting the tribunal or, if the tribunal consists of more than one person, the chair of the tribunal may certify to the judge the facts relied on to establish that the attendance or other participation of the person summoned is material to the ends of justice, and the judge may accept the certificate as proof of the facts.

Same

(7) Where the application is made by a party to the proceeding, the facts relied on to establish that the attendance or other participation of the person is material to the ends of justice may be proved by the party's affidavit.

R.S.O. 1990, c. S.22, s. 12; S.O. 1994, c. 27, s. 56.

Contempt proceedings

13. (1) Where any person without lawful excuse,

- (a) on being duly summoned under section 12 as a witness at a hearing makes default in attending at the hearing; or
- (b) being in attendance as a witness at an oral hearing or otherwise participating as a witness at an electronic hearing, refuses to take an oath or to make an affirmation legally required by the tribunal to be taken or made, or to produce any document or thing in his or her power or control legally required by the tribunal to be produced by him or her or to answer any question to which the tribunal may legally require an answer; or
- (c) does any other thing that would, if the tribunal had been a court of law having power to commit for contempt, have been contempt of that court,

the tribunal may, of its own motion or on the motion of a party to the proceeding, state a case to the Divisional Court setting out the facts and that court may inquire into the matter and, after hearing any witnesses who may be produced against or on behalf of that person and after hearing any statement that may be offered in defence, punish or take steps for the punishment of that person in like manner as if he or she had been guilty of contempt of the court.

Same

(2) Subsection (1) also applies to a person who,

- (a) having objected under clause 6(4)(b) to a hearing being held as a written hearing, fails without lawful excuse to participate in the oral or electronic hearing of the matter; or
- (b) being a party, fails without lawful excuse to attend a pre-hearing conference when so directed by the tribunal.

R.S.O. 1990, c. S.22, s. 13; S.O. 1994, c. 27, s. 56; S.O. 1997, c. 23, s. 13.

Protection for witnesses

14.--(1) A witness at an oral or electronic hearing shall be deemed to have objected to answer any question asked him or her upon the ground that the answer may tend to criminate him or her or may tend to establish his or her liability to civil proceedings at the instance of the Crown, or of any person, and no answer given by a witness at a hearing shall be used or be receivable in evidence against the witness in any trial or other proceeding against him or her thereafter taking place, other than a prosecution for perjury in giving such evidence.

(2) REPEALED: S.O. 1994, c. 27, s. 56(29), effective April 1, 1995 (O. Gaz. 1995 p. 438).

R.S.O. 1990, c. S.22, s. 14; S.O. 1994, c. 27, s. 56.

What is admissible in evidence at a hearing

15.--(1) Subject to subsections (2) and (3), a tribunal may admit as evidence at a hearing, whether or not given or proven under oath or affirmation or admissible as evidence in a court,

- (a) any oral testimony; and
- (b) any document or other thing,

relevant to the subject-matter of the proceeding and may act on such evidence, but the tribunal may exclude anything unduly repetitious.

What is inadmissible in evidence at a hearing

(2) Nothing is admissible in evidence at a hearing,

- (a) that would be inadmissible in a court by reason of any privilege under the law of evidence; or
- (b) that is inadmissible by the statute under which the proceeding arises or any other statute.

Conflicts

(3) Nothing in subsection (1) overrides the provisions of any Act expressly limiting the extent to or purposes for which any oral testimony, documents or things may be admitted or used in evidence in any proceeding.

Copies

(4) Where a tribunal is satisfied as to its authenticity, a copy of a document or other thing may be admitted as evidence at a hearing.

Photocopies

(5) Where a document has been filed in evidence at a hearing, the tribunal may, or the person producing it or entitled to it may with the leave of the tribunal, cause the document to be photocopied and the tribunal may authorize the photocopy to be filed in evidence in the place of the document filed and release the

document filed, or may furnish to the person producing it or the person entitled to it a photocopy of the document filed certified by a member of the tribunal.

Certified copy admissible in evidence

(6) A document purporting to be a copy of a document filed in evidence at a hearing, certified to be a copy thereof by a member of the tribunal, is admissible in evidence in proceedings in which the document is admissible as evidence of the document. R.S.O. 1990, c. S.22, s. 15.

Use of previously admitted evidence

15.1 (1) The tribunal may treat previously admitted evidence as if it had been admitted in a proceeding before the tribunal, if the parties to the proceeding consent.

Definition

(2) In subsection (1),

"previously admitted evidence" means evidence that was admitted, before the hearing of the proceeding referred to in that subsection, in any other proceeding before a court or tribunal, whether in or outside Ontario.

Additional power

(3) This power conferred by this section is in addition to the tribunal's power to admit evidence under section 15.

S.O. 1994, c. 27, s. 56; S.O. 1997, c. 23, s. 13.

Witness panels

15.2 A tribunal may receive evidence from panels of witnesses composed of two or more persons, if the parties have first had an opportunity to make submissions in that regard.

S.O. 1994, c. 27, s. 56.

Notice of facts and opinions

16. A tribunal may, in making its decision in any proceeding,

- (a) take notice of facts that may be judicially noticed; and
- (b) take notice of any generally recognized scientific or technical facts, information or opinions within its scientific or specialized knowledge. R.S.O. 1990, c. S.22, s. 16.

Interim decisions and orders

16.1 (1) A tribunal may make interim decisions and orders.

Conditions

- (2) A tribunal may impose conditions on an interim decision or order.

Reasons

- (3) An interim decision or order need not be accompanied by reasons.

S.O. 1994, c. 27, s. 56.

Time frames

16.2 A tribunal shall establish guidelines setting out the usual time frame for completing proceedings that come before the tribunal and for completing the procedural steps within those proceedings.

S.O. 1999, c. 12, Sched. B, s. 16.

Decision

17. (1) A tribunal shall give its final decision and order, if any, in any proceeding in writing and shall give reasons in writing therefor if requested by a party. R.S.O. 1990, c. S.22, s. 17(1); S.O. 1993, c. 27, Sched.

Interest

(2) A tribunal that makes an order for the payment of money shall set out in the order the principal sum, and if interest is payable, the rate of interest and the date from which it is to be calculated.

R.S.O. 1990, c. S.22, s. 17; S.O. 1993, c. 27, Sched.; S.O. 1994, c. 27, s. 56.

Costs

17.1 (1) Subject to subsection (2), a tribunal may, in the circumstances set out in a rule made under section 25.1, order a party to pay all or part of another party's costs in a proceeding.

Exception

(2) A tribunal shall not make an order to pay costs under this section unless,

- (a) the conduct or course of conduct of a party has been unreasonable, frivolous or vexatious or a party has acted in bad faith; and
- (b) the tribunal has made rules under section 25.1 with respect to the ordering of costs which include the circumstances in which costs may be ordered and the amount of the costs or the manner in which the amount of the costs is to be determined.

Amount of costs

(3) The amount of the costs ordered under this section shall be determined in accordance with the rules made under section 25.1.

Continuance of provisions in other statutes

(4) Despite section 32, nothing in this section shall prevent a tribunal from ordering a party to pay all or part of another party's costs in a proceeding in circumstances other than those set out in, and without complying with, subsections (1) to (3) if the tribunal makes the order in accordance with the provisions of an Act that are in force on the day this section comes into force.

S.O. 1999, c. 12, Sched. B, s. 16.

Notice of decision

18. (1) The tribunal shall send each party who participated in the proceeding, or the party's counsel or agent, a copy of its final decision or order, including the reasons if any have been given,

- (a) by regular lettermail;
- (b) by electronic transmission;
- (c) by telephone transmission of a facsimile; or
- (d) by some other method that allows proof of receipt, if the tribunal's rules made under section 25.1 deal with the matter.

Use of mail

(2) If the copy is sent by regular lettermail, it shall be sent to the most recent addresses known to the tribunal and shall be deemed to be received by the party on the fifth day after the day it is mailed.

Use of electronic or telephone transmission

(3) If the copy is sent by electronic transmission or by telephone transmission of a facsimile, it shall be deemed to be received on the day after it was sent, unless that day is a holiday, in which case the copy shall be deemed to be received on the next day that is not a holiday.

Use of other method

(4) If the copy is sent by a method referred to in clause (1) (d), the tribunal's rules made under section 25.1 govern its deemed day of receipt.

Failure to receive copy

(5) If a party that acts in good faith does not, through absence, accident, illness or other cause beyond the party's control, receive the copy until a later date than the deemed day of receipt, subsection (2), (3) or (4), as the case may be, does not apply.

S.O. 1994, c. 27, s. 56; S.O. 1997, c. 23, s. 13.

Enforcement of orders

19. (1) A certified copy of a tribunal's decision or order in a proceeding may be filed in the Ontario Court (General Division) by the tribunal or by a party and on filing shall be deemed to be an order of that court and is enforceable as such.

Notice of filing

(2) A party who files an order under subsection (1) shall notify the tribunal within 10 days after the filing.

Order for payment of money

(3) On receiving a certified copy of a tribunal's order for the payment of money, the sheriff shall enforce the order as if it were an execution issued by the Ontario Court (General Division).

S.O. 1994, c. 27, s. 56.

Record of proceeding

20. A tribunal shall compile a record of any proceeding in which a hearing has been held which shall include,

- (a) any application, complaint, reference or other document, if any, by which the proceeding was commenced;
 - (b) the notice of any hearing;
 - (c) any interlocutory orders made by the tribunal;
 - (d) all documentary evidence filed with the tribunal, subject to any limitation expressly imposed by any other Act on the extent to or the purposes for which any such documents may be used in evidence in any proceeding;
 - (e) the transcript, if any, of the oral evidence given at the hearing; and
 - (f) the decision of the tribunal and the reasons therefor, where reasons have been given.
- R.S.O. 1990, c. S.22, s. 20.

Adjournments

21. A hearing may be adjourned from time to time by a tribunal of its own motion or where it is shown to the satisfaction of the tribunal that the adjournment is required to permit an adequate hearing to be held.

R.S.O. 1990, c. S.22, s. 21.

Correction of errors

21.1 A tribunal may at any time correct a typographical error, error of calculation or similar error made in its decision or order.

S.O. 1994, c. 27, s. 56.

Power to review

21.2 (1) A tribunal may, if it considers it advisable and if its rules made under section 25.1 deal with the matter, review all or part of its own decision or order, and may confirm, vary, suspend or cancel the decision or order.

Time for review

(2) The review shall take place within a reasonable time after the decision or order is made.

Conflict

(3) In the event of a conflict between this section and any other Act, the other Act prevails. S.O. 1994, c. 27, s. 56; S.O. 1997, c. 23, s. 13.

Administration of oaths

22. A member of a tribunal has power to administer oaths and affirmations for the purpose of any of its proceedings and the tribunal may require evidence before it to be given under oath or affirmation. R.S.O. 1990, c. S.22, s. 22.

Abuse of processes

23.--(1) A tribunal may make such orders or give such directions in proceedings before it as it considers proper to prevent abuse of its processes. R.S.O. 1990, c. S.22, s. 23(1).

Limitation on examination

(2) A tribunal may reasonably limit further examination or cross-examination of a witness where it is satisfied that the examination or cross-examination has been sufficient to disclose fully and fairly all matters relevant to the issues in the proceeding.

