Summary of Physician FFS Post-Payment Audit Process

The Ministry of Health (the ministry) is committed to providing information to assist physicians with appropriate claims submissions in order to receive the payment they are entitled to for the provision of Ontario Health Insurance Plan (OHIP) insured services. The ministry and the Ontario Medical Association (OMA) provide billing education and other supports on the ministry website to assist physicians with questions and with understanding the appropriate fee codes to submit for the services provided.

OHIP payment requirements are set out in the *Health Insurance Act* (HIA) and *Regulation 552* (including the *Schedule of Benefits for Physician Services*). These Acts and regulations are available on the government website. The most recent Schedule of Benefits can also be accessed on the ministry website.

The ministry's post payment review process is governed by various principles designed to ensure procedural fairness, integrity, transparency, and accountability, as required by law, including:

- Impartiality in the selection of physicians for review.
- Staff who are trained in the process of post-payment audit.
- The ability to dispute a General Manager's Opinion at the Health Services Appeal and Review Board (HSARB), meaning that unless there is a voluntary settlement between the physician and the GM, payments can only be recovered following an order of that tribunal.
- The GM of OHIP to demonstrate at HSARB that an order should be made.
- The ability to retain legal representation at any time in the process.
- Privacy and confidentiality maintained throughout the audit process.
- An emphasis on professional and courteous behaviour.
- Timely communication of all relevant information.
- The ability to provide information to the GM throughout the audit process
- The ability to make written or oral submissions at the HSARB.
- The ability to submit a complaint about ministry conduct during audits without fear of reprisal

For ease of reference and to help understand some of the commonly used terminology, a glossary is provided at the end of this document.

To facilitate payment of the high volume of claims submitted, claims are paid on an honour system after being processed through automatic computerized checks which apply payment requirements in accordance with the HIA, Regulation 552 and the Schedule of Benefits. As not all payment rules can be computerized, these initial checks and the resulting payment do not necessarily mean that all payment requirements have been met**.**

Under the authority of Section 18 of the HIA, post-payment reviews of physicians' claims for payment may be performed as a component of measures that contribute to overall accountability for the use of OHIP funds and ensures that payments made by OHIP are authorized by the HIA. Section 18 and Schedule 1 to the HIA describe the ministry's authorities and the process for post-payment review of physician payments read section 18 and Schedule 1 of the HIA. For example, subsection 18(8) of the HIA allows the ministry to refer a post-payment billing review matter to the Health Services Appeal and Review Board if the General Manager of OHIP forms the opinion that one of the following circumstances exists:

1. all or part of the insured service was not in fact rendered;
2. the service was not rendered in accordance with the HIA and the regulations thereto;
3. there is an absence of a record, as described in section 17.4 of the HIA;
4. the nature of the service is misrepresented, whether deliberately or inadvertently;
5. all or part of the service was not medically necessary (after consulting with a physician); or
6. all or part of the service was not provided in accordance with accepted professional standards and practice.

The ministry conducts post-payment reviews of physicians' OHIP claims in accordance with applicable law and policy. The purpose of these reviews is to identify potential billing concerns, to communicate with physicians and to provide billing education to ensure that future claims for payments meet the requirements of the HIA.

There are three main stages of a post-payment review:

1. Initial Action;
2. Full Audit Review; and
3. Board Hearing.

Not all reviews progress through all stages of the process. Negotiation of a settlement can happen at any point in the process.

A diagram and further detail about the procedural steps in the process is included below.

This explanation of the ministry's general process for audit of physician payments is provided so physicians are aware of what to expect if their claims are reviewed and understand the general factors the ministry considers in the post-payment review process. This explanation does not replace the law and processes set out in the HIA. It is important to recognize that all reviews are guided by the factual nature of the audit and that review steps are determined on a case-by-case basis, with consistent and impartial application of the audit process and payment requirements.

Physicians are entitled to seek legal advice and to be represented by legal counsel during this process.

