MINISTRY OF HEALTH

Ontario Health Insurance Plan

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The Ontario Health Insurance Plan (OHIP), which was established under the *Health Insurance Act*, pays at specified rates for insured services provided to residents of Ontario by physicians and other health care providers, commercial laboratories, diagnostic and therapeutic facilities. OHIP also pays for medical and hospital treatment provided to Ontario residents in other provinces and outside of Canada.

The Assistant Deputy Minister, Health Insurance and Related Programs, is the General Manager of OHIP and is responsible under the Act for OHIP's overall administration.

The Registration and Claims Branch and the Provider Services Branch administer the day-to-day operations of OHIP. The Registration and Claims Branch is responsible for registering eligible Ontario residents and processing medical claims submitted by health care providers. The Provider Services Branch is responsible for developing and providing medical consulting services which include:

- adjudicating complex claims and approving out-of-country claims;
- maintaining a registry of all health care providers who bill OHIP; and
- verifying that:
  - medical claims are for services that have been rendered;
  - the nature of the services has not been misrepresented;
  - the services were medically necessary; and
  - services were performed in accordance with accepted professional standards and practices.

In the 1997/98 fiscal year, OHIP paid approximately 134 million claims totalling $5.1 billion in its nine district offices.

OBJECTIVES AND SCOPE

The objectives for our audit of OHIP were to assess whether system controls and related procedures were adequate to ensure the proper approval, processing and payment of health care provider and commercial laboratory claims, and whether the Ministry had adequate policies and procedures in place:

- to ensure that OHIP was managed with due regard for economy and efficiency and in accordance with applicable legislation; and
- to measure and report on the effectiveness of the OHIP system.

Our audit was performed in accordance with the standards for assurance engagements, encompassing value for money and compliance, established by the Canadian Institute of Chartered Accountants, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

Our audit focused on the systems and procedures related to the payments to, and the related claims from, fee-for-service health care providers and commercial laboratories, and out-of-country claims. For the 1997/98 fiscal year, these payments totalled approximately $4.9 billion or 96% of all payments made. Prior to the commencement of the audit, we identified audit criteria that would be used to address our audit objectives. These were reviewed and accepted by the Assistant Deputy Minister, Health Insurance and Related Programs.

In conducting our audit, we reviewed and analyzed OHIP's policies and procedures as well as those of the Medical Review Committee of the College of Physicians and Surgeons of Ontario; interviewed appropriate ministry staff and outside experts; and reviewed relevant literature. We also reviewed and relied on relevant work completed by the Ministry's Audit Branch. Our audit was substantially completed in March 1998.

OVERALL AUDIT CONCLUSIONS

The Ministry's controls over OHIP claims needed to be more effective. Additionally, procedures currently in place to assess the effectiveness of the OHIP system needed improvement. More effort was required to address inappropriate payments by improving the monitoring of health care provider billings. The Ministry also needed to:

- complete the verification of persons registered prior to 1995 to better ensure that services are provided only to eligible individuals;
- strengthen policies and procedures for verifying the authenticity of out-of-country claims to ensure that only valid claims are processed;
- regularly review the use of claims processing override codes to ensure that only valid claims are paid;
- ensure that the Verification Letters System is meeting its objective;
- examine options with the College of Physicians and Surgeons of Ontario to improve the effectiveness of the Medical Review Committee process and the timeliness of the review of questionable practitioner billings; and
- implement sanctions permitted under the *Health Insurance Act.*

In assessing whether resources were managed with due regard for economy and efficiency, our audit focused on the information technology used in processing OHIP claims, including the process for controlling system changes, and the existence of a system business resumption plan. We found that these aspects of the OHIP system were managed with due regard for economy and efficiency.

DETAILED AUDIT OBSERVATIONS

REGISTERED PERSONS DATABASE

Under the *Health Insurance Act* every person who is a resident of Ontario is entitled to OHIP coverage. A resident is defined by the Act as a person who is legally entitled to remain in Canada, who makes his or her home in Ontario and is ordinarily present there.

The Ministry maintains a Registered Persons Database (RPDB) that contains information on individuals such as their health number, surname, given name, gender, date of birth and address. As of April 1998, the RPDB had recorded 11.8 million people as insured persons under the Act.