Exclusion of agents

(3) A tribunal may exclude from a hearing anyone, other than a barrister and solicitor qualified to practise in Ontario, appearing as an agent on behalf of a party or as an adviser to a witness if it finds that such person is not competent properly to represent or to advise the party or witness or does not understand and comply at the hearing with the duties and responsibilities of an advocate or adviser. R.S.O. 1990, c. S.22, s. 23(3). R.S.O. 1990, c. S.22, s. 23; S.O. 1994, c. 27, s. 56.

Notice, etc.

24.--(1) Where a tribunal is of the opinion that because the parties to any proceeding before it are so numerous or for any other reason, it is impracticable,

- (a) to give notice of the hearing; or
- (b) to send its decision and the material mentioned in section 18,

to all or any of the parties individually, the tribunal may, instead of doing so, cause reasonable notice of the hearing or of its decision to be given to such parties by public advertisement or otherwise as the tribunal may direct.

Contents of notice

(2) A notice of a decision given by a tribunal under clause (1) (b) shall inform the parties of the place where copies of the decision and the reasons therefor, if reasons were given, may be obtained. R.S.O. 1990, c. S.22, s. 24.

Appeal operates as stay, exception

25. (1) An appeal from a decision of a tribunal to a court or other appellate body operates as a stay in the matter unless,

- (a) another Act or a regulation that applies to the proceeding expressly provides to the contrary; or
- (b) the tribunal or the court or other appellate body orders otherwise.

Idem

(2) An application for judicial review under the Judicial Review Procedure Act, or the bringing of proceedings specified in subsection 2 (1) of that Act is not an appeal within the meaning of subsection (1). R.S.O. 1990, c. S.22, s. 25(2). R.S.O. 1990, c. S.22, s. 25; S.O. 1997, c. 23, s. 13.

Control of process

25.0.1 A tribunal has the power to determine its own procedures and practices and may for that purpose,

- (a) make orders with respect to the procedures and practices that apply in any particular proceeding; and
- (b) establish rules under section 25.1.

S.O. 1999, c. 12, Sched. B, s. 16.

Rules

25.1 (1) A tribunal may make rules governing the practice and procedure before it.

Application

(2) The rules may be of general or particular application.

Consistency with Acts

(3) The rules shall be consistent with this Act and with the other Acts to which they relate.

Public access

(4) The tribunal shall make the rules available to the public in English and in French.

Regulations Act

(5) Rules adopted under this section are not regulations as defined in the Regulations Act.

Additional power

(6) The power conferred by this section is in addition to any power to adopt rules that the tribunal may have under another Act. S.O. 1994, c. 27, s. 56.

Regulations

26. The Lieutenant Governor in Council may make regulations prescribing forms for the purpose of section 12. S.O. 1994, c. 27, s. 56.

Rules, etc., available to public

27. A tribunal shall make any rules or guidelines established under this or any other Act. R.S.O. 1990, c. S.22, s. 27; S.O. 1994, c. 27, s. 56; S.O. 1999, c. 12, Sched. B, s. 16.

Substantial compliance

28. Substantial compliance with requirements respecting the content of forms, notices or documents under this Act or any rule made under this or any other Act is sufficient. R.S.O. 1990, c. S.22, s. 28; S.O. 1994, c. 27, s. 56; S.O. 1999, c. 12, Sched. B, s. 16.

29. REPEALED: S.O. 1994, c. 27, s. 56(40), effective April 1, 1995 (O. Gaz. 1995 p. 438).

30. REPEALED: S.O. 1994, c. 27, s. 56(40), effective April 1, 1995 (O. Gaz. 1995 p. 438).

31. REPEALED: S.O. 1994, c. 27, s. 56(40), effective April 1, 1995 (O. Gaz. 1995 p. 438).

Conflict

32. Unless it is expressly provided in any other Act that its provisions and regulations, rules or by-laws made under it apply despite anything in this Act, the provisions of this Act prevail over the provisions of such other Act and over regulations, rules or by-laws made under such other Act which conflict therewith. R.S.O. 1990, c. S.22, s. 32; S.O. 1994, c. 27, s. 56.

33. REPEALED: S.O. 1994, c. 27, s. 56(43), effective April 1, 1995 (O. Gaz. 1995 p. 438).

34. REPEALED: S.O. 1994, c. 27, s. 56(43), effective April 1, 1995 (O. Gaz. 1995 p. 438).

Form 1

REPEALED: S.O. 1994, c. 27, s. 56(44), effective April 1, 1995 (O. Gaz. 1995 p. 438).

Form 2

REPEALED: S.O. 1994, c. 27, s. 56(44), effective April 1, 1995 (O. Gaz. 1995 p. 438).

LEGISLATION IN OTHER JURISDICTIONS RE MEDICAL AUDIT PRACTICE: CITATIONS AND WEB SOURCES

Canada

Alberta

- *Alberta Health Care Insurance Act*, R.S.A. 2000, c. A-20.
<<http://www.canlii.org/ab/laws/sta/a-20/20050110/whole.html>>
- Medical Benefits Regulation, A.R. 173/93.
<<http://www.canlii.org/ab/laws/regu/1993r.173/20050110/whole.html>>

British Columbia

- *Medicare Protection Act*, R.S.B.C. 1996, Chapter 286.
<http://www.qp.gov.bc.ca/statreg/stat/M/96286_01.htm>
- Medical and Health Care Services Regulation, B.C. Reg. 426/97.
<http://www.qp.gov.bc.ca/statreg/reg/M/MedicareProtection/426_97.htm>

Manitoba

- *Health Services Insurance Act*, C.C.S.M., c. H35.
<<http://www.canlii.org/mb/laws/sta/h-35/20050110/whole.html>>
- Medical Services Insurance Regulation, Man. Reg. 49/93.
<<http://www.canlii.org/mb/laws/regu/1993r.49/20050110/whole.html>>

New Brunswick

- *Medical Services Payment Act*, S.N.B. c. M-7.
<<http://www.canlii.org/nb/laws/sta/m-7/20050114/whole.html>>
- Medical Services Payment Act, N.B. Reg. 84-20.
<<http://www.canlii.org/nb/laws/regu/1984r.20/20050114/whole.html>>

Newfoundland

- *Medical Care Insurance Act, 1999*, S.N.L.1999, c. M-5.1.
<<http://www.canlii.org/nl/laws/sta/m-5.1/20050112/whole.html>>
- Medical Care Insurance Beneficiaries and Inquiries Regulations, C.N.L.R. 20/96.
<<http://www.canlii.org/nl/laws/regu/1996r.20/20050112/whole.html>>
- Physicians and Fee Regulations, N.L.R. 69/03.
<<http://www.canlii.org/nl/laws/regu/c2003r.69/20050112/whole.html>>

Nova Scotia

- *Health Services and Insurance Act*, R.S., c. 197, s.1.
<<http://www.canlii.org/ns/laws/sta/r1989c.197/20050110/whole.html>>
- M.S.I. Regulations, N.S. Reg. RI/69.
<<http://www.canlii.org/ns/laws/regu/1969r.41/20050110/whole.html>>

Ontario

- *Health Insurance Act*, R.S.O. 1990, c. H.6.
<<http://www.canlii.org/on/laws/sta/h-6/20050111/whole.html>>
- General, R.R.O. 1990, Reg. 552.
<<http://www.canlii.org/on/laws/regu/1990r.552/20050111/whole.html>>
- Information, O. Reg. 57/97.
<<http://www.canlii.org/on/laws/regu/1997r.57/20050111/whole.html>>
- Number of Members on Committees, O. Reg. 222/94.
<<http://www.canlii.org/on/laws/regu/1994r.222/20050111/whole.html>>

Prince Edward Island

- *Health Services Payment Act*, R.S.P.E.I. 1988, c. H-2.
<<http://www.canlii.org/pe/laws/sta/h-2/20050110/whole.html>>
- General Regulations, P.E.I. Reg. EC453/96.
<<http://www.canlii.org/pe/laws/regu/1996r.453/20050110/whole.html>>

Quebec

- *Health Insurance Act*, R.S.Q. 2000, c. A-29.
<<http://www.canlii.org/qc/laws/sta/a-29/20050111/whole.html>>
- An Act Respecting Administrative Justice, R.S.Q., c- J-3.
<<http://www.canlii.org/qc/laws/sta/j-3/20050111/whole.html>>

Saskatchewan

- *The Saskatchewan Medical Care Insurance Act*, R.S.S. 1978, c. S-29.
<<http://www.canlii.org/sk/laws/sta/s-29/20050113/whole.html>>
- The Medical Care Insurance Peer Review Regulations, c.S-29 Reg. 18.
<<http://www.canlii.org/sk/laws/regu/s-29r.18/20050113/whole.html>>

Yukon

- *Health Care Insurance Plan Act*, R.S.Y. 2002.
<<http://www.canlii.org/yk/laws/sta/107/20041124/whole.html>>

International**Australia**

- *Health Insurance Act 1973*, No. 42, 1974.
<<http://scaleplus.law.gov.au/cgi-bin/download.pl?/scale/data/pasteact/0/114>>

New Zealand

- *Health Act 1956*, (N.Z.) 1956/65.
<http://www.legislation.govt.nz/browse_vw.asp?content-set=pal_statutes>

United States of America

- *Medicare Prescription Drug, Improvement and Modernization Act* (2003) Public Law H.R. 1 108th Congress.
<<http://www.cms.hhs.gov/provders/mr/>> (see Medicare Modernization Act)

REMUNERATION RATES FOR MEMBERS OF PROVINCIAL AUDIT REVIEW BODIES

PROVINCE / TERRITORY	REVIEW BODY	HOURLY	PER DIEM
Alberta	Peer Review Committee		\$650.00 (Chair) \$600.00 (Phys)
British Columbia	Inspectors	\$85.00	
	Audit & Inspection Committee	\$117.21 (Chair) (+\$350 for chairing)	\$820.48 (Phys) \$300.00 (Pub)
	Audit Hearing Panel		\$850.00 (Gov/Chair) \$500.00 (Pub) \$820.48 (BCMA)
Manitoba	Medical Review Committee	\$71.56 (GP) \$91.83 (Spec)	
	Formal Inquiry Committee	\$71.56 (GP) \$91.83 (Spec)	
New Brunswick	Peer Review Committee		\$350.00/\$590.00 ¹ (Chair) \$280.00/\$460.00 (Phys)
Newfoundland	Medical Consultants Committee	\$125.00	
	Audit Review Board	\$125.00	
Nova Scotia	Medical Review Committee	\$104.50 ² (Phys) \$35.00 (Pub)	

¹In-town Chairs receive \$350 per day; out-of-town Chairs receive \$590 per day. In-town members receive \$280; out-of-town members receive \$460. All Committee members are physicians.

PROVINCE / TERRITORY	REVIEW BODY	HOURLY	PER DIEM
Ontario	Medical Review Committee		\$436.00 (Phys) \$363.00 (Pub)
	MRC Inspectors		\$436.00
	HSARB		\$350.00 (Chair) \$250.00 (V-chair)
			\$200.00 (Mem)
	Transitional Physician Audit Panel		\$550.00 (Chair & mem)
Prince Edward Island	Medical Advisory Committee	\$100.00 (Chair) \$75.00 (Mem)	To max of \$600.00 To max. of \$500.00
Quebec	Regie de l'Assurance Maladie du Quebec (RAMQ)	N/A	N/A
Saskatchewan	Joint Medical Professional Review Committee		\$425.00 (Chair) \$325.00 (Phys) Physician members and Chair also receive 2 days prep time
North West Territories	N/A	N/A	N/A
Nunavut	N/A	N/A	N/A
Yukon	N/A	N/A	N/A

² Physician members are paid 50 units per hour of Committee work. Current rate per unit is \$2.09.

