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NEW OHIP AUDIT PROVISIONS - FOR BETTER OR WORSE

Originally published January 8th, 2007. Tremayne-Lloyd, Tracey, "New OHIP Audit Provisions – For Better or Worse." Health Law Group at Gardiner Roberts LLP.

http://www.gardiner-roberts.com/documents/articles/New OHIP 20Audit Provisions - For Better or Worse.pdf

RECENT ANNOUNCEMENT OF THE AMENDMENTS TO THE OHIP AUDIT PROVISIONS REQUIRES MORE THAN A BRIEF STATEMENT SAYING "A NEW FAIR AUDIT SYSTEM PROPOSAL INTRODUCED".

While the legislative amendments may prove to be "fairer" for the Province's physicians than the preceding MRC process, it is too early to make such pronouncements in view of the fact that, while some offensive provisions have been removed, other provisions which could have very serious and dangerous repercussions, have been added.

On balance, while we all hope that the changes will prevent the anxiety, depression and financial hardship our doctors endured under the previous regime, the new system has its own legal hurdles and challenges and needs to be properly understood, accessed and tested by our medical profession before the final verdict is in.

Excellent amendments include:

- Restricting the financial claw-back on any audit to a twelve-month billing period rather than the several years that was typical under the previous regime;
- Removing the threat of public humiliation for administrative errors by taking away the authority to publish the names of physicians being audited to make repayments;
- Removing (at least for your first audit), the practice of extrapolation from a "sampling" of a physician's billing practice to include his or her entire practice over several years;
- Requiring that an audit proceed within a reasonable period of time and not be "sat on" for years before the physician becomes aware of the fact that he or she is under scrutiny. On the other hand, the old saying that one gets "nothing for nothing" is also applicable to amendments.

An overview of the proposed changes reveals the following concerning provisions:

Once the General Manager of OHIP makes an order that a physician should repay money to the Plan, the physician has 20 days to request a hearing before the newly established "Physician Payment Review Board".

The "Hearing" contemplated is to be conducted in accordance with the "Rules of Natural Justice". While we have always advocated for this, you must understand that this means a real trial, with evidence produced to defend your position, testimony given under oath, witnesses potentially being called to support your position, and an official transcript being made of the entire proceedings. Such a "Hearing" must be prepared for well in advance. The theory of your defence must be well established and understood. Reasonable time must be allowed to prepare the physician's defence and to assemble whatever experts or other testimony counsel deems appropriate in the circumstances. In short, preparing for and participating in this hearing will be no small task.

Depending on the extent of the General Manager's Decision and the amount of time involved in the presentation of the case, the "Hearing" can be a lengthy and expensive proposition. When we understand more precisely the manner in which the General Manager will "perform the audit" (which is now unclear, since the inspection process has been repealed), we will be in a better position to provide an outline of the anticipated legal costs for the physician in such a process. The good news is that if you disagree with the Decision of the Review Board, you have an absolute right of appeal to the Divisional Court and the clawback (or collection) will be stayed pending the outcome of that appeal;

The success of your appeal to the Divisional Court is entirely and completely dependent on the job done and the "record" made at the Board below. In other words, how you start is how you finish. On the other hand, the change under "Stay" provisions is significant. Our doctors now have the option (as they did in the years before the recently repealed MRC provisions) of creating legal precedent on these issues and thus preventing the same issue being litigated over and over again with potentially different and inconsistent penalties from physician to physician.

The bad news is the inclusion of a power that did not exist at any of the levels of hearings or appeals that were available under the previous legislative scheme. The Review Board can make orders to suspend a physician's right to submit bills to the Plan (in essence, preventing the continuation of their practice of medicine), in circumstances where:

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i. The physician knew or ought to have known that the claims submitted to the Plan or to insured persons were false; or

ii. The physician has demonstrated a history of submitting claims to the Plan or to insured persons that were not in accordance with the Act whether or not the other claim were subject to an order by the Medical Review Committee, the Appeal Board or the Review Board.

This extremely onerous power is not stayed pending appeals to the Divisional Court. A request for a stay can be applied for, but must be done within 15 days of filing the appeal to Divisional Court. The actual application to obtain the Stay of the Order pending appeal must be made to the Review Board itself. Whether or not we will have a right to ask that the panel hearing be different from the stay application from the one that ordered the suspension in the first place is not clear from the legislation.

This particular provision will also be legally challenging, in that the onus of proving a "history of submitting claims not in accordance with the Act" and who has that onus, will likely be the subject of much legal argument. On the other hand, those physicians who have been the subject of previous orders of the Medical Review Committee or Orders of the previous Health Services Appeal and Review Board will begin the process with a "history", and to what extent this will lead to these very serious suspension Orders will remain to be seen.

Another concern provision in the new review process is one that allows the General Manager to recover from a referring physician fees relating to a service performed by another physician or a health facility, where the General Manager deems the referral not to have been medically necessary. As with other attempts by the General Manager to recover fees, a hearing would have to be held by the Review Board before any recovery could be made. However, if the Review Board finds that a requested service was not medically necessary, then the physician who requested the service will be required to reimburse OHIP in the amount paid to the physician or health facility who performed this service.

Presumably, this section would be applied when a specialist is undergoing a review and OHIP alleges that the service performed by the specialist was not medically necessary. In theory, the specialist could then seek to hold the referring physician responsible for reimbursing OHIP in these circumstances. More likely, however, this section is aimed at physicians who refer patients for "too many" or unnecessary tests and investigations or rehabilitative services. The inclusion of this section in the new audit process serves as a reminder that physicians must document the basis and medical necessity for every referral, as well as every test and investigation he or she requests or orders.

The Health Law Group at Gardiner Roberts will continue to analyze and review the legislation and any regulations created thereunder as they

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are released and will provide further updates and analysis including recommendations for your protection and successful defence in the event that you find yourself the subject of an OHIP audit in the future. If you have any questions about how the new audit regime will impact you, and what you can do to prepare for it, please contact a member of our health law group, found at www.ontariohealthlaw.com.

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