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In 1990 the Ministry replaced the OHIP family-based registration system with an individual-based system and issued a new health card to each resident of Ontario. The RPDB was established based on information contained in the family-based system. However, the accuracy of that information and the eligibility of individuals was not verified at that time because the Ministry wanted to ensure speedy registration and continuous health coverage. The Ministry had planned to verify the data and eligibility of residents after the registration process to ensure that:

- every eligible resident had one health number and had received a card; and
- each person who had been issued a health card met minimum eligibility criteria.

In our *1993 Annual Report* we noted that the Ministry had initiated the establishment of a Registration Verification and Control Unit to verify the data and eligibility of individuals who had been registered. In our follow-up in 1995, we were informed that a Registration Enhancement Project had been initiated with a two-year mandate to develop prototype tools and opportunities to improve the quality of the RPDB. The work of the project has now been integrated into the operations of the Verification Unit and the Registration and Claims Branch.

Since 1994, the Ministry has verified the data and eligibility of all registered persons applying for a new, renewed or replacement card. These requirements were continued with the introduction of photo health cards in 1995. During our current audit, we were informed by ministry staff that since 1995, 2.3 million photo health cards have been issued, of which 1.3 million were replacement cards for individuals registered before 1995. The remaining pre-1995 registrants continue to use the old card. Verification of the eligibility of these individuals has been carried out only when an individual's eligibility is suspect.

Recommendation

To better ensure that services are provided only to eligible individuals, the Ministry should complete the verification of persons registered prior to 1995.

Ministry Response

In 1994, the Ministry strengthened the security and integrity of the registration process, incorporating a number of procedures recommended by external forensic auditors and requiring individuals applying for a new card to first confirm their eligibility for the Ontario Health Insurance Plan. Changes were also made to the information presented on the red and white health card to include the card holder's birth date and sex and a date range indicating the period of time for which the card was valid. These requirements were continued and strengthened with the province-wide introduction of re-registration for photo health cards in 1995. These enhanced processes are used for new, renewed and replacement health cards.

In June 1995, the government asked the Ministry to review its card technology, processes and potential for a common government service card. Verification of persons registered prior to 1995 is expected to resume once the review is completed.

CLAIMS PROCESSING

Claims submitted to OHIP include the physician's registration number, the patient's health card number, date of birth, the service date, the fee service code for services rendered and the fee billed. In the 1997/98 fiscal year, approximately 134 million claims averaging $38 per claim were paid. Ninety-six percent of the claims were submitted on computer disks or tapes, with the remainder being submitted on paper or transmitted electronically. OHIP's computer system matches the information contained on the claim to the following databases:

- Registered Persons Database;
- Health Resources Registry, which contains a list of the licensed service providers and the types of services each provider is allowed to perform;
- Fee Schedule Master; and
- Medical Rules.

MANUAL CLAIMS CORRECTIONS

During the 1997/98 fiscal year, 6.2 million claims were rejected by the OHIP system and flagged for manual assessment. Rejected claims are directed to the Online Claims Correction System (OCCS) where they are assessed by claims assessors at district offices for possible resubmission to the system. As at March 31, 1998, OHIP employed approximately 132 claims assessors.

Claims assessors identify claims that should be referred to the medical consultants for adjudication. Subsequently, the assessors select the corrective action appropriate for these and other rejected claims, such as:

- returning the claim to the health provider;

- adjusting the approved fee assigned by the system;
- selecting an assessment or "bypass" code to instruct the system to reprocess the claim and bypass one or more computer checks (for example, fee schedule and medical rules); or
- changing any of the information submitted by the health care provider such as the service code, number of services or fee billed.

In our *1993 Annual Report* we found that improvements were needed in the procedures used for ensuring that appropriate and consistent action was being taken to address rejected claims. At that time the Ministry replied that a claims project was under way with the mandate of redesigning the claims processing system. A number of our concerns had still not been addressed. In our current audit we noted the deficiencies indicated below.

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- There was no evidence of ongoing management review of the use of bypass codes. The system did not produce any reports indicating the reason for the approval of rejected claims. In addition, the necessary identifying information for management to reference individual claims to the OCCS was absent.
- The OCCS permitted original claims data to be changed in order to allow claims assessors to correct keypunch errors on manual claims. The assessors could also change the data for claims submitted in electronic format. However, the changes were not traceable because the system did not record the source of the changes.
- The ability to establish accountability and to monitor the performance of claims assessors was limited because the system did not record the identity of the clerk approving each rejected claim.

