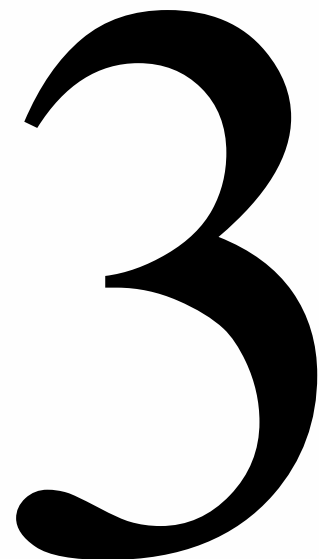


3. PAYMENT INTEGRITY

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3. PAYMENT INTEGRITY

3.1 Overview

The Ministry of Health and Long-Term Care is committed to ensuring that physicians who provide insured services to insured persons in Ontario receive full payment, within the requirements of the [Health Insurance Act](#) (HIA) and its regulations (including the [Schedule of Benefits for Physician Services](#)).

The ministry is accountable for fees paid to physicians for services insured under the Ontario Health Insurance Plan (OHIP). In support of that mandate, the Payment Integrity unit of the Provider Services Branch is responsible for reviewing the fee-for-service claims of physicians and responding to other payment concerns.

The authority under which the unit may act is outlined in the [Health Insurance Act](#) (HIA), the [Commitment to the Future of Medicare Act](#) (CFMA) and their respective regulations.

3.2 Processes

Payment integrity uses computer query tools and other computer software to conduct routine analysis on OHIP fee-for-service claims. In specific situations, Payment Integrity may be required to conduct further analysis of claims as a result of a call or complaint from a patient, another health care provider or some other source. Another prompt for further analysis may be the return, from a patient, of an adverse verification letter.

Computer Tools

Software is used to review post-payment claims. In general, most claims are paid as submitted, however; there are some computer checks performed on claims prior to payment. These checks are relatively general in nature (e.g., valid health number, maximum billing of a claim on one day) and cannot validate that the claim submitted is correct or appropriate for the service provided. Therefore, post-payment review through the use of software is required to identify other situations which may be of concern.

3.2 Processes (Continued)

Calls or Complaints

When a call or complain is received, Payment Integrity reviews the information and may conduct additional analysis based on the call or complaint. If there are concerns, Payment Integrity may request records or send written correspondence to the physician to clarify the matter of concern. Calls or complaints may also result in investigations under the CFMA. Physicians should be aware of their responsibilities under the CFMA to know what services are insured.

Verification Letters

The Verification Letter Program sends randomly generated letters to individual patients on a monthly basis. These letters are used to confirm that specified insured health services were received from a specified physician on a specified date. If the patient did not receive the service, or is unsure, the patient returns the letter to the ministry. Payment Integrity may then follow-up with the physician. Random verification letters are generated from all claims that are submitted to OHIP and do not specifically target a physician or patient.

3.3 Actions

Actions which may result from the processes of Payment Integrity include:

- Education
- Records review/audit
- Request for Reimbursement of Funds
- Referral to an Independent Board
- Referral to the Fraud Branch

Education

One of the functions of the Payment Integrity unit is to educate and assist physicians in correctly billing OHIP for services provided. In addition to correspondence addressed to individual physicians for very specific billing matters, the unit also addresses larger groups of physicians through its Provider Education Program (PEP). The PEP, initiated in 2001, was designed to improve physician awareness and understanding of payment requirements for a specific fee code or codes. PEP 'studies' are conducted on specific fee codes (or fee code combinations) and physicians meeting certain criteria may receive a letter clarifying the payment requirements.

3.3 Actions (Continued)

Records Review/Audit

As noted earlier, Payment Integrity may request records under certain circumstances. The authority to make this request is in the HIA or the CFMA (depending on the circumstance) and physicians have (for the CFMA, it is 21 days, for the HIA, it is within the time period the General Manager may require) to provide the records. Records are usually requested in order to ensure the proper claim was submitted for the service provided or to ensure that a fee has not been charged to a patient for an insured service.

Request for Reimbursement of Funds

Where Payment Integrity determines that an amount is owing to OHIP, the physician may be asked, in writing, to make a reimbursement. If the physician disagrees with the determination of an amount owing, there is an appeal process in place, details of which are given to the physician when notified of an amount owing.

Referral to an Independent Board

In situations where education has not been successful, and/or where a records review or audit has resulted in a disagreement between the ministry and the physician, the concern may be referred for consideration by an independent board. Physicians referred to the independent board will be notified and have the opportunity to make representations (either in person or through independent counsel) at the board.

Referral to the Fraud Branch

In situations where the concern is that the billing may be intentionally incorrect or inappropriate, Payment Integrity may refer the concern to the Fraud Programs Branch of the Ministry of Health and Long-Term Care. This branch reviews the concern and makes a determination on whether to forward to the Ontario Provincial Police (OPP) for possible criminal investigation.