01-HIA-0147

HEALTH SERVICES APPEAL AND REVIEW BOARD

P R E S E N T:

Thomas Kelsey, Vice-Chair
Kathleen Osborne, Vice-Chair
Elaine Shin, Member

The 10th, 11th, 12th and 13th days of September, 2002
at Toronto, Ontario

IN THE MATTER OF A HEARING UNDER SECTION 20(3) of the *Health Insurance Act*,
Revised Statutes of Ontario, 1990, Chapter H.6 -

B E T W E E N:

DR. BRIAN DOUGLAS LYTTLE

Appellant

- and -

**THE GENERAL MANAGER,
THE ONTARIO HEALTH INSURANCE PLAN**

Respondent

- and -

**MEDICAL REVIEW COMMITTEE OF THE
COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO**

Respondent

Appearances:

For the Appellant:

Joseph J. Colangelo, Counsel

For the Respondent,

General Manager, OHIP:

John Johnston, Counsel

For the Respondent,

Medical Review Committee:

Donald Posluns, Counsel

FINAL DECISION & REASONS

Summary

This is an appeal by Dr. Brian Lyttle from the final direction of Medical Review Committee of the College of Physicians and Surgeons of Ontario dated August 16, 2001. For the reasons that follow, the Board has granted the appeal.

Background

Dr. Lyttle

Dr. Lyttle is a pediatric respirologist practising in London, Ontario. He is the Director of the Cystic Fibrosis Clinic at Children's Hospital of Western Ontario, Co-Director of the Muscular Dystrophy Clinic and Assisted Ventilation Clinic, and has a private practice in pediatric pulmonology, composed primarily (95%) of asthma patients. Dr. Lyttle is also a part-time Assistant Professor at the University of Western Ontario.

Dr. Lyttle has a specialized and unique medical practice. The number of pediatric respirologists in Canada as a whole is very small, with approximately 30 practising across the country. Dr. Lyttle is one of only ten paediatric respirologists in the province, and the only paediatric respirologist in south-western Ontario. As a result, he draws patients from a very large geographic area. He has what can only be described as a complex and challenging caseload. Many of his patients are chronically ill, and suffer from conditions which require regular follow-up. A significant portion of his practice is very young: approximately 70% of his patients are under the age of 8, and 55% of patients are under age 5.

All other paediatric respirologists in the province are attached to a hospital, meaning that they practise as geographic full-time members of the teaching staff at a university hospital, and are paid under alternate payment plans established by the Ministry of Health and Long-Term Care. Dr. Lyttle, on the other hand, practises in an office setting and bills the Ontario Health Insurance Plan ("OHIP") on a fee-for-service basis.

THE MRC PROCEEDINGS

Dr. Lyttle appeals a decision of the Medical Review Committee ("MRC") of the College of Physicians and Surgeons of Ontario ("CPSO"). The MRC was established under the *Health Insurance Act* as a committee of the CPSO for the purpose of providing peer review of physician billing practices. The MRC is composed of both physicians and public members. When the Ontario Health Insurance Plan ("OHIP") identifies concerns regarding a physician's billing practices, the MRC reviews billing records and interviews the physicians whose billings are under review. The decision to refer a case to the MRC is made by the General Manager of OHIP.

The claims review and audit processes are clearly extremely important to the integrity and sustainability of the Ontario Health Insurance Plan. According to a Ministry witness there are 130 million claims to OHIP each year, including both physician and practitioner claims. These claims amount to approximately \$4 billion annually. He also indicated that claims checks

uncover \$17 million per month in errors alone. Claims are monitored by the Ministry in a number of ways including computer monitoring, verification letters sent to patients, statistical computer analysis, detailed screening of individuals or groups, and detailed screening where information is received from the public, Ministry program areas, OHIP district offices or, in some cases, the Ontario Provincial Police.

The MRC proceedings which give rise to this appeal are described in the written reasons of the MRC panel dated August 16, 2001. We will attempt to briefly summarize the history surrounding those proceedings in the following paragraphs.

By way of letter dated December 12, 1999, the General Manager of OHIP requested that the MRC review Dr. Lyttle's billings for certain insured services. The General Manager expressed concern with Dr. Lyttle's billing practices, noting a large number of claims for General Assessment (Fee Code A473 in the *Schedule of Benefits for Physician Services*). Pursuant to section 39.1(3) of the *Health Insurance Act*, the General Manager requested that the review be performed by a single member of the MRC.

On January 11, 2000, the MRC notified Dr. Lyttle of the request for review of his billings. He was advised that his billings for General Assessments for the period March 1, 1997 through February 28, 1999 were to be reviewed. The reason stated for the review was that Dr. Lyttle's billing profile demonstrated an unusual number of claims for general assessment in contrast to the number of claims he submitted for partial assessment. Dr. Lyttle was invited to attend for an interview, and was asked to bring 100 randomly selected charts containing records of patient encounters for which he had submitted a claim to OHIP for a general assessment during the period under review.

The review was conducted by a single member of the MRC. The MRC member assigned to his case was Dr. C. Morana, a general practitioner. Following the review of Dr. Lyttle's accounts for General Assessment, the MRC directed that Dr. Lyttle be required to repay to OHIP the difference between the amount paid under the Plan for General Assessment, and the amount payable for Intermediate Assessment (A007), for 90 percent of the General Assessments provided by him during the period under review. Dr. Morana's direction and reasons were released on January 30, 2001.

On February 15, 2001 Dr. Lyttle requested reconsideration by a full three-member MRC panel, something he is entitled to do under the *Health Insurance Act*. Dr. Lyttle appeared before the MRC panel at the CPSO offices on April 11, 2001. The three-member panel assigned to consider the matter consisted of two general practitioners (Dr. S. Felsen and Dr. P. Noble) and a public member (Ms. M. Hogarth). The panel considered a number of documents and materials filed by the parties, including 95 of the patient records that had been selected randomly for review (the remaining services were rendered in hospital and were therefore recorded in the patients' hospital charts). The Committee also considered Dr. Lyttle's explanations of his procedures for recording patient encounters, and considered submissions on the nature of his practice and the unique patient population he served.

The direction and reasons of the MRC panel were released on August 16, 2001. In its decision, the Committee focused on the nature of the examinations conducted by Dr. Lyttle. The Committee took the position that in order to bill a general assessment, the physician must take a

full history and make an enquiry into *all parts and systems*. [emphasis added] In the view of the panel, many of the records reviewed did not provide evidence of an investigation into all parts and systems; the services were therefore not properly represented as general assessments. The Committee also found that in several instances Dr. Lyttle's documentation for general assessments fell below accepted professional standards.

The MRC panel wrote the following in its reasons:

. . . We listened carefully to Dr. Lyttle's explanation of his procedures for recording such patient encounters. This information did not persuade us that Dr. Lyttle routinely carried out an investigation into all parts and systems such as would be accurately represented by an account for a general assessment (A473). Dr. Lyttle's description of the services he provided many of his patients, and the content of the form presented appeared to us to be characteristic of a much more focussed examination of the respiratory system such as would be most accurately represented by an account to the Plan for an intermediate assessment (A007).

In our review of the material furnished by OHIP in conjunction with this referral, we were also concerned that in many instances a patient would be seen and a consultation (A475), provided by Dr. Lyttle, with a general assessment (A473) following a short time later. . . . In our opinion, the information acquired in the initial consultation would have provided Dr. Lyttle with sufficient information for his patient database that on subsequent visits within a short time the taking of a full history such as would be included in a services represented as a general assessment (A473) would be medically unnecessary. While we, as a Committee, were prepared to accept that many of Dr. Lyttle's patients were chronically ill, we were not convinced that his service to them had included the taking of a full history on each occasion where a general assessment (A473) was billed.

. . . . Eighty-five or 89 percent of the 95 records reviewed, and Dr. Lyttle's description of the encounters which he had represented to the Plan by an account for general assessment (A473) portrayed examinations that while thorough in addressing the presenting complaints, did not include an investigation into all parts and systems. The additional submissions made by counsel, while helpful to the Committee in understanding the nature of Dr. Lyttle's practice, also did not persuade us that the services to the majority of patients whose records were selected for review were accurately represented as general assessments (A473). Given that Dr. Lyttle submitted his accounts as a respirologist, if we were to restrict our direction to those billing codes available to respirologists, we would direct that a portion of his accounts be reduced to the amount payable for partial assessments (A478). Dr. Lyttle's practice is primarily composed of children under eight years of age, and it was apparent to us that Dr. Lyttle spent time with his patients conducting a focussed examination relevant to the presenting complaint. We are therefore inclined to direct that Dr. Lyttle retain payment for these accounts in the amount equivalent to that which would be paid for an intermediate assessment (A007), as it is our conclusion that this would be the most accurate representation of 89 percent of the services under review. . . .

. . Since the 95 charts were randomly selected, the Committee concludes that we have reasonable grounds to believe that approximately 89 percent of the services for which Dr. Lyttle billed the Plan for general assessment (A43), would have been more accurately

represented by a billing for intermediate assessment (A007), in that Dr. Lyttle's records and explanations of the services rendered did not establish for the Committee that a complete physical examination of all parts and systems had been done. . .

It is also our conclusion having reviewed Dr. Lyttle's records for general assessment (A473) that in several instances, his documentation of this service fell below accepted professional standards. In the majority of the instances where we were prepared to accept that the nature of the service provided had been accurately represented in Dr. Lyttle's accounts to the Plan, we found that the documentation lacked some of the information that one would expect to see recorded for a service which requires a full history and an examination of all body parts and systems. In eight, or eight percent of the records reviewed, Dr. Lyttle had failed to record an adequate amount of detail to adequately inform with respect to the history and functional enquiry. . .

The basis of the MRC's direction is set out in an addendum to the decision. The information in this addendum indicates that:

- services recorded in 85 of the charts examined were misrepresented as General Assessments and were, instead, characteristic of Intermediate Assessments; and
- services recorded in eight of the charts were not performed to standard for General Assessment with respect to documentation.

In its decision, the Medical Review Committee of the College of Physicians and Surgeons of Ontario directed the General Manager of OHIP to require Dr. Lyttle to repay:

1(a) The difference between the amount paid under the Plan for general assessment (A473), and the amount payable for intermediate assessment (A007), for 85 percent of the general assessments (A473), provided by him between March 1, 1997 and February 28, 1999.

(b) 5 percent of the payment made under the Plan for 5 percent of the general assessments (A473), provided by him between March 1, 1997 and February 28, 1999.

The amount paid for a general assessment during the relevant time period was \$53.60 and the amount paid for an intermediate assessment was \$24.80.

Dr. Lyttle appeals the decision of the three-member MRC panel dated August 16, 2001 to this Board.

Law

Under section 17(1) of the *Health Insurance Act* ("the Act"), physicians must prepare accounts for their insured services in the form and manner prescribed by the General Manager of OHIP. Accounts must meet the requirements prescribed by regulation. Section 17.3 of the Act provides that the basic fee payable to a physician for an insured service is the amount set out in the regulation. The amount may differ for different classes of physician. Fees for physician services are set out in the *Schedule of Benefits for Physicians Services under the Health Insurance Act*

(“Schedule of Benefits”). The Schedule of Benefits identifies the maximum amounts prescribed as payable under the *Health Insurance Act* for insured services rendered by physicians.