Recommendation

To help obtain assurance that appropriate and consistent corrective action is taken on rejected claims:

- **information on individual rejected claims that have been approved by the claims assessors should be maintained for ready access by management;**
- **management should regularly review the use of bypass codes;**
- **any changes made in the Online Claims Correction System (OCCS) to original claims data submitted by health care providers should be traceable; and**
- **the identity of the claims assessors responsible for any changes made in the OCCS should be determinable.**

Ministry Response

The Claims Project to redesign the legacy claims system that was under way in 1993 has been interrupted for a number of other priorities. In the interim, a number of other mechanisms to facilitate the on-line monitoring of claims and potential fraud have been introduced, and training sessions for all claims processing staff are scheduled for the fall of 1998 to help ensure assessment codes are used properly and consistently.

Further systems enhancements, including ready management review or access to reports of modified or bypassed claims, cannot be addressed until Year 2000 changes are completed.

FEE SCHEDULE MASTER AND MEDICAL RULES

The Ministry's Fee Schedule Master contains over 5,000 types of medical services insured under the *Health Insurance Act* and the OHIP fee payable for each service. The insured services and corresponding fees are determined through negotiations between the Ministry and the associations representing the various health care providers. The largest health care provider association is the Ontario Medical Association that annually negotiates fees and services on behalf of approximately 22,000 physicians registered with OHIP. All services and fees are approved by regulations as required by the Act.

In our *1993 Annual Report*, we noted that: "There were 57 new or revised medical rules which were awaiting inclusion on the system and which could have a financial impact on the amounts paid to a health care provider." At the time of our current audit, we noted that this backlog had been eliminated and that there were 167 medical rules being applied by the OHIP system to determine the validity of a claim. For example, where more than one related service code is used, the appropriate medical rules for the service codes are applied to determine whether there are more encompassing codes for the same services that will result in a lower claimable amount.

The application of a medical rule will result in one of the following actions:

- allowing claim amounts up to the fee listed in the Fee Schedule Master;
- rejection of a claim for review by a claims assessor; or
- disallowance or reduction of the amount claimed.

Our tests indicated that the medical rules were generally being properly applied and that payments were based on the rules in place at that time.

ONCE-IN-A-LIFETIME OPERATIONS

Some operations can be performed only once in the lifetime of an individual (for example, a gall bladder removal). When a claim for such an operation is processed, the system checks the claims reference file for that health card number to determine whether a claim for the same procedure has previously been paid. However, the system does not maintain a record of

operations performed more than seven years ago. Therefore OHIP will pay the current claim even though a similar claim may have been made over seven years ago.

Recommendation

To avoid paying twice for the same service, information on once-in-a-lifetime operations already performed should be retained in the claims system until the insured person is deceased or otherwise ceases to be eligible.

Ministry Response

It is agreed that one-time services should be retained in the claims system until the insured person is deceased. However, because the highest priority for systems resources is Year 2000 compliance, implementation will not occur until after the Year 2000 changes are complete.

OUT-OF-COUNTRY CLAIMS

Regulations under the *Health Insurance Act* state that licensed facilities outside Canada where medical or surgical services are rendered are to be considered health facilities for the purposes of the Act. Services provided by these facilities to Ontario residents are insured and are paid at the rates prescribed in the regulations. In the 1997/98 fiscal year, OHIP paid approximately $34 million for out-of-country claims.

PRIOR APPROVAL

Regulations under the *Health Insurance Act* permit the Ministry to enter into a "preferred provider arrangement" with the operators of hospitals and health facilities outside Canada for the provision of specified medical services to OHIP-insured persons. The amounts payable for these medical services are specified in the individual agreements with the providers.

Services are eligible for coverage if the treatment is generally accepted in Ontario as being appropriate under the specific circumstances and is either not performed in Ontario or requires the individual to travel outside Canada as it is medically necessary to have the procedure performed without delay.

The regulations also specify the conditions of payment for such services and require an application to be made to the General Manager of OHIP by a physician who practices medicine in Ontario. The General Manager must give written approval of the amount to be paid before the services are rendered. However, at the time of our audit, approval was actually recommended by ministry medical consultants. Approval was not given by the General Manager as required by the Act.

