3. MONITORING AND CONTROL

3

3. MONITORING AND CONTROL

3.1 Overview

Under the Ontario Health Insurance Plan (OHIP), the General Manager is accountable for fees paid to physicians for services insured under the Plan. The Monitoring and Control section of Provider Services Branch is responsible for monitoring physicians' claims. This includes identifying claims that are incorrect and taking appropriate action depending on the nature of the problem. The authority for this action is found in the *Health Insurance Act* and its regulations (including the Schedule of Benefits).

3.2 Processes

There are several processes involved in the monitoring and control of OHIP claims.

Computer Screening of All OHIP Claims Prior to Payment

All OHIP claims undergo a sophisticated computerized screening process upon submission. Claims are assessed, and the amounts payable are determined. This process may result in refusing to pay claims or paying a reduced amount.

Detection of Improper Claims Post Payment

Improper claims by physicians to OHIP are detected in one of three ways:

- Audit or verification letters sent to subscribers to check on the service and the date that were claimed by a physician
- Various sophisticated computer tools to screen all physician claims
- Complaints or reports from other internal or external sources, including:
    - observations of ministry claims staff and medical consultants
    - reports from other program areas of the ministry
    - specifically requested ad hoc statistical reports
    - complaints from the public, health care providers and health care workers
    - reports from the various professional regulatory bodies
    - inquiries and reports from insurance companies
    - media reports of unusual circumstances concerning providers

3.2 Processes (Continued)

Analysis of Individual Claims Patterns

If a physician has been identified as having submitted questionable claims to OHIP, the claims submission practice of that physician is subjected to a detailed analysis. The analysis is essentially statistical in nature, but considers the data in the context of the physician's apparent medical practice. In the case of physicians, a medical consultant conducts the review because of the complexity of the fee schedule, particularly as it relates to clinical practice.

Identification of Billing Concerns for Province-Wide Analysis

If a billing concern is identified that has not been reviewed before or has not been recently reviewed, in addition to determining the action to take in the initial physician's case, the Monitoring and Control section conducts a detailed analysis of the pattern province-wide. The purpose of this analysis is to determine if the identified concern warrants action only for an individual physician, or if the concern requires action on a larger scale.

Technology

Over the past 5 years, the Monitoring and Control section has upgraded its computer technology. Sophisticated computer query tools now give ministry medical consultants the ability to analyze individual physician's billing patterns as well as that of the province overall at the desktop. In 2003, the ministry is implementing new technology to enhance the ministry's ability to identify billing issues at an early stage.

3.3 Options for Action

Education

In some instances, physicians reviewed by Monitoring and Control require no other action than a direct written communication from a medical consultant, either from head office or the district office, and subsequent follow-up of the claims. In these cases, subsequent claims may be monitored to ensure that change has occurred. In 2001, the ministry formalized its educational activities through the creation of the Provider Education Program. Regular educational initiatives have been undertaken to address a number of pre-determined billing concerns.

3.3 Options for Action (Continued)

Reimbursement of Fees Paid

Section 18 of the Health Insurance Act authorizes the General Manager of OHIP, in specific circumstances, to require a physician to reimburse an amount paid for a service. In general, reimbursements made under this authority rely mainly on claims data and do not require the extensive use of patient records.

In accordance with Section 18.0.1 of the Health Insurance Act, the physician may request that the Transitional Physician Audit Panel review any decisions by the General Manager to require reimbursement of previously paid claims as well as any decision to refuse to pay a claim or to pay a reduced amount.

Review of Medical Records

Where a review of a physician's medical records is required to ensure compliance with the Health Insurance Act (including the Schedule of Benefits for Physician Services), the General Manager of OHIP will notify the physician of his or her concerns. The physician may then choose to undergo a ministry audit or elect to have their audit placed on hold pending the introduction of a new audit process (recommendations are expected in the spring of 2005). Should the physician choose the ministry audit and subsequently dispute the decision of the General Manager, he or she may then request that the Transitional Physician Audit Panel review the decision.

More information regarding the ministry audit process is available from the Monitoring and Control section of the Ministry of Health and Long-Term Care at (613) 536-3098.

Referral for Criminal Investigation

In cases where ministry medical consultants suspect an incorrect billing practice may be intentional, the case is referred to the Ontario Provincial Police (OPP) Investigation Unit for possible criminal investigation. Recommendations for fraud referrals are made to the Director of PSB by the Monitoring and Control Section, and are then forwarded directly to the Investigation Unit.

3.4 Recovery of Funds

The Health Insurance Act permits the General Manager to deduct ("set off") from future amounts payable by the Plan to a physician any money the physician owes to the Plan. Once the decision of the General Manager or the direction of the MRC is conveyed to the physician, the ministry contacts the physician to arrange a payment schedule.

It is the policy of the ministry that the money will be collected as quickly as possible, and over a period of no longer than 12 months. In exceptional cases the recovery period is extended beyond 12 months, but only when justified by full financial disclosure. Interest is collected at the rate set by the Minister of Finance.

3.5 Unauthorized Payments

The Ministry of Health and Long-Term Care is responsible for administering the Commitment to the Future of Medicare Act (CFMA). Under the CFMA, it is an offence for a physician, or any other person or entity, to accept an unauthorized payment for an insured service. The ministry investigates all complaints of unauthorized payments and situations that might involve such payments that come to its attention. Part II of the CFMA, Health Services Accessibility, provides the ministry's authority to investigate and resolve these matters.

The following brief introduction to Part II of the CFMA is intended for general information only and should not be relied on as authoritative. For example, authoritative text, please refer to the Act and Regulations with are available on E-Laws.