The services at issue in this appeal were billed as General Assessments, and were contained in the section of the Schedule of Benefits dealing with Respiratory Disease (Fee Code A 473). The definition or descriptor for General Assessment is set out in the General Preamble to the Schedule of Benefits. This definition was amended during the two-year period for which the Appellant’s accounts were reviewed. The descriptors for General Assessment read as follows:

Effective October 1, 1991 until March 31, 1998

General Assessment: includes a full history, an enquiry into and an examination of all parts or systems (and may include a detailed examination of one or more parts or systems). Under the heading of “Family Practice and Practice in General”, a general assessment may be billed for the Annual Health examination of an adult or adolescent patient (Use diagnostic code 917 for Annual Health exam.)

Benefits for general assessments are limited to one per year per patient by any one physician except if the same patient presents again within the year to the same physician with a clearly defined unrelated diagnosis, one additional general assessment may be claimed per year.

In the case of a patient who proceeds directly to hospital, the admitting physician may claim one additional general assessment per year provided 90 days have elapsed since the last general assessment rendered (anywhere) to that patient by the admitting physician.

If the patient does not qualify for a general assessment by the admitting physician, he/she may claim a general re-assessment.

General assessments claimed in excess of these limits will be paid at a lesser assessment fee.

A general assessment is not to be billed for an assessment provided in the patient’s home (see housecall assessment” listing).

Effective April 1, 1998

General Assessment: is a service provided somewhere other than the patient’s home and includes a full history (the elements of which must include a history of the presenting complaint, family medical history, past medical history, social history, and a functional inquiry into all body parts and system) and an examination of all body parts and systems, and may include a detailed examination of one or more parts or systems.

Where more than one general assessment is rendered to a patient by a physician in a year, any additional general assessment rendered by that physician to the same patient in the same year is paid at a lesser assessment fee, except a second general assessment within the same year is payable at the listed fee where either:

- i the patient presents a second time with a clearly defined unrelated diagnosis, or
- ii the patient proceeds directly to a hospital and at least 90 days have elapsed since the date of the last general assessment.

NOTE: Under the Heading of “Family Practice and Practice in General”, a general assessment may be billed for the Annual Health examination of an adult or adolescent patient. (Use diagnostic code 917 for annual health exam.)

We note that the part of the descriptor for General Assessment that is at issue in this appeal was changed from “examination of all parts and systems” to examination of all body parts and systems”, effective April 1, 1998. This change does not affect the underlying issue in this appeal, and was not a factor in the positions or arguments of the parties. For the sake of clarity, in this decision we will refer to the later version when discussing the descriptor for General Assessment (“all body parts and systems”).

Effective June 1, 2000, the descriptors for medical specialist “General Assessment” and “General Re-assessment” fee codes were changed to “Medical Specific Assessment” and “Medical Specific Re-assessment” for listed specialties, including respirology. The descriptions of “Specific Assessment” and “Specific Re-Assessment are set out, in part, in the following paragraphs:

e. Specific Assessment: is a service rendered by a specialist provided somewhere other than the patient’s home and requires a full history of the presenting complaint and detailed examination of the affected part(s), region(s) or system(s) needed to make a diagnosis, and/or exclude disease and/or assess function.

...

f. Specific Re-Assessment: is a service rendered by a specialist and:

- (i) requires a full relevant history and comprehensive physical examination of one or more systems;
- (ii) for those procedures prefixed with a “Z” or marked as Independent Operative Procedure (IOP), this service is the admission assessment by a surgical specialist who has assessed the patient prior to admission in respect of the same illness; and
- (iii) for those patients who have been assessed by a physician and subsequently admitted to hospital for the same illness by the same physician, this service is the admission assessment.

It should be noted, however, that the Specific Assessment and Specific Re-assessment fee codes and descriptors were not in place during the period for which Dr. Lyttle’s billings were reviewed.

Section 18(1) of the *Health Insurance Act* requires that the General Manager determine all issues relating to accounts for insured services and make payments from the Plan that are authorized under the Act. Section 18(2) of the Act allows the General Manager to refuse to pay for a service rendered by a physician or to pay a reduced amount in certain circumstances. That section states:

- 18(2) The General Manager may refuse to pay for a service provided by a physician, practitioner or health facility or may pay a reduced amount in the following circumstances:

1. If the General Manager is of the opinion that all or part of the insured service was not in fact rendered.
2. If the General Manager is of the opinion that the nature of the service is misrepresented, whether deliberately or inadvertently.
3. For a service provided by a physician if the General Manager is of the opinion, after consulting with a physician, that all or part of the services was not medically necessary.
4. For a service provided by a practitioner, if the General Manager is of the opinion, after consulting with a practitioner who is qualified to provide the same service, that all or part of the service was not therapeutically necessary.
5. For a service provided by a health facility if the General Manager is of the opinion, after consulting with a physician or practitioner, that all or part of the service was not medically or therapeutically necessary.
6. If the General Manager is of the opinion that all or part of the service was not provided in accordance with accepted professional standards and practice.
7. In such other circumstances as may be prescribed.

UNDER SECTION 20(1)(3) OF THE ACT, THE AFFECTED PHYSICIAN MAY APPEAL A DIRECTION OF THE MEDICAL REVIEW COMMITTEE TO THE HEALTH SERVICES APPEAL AND REVIEW BOARD. DR. LYTTLE APPEALED THE DECISION OF THE THREE-MEMBER MRC PANEL, DATED AUGUST 16, 2001, TO THIS BOARD.

Issues

The broad issue before the Board in this appeal is whether the General Manager of OHIP is entitled to refuse to pay for services provided by the Appellant, or to pay a reduced amount on the basis that one of the circumstances described in section 18(2) of the Act existed. Specifically:

1. Was all or part of the insured service not rendered?
2. Was the nature of the service misrepresented, whether deliberately or inadvertently?
3. Was all or part of the services not medically necessary?
4. Was all or part of the service not provided in accordance with accepted professional standards and practice?

The Respondents concede that there is no issue with respect to items 1, 3 and 4: the services were rendered, they were medically necessary, and they were provided in accordance with accepted professional standards. Accordingly, the only remaining issue is whether the nature of the services was misrepresented, either deliberately or inadvertently.

In order to answer this question, the Board must determine whether the general assessments billed by the Appellant were rendered in accordance with the provisions of the Schedule of Benefits. In the present case, this requires the board to examine the descriptor for “General Assessment” set out in the Schedule of Benefits. More specifically, the Board must determine whether the descriptor for “General Assessment” requires the Appellant to examine all parts and systems of the patient’s body – including gynaecological and rectal systems – in order to properly bill for a General Assessment (Code A473).

Evidence

Although we heard considerable evidence with respect to Dr. Lyttle's practice, the quality of care he provides, and his conformance to accepted standards relevant to the areas in which he practices, we do not propose to review this evidence in any detail. There is no suggestion that Dr. Lyttle provided inadequate, unnecessary or inappropriate care, or that he did not conform to accepted clinical or practice standards. On the contrary, the evidence before the Board in this appeal suggests that Dr. Lyttle provides first-rate care to his patients. As well, we note that the MRC decision states clearly that the committee was of the opinion that Dr. Lyttle rendered good patient care, and the Respondents conceded during the course of the hearing that Dr. Lyttle practises appropriately, and meets the applicable standards of care. The quality of care provided by Dr. Lyttle, and related issues, are therefore not in dispute in the present appeal.

The key issue that the Board must decide in this case relates to the interpretation of the descriptor for General Assessment that was in place during the period under review. Before proceeding with our analysis of this and related issues, we will review the evidence before the Board in the following key areas:

- the history and development of the Schedule of Benefits for Physician Services;
- changes to the Schedule of Benefits;
- the definition of General Assessment;
- the June 2000 changes to the Schedule of Benefits;
- Dr. Lyttle's examinations/assessments; and
- Dr. Lyttle's OHIP claims.

The History and Development of the Schedule of Benefits for Physician Services

Mr. Peter Fraser, a fact witness called by the Appellant, testified at some length with respect to the history and development of the Schedule of Benefits. Mr. Fraser is a former employee of the Ontario Medical Association. He served in several different capacities during his thirty-three year career with the association, and was the Chief Executive Officer at the time of his retirement in 1994. Among his many roles, he served as Secretary to the OMA's Central Tariff Committee. Mr. Fraser was also actively involved in drafting the Schedule of Fees and the Schedule of Benefits, including the definition of General Assessment. Mr. Fraser testified that he prepared the Schedule of Fees beginning in 1968, and was familiar with the interpretation of the schedule over the years. His experience in this area pre-dated the advent of Medicare and the events that followed Ontario's joining the Federal Medicare program in 1969.

According to Mr. Fraser, the Ontario Medical Association has produced a Schedule of Fees for many years. Prior to the advent of Medicare, the OMA Schedule was utilized by physicians as a guide in billing for their services, and was used by third parties for the payment of claims for medical services. The OMA Fee Schedules were prepared by the OMA Tariff Committee, which was composed of several practicing physicians. This Committee later came to be known as the Central Tariff Committee to distinguish it from the tariff committees established by various OMA clinical sections.

After Ontario entered the federal Medicare scheme in 1969, the Ontario government decided that it would use the OMA's 1969 Schedule of Fees as the basis for payment of physician fees. At that time the government paid physicians 90% of the amounts set out in the OMA Schedule, apparently on the basis that prorating was justified since physicians' administrative costs and bad debts would be reduced as a result of the universal Medicare program.

The OMA produced its next Schedule of Fees in 1971 with the government continuing to reimburse physicians at 90% of the fees contained in the Schedule. After publication of the 1971 Schedule, the Joint Committee on Physicians' Compensation ("JCPC") was created. The JCPC – a committee consisting of three OMA physician representatives, three government representatives and a neutral Chairman – would negotiate the global percentage increase in OHIP payments. The OMA Schedule continued to be used as the basis for those payments.

The global increases in 1976, 1977 and 1978 were negotiated, but apparently were constrained by wage and price controls imposed by the federal government in the fall of 1975. According to Mr. Fraser, the OMA produced a Schedule of Fees in 1978 when these controls were lifted which its members felt more fairly represented the value of physicians' services. The total increase reflected in the 1978 OMA Schedule amounted to 36%, while the global increase for that year was 6%.

The government responded to the increases in the OMA Fee Schedule by producing its own Schedule of Benefits, effective May 1, 1978. The government adopted the preamble, definitions and fee listings contained in the OMA schedule, but assigned different dollar amounts for the fees in the OHIP Schedule of Benefits (for example, a service with a fee of \$100 in the OMA Schedule might have a fee of \$70 in the OHIP Schedule of Benefits). This practice continued for a number of years, with the government essentially replicating the OMA Schedule, with the exception of the fee amounts. In terms of fees, the government continued to assign lower dollar amounts in its Schedule of Benefits.