The average amount of an out-of-country claim is approximately ten times the average claim from Ontario service providers. Considering the significant average size of individual claims,

these applications warrant review and approval by more senior management so that value for money is achieved with respect to out-of-country services.

Recommendation

To help ensure that service proposals receive adequate management review, the Ministry should establish appropriate levels of authorization for the prior approval of out-of-country services before becoming liable for the payment of significant amounts for such services.

Ministry Response

Under the* Health Insurance Act, *the General Manager may delegate authority for approval of claims. The following changes were being implemented at the time of the audit:

- ***Effective January 1, 1998, all prior approved expenditures where estimates exceed $100,000 are reviewed by the manager of Provider Payments and Policy prior to confirmation of payment.***
- ***As of March 1, 1998, all applications approved by the medical consultants require the Director of Provider Services Branch's approval prior to treatment authorization.***

CLAIMS VERIFICATION

While the Ministry uses verification letters to substantiate claims from Ontario practitioners, no similar practice exists with regard to the verification of out-of-country claims. Because of the significant amounts involved, out-of-country claims should also be subject to a regular verification process. Such a process could include random audits of third-party claims, interviewing insured individuals and verifying the existence and licensing of the service providers with governing bodies.

Recommendation

To help ensure that only valid claims for out-of-country services are being made and paid, the Ministry should establish policies and procedures for verifying the authenticity of such claims.

Ministry Response

The Out-of-country Claims Unit, in collaboration with the Investigation Unit, is strengthening its review of suspicious claims.

STALE-DATED CLAIMS

Under the *Health Insurance Act*, physicians and other health care providers are entitled to a prescribed fee if claims are submitted no later than six months after the medical service has been provided. When claims are being processed for payment, the OHIP system currently does not count the month in which the service was performed when calculating the time between the service date and the date of submission. Also, claims that are input within the first 18 days of a month are treated by the system as having been received on the last day of the previous month. Accordingly, a claim can be submitted more than seven months after the service date and still be honoured.

For out-of-country claims, OHIP accepts a claim even if it is submitted one year after the date of service.

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Recommendation

The Ministry should implement system controls and procedures to help ensure that claims are not paid unless they meet the *Health Insurance Act's* requirement that service providers submit claims within six months of the date of service.

Ministry Response

The Ministry believes that, given adequate warning, most providers would ensure that claims are submitted within the allowable timeframes.

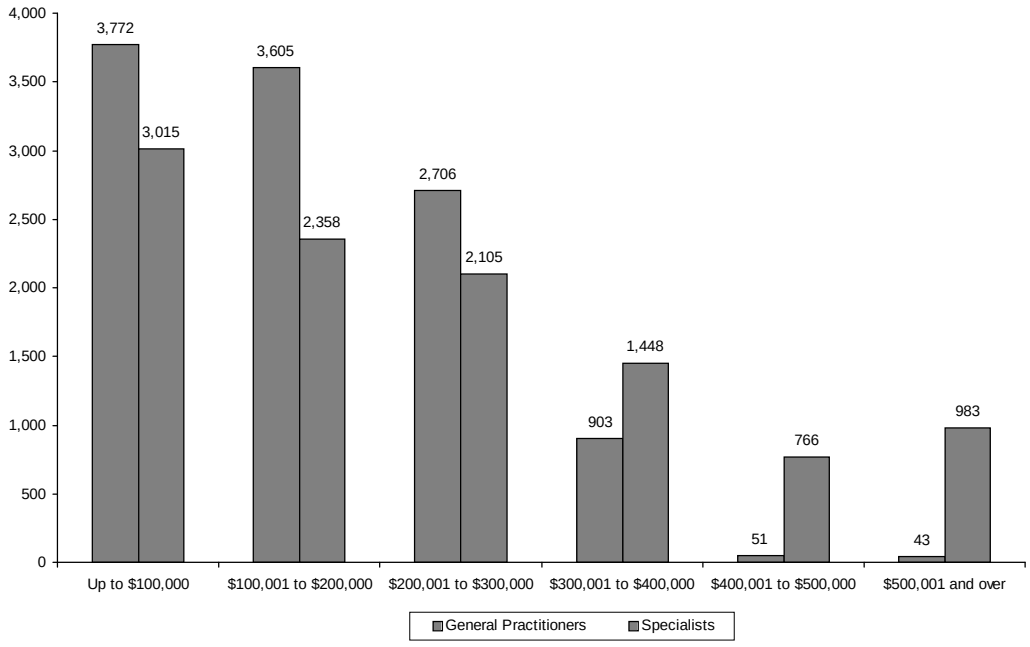
The implications of refining the stale-dated formula and related assessment process within the legacy batch system will be assessed opposite other claims system refinements for action after the Year 2000 changes are complete.