Unauthorized Payment

An unauthorized payment is a charge or acceptance of payment or other benefit by any person or entity for an insured service provided to an insured person except as permitted by the Act and Regulations.

The CFMA prohibits physicians and designated practitioners from charging or accepting payment or other benefit for an insured service in addition to the amount that is payable by OHIP. They are also prohibited from accepting payment or other benefit for an insured service except from the Plan. Specific exceptions are listed in the Act. In addition, the Act prohibits any other person or entity from charging or accepting payment or other benefit for an insured service rendered to an insured person unless permitted by regulations.

Non-designated practitioners are prohibited from accepting payment except from the Plan for the part of their accounts that is payable by the Plan.

3.5 Unauthorized Payments (Continued)

Queue - Jumping and Mandatory Reporting

No person or entity is permitted to charge or accept a payment or other benefit for giving an insured person preferential access to an insured service. Furthermore, the Act makes it mandatory for a physician or other prescribed person, who believes that a person has paid or accepted a payment or benefit for this purpose, to inform the General Manager.

Requirements for Physicians to Disclose Information

The Act authorizes the General Manager to require a physician, practitioner, other person or entity to submit any information that is relevant to determining if:

- a charge has been made, payment accepted or benefit received for an insured person to receive an insured service
- a charge has been made, payment accepted or benefit received for an insured person to receive preferred access to an insured service
- an illegal facility fee has been charged or accepted
- a block fee has been accepted or charged in violation of Section 18 of the Act and Regulations

If the required information is not provided within 21 days, and the failure to comply is without just cause, the General Manager is authorized to suspend payments under the Plan or under the Independent Health Facilities Act (IHFA) whether or not the person or entity is convicted of an offence.

Facility Fees

A facility fee is a charge, fee or payment for, or in respect of, a service or operating cost that supports, assists and/or is a necessary adjunct to an insured service but is not part of the insured service. This includes charges for the premises, equipment, supplies or personnel that are required to provide the specific elements of an insured service that is provided outside a hospital but which are not included in the insured service. Such is the case for fee codes with a # prefix and services for which there is a separately payable H fee.

Facility fees are payable only by the Minister of Health and only to Independent Health Facilities that are licensed under the IHFA. In any other situations, charges for facility fees are an offence under the IHFA.

Whistle Blowers Protected

Any person can report any information to the ministry with respect to unauthorized payments and queue-jumping even if the information is personal, confidential and/or privileged. (Solicitor-client privilege is exempted.) In this event, the Act protects that person from liability and retaliation unless the person acts maliciously and the information is not true.

3.5 Unauthorized Payments (Continued)

Penalties Include Fines, Compensation and Restitution

An individual who contravenes Part II of the Act is guilty of an offence and liable to a fine of not more than $10,000. A corporation that contravenes a provision of Part II of the Act is guilty of an offence and liable to a fine of not more than $25,000. In addition, the court may order the person or corporation to pay compensation or make restitution to any person who suffered a loss as a result of the offence.

Responsibility to Know What is Insured

The General Preamble and individual chapter Preambles in the Schedule of Benefits list the common and specific elements of insured services that are insured as part of the insured service. Uninsured services and exclusions to uninsured services are listed in Section 24 of Regulation 552 of the Health Insurance Act. The exclusions to uninsured services are insured as part of the insured service. Knowing these sections of the Schedule and the Regulation will enhance your ability to discriminate between insured and uninsured services. As a guiding principle, all services provided by physicians are insured unless specifically excluded by Regulation 552. For convenience, Section 24 is reproduced in Appendix A to the Schedule of Benefits.

Charges for Uninsured Services

The authority for charges for uninsured services by physicians is the College of Physicians and Surgeons of Ontario (CPSO). Such charges are commonly called block fees. The College has a policy on this subject that is available on the CPSO website.

The ministry's interest in such charges is to ensure that they do not include payment or receipt of other benefit for insured services or components of insured services. Any such charge by the physician, other person or entity is an offence under Section 15 of the Health Insurance Act, and subject to action under the Commitment to the Future of Medicare Act (CFMA).

3.6 Verification Letters

Verification letters are one of the mechanisms used to detect improper claims. The program is not targeted at any specific physician. Claims are randomly selected from the approved fee-for-service claims file each month. Verification letters are sent by the ministry to members of the public asking for confirmation that health services were received from particular health care providers on specified days.

The verification letter contains the patient's name and address, the provider's name, the service date and the amount paid by OHIP. The amount paid by OHIP is not intended to reflect the time or quality of the interaction with the provider but rather to inform the subscriber regarding the amount paid by OHIP for the service received.

The objectives the Verification Letter Program include:

- deterring inappropriate and fraudulent billing
- detecting and monitoring the incidence of inappropriate and fraudulent billing
- increasing public awareness of health care costs
- supporting the review of provider claims

Certain claims are excluded from selection for the verification letter including those for specific diagnostic and fee schedule codes of a sensitive nature. In addition, a physician can request the exemption of a particular claim under special circumstances in which it is not in the patient's best interest that a specific visit or procedure be the subject of a verification letter. In this case, a written explanation from the physician must be submitted to the ministry along with the claim. Physicians who submit on machine readable input may also request the exemption of a specific claim by submitting the claim using the correct diagnostic code and a manual review indicator. The manual review document must indicate "confidential" or "no verification" and include a written explanation. The claims are than identified as "no verification" in the system and will not be selected for the verification letter program. The usage of exemptions is monitored on an ongoing basis.