Changes to the Schedule of Benefits

The Schedule of Benefits is an evolving document which is subject to change on a regular basis. Among other things, new procedures are added, others are deleted, fee amounts are increased or decreased, and specific requirements are changed from time-to-time. Dr. Gary Ollson, Ministry Medical Consultant and Manager of OHIP's Audit and Control Division from 1990 until January 2002, provided a brief overview of the reasons and process for changes to the Schedule of Benefits. According to Dr. Ollson, changes to the Schedule of Benefits can arise in a number of ways, although they are typically initiated by the OMA, or by the Ministry on its own initiative. Dr. Ollson testified that a number of circumstances can give rise to amendments to the Schedule of Benefits. These include:

- removal (or de-listing) of medical services;
- addition of new services;
- modification of services;
- situations where the schedule doesn't reflect current practice; or
- clarification of provisions where they are not fully understood by physicians.

According to Dr. Ollson, where physicians have concerns with the Schedule of Benefits, they are advised to go to the Tariff Committee for their section. Sections then take their recommendations to the OMA's Central Tariff Committee. The Central Tariff Committee adopts appropriate changes into the OMA Schedule and recommends changes to the OHIP Schedule of Benefits. The Physicians Services Committee – a joint Committee of the Ministry and the OMA – examines any issues relating to the Schedule of Benefits, and makes recommendations to the Ministry. Ultimately, however, the Ministry is not bound by the recommendations of the Physician Services Committee. As part of the review process, any changes that come from the Physician Services Committee or the Central Tariff Committee are reviewed by OHIP's Monitoring and Control Branch to ensure that the changes will be understood and properly applied by physicians and practitioners. Changes to the Schedule must go through a Ministry approval process, and ultimately are subject to the approval of the Lieutenant Governor in Council.

Doctors receive a copy of the Schedule of Benefits when they first register with OHIP. Subsequent amendments to the Schedule of Benefits are set out individually. The Ministry Bulletins which announce and describe amendments to the Schedule of Benefits go to the OMA for review and input, and are issued by the Ministry after completing the Ministry sign-off process. Dr. Ollson described the Bulletins as “policy” and “a communication tool”, and noted that the law is contained in the Schedule of Benefits itself.

The Definition of General Assessment

During the period of time for which Dr. Lyttle's billings were reviewed, the OHIP Schedule of Benefits contained thirteen different numerical codes for General Assessment, including General Assessment codes for twelve medical specialties, as well as a general assessment code for use by general practitioners. The list of codes for general assessment included a unique code for the “Respiratory disease” specialty (A473). It is Dr. Lyttle's billings for this code which gave rise to the MRC proceedings and subsequently led to this appeal. During the relevant time period, the list of general assessment codes was as follows:

Specialty	Code	Description of Code
Family practice and practice in general	A003	General Assessment
Cardiology	A603	General Assessment
Clinical immunology	A623	General Assessment
Gastroenterology	A413	General Assessment
Geriatrics	A073	General Assessment
Haematology	A613	General Assessment
Internal Medicine	A133	General Assessment
Neurology	A183	General Assessment
Paediatrics	A263	General Assessment
Physical medicine and rehabilitation	A313	General Assessment
Radiation oncology	A343	General Assessment
Respiratory disease	A473	General Assessment
Rheumatology	A483	General Assessment

The descriptor for General Assessment contained in the General Preamble to the Schedule of Benefits stated, in part, that a general assessment “includes . . . an examination of all body parts and systems. . . .” John Downing – a litigation lawyer with the London Office of McCarthy Tétrault LLP – represented Dr. Lyttle at both MRC proceedings (the single-member panel on February 12, 2000 and the three-member panel on April 11, 2000). At the hearing before the Health Services Appeal and Review Board, Mr. Downing testified that at the first MRC proceeding he asked Dr. Morano directly whether Dr. Lyttle was required to perform a gynecological and rectal examination of a patient in order to bill for a General Assessment. He stated that Dr. Morano’s response was that it was necessary to perform an examination of each and every body system, including a rectal/gynecological assessment. He testified that when he posed a similar question to the three-member MRC panel, one of the panel members responded by stating: “all systems need to be examined in order to bill for a general assessment.” Dr. Gary Ollson, the sole witness for the Respondent Ministry of Health and Long-Term Care, shared this view. He disagreed with the suggestion that words contained in the description of General Assessment should not be taken literally, and said that there was no question at the Ministry as to what the definition meant. In Dr. Ollson’s view, all systems must be inquired into and examined in order to bill for a General Assessment.

Other witnesses suggested that a more contextual approach should be taken. According to Mr. Fraser, when the OMA produced its Schedule of Fees in 1962, the practice of medicine was quite different from what it is today. At that time, specialists in internal medicine provided services that are now provided more exclusively by sub-specialists in areas such as cardiology, respiratory disease, allergy and immunology, gastroenterology, geriatrics and rheumatology.

Mr. Fraser’s evidence was that the Central Tariff Committee used the term “General Assessment” to describe the major (unreferred) medical assessment provided by general practitioners and all medical specialists except dermatology, anaesthesia and psychiatry. As the medical sub-specialties became recognized by the Royal College of Physicians and Surgeons over the intervening years, the Central Tariff Committee created consultation and visit fee listings for them that were identical to those for internal medicine. He noted that many internists continued to do sub-specialty work without attempting to actually become certified in a sub-specialty. This apparently was one of the justifications for maintaining the listings and fees for internal medicine and its sub-specialties at the same level.

According to Mr. Fraser, while the definition of a General Assessment was and is fairly comprehensive and reflects the more general nature of internal medicine practice of earlier days, the Central Tariff Committee did not feel it was practical to try to write a specific definition of a General Assessment for each of the medical sub-specialties. He testified that it would be difficult to write a specific definition of General Assessment for each specialty and sub-specialty. He also testified that while sub-specialists would not likely examine all body parts and systems when doing a General Assessment, they would certainly do a more thorough examination of the systems in which they specialize. He noted that these examinations would certainly include a more detailed examination of the affected part(s) and system(s) that brought the patients to the sub-specialists in the first place. In the course of such an examination, the specialist could often spend as much time with the patient as a general internist who was doing a more general examination. Mr. Fraser’s testimony at hearing was consistent with the following passage from his witness statement:

The definition of a general assessment was not intended to capture with precision the concept of what would be appropriate in all circumstances for all time, for all specialties and sub-specialties as they evolved. The idea was to compensate physicians fairly for the time and effort they expended in performing services. The Central Tariff Committee never expected that a specialist in respiratory diseases, for example, would carry out exactly the same physical examination as an internist. Again for illustrative purposes, no one would have expected the specialist in respiratory disease to carry out a pelvic or rectal examination on his patients. In spite of these practical differences in general assessments, the Central Tariff Committee felt that the fees should be the same for internal medicine and its sub-specialties. Much of what was required as part of any general assessment by any specialist or sub-specialist as the profession evolved over time was a matter of common sense as to what would be required by a member of that specialty or sub-specialty in the circumstances.

Mr. Fraser testified that the Schedule reflected the concept of “fair value for time spent”. He stated that there was recognition that sub-specialties may spend more time examining even though they do not examine all parts.

Mr. Fraser indicated that for several years he has been called upon to give advice with respect to the interpretation of the Schedule of Benefits. He also stated that he has served as a “friend in court” for many OMA members appearing before the MRC when the General Manager of OHIP had identified unusual billing practices. He noted that while the matter of what services were provided when General Assessments were billed was often an issue, he could say without reservation that he could not ever recall the MRC insisting that a physician had to examine absolutely every part and system in every case to justify charging for a General Assessment.

Mr. Fraser testified that he had drafted both the Schedule of Fees and the Schedule of Benefits, including the descriptor for General Assessment. In response to a question from Appellant’s counsel, Mr. Fraser testified that as a drafter of the definition of General Assessment, he would not expect Dr. Lyttle to do a rectal or gynecological examination on a pediatric patient. Mr. Colangelo then asked, “Did you consider in drafting the definition that a specialist had to examine all systems, including rectal and gynecological?” Mr. Fraser answered, “no.” When asked, “why not?” Mr. Fraser stated that, “common sense dictates that there are situations where a complete examination of all systems is not appropriate.” He testified further that he doesn’t believe that the Central Tariff Committee implicitly or explicitly believed that a specialist would examine all parts or systems.

Darryl Weinkauff, also called as a fact witness called by the Appellant, also spoke to issues of interpretation relating to the Schedule of Benefits generally and General Assessment more specifically. Mr. Weinkauff is the current Chief Operating Officer and Chief Economist of the Ontario Medical Association. He has been employed by the OMA since 1981. Mr. Weinkauff’s duties – which are outlined in a resume filed with the Board – include management and direction of economic research and policy analysis in support of various OMA committees, the association’s Board of Directors, Clinical Sections, and the OMA membership generally. Major areas of responsibility relate to establishing fees for medical services, negotiations, and the evaluation of policy options with respect to various health care issues. At the outset of his testimony, Mr. Weinkauff indicated that he was very familiar with the Schedule of Fees and the

Schedule of Benefits, and that he had developed specific familiarity and expertise with respect to the definition of General Assessment in the course of his work with the OMA.

Mr. Weinkauff testified that prior to the enactment of legislation prohibiting billing for insured services outside of OHIP, the OMA had responsibility for the interpretation of the Schedule of Benefits. From time-to-time, the College of Physicians and Surgeons of Ontario and the Ministry of Health would ask the OMA for a ruling or an interpretation of certain provisions of the Schedule of Benefits. Such interpretation issues were typically the work of the OMA's Central Tariff Committee. Mr. Weinkauff testified that the Central Tariff Committee did not adopt a strict, literal interpretation of General Assessment. To do so, he said, would create an absurd situation of having a code that could not be used by any physician in the province. When queried about how the Central Tariff Committee would have responded to Dr. Lyttle's situation, Mr. Weinkauff testified that failure to perform a rectal/gynecological examination would not disentitle a specialist like Dr. Lyttle from billing a General Assessment. He added that "the Central Tariff Committee has always known common sense had to prevail." Mr. Weinkauff's testimony on this point closely tracked comments contained in his witness statement. In that statement he wrote the following:

In the case of Dr. Brian Lyttle, if an issue had been raised as to whether he was appropriately billing for general assessments in the circumstances described in the charts reviewed by the Medical Review Committee, the Central Tariff Committee would have considered whether Dr. Lyttle was performing an appropriate service within the scope of his specialty and was performing an appropriate general assessment. It was never intended that the wording of general assessment as contained in the Schedule of Benefits would be interpreted literally. It had to be recognized that some discretion was to be permitted and that what constituted a full assessment had to be interpreted in light of the context of the specific specialty in issue.

Mr. Weinkauff also testified with respect to remarks made in a presentation to the Board of Directors at its meeting of December 1 and 2, 1999 by Dr. Ian Crawford, former chair of the MRC. Mr. Weinkauff confirmed that he attended this meeting and was present during Dr. Crawford's presentation. According to Mr. Weinkauff, Dr. Crawford stated that the MRC did not interpret the Schedule of Benefits literally and that on the issue of what constituted a General Assessment, common sense would have to be applied. He testified further that when a member asked whether the MRC interpreted the definition of General Assessment literally and whether the MRC insisted on a full examination of all parts and systems, including a gynecological and rectal examination, Dr. Crawford said, "no, we do not".

Mr. Weinkauff testified that if physicians were strictly required to examine all parts and systems, a specialist would never be entitled to bill the General Assessment codes. Mr. Weinkauff suggested that common sense be applied in interpreting the definition of General Assessment. In his view, the definition does not require examination of all parts and systems regardless of presenting condition and the physician's scope of practice and expertise. He discussed the concept of "breadth vs. depth", noting that it is accepted at the OMA and by physicians generally that the more highly specialized a physician is, the narrower but the more in-depth the examination will be. A general practitioner, on the other hand, will perform a broader, but less in-depth examination to satisfy the requirements for the General Assessment contained in the Schedule of Benefits.