The Ministry will review the out-of-country claims payment policy and, if it is determined that the current policy should be retained, will seek appropriate regulatory authority.

MONITORING AND CONTROL UNIT

Monitoring and control staff of the Provider Services Branch are responsible for reviewing physician and practitioner billings. The following chart indicates the billings of fee-for-service physicians during the 1997/98 fiscal year.

Distribution of Physicians by Billing Volume



Source: Ministry of Health

PHYSICIANS MONITORING SYSTEM

Prior to 1996, the Ministry used its Physicians Monitoring System to identify, on an ongoing basis, physicians who had practices that varied significantly from those of their peers. The parameters covered included: number of patients seen; number of services billed; and the fee charged per service by the particular specialty. The system also took into account the patient mix, the population and geographical region where the physician practised.

In our *1990* and *1993 Annual Reports*, we reported that the Physicians Monitoring System was generally working well in identifying questionable billings. However, those billings that might have been well outside the acceptable range for a particular procedure were unlikely to have been identified as long as the physician's overall activity fell within the average practice. Accordingly, we recommended that the system should be refined to highlight significant variations in specific services or procedures. The Ministry responded, in part, that it had initiated a project that would look at redevelopment of the system.

In 1994 Queen's University was retained by the Ministry to develop a strategic plan for monitoring and controlling the system. This plan recommended that the Ministry "upgrade or replace the Physicians Monitoring System to improve functionality and remove the most serious limitations. Specifically, modify the system to allow run-anytime mode (instead of annually-only); create data set outputs as well as paper reports, to permit subsequent analysis; allow real-time access to major files in the system."

In 1996 the Ministry replaced the Physicians Monitoring System with customized reports to identify physicians with unusual billing patterns. Although the number of referrals to the Medical Review Committee has increased, the Unit has recognized the need for a system that uses rigorous mathematical models and has a data interrogation capability for analyzing billings using various risk factors. Such a system should be able to track trends in a physician's billing,

identify billing codes that are inconsistent with the physician's specialty, identify exceptionally high levels of certain service types and identify codes that should not be billed together for the same patient on the same day.

To complement the system used to monitor physicians, at least one other province carries out audits of health care providers. This matter was also raised in our *1993 Annual Report*. At that time, the Ministry responded that it would explore legislative and policy alternatives to enhance the authority of the General Manager for audit and investigative purposes. While relevant legislative amendments were introduced in 1995 as part of Bill 26, they were not passed into legislation.

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Recommendation

To better highlight questionable billing practices, the Ministry should ensure that screening tools are developed to replace the Physicians Monitoring System.

Ministry Response

The Ministry has augmented its monitoring capacity by the addition of full-time and part-time medical consultants and continues to develop enhanced monitoring tools. The Ministry is using a monitoring system developed in partnership with Queen's University which utilizes statistical analysis software and is in the early stages of examining "data-mining" tools, including neural networks.

VERIFICATION LETTERS SYSTEM

The Ministry's Verification Letters System produces computer-generated letters that are sent to patients to confirm certain details of services paid for on their behalf. The Verification Letters system is used to detect abuse, deter fraudulent billings and create public awareness.

Letters are not generated for services pertaining to diseases or conditions that are considered to be sensitive. They are also not sent for out-of-country claims, nor for commercial laboratory or other diagnostic and therapeutic procedures since the patients are not likely to have seen the providers who billed for the services. The patient is asked to return the letter to the appropriate district office and to indicate whether the health care provider named was seen on the date shown.

These letters are sent to patients selected at random indicating the date of service provided, the amount paid and the name of the health care provider. However, no description of the services rendered is included. As we noted in our *1993 Annual Report*, the verification letters used by the Ministry of Health in British Columbia contain a description of the services provided in layman's terms.