In performing post-payment audit reviews the ministry is committed to educating physicians on appropriate billing. In addition, the ministry will treat physicians professionally, courteously and with respect throughout the process, provide procedural fairness, ensure privacy and confidentiality, and pay providers for the insured services they deliver to patients as required by law. The ministry does not release audit information to the public unless required by law to do so.

Stages of the Post-Payment Audit Process

Claims for payments are to be submitted to the ministry in accordance with the HIA, Regulation 552 and the Schedule of Benefits payment requirements. The ministry's Provider Audit Unit conducts reviews of claims where a potential billing concern arises. A potential billing concern means that payment requirements may not have been met for the claim(s) submitted. Some examples include billing for services which were apparently not rendered, billing for a more complex service when a lesser service appears to have been performed, and billing multiple codes for a service that appears to be described by one fee code. The Provider Audit Unit is staffed with trained individuals who specialize in reviewing OHIP billing claims. The Provider Audit Unit has access to medical consultants who may assist in the review of OHIP claims, and the unit has quality assurance processes to enhance the quality of post-payment audits.

Post-payment audits of physician billings will be conducted in accordance with the following process.

1. Initial Action

Identifying Potential Billing Concerns

Potential billing concerns come to the ministry's attention in a number of ways. Currently, the majority of billing concerns are identified through tips or complaints received from the public, employees in the health care system, or other physicians. The ministry may also become aware of billing concerns through other government program area reviews as well as other organizations and regulatory bodies (such as the College of Physicians and Surgeons of Ontario). Examples of other government program area reviews that could lead to a referral include, the Commitment to the Future of Medicare Act Program identifying a potential OHIP billing concern while performing an investigation related to extra billing, or a ministry program area noting through the course of their work changes in historical billing behavior or volumes (e.g. utilization of a new fee schedule code).

To report suspected cases of abuse, both health care providers and members of the public may call 1-888-781-5556 or send an e-mail to the ministry. Reports can be made anonymously.

No determination with respect to the billings submitted by physicians have been made by the ministry at this stage in the process.

Preliminary Review/Claims Data Review

When a potential billing concern is identified, the Provider Audit Unit conducts an impartial review of the physician's claims history data from the ministry's claims payment system to obtain more information about the concern and understand the physician's practice and whether there is merit to the billing concern.

Based on the findings of the preliminary review of a potential billing concern, the ministry may choose:

- take no further action if no billing concern is identified; or
- contact the physician to provide billing education to improve claim submission accuracy; and/or,
- request that the physician review their own records and correct a payment error if, in the physician's own assessment, a payment error has occurred; or,
- proceed to a full audit if a potentially substantial billing concern is identified; there has been no determination by the ministry with respect to the billings submitted at this point.

As each review is guided by its own facts, the determination that a potentially substantial billing concern exists may vary depending on the circumstances.

2. Full Audit Review

Request for Records and Information

If a potentially substantial billing concern is identified during the Initial Action stage, the ministry will contact the physician in writing to inform them of the existence of the review, provide information about the audit process (including a link to this description of the audit process), and request medical records and other practice information that the physician may have in their possession to support the review. Initial correspondence during this stage will clearly explain the ministry is collecting information about a potential billing concern and that nothing has been decided. This is also one of many opportunities in the process for the physician to provide any information to the ministry that the physician believes the ministry should know in conducting a review of their claims for payment. The information provided by the physician will help the ministry to better understand the services provided and determine the appropriateness of the fee schedule code(s) claimed.

The ministry requests a response from the physician within two weeks to confirm that the requested information will be provided to the ministry and if the timeline for submission of the request is achievable. Reasonable requests for extension will be approved. Refusal to provide records may have serious consequences, including the suspension of payments and/or court action where a judge or justice of the peace may order the physician to provide the records.