Mr. Weinkauff testified that the definition of General Assessment had been in place since 1969, but that the Medical Review Committee began adopting a strict, literal interpretation of the definition of General Assessment only in 1999 and 2000. When asked under cross-examination why changes were not made to the definition earlier, he said “because no one expected the Schedule to be interpreted literally.” He noted that he was in disbelief when the MRC took a literal interpretation of the definition, and that in his opinion it is a mistake to interpret words literally.

Mr. Weinkauff was aware that a number of specialty groups had approached the board and others in the OMA with concerns that the MRC was misinterpreting the Schedule of Benefits. He noted that there was a feeling amongst specialists that they were being treated unfairly. As a result of these concerns, negotiations took place between the OMA and the Ministry in an effort to address the issue. According to Mr. Weinkauff, these discussions resulted in the changes to the Schedule of Benefits reflected in OHIP Bulletin 4354, dated June 15, 2000.

Dr. Ollson also spoke to the changes reflected in Bulletin 4354. In his role as Manager of Monitoring and Control, Dr. Ollson served as a key representative to the Ministry of Health’s Schedule of Benefits Working Group. He testified that he was tasked personally with coming up with a solution to the General Assessment issue that was raised by the OMA. He stated that the issue was that for certain medical specialties, the fee paid for Partial Assessment didn’t adequately remunerate some physicians. Due to the complexity of patient problems and the comprehensive and complex follow-up required for some patients, over time the Partial Assessment did not adequately compensate the physician for these patients. As well, he noted that the General Assessment code could not be used for follow-up assessments. Dr. Ollson testified that he put forth a recommendation that an additional assessment be added to the Schedule.

The June 2000 Changes to the Schedule of Benefits

The Schedule of Benefits was amended on June 1, 2000 to provide new codes for 12 groups of specialists called “Medical Specific Assessment” and “Medical Specific Re-Assessment”. On June 15, 2000, OHIP sent a Bulletin to physicians, hospitals, clinics and laboratories to notify them of the changes to the Schedule of Benefits (Bulletin 4354). Because the changes to the Schedule were central to the Appellant’s case, the contents of that Bulletin are reproduced, in full, below:

Bulletin Number 4354	June 15, 2000
Distribution:	Physicians, Hospitals, Clinics, and Laboratories
Subject:	Physician Schedule of Benefits: Medical Specific Assessments and Re-Assessments

The Ministry of Health and Long-Term Care and the Ontario Medical Association have accepted recommendations from the Physician Services Committee to revise descriptors for the existing medical specialist “General Assessment” and “General Re-assessment” fee codes. Effective June 1, 2000, the descriptors for these fee codes will be changed to “Medical Specific Assessment” and “Medical Specific Re-assessment” for the specialties

listed below and reflect accepted standards of practice for these particular medical specialists. The amounts payable for the affected fee codes are unchanged.

The required specific elements that apply to the revised fee codes are changed from those for General Assessment and Re-assessment, General Preamble B.4 (a & b), to those for “specific Assessment” and “Specific Re-assessment, General Preamble B.4 (e & f), is revised to reflect this change.

The amounts payable and limits for Medical Specific Re-assessments remain the same as for the former General Assessments and General Re-assessments. The General Preamble B.4 (3 & f) is revised to reflect this.

Fee code descriptors, amounts payable and limits for existing Specific Assessments and Re-assessments for surgical and other specialist groups are unchanged.

Fee code descriptors, amounts payable and limits for exiting Specific Assessments and Re-assessments for surgical and other specialist groups are unchanged.

Fee code descriptors for General Assessment and General Re-assessment fee codes are changed to Medical Specific Assessment and Medical Specific Assessment for the following medical specialist groups:

Cardiology	Immunology	Gastroenterology
Geriatrics	Haematology	Internal Medicine
Occupational Medicine	Neurology	Physical Medicine
Radiation Oncology	Respirology	Rheumatology

The evidence before the Board – including the evidence of Dr. Ollson and documentary evidence filed with the Board in this appeal – confirms that the changes to the Schedule of Benefits eliminated General Assessment as a service for the listed specialist groups and created a new Medical Specific Assessment code for these groups. The new Medical Specific Assessment code had a new descriptor – one which differed in key respects from the General Assessment descriptor – but both the alpha-numeric designation and amounts payable were not changed, and remained as they were for the General Assessment code previously available to the listed specialist groups.

The most significant change to the descriptor for the Medical Specific Assessment in the context of this appeal is the description of the requirements of the physical examination. Unlike the descriptor for the old General Assessment code – which set out a requirement for “an *examination of all body parts and systems*” – the descriptor for the new Medical Specific Assessment requires a full history of the presenting complaint and “a *detailed examination of the affected part(s), region(s) or system(s) needed to make a diagnosis, and/or exclude disease and/or assess function.* [Emphasis added]. The Ministry Bulletin confirmed that the new descriptors “reflect accepted standards of practice for these particular medical specialists.”

Dr. Lyttle's examinations/assessments

Dr. Lyttle has what is referred to as a sub-specialist practice in pediatric respiratory. This type of sub-specialty practice was described as a referral-based practice, meaning that there is an assumption that patients will have had an annual physical from their primary care provider (usually a family doctor or general practitioner). Dr. Lyttle's practice was characterized as a low-volume practice as he sees an average of only sixteen patients per day. The MRC decision describes these as atypical pediatric or respiratory cases requiring longer appointments, histories and examinations.

During his testimony, Dr. Lyttle provided an overview of "typical" patient encounters for both cystic fibrosis ("CF") and asthma patients, and described the nature and scope of examination and treatment for each of these patient groups. He indicated that while the approach is very age-dependent, he would look at a number of body parts and systems in a CF exam, including fingers, neck, ears, nose, chest, cardiovascular system and abdomen. He would also examine various areas of the body for eczema. He noted that he would be looking at the same systems for asthma patients. Dr. Lyttle also reviewed the charts of one CF patient and one asthma patient, and described the nature and scope of services that he provided in each case.

Under cross-examination, Dr. Lyttle readily conceded that he did not do comprehensive examinations of all body parts and systems. Instead, he noted that he examined all *relevant* body parts and systems. He noted that this is a common practice and that even General Practitioners tailor their examinations to the presenting complaint. In response to the question "are GPs examining all functions and systems?" Dr. Lyttle stated, "No. No one is doing all of that."

Dr. Lyttle testified that it was not appropriate to do a rectal or gynecological examination on asthma patients, because there is no disease where the pulmonary system interacts with gynecological function. Similarly, he would not perform such examinations on CF patients. He testified that his examinations are consistent with accepted guidelines for CF and asthma and further, that the guidelines for each of these diseases do not require routine rectal or gynecological exams. Dr. Lyttle also stated that performance of a rectal or gynecological exam for both CF and asthma patients is "inappropriate, medically unnecessary and futile." He also noted that he would be open to sexual abuse charges if he did one of these exams on an asthma or CF patient. He testified that in the context of the MRC proceedings he was told that it didn't matter if rectal or gynecological exams were relevant or appropriate: that was what was required if he used the General Assessment fee code.

Dr. Thomas Kovesi, also a pediatric respirologist, expressed similar views in his testimony with respect to the nature of sub-specialty practice and the appropriateness of a pediatric respirologist performing rectal or gynecological exams. Dr. Kovesi is an Associate Professor of Pediatrics at the University of Ottawa, and has practiced as a pediatric respirologist at the Children's Hospital of Eastern Ontario (CHEO) since 1992. He is Co-Director of the Cystic Fibrosis Clinic and Director of the Bronchopulmonary Dysplasia Clinic at CHEO.

Dr. Kovesi noted that Dr. Lyttle occupies a unique position among pediatric respirologists in Canada, as he is in private practice, as well as working within a teaching hospital. In his view this makes it not merely difficult, but impossible, to find a true peer for Dr. Lyttle. Dr. Kovesi

described the nature of practice in the sub-specialty of pediatric respirology, and described the nature and elements of an initial assessment, as well as repeat visits. He noted that the types of assessments performed by Dr. Lyttle are “detailed, comprehensive and time-consuming.” He testified that there is no reason to do a complete history and examination of all parts and systems, since that is the job of the community physician. He also noted that the general practitioner asks him, as a pediatric respirologist, to focus on a specific system. In Dr. Kovesi’s view, a complete history and examination of all body parts and systems would be “duplicating service”, “redundant”, “a waste of time”, and would “lengthen wait lists”.

Dr. Kovesi made a number of general comments during his testimony with respect to the issue of appropriateness of rectal or gynecological exams. First, he noted that a pediatric respirologist is concerned with diseases of the respiratory system. He stated that rectal or gynecological exams are not appropriate for asthma patients, and that CF might warrant a rectal exam, but only in very limited clinical circumstances. Dr. Kovesi testified that unnecessary examination of a sexually sensitive area would be inappropriate and upsetting for the child. He stated further that performance of such an exam where unnecessary could be grounds for sexual misconduct.

In his testimony, Dr. Kovesi explored the issues surrounding examination of various body parts and systems in the context of the practice of pediatric respirology in some detail. His testimony on these issues was consistent with the following passage from his witness statement:

In the case of pediatric respirology, there are a number of body parts and systems where examination by the consultant would be unnecessary and inappropriate. There are no pediatric respiratory conditions complicated by abnormalities in the appearance or structure of the female genital tract, and examination of the female genital tract in a girl would be inappropriate. Only a few rare, genetic diseases are associated with lung disease and abnormalities in the appearance or structure of the male genital tract. Such conditions would include Noonan Syndrome and Smith-Lemli-Opitz Syndrome. Routine evaluation of this body system in the child with respiratory symptoms would therefore also be unnecessary. There are also no convincing indications for routine examination of anus and rectum in the child with respiratory disease . . . Similarly, I can think of virtually no situation where breast examination would be indicated in a child with pulmonary findings. Even in the child with pulmonary nodule(s) of uncertain etiology, metastasis breast cancer is so exceptionally rare that breast examination would virtually never be performed. In addition, given the traumatic nature of these examinations in the young child or younger adolescent, such examinations would also be inappropriate. Breast examination of a child where such evaluation is irrelevant to the child’s complaints has been grounds for criminal prosecution. . . and would presumably meet the College of Physicians and Surgeons of Ontario’s criteria for Professional Misconduct.

Dr. Lyttle’s Claims to OHIP

The General Assessment code that is at issue in this appeal is just one of many billing codes contained in the Schedule of Benefits. Physicians are not free, however, to bill for any and all of the codes contained in the Schedule. Among other things, physicians face certain restrictions or limitations based on their area of practice. This is the case for Dr. Lyttle who testified that while he is a pediatric respirologist he was prohibited by OHIP from billing as a pediatrician and was required, instead, to use the code(s) for Respirology. Billing as a respirologist, Dr. Lyttle had a

limited number of codes available to him when he performed patient assessments. The only assessment codes available to Dr. Lyttle were the General Assessment (Code A473) at \$53.60, the General Re-Assessment (A474) at \$38.65, and the Partial Assessment (Code A478) at \$23.10. Dr. Lyttle was unable to bill for an Intermediate Assessment, a code which was available to some physician groups. Dr. Ollson spoke to the gap in billing codes for specialists in the course of his testimony. He noted that the fee for a General Assessment is set around \$50, the fee for a partial assessment is about \$20, and that for most specialties (with the exception of surgical specialists), “there is nothing in between.”