If a patient disputes a service, the medical consultant in the district office attempts to resolve the issue. Where the district office believes that the service has not been provided and the case is not an isolated incident, the issue is referred to the Provider Services Branch for further

investigation. This may entail sending letters to other patients who have received similar services from the same health care provider. A significant number of discrepancies can lead to referral to the Investigation Unit if fraudulent billings are suspected.

During our current audit, management informed us that adverse responses to verification letters were not tracked to ensure that follow-up was adequate and that not all of the required monthly summaries were being submitted in a timely manner showing the results of verification activities.

Recommendation

The Ministry should review the effectiveness of the Verification Letters System to ensure that it meets the objective of detecting abuse and deterring fraudulent claims. In order to enhance the possibility of obtaining better information for analysis purposes, the Ministry should also consider including in the verification letters a description of the services rendered in non-medical terms.

Ministry Response

The Ministry has initiated a number of changes to support the Verification Letters System, including:

- ***increasing the number of letters;***
- ***developing an automated tracking system which is currently in pilot use; and***
- ***documenting and establishing procedures with district offices.***

The Verification Letters System is only one of the ways of monitoring invalid claims. Its main use is in detecting claims which are submitted for services that have not been rendered. Internal ministry monitoring detects invalid claims which relate to inappropriate billing behaviour.

MEDICAL REVIEW COMMITTEE

Under the *Health Insurance Act,* the General Manager of OHIP may refuse to pay for a service provided by a physician, practitioner or health facility, pay a reduced amount or require a reimbursement of the amount paid for a service, if the General Manager is of the opinion that:

- all or part of the insured service was not in fact rendered;
- the nature of the service was misrepresented;
- all or part of the service was not medically or therapeutically necessary; or
- all or part of the service was not provided in accordance with accepted professional standards and practice.

The General Manager may refer any matter pertaining to any of these circumstances regarding physicians to the Medical Review Committee (MRC) of the College of the Physicians and

Surgeons of Ontario before deciding on payment or reimbursement. The MRC is a committee established under the *Health Insurance Act* and is required to make recommendations to the General Manager on any matter referred to it. In the 1997/98 fiscal year, the Ministry paid the College approximately $1.8 million for the services provided by the MRC.

REFERRALS TO THE MRC

In our *1993 Annual Report*, we indicated that 156 cases were pending and that the average length of time between a referral and a recommendation was 32 months. The Ministry responded that amendments to the *Health Insurance Act* would expand the membership of the MRC, thus permitting the handling of a larger number of cases.

In 1996 the Committee membership was increased from 8 to 24, comprising 18 physicians who are members of the College of Physicians and Surgeons of Ontario (CPSO) and 6 members of the public who are not physicians or medical practitioners. However, as at March 31, 1998, only four public members had been appointed and two positions had been vacant for a number of months.

Between 1993 and November 1997, the average length of time between a referral and a recommendation had increased to 48 months. Moreover, 271 cases were pending as at March 31, 1998. During our audit we were informed by the MRC that the Ministry had approved funding to hire more staff to address the backlog.

In the 1997/98 fiscal year, the MRC determined that no adjustment was necessary in 9 of its 39 decisions, but recommended recovery action in 30 situations. Where recovery action is to be taken, the physician may appeal the decision to the Health Services Appeal Board (HSAB). During the 1997/98 fiscal year, one case was appealed.

Where recoveries are to be made, collection begins immediately and physicians are required to repay in full within one year. However, interest is not charged on recoverable amounts until one year after the General Manager's decision to recover. For the 1997/98 fiscal year, approximately $2.3 million of paid, pre-May 1996 services became recoverable from 30 physicians as a result of MRC recommendations. The recoverable amounts included incorrect billings resulting from physicians misunderstanding the meaning of some service codes in the Schedule of Benefits. The Ministry collected $800,000 during the year and was owed $7.3 million by physicians at the end of the year, including approximately $5 million from prior years.

Where a physician repeats the same behaviour, the recourse available to the General Manager is a re-referral to the MRC. However, in another province sanctions are available, not just a simple repayment of claims as recommended by the MRC. In that province, the right to bill the provincial health plan directly can be removed when the health care provider repeatedly claims for services that were not medically necessary.