In rare circumstances, the ministry may collect records and other information at a physician's office through use of an on-site reviewer. The on-site reviewer is a physician who has received training. Although the use of on-site reviews is exceptional, they can be necessary when, for example, a physician refuses to provide records following multiple requests or acts in a manner that causes the ministry to reasonably question the accuracy of records submitted. The records and information collected through an on-site review are used to continue the audit process.

The Request for Records and Information process is typically completed within 3 to 6 months, dependent on the scope of the records request and the timeliness of response by the physician.

Records Review and Findings

Medical records and other relevant information provided by the physician are reviewed by the Provider Audit Unit to confirm that the fee schedule code(s) billed were appropriate based on the payment requirements in the HIA, Regulation 552, the Schedule of Benefits and, as demonstrated in the medical record, that a medically necessary OHIP insured service was provided. The ministry may seek assistance of external medical experts as part of the process. Once the initial review findings are prepared, the ministry informs the physician in writing and the physician is given an opportunity to provide a written response to the ministry's findings. In addition to the review findings, the physician's submission may assist the ministry further in gaining a better understanding of the physician's billings to OHIP.

The ministry is committed to ensuring all payment requirements are applied consistently.

The Records Review and Findings process is typically completed within 3 to 6 months from the date records and other relevant information are received from the physician.

OHIP General Manager's Opinion

The General Manager's Opinion will describe the outcome of the ministry's audit. The Opinion is formed based on information provided by the Provider Audit Unit including the ministry's claims data and medical records review, as well as all information provided by the physician to the ministry. The ministry will notify the physician of the General Manager's Opinion in writing.

If the ministry is satisfied with the physician's explanation of billing practice and concludes that the claims reviewed were appropriate for the service(s) rendered, the ministry will notify the physician and take no further action. Conversely, if the ministry concludes that inappropriate claims were submitted, the ministry may choose to:

- contact the physician to provide billing education to improve claim submission accuracy and advise the physician that further review of claims may occur; and/or,
- seek to resolve the audit outcome through a settlement with the physician; and/or,
- refer the matter to the Health Services Appeal and Review Board (HSARB) for a hearing.

Formation of the General Manager's Opinion and notification to the physician is typically completed within 1 to 3 months following the Records Review and Findings process.

The ministry endeavors to complete audits as quickly and efficiently as possible, while providing clear, accurate and timely information to physicians. Generally, the entire audit process takes less than 12 months to complete. Note that case specific factors can extend the time needed for any part of the review process. The ministry will be in communication with the physician throughout the process.

3. Board Hearing

If the General Manager (GM) is of the opinion that a circumstance in subsection 18(6) of the HIA exists with respect to payments made to a physician, the GM may refer the matter to the Health Services Appeal and Review Board (HSARB) for a hearing. The HSARB is an independent quasi-judicial adjudicative tribunal with jurisdiction to decide billing audit disputes between the GM and physicians. A review panel will be three members, consisting of one physician and two non-physicians (one of whom must be a lawyer).

HSARB replaced the old Physician Payment Review Board and its processes.

The physician will be notified of matters referred to the HSARB and will have the opportunity to make representations. The Board will conduct a hearing and make an order pursuant to the process set out in Schedule 1 of the HIA, and the Board's Rules of Procedure. Audit information may become public through the HSARB process.

Absent a settlement agreement or voluntarily repayment, the ministry can only recover funds if repayment is ordered by the HSARB.

The HSARB can only order repayment for a period that is no more than 24 months in duration and that commenced no more than five years before the GM's request for a review.

If either party is unsatisfied with the Board's order, that party may appeal the Board's decision to the Ontario Superior Court of Justice – Divisional Court.

Visit the HSARB website for additional information.

Referrals

At any point in the process the ministry may also refer matters to other bodies as appropriate, including:

- the College of Physicians and Surgeons of Ontario (CPSO) for investigation; where the Minister or General Manager is of the opinion that it is advisable to do so for the proper administration of the Regulated Health Professions Act, 1991 or an Act named in Schedule 1 to that Act, the Minister or General Manager is required to disclose information to a College. This would include circumstances, for example, where professional misconduct or patient safety concerns are suspected; and/or,
- other ministry program areas if impacted by the concern identified through the ministry's audit (such as Digital Health); and/or,
- the Ontario Provincial Police (OPP) Health Fraud Investigation Unit for investigation if fraud is suspected.