Unlike the descriptor for General Assessment – which stated that a General Assessment includes enquiry into and examination of all body parts and system – the descriptor for the Intermediate Assessment that was in place during the time period relevant to this appeal provided that the Intermediate Assessment, “includes a history of the presenting complaint(s), enquiry concerning and examination of the affected part(s), region(s), or system(s) or mental or emotional disorder as needed to make a diagnosis, exclude disease and/or assess function. . .” [emphasis added]

Dr. Lyttle testified that he did not prepare billings for submission to OHIP and that his wife assumed responsibility for this task. Under cross-examination, he agreed that decisions around billing code selection were probably “time-driven” decisions. Dr. Lyttle also stated that he remembered getting the OHIP Bulletin relating to the addition of new fee codes for “Medical Specific Assessment” and “Medical Specific Re-assessment, but could not recall reading the General Preamble to the Schedule of Benefits prior to notification of the MRC audit. He noted that after receiving the Bulletin, he would bill for a Medical-Specific assessment in cases where he previously would have billed for a General Assessment. He testified that when billing for the Medical-Specific Assessment he would not do anything different than when he billed for a General Assessment during the pre-bulletin period.

Discussion and Analysis

In my view, counsel for the Respondent correctly stated that Dr. Lyttle’s claims were subject to four criteria:

1. Were the insured services rendered?
2. Were the services medically necessary?
3. Were the services misrepresented deliberately or inadvertently?
4. Were the services provided in accordance with accepted medical standards?

As noted earlier in this decision, the Respondent conceded that Dr. Lyttle met the first, second and fourth criteria. The only remaining issue is whether Dr. Lyttle misrepresented the nature of services, either deliberately or inadvertently, when he submitted the claims for General Assessment.

In this case, to determine whether the services were misrepresented the Board must examine the descriptor for General Assessment contained in the Preamble to the Schedule of Benefits, and determine whether Dr. Lyttle’s assessments conformed to the requirements set out in the Schedule. More specifically, we must determine whether the descriptor should be interpreted literally so as to require that Dr. Lyttle examine all parts and systems, including gynecological and rectal systems, in order to bill for a General Assessment.

The Positions of the Parties

The Respondents submit that the services in issue were incorrectly represented as General Assessments. Their position is quite straightforward. Essentially, they argue that the descriptor for General Assessment contained in the General Preamble to the Schedule of Benefits should be given its plain meaning. The Respondents argue that one should only explore other rules of statutory interpretation if the meaning of a provision is ambiguous. They argue that this is not the case here since, in their view, the descriptor is clear and unambiguous when it states that a General Assessment includes a full history and an examination of all body parts and systems. They argue that “all body parts and systems”, means *all*, not *some*, and would therefore include gynecological and rectal examinations.

The Respondents specifically rejected any suggestion that they were advocating that Dr. Lyttle perform medically unnecessary or inappropriate examinations on his young patients. They explained that OHIP and the MRC were not trying to tell Dr. Lyttle how to practice (*i.e.* they were not suggesting that Dr. Lyttle should be performing inappropriate rectal and gynecological examinations so that he could fulfill the requirements for billing general assessments). They noted that clinical decisions are to be made separately (and prior to) fee code selection decisions. A physician makes appropriate inquiries, performs the appropriate examination or assessment based on the patient’s circumstances and presenting complaint, and renders appropriate and medically necessary treatment, where required. Selection of the appropriate fee code is made after-the-fact based on services rendered, and is not intended to guide the clinical decision-making process. In the Respondents’ view, while Dr. Lyttle provided medically necessary and appropriate care to his patients, he was not entitled to bill for General Assessments where he had not examined all body parts and systems (including gynecological and rectal systems).

The Respondents urged the Board to follow *Moniz*, a 1995 decision of this Board (*Moniz and The General Manager of the Ontario Health Insurance Plan and the Medical Review Committee of the College of Physicians and Surgeons of Ontario*, February 13, 1995). The main issue in that appeal turned on the interpretation of the definition of General Assessment and General Re-Assessment.

The Appellant submits that the final direction of the MRC wrongly interpreted the Schedule of Benefits as requiring a respirologist to examine literally all parts and systems of the body in order to appropriately bill for a General Assessment (Code A473). Although Appellant’s counsel advanced arguments which were broadly categorized under three headings – (1) statutory interpretation, (2) effect of June 1, 2000 amendments, including duty to reduce or mitigate the penalty or forfeiture in accordance with section 14(2)(d) of the *Interpretation Act* and (3) consistency with parent legislation – we propose to deal primarily with the statutory interpretation arguments advanced by the Appellant.

The Appellant’s position is that the descriptor should not be interpreted very literally as requiring examination of all body parts and systems, including gynecological and rectal systems. The Appellant argued that the practical result of such an interpretation would be absurd. He submitted that if the Respondents’ very literal interpretation were adopted, it would render the General Assessment code essentially unusable by specialists, since most specialists would never examine literally all body parts and systems in the course of a patient assessment. He argued that this

could not have been intended, since the availability of billing codes for “General Assessment” for physicians in the listed specialty groups attests to the fact that they could bill OHIP for General Assessments. He argued that the Respondents’ interpretation suggests that the drafters of the Schedule never intended that the General Assessment code would be used by a specialist even though they specified twelve discrete General Assessment codes for the listed specialist groups. He rejected the consequences of the literal interpretation advanced by the Respondents as absurd.

The Appellant’s position is that the ordinary meaning of a statute should not be adhered to where such application would lead to an absurdity, and that the grammatical and ordinary sense of the words should be modified to avoid absurdity. Counsel for the Appellant submits that the meaning of the provision in question should be determined in its total context having regard to the purpose of the legislation, the consequences of a proposed interpretation, the presumptions and special rules of interpretation, as well as admissible external aids. He submits that the intent of the drafters of the definition of “General Assessment” was to require such examination of the body as was appropriate and applicable to the particular specialty in the circumstances.

Analysis

During the time period relevant to this appeal, the Schedule of Benefits contained different alpha-numeric codes for General Assessment for various specialty groups, as well as a code for use by general practitioners. In contrast to the 13 practice-specific General Assessment alpha-numeric codes, the General Preamble contained a single definition of “General Assessment”, applicable to all physicians billing for General Assessment. The Board heard that this definition is well-suited to general practitioners who tend to perform a more cursory examination of all body systems during the course of an annual health examination. Counsel for the Appellant argued, however, that when applying the definition to specialists, it must be interpreted in a manner that reflects the type of assessment and examination conducted by a specialist. Counsel argued that the intent of the drafters of the definition of “General Assessment” was to require such examination of the body as was appropriate and applicable to the particular specialty in the circumstances (“all *relevant* body parts and systems”).

We accept the evidence of Dr. Lyttle and Dr. Kovesi with respect to the ordinary nature and scope of specialty practice. It is clear from their evidence that a specialist performs a physical examination within the bounds of his or her specialty. Dr. Lyttle, for example, would focus on systems falling within the realm of respirology. While he admitted that he would not examine all body parts and systems, the evidence indicates that he would conduct a much more detailed examination of select systems than would a general practitioner. This notion was captured neatly by Mr. Weinkauf in his discussion of the “breadth versus depth” concept.

The evidence also clearly indicates that there are certain systems which a specialist does not (and should not) examine because it would be inappropriate given the nature of his or her practice. The Board heard that it would be inappropriate for a respirologist, such as Dr. Lyttle, to perform a gynecological examination on any patient. Similarly, the Board heard that there would be certain systems that other specialists – such as cardiologists or neurologists – would never examine. The practical effect of this is that Dr. Lyttle and many other specialists would never be able to bill for a General Assessment if the more literal interpretation proposed by the Respondents were adopted. We find this very literal interpretation problematic when viewed in the context of a

specialty practice such as Dr. Lyttle's, and are of the view that the result of such an interpretation cannot be supported on the evidence before us.

It is well established that the ordinary meaning of a statute should not be adhered to where such application would lead to an absurdity. If an absurdity would result, the grammatical and ordinary sense of the words may be modified so as to avoid that absurdity. The current view of a court's jurisdiction to avoid absurdity is described succinctly in R. Sullivan, ed., *Driedger on the Construction of Statutes*, 3rd ed. (Toronto: Butterworths 1994) at p. 85: [hereafter "*Driedger*"]

It is now well established that the consequences of applying legislation may be taken into account in every case, and to avoid absurd or unacceptable consequences, the ordinary meaning may be rejected even if it is "plain". There is only one limitation on the court's jurisdiction to avoid absurdity: the interpretation adopted must be one that the words are reasonably capable of bearing.

The author goes on to quote the following passage from the Supreme Court of Canada's judgment in *Beradinelli v. Ontario Housing Corp.* (1978), 90 D.L.R. (3d) 481, at 495 (S.C.C.):

Where one interpretation can be placed upon a statutory provision which would bring about a more workable and practical result, such an interpretation should be preferred if the words invoked by the Legislature can reasonably bear it.

If we accept the interpretation urged for by the Respondents, most specialists would for all practical purposes never be able to bill for a General Assessment, even though the Schedule of Benefits provided separate and specific General Assessment billing codes for each of the listed specialist groups. We are not persuaded that the Lieutenant Governor in Council intended to include in the Schedule of Benefits 12 billing codes which could never be billed by physicians in the 12 listed specialty groups. As noted in *Driedger* at p. 35:

It is presumed that legislation is enacted for a purpose and that each feature in a legislative scheme has some function to fulfill. An interpretation that defeats the purpose of legislation or renders some feature of it pointless or futile is likely to be labelled absurd.

A review of the evidence relating to other billing code options available to Dr. Lyttle during the time period relevant to this appeal also suggests that the definition should be interpreted more broadly. The evidence indicates that Dr. Lyttle had a limited number of codes available to him when he performed patient assessments during the period of time relevant to this appeal. The only assessment codes available to Dr. Lyttle during this period were the General Assessment (Code A473) at \$53.60, the General Re-Assessment (A474) at \$38.65, and the Partial Assessment (Code A478) at \$23.10. Dr. Lyttle was unable to bill for an Intermediate Assessment, a code which was available to some other physician groups, including family physicians. It strikes us as somewhat illogical to think that the drafters of the Schedule would have intended that the most highly specialized physicians in the province would be consistently obliged to use the Partial Assessment code – the lowest-paying of the assessment fee codes – while some other physicians, such as general practitioners, would have available to them the higher-paying Intermediate Assessment code.

Dr. Ollson testified that the Schedule is based on an averaging principle. He used the example of extraction of glass from a patient's foot. He stated that while this procedure might take four seconds in one case, in another it might take 40 minutes. Regardless of time spent, the physician will always get \$14 for this procedure. He indicated that the physician, on average, will get paid what he or she should. It appears, however, that this would not be the case if the Respondents' very literal interpretation were adopted. We have already concluded that most specialists would never be able to bill for a General Assessment if they were strictly required to examine all body parts and systems – including gynecological and rectal systems – in order to bill for a General Assessment. It appears to us that such specialists would not get paid, on average, what they should for conducting patient assessments; instead, they would be regularly and consistently obliged to use the Partial Assessment code, the lowest-paying of all of the assessment codes.