In our *1993 Annual Report* we recommended that, to deter misuse of the system by health care providers, the Ministry should consider sanctions against health care providers whose patterns of practice continued to be undesirable. Amendments to the *Health Insurance Act*, passed in 1996, extended the Ministry's powers with respect to financial recoveries, sanctions and obtaining information relating to insured services. While the Ministry has developed a plan to implement certain aspects of the additional powers, the following provisions had not been actioned.

- Physicians objecting to the General Manager's decision to adjust a claim before payment or to recover previously paid fees can request a review by the MRC. Physicians may also request that the review be performed by a single member of the MRC, if the amount of money in dispute is less than a prescribed amount or if the General Manager consents to a review by a single committee member. However, the Ministry has established neither the prescribed amount nor the procedures and criteria pertaining to the General Manager's approval of such requests.
- A physician can now be charged interest on recoverable amounts sooner than previously was the case, provided the Ministry establishes the date from which interest is applicable. However, the Ministry has not established that date, nor has it prescribed the interest rate calculation method.
- A physician is not required to pay for the cost of the MRC review or for the cost of any reconsideration of a review if the General Manager's original decision is upheld.
- A physician's identity, practice location, a description of the situation reviewed and amount to be repaid are not publicized.

  A number of years previously, the CPSO discontinued publicizing the results of MRC decisions. While the identity of the physician was not disclosed, the circumstances surrounding the review were presented.

The length of the process involved, the failure to charge interest from the date of the decision to recover, and the lack of sanctions permit continuing misuse of the system by some physicians and may not deter further abuse by others.

Recommendation

To deter misuse of the system by health care providers and to expedite the recovery of inappropriate billings, the Ministry should:

- **exercise its full authority under the *Health Insurance Act* with respect to sanctions and assess the need for further sanctions on those health care providers who are found to be repeatedly abusing the system;**
- **hold orientation sessions and provide reference material to help reduce the incidence of incorrect billings resulting from the misinterpretation of service codes in the Schedule of Benefits;**
- **assess the referral process and work with the Medical Review Committee to improve the timeliness of its reviews;**
- **fill MRC vacancies to decrease the backlog of cases and to expedite the review of new referrals; and**
- **request the MRC to reinstate the practice of publishing its recommendations, thus helping to prevent inappropriate treatments and billings.**

Ministry Response

The Ministry is applying a full range of sanctions in accordance with the* Health Insurance Act, *including new powers introduced in 1996 (that is, direct recoveries from physicians). Regulations will be introduced which will apply to cases where services were provided on or after May 1, 1996.

The Ministry will participate in education seminars for currently practising physicians and will introduce training for new registrants.

The timeliness of MRC reviews will be improved as its size has been tripled and measures have been introduced to reduce the case backlog. The Ministry is committed to handling at least 100 cases annually, either for direct recovery action by the Ministry or for MRC referral. One public member vacancy has now been filled, and the the remaining vacancy will be filled as soon as possible.

The Ministry has been advised by the College of Physicians and Surgeons of Ontario that it will recommence publishing MRC case information this fall.

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INVESTIGATION UNIT

The Investigation Unit of the Ministry is responsible for investigating matters pertaining to all ministry programs that have been referred to it by ministry staff or the public. In the 1997/98 fiscal year, the Unit opened 77 OHIP files and closed 23 cases. In the same year, law enforcement agencies laid charges in seven cases.

In May 1997 the Minister of Health appointed a consultant to investigate and propose appropriate recommendations relating to the processes and procedures used by the Ministry to detect, prevent and eradicate fraud in the health care system. The investigation included an assessment of the effectiveness and role of the Investigation Unit. In September 1997, the consultant recommended that an experienced commercial crime investigator be put in charge of the Unit on a temporary basis. Part of the investigator's mandate would be to review the organization of the Unit. The review would include evaluating the abilities of the Unit's personnel, developing policies relating to investigations, meeting with related enforcement groups, and recommending how the public and the Minister are to be informed about the Unit's activities.

The Ministry seconded a staff sergeant from the Ontario Provincial Police to conduct this review. The resulting report indicated that the Unit should be re-engineered to increase its efficiency and effectiveness. In particular, the report identified a need to improve investigative credibility, communications and case management. Ministry management agreed and is implementing a plan to address this need.