Glossary

- **General Manager of OHIP (GM)**: Under the HIA the GM is appointed to carry out responsibilities with respect to OHIP, including but not limited to, administration of OHIP, make payments under the Plan, determine eligibility and amounts, establish and maintain branch offices, etc.
  - OHIP INFO-GO

- **General Manager's Opinion**: is a step in the audit process which represents the formal written position of the GM being provided to the physician subject to a post-payment audit. The GM's Opinion is formed based on information provided by the Provider Audit Unit, including the ministry's claims data and findings from the review of medical records provided by the physician, as well as all information provided by the physician to the ministry.

- **Health Insurance Act**: is provincial legislation (including a number of Regulations) that, among other things, gives authority to the GM to administer OHIP in accordance with the law.
  - Regulation 552

Health Services Appeal and Review Board (HSARB): the HSARB is an independent quasi-judicial adjudicative tribunal with jurisdiction to decide billing audit disputes between the OHIP GM and physicians. The HSARB and its processes have replaced the Physician Payment Review Board and its processes.

- HSARB website
- Rules of Procedure

- **Potential Billing Concern**: means that payment requirements for physicians, in the HIA and regulations, including the Schedule of Benefits for Physician Services, may not have been met for the claim(s) submitted.

- **Provider Audit Unit (PAU)**: Provider Audit and Adjudications Unit of the Health Services Branch in the OHIP Division of the Ministry of Health. PAU conducts reviews of selected Health Services Branch funded programs to ensure accountability for the payment of taxpayer funds allotted to OHIP. This includes payments for Physician, Dental, Optometry Services and Independent Health Facilities Services.

Physician Post-Payment Audit Review Process – Combined Ministry Operational and Legislative Parameters [1]

Initial Action

Referral received or Potential Billing Concern identified
(ministry internal process)

Preliminary review / claims data review
(ministry internal process)

or

Billing education letter or other communication and close
(physician letter/interaction)

or

No action and close
(ministry internal process)

or

Request for records and information letter
(physician letter/interaction)

Full Audit Review

Records review
(ministry internal process)

GM Opinion
(ministry internal process)

Formation of GM Opinion

Prepare review findings
(ministry internal process)

Physician provides written submission
(physician letter/interaction)

Inform physician/give opportunity for written submission
(physician letter/interaction)

Review complete/no further steps letter
(physician letter/interaction)

or

Billing education letter and close
(physician letter/interaction)

Billing education letter and seek negotiated settlement
(physician letter/interaction)

or

GM referral to Appeal Board
(HSARB hearing process)

Board Hearing [2]

Written submissions, documentary production, etc.
(HSARB hearing process)

Pre-hearing conference(s)
(HSARB hearing process)

Appeal Board hearing
(HSARB hearing process)

Opportunity for negotiated settlement or clarification and close

Board order[3] – no reimbursement
(HSARB hearing process)

or

Board order[3] reimbursement
(HSARB hearing process)

Potential for judicial review

Repayment plan
(physician letter/interaction)

Ministry internal process

Physician letter / interaction

Health Services Appeal and Review Board (HSARB) hearing process

Refer to the Summary of Physician Fee-For-Service Post-Payment Audit Process within this document for other details.

[1] Process to be applied May 1, 2021 for claims submitted on or after May 1, 2021 and items that were in the audit process prior to the proclamation of Bill 138.

[2] In accordance with HSARB rules.

[3] May also include order for future claims submission in accordance with the order as well as restriction or suspension of entitlement to submit claims etc.

Note: The ministry may also refer cases to the OPP, CPSO, CFMA, other ministry program areas etc. at any point in the process.