We are also troubled by that part of the MRC direction and reasons which suggests that Dr. Lyttle's assessments would have been most accurately represented by a claim for Intermediate Assessment, given evidence indicating that Dr. Lyttle was unable to use the Intermediate Assessment code. The panel wrote the following in its written reasons:

Dr. Lyttle's description of the services he provided many of his patients, and the content of the form presented appeared to us to be characteristic of a much more focussed examination of the respiratory system such as would be most accurately represented by an account to the Plan for an intermediate assessment (A007).

The MRC briefly acknowledged the fact that the Intermediate Assessment code was not available to Dr. Lyttle, but went on to incorporate that code into its direction for repayment. In its direction the MRC directed the General Manager of OHIP to require Dr. Lyttle to repay:

- 1(a) The difference between the amount paid under the Plan for general assessment (A473), and the amount payable for intermediate assessment (A007), for 85 percent of the general assessments (A473), provided by him between March 1, 1997 and February 28, 1999.
- (b) 5 percent of the payment made under the Plan for 5 percent of the general assessments (A473), provided by him between March 1, 1997 and February 28, 1999.

The committee thus concluded that Dr. Lyttle would more properly have billed for a code for which he was not even permitted to bill, and then went on to use this unbillable code as the basis for its direction for repayment. We find this aspect of the committee's conclusions and directions to be puzzling and somewhat illogical in light of evidence which establishes that the Intermediate Assessment code was not available to Dr. Lyttle.

The June 2000 amendments to the Schedule of Benefits that were announced in Bulletin 4354 also suggest that a broader and more contextual approach be taken to the interpretation of the definition of General Assessment. The changes to the Schedule which were the subject of this Bulletin eliminated General Assessment as a service for the listed medical specialties and created a new Medical Specific Assessment code for these groups. The new Medical Specific Assessment code had a new descriptor, but both the alpha-numeric code and amounts payable

were not changed, and remained as they were for the General Assessment code previously available to the listed specialist groups. Unlike the descriptor for the old General Assessment code – which set out a requirement for “an *examination of all body parts and systems*” – the descriptor for the new Medical Specific Assessment requires a full history of the presenting complaint and “a *detailed examination of the affected part(s), region(s) or system(s) needed to make a diagnosis, and/or exclude disease and/or assess function.* [Emphasis added]. The explanatory paragraph contained in Bulletin 4354 states clearly that the amendments “reflect accepted standards of practice” for the affected medical specialists.

We have reviewed all of the evidence and find that it does not support the very narrow and literal interpretation urged for by the Respondents. The evidence on the history of the Schedule of Benefits, the development and interpretation of the General Assessment code, the nature and scope of Dr. Lyttle’s practice (and specialty practice more generally), and the billing code options available during the relevant time period all suggest that the descriptor should be read in a manner that reflects the realities of medical practice. While not determinative, we are also of the view that the subsequent amendments to the Schedule which were reflected in Bulletin 4354 lend some support to this view. We have considered the Board’s decision in *Moniz* and are satisfied that there are a number of significant differences between that decision and the present case in terms of the factual context, the evidence, and the nature of the legal arguments advanced by counsel for the Appellant in each case. We agree with Appellant’s counsel that the *Moniz* case is distinguishable from the present case on both a factual and legal basis, and note that we are not bound to follow it in any event.

We are of the view that the meaning to be accorded to the words “all body parts and systems” must be consistent with common sense and avoid absurdity when viewed in the context of the realities of medical (especially specialty) practice. In our view, the broader and more contextual interpretation proposed by counsel for the Appellant leads to a result that is more acceptable and appropriate than the very literal interpretation suggested by the Respondents, and can be better justified in terms of its purpose, plausibility, efficacy and acceptability. This is consistent with the contemporary approach to interpretation of statutes which is described in the oft-quoted passage from *Driedger* at p. 132:

There is only one rule in modern interpretation, namely, courts are obliged to determine the meaning of legislation in its total context, having regard to the purpose of the legislation, the consequences of a proposed interpretation, the presumptions and special rules of interpretation, as well as admissible external aids. In other words, the courts must consider and take into account all relevant and admissible indicators of legislative meaning. After taking these into account, the court must then adopt an interpretation that is appropriate. An appropriate interpretation is one that can be justified in terms of (a) its plausibility, that is, its compliance with the legislative text; (b) its efficacy, that is, its promotion of the legislative purpose; and (c) its acceptability, that is, the outcome is reasonable and just.

We are cognisant of the difficulties that the Ministry must face in drafting and applying the Schedule of Benefits to ensure fair and proper payment of physician claims, and can appreciate the Ministry’s desire and need to bring some precision to code requirements, claims submission, and the monitoring, audit and claims review processes. We also want to be clear that we are not suggesting that it is appropriate for physicians to simply adopt a “time-spent” approach to billing.

On the evidence before us, however, we cannot accept the very narrow and literal interpretation proposed by the Respondents, and prefer an interpretation that better reflects the realities of medical practice.

The MRC's direction was based on findings that (a) services recorded in 85 of the charts examined were misrepresented as General Assessments and were, instead, characteristic of Intermediate Assessments; and (b) services recorded in eight of the charts were not performed to standard for General Assessment with respect to documentation. The finding of misrepresentation was based on the very literal interpretation of the descriptor for General Assessment which required examination of all body parts and systems – including gynecological and rectal systems – in order to bill for a General Assessment. Although the documentation issue was not specifically argued at hearing, it would appear from the MRC's written reasons that this finding was also based largely on the same narrow interpretation of descriptor for General Assessment. We were not advised of any particular insufficiency that was not related to the interpretation of General Assessment.

In summary, on the evidence before us we find that the very literal and narrow interpretation of the definition of General Assessment that would require examination of all body parts and systems – including gynecological and rectal systems – is one that cannot be supported. We are of the view that the definition should be read in a manner that reflects the realities of medical (particularly specialty) practice by encompassing some notion of relevant or affected body parts and systems. In light of our findings, we cannot conclude that Dr. Lyttle misrepresented the services as General Assessments, either deliberately or inadvertently. It also follows in the circumstances, that there is no evidence to support a finding that services were not performed to standard with respect to documentation.

Decision

Under section 21.(1.0.1) of the *Health Insurance Act*, the Board may amend a direction of the General Manager or the Medical Review Committee in accordance with the Act and the regulations.

For the reasons we have given, the direction of the MRC panel cannot stand and must be set aside. In its place we would issue a direction ordering the General Manager of OHIP to reimburse the Appellant for any monies collected pursuant to the MRC decision dated August 16, 2001.

Appeal allowed.

DATED at TORONTO this 10th day of July, A.D. 2003.

Kathleen Osborne

Kathleen Osborne, Vice Chair

Thomas Kelsey

Thomas Kelsey, Vice-Chair

Elaine Shin

Elaine Shin, Vice-Chair

Lyttle v. Ontario (Health Insurance Plan, General Manager)

Between
Brian Douglas Lyttle, appellant (respondent on appeal),
and
The General Manager, the Ontario Health Insurance Plan,
respondent (appellant on appeal), and
Medical Review Committee of the College of Physicians
and Surgeons of Ontario, respondent (respondent on
appeal)

[2004] O.J. No. 4575

Court File No. 484/03

Ontario Superior Court of Justice**Divisional Court****Meehan, Ferrier and Pitt JJ.**

Heard: October 25, 2004.

Oral judgment: October 25, 2004. Released: November 2, 2004.
(12 paras.)**Counsel:**

Joseph J. Colangelo, for the Respondent on Appeal

John W.R. Johnston and Lise Favreau, for the General Manager, the Ontario Health Insurance
Plan (Appellant on Appeal)

The judgment of the Court was delivered by

¶ 1 **MEEHAN J.** (orally):— This is an appeal by the General Manager of the Ontario Health Insurance Plan from a decision of the Health Services Appeal and Review Board, dated July 10, 2003, wherein the Board set aside the Direction of the Medical Review Committee of College of Physicians and Surgeons of Ontario, dated August 16, 2001, directing the respondent Doctor, Brian Douglas Lyttle, to reimburse the Ontario Health Insurance Plan for monies he had billed for "General Assessments" in his practice as a paediatric respirologist.

¶ 2 The General Manager seeks upon this appeal, an order setting aside the decision of the Appeal Tribunal and reinstating the MRC's decision.

¶ 3 The standard of review in regard to this decision is based upon the principles set out in *College of Physicians and Surgeons v. Dr. Q.* [2003] 1 S.C.R. 226, and in our opinion, is that of reasonableness. In this case, the Appeal Board heard substantial evidence from the respondent doctor, another respirologist, another witness and as well the drafter of the fee schedule and some

of its definitions. As well, evidence was called on behalf of the Manager, producing a Dr. Olson, who was familiar with billing matters arising from past experience.

¶ 4 At the times in question from March 1, 1997 to February 28, 1999, there was a code for general assessments available to respirologists. The definition of "general assessment" for a portion of that time was originally: "includes a full history, an enquiry into and an examination of all parts or systems (and may include a detailed examination of one or more parts or systems)." The second definition in 1998 was: "includes a full history, the elements of which must include a history of the present complaint, former medical history, past medical history and a functional enquiry into all body parts and an examination of all body parts and systems and may include a detailed examination of one or more parts or systems."

¶ 5 The Medical Review Panel fixed the amounts at the difference between the fee payable for a general assessment and the amount payable for an intermediate assessment for 85% of the matters billed as General Assessment A473 by Dr. Lyttle between the relevant time periods and as well, 5% of the payments made for 5% of the General Assessments A473 billed during that time. We are informed that the amount approximately at issue is approximately \$76,000.00.

¶ 6 The evidence discloses that the Doctor himself could not have billed at the level which was recommended to the Manager by the original Board.

¶ 7 The material upon which the original Board based its decision was a review of a portion of the Doctor's bills and records. He was dissatisfied with the result and appealed the matter to the Appeal Board. That Board found upon the evidence, that the definition of General Assessment did not require a rare paediatric respiratory specialist to do a full bodily assessment and examination as set out in the definition. The evidence, not surprisingly, disclosed that when he dealt with a full general assessment, it related to the portions of his patient's bodies affected by cystic fibrosis and asthma. Namely, those portions of the body relevant to the respiratory system.

¶ 8 No issue was taken at that hearing as to other criteria which might affect the billability by a specialist of this nature for a general assessment.

¶ 9 The Board found that the realities of medical practice, particularly specialty practice encompassed some notion of relevant or affected body parts and systems. In light of those findings, they were unable to conclude that Dr. Lyttle misrepresented the services as general assessments, either deliberately or inadvertently. It also followed in the circumstances that there was no evidence to support a finding that services were not performed to standard with respect to documentation.

¶ 10 It appears upon the evidence that sometime later the Regulations were amended to allow respirologists to bill for medically specific assessments which required a full history, but only in relation to the complaint and an examination of the particularly affected parts.

¶ 11 Considering the nature of the Board, the issues before the Board, the conflicting definitions of general assessment between the MRC and the Board, and the evidence particularly heard by the Board, we are of the view that the decision in the circumstances was reasonable and the appeal will be dismissed.

¶ 12 Costs fixed at \$15,000, including disbursements.

MEEHAN

J.

FERRIER

J.

PITT J.

QL

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