While the changes will strengthen the Unit's ability to deal with potential abuses of the system, its effectiveness depends on referrals by ministry staff. Therefore, it is critical that staff understand what constitutes a questionable practice and that criteria be developed for referrals to the Unit.

Recommendation

To ensure that irregular practices are reviewed and investigated, criteria and procedures for referring concerns to the Investigation Unit should be developed and distributed to staff members.

Ministry Response

The program area staff meets regularly with Investigation Unit staff to discuss and/or seek guidance on suspicious cases. More formalized policies and guidelines regarding referrals to the Investigation Unit will be developed and "signed off" jointly by the program areas and the Unit.

The Unit has now been reorganized and a common registrant information tracking and case management system has been introduced. The system consists of several modules developed to share information and direct referral/intervention on all files identified as potential misuse/abuse/fraud.

PARAMETERS OF PRACTICE

A physician uses professional judgment to determine whether medical procedures are necessary and which procedures to perform. Where available, standards and guidelines (parameters of practice) can be used by a physician to determine actions to be taken under different scenarios. Parameters of practice help ensure proper care and treatment and assist in identifying and reducing inappropriate or unnecessary medical procedures.

In our *1993 Annual Report*, we noted that some clinical practice parameters had been developed and the development of others was ongoing. We recommended that the Ministry continue its efforts to facilitate the development of parameters of practice in the health care professions. Since then the Ministry has facilitated the development of parameters for facilities licensed under the *Independent Health Facilities Act* and has adopted a legislated mandate for ensuring the implementation of such parameters. Compliance with the parameters is assessed by the College of Physicians and Surgeons of Ontario (CPSO). However, there are currently no province-wide standards or guidelines of practice for most medical procedures.

In 1992 the Ministry and the Ontario Medical Association (OMA) established the Institute for Clinical Evaluation Sciences (ICES). ICES is looking at, among other things, the rates of medical procedures being performed, lengths of hospital stays and drugs being used. ICES attempts to determine the reasons for variations in procedures and treatments being given. Eventually the efforts of ICES may result in guidelines for physicians and public education campaigns. For example, a recent research study by ICES found that members of the medical profession had no clear sense of the appropriate amount of time family physicians should be spending with their patients. Guidelines would help physicians be more consistent in the time they spend with patients.

CPSO and ICES have recognized the need to work together more closely with the OMA and the Ministry to develop practice parameters. During our current audit, a joint Ministry and

OMA Guideline Advisory Committee was formed for the implementation of practice and referral guidelines.

Under the *Regulated Health Professions Act,* all self-governing colleges of health professions must have developed quality assurance programs by 1997 to address the effectiveness and appropriateness of treatments and to monitor the continuing competence of its members, as well as, changing standards of practice based on patient outcomes. The CPSO has established quality assurance programs under its Quality Management Division, which is separate from the MRC. The CPSO has indicated that its experience with Independent Health Facilities has demonstrated the potential for improved care and cost savings.

However, senior management at the CPSO was concerned that information was not being shared by the Ministry. For instance, amendments to the *Health Insurance Act* permit the Ministry to enter into agreements with private and public sector organizations to collect and disclose information in order to detect inappropriate services. The CPSO believes that, if it were given certain information from the OHIP database, it would be better able to fulfil its quality assurance responsibilities. We also noted that the CPSO does not share its quality assurance information which could be used by the Ministry to follow up inappropriate billings.

Recommendation

To improve patient care and help ensure that provincial funding for health care is utilized economically and effectively, the Ministry should facilitate the development of additional parameters of practice in the health care professions.

The Ministry should pursue sharing information with the College of Physicians and Surgeons of Ontario. The use of any information should be clearly defined and within legislated limitations.

Ministry Response

The Ministry will continue to work with the 21 regulatory colleges under the* Regulated Health Professions Act *to strengthen their quality assurance programs. Regulations will be in place for all colleges this year. Encouraging the colleges to develop more and better standards of practice is a component of this work. Colleges are expected to involve their membership and professional associations in developing meaningful standards. As well, the Health Professions Regulatory Advisory Council is undertaking an independent assessment of the colleges' quality assurance programs and will be providing its advice to the Minister in two reports (interim due December 1998; final in year 2000).

The Ministry is encouraging the College of Physicians and Surgeons of Ontario to enter into an information sharing arrangement.