MONITOR TELEGRAM

PART 1 OF THE *WHITEPAPER* SERIES

HEALTHCARE FRAUD IN CANADA

WHY IS IT NOT A HOT TOPIC?

Our healthcare system is haemorrhaging $37.5 million per day and nothing is being done about it

WHY IS HEALTHCARE FRAUD NOT A HOT TOPIC IN CANADA?

Canadians are known as a polite people. Perhaps too polite when it comes to discussing or investigating the topic of fraud in this country's healthcare system. It probably seems discourteous to most, if not downright rude, to impugn the character of healthcare organizations and providers which are entrusted to handle their most important commodity–their health.

We tend to believe that these paragons of caring and healing are above ripping off the very system which supports them. Looking over the press in recent years, our governments must certainly think this way.

Healthcare funding is the most talked about topic by government leaders in this country–talks between the federal government and the provinces over funding have been a major story for months. Yet, we rarely hear anything about curtailing potential fraud within the system.

IS CANADA REALLY A FRAUD-FREE PARADISE IN HEALTH CARE?

Let's look at the American experience for a moment.

The U.S. operates a socialized healthcare system for the indigent, elderly, military, disabled and children/youth with their Medicaid, Medicare and Tricare systems.

- Medicare and Medicaid are two different government-run programs that were created in 1965 in response to the inability of older and low-income Americans to buy private health insurance.
- Medicare is a federal program that provides health coverage if you are 65 or older or have a severe disability, no matter your income.

- Medicaid is a state and federal program that provides health coverage if you have a very low income.[1]

- Tricare, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), is a health care program of the United States Department of Defense Military Health System.

The U.S. spent $540 billion US on Medicare in 2015 on some 57 million people[2] and another $532 billion US on Medicaid.[3] In comparison, per the Canadian Institute for Health Information, Canada spent $228 billion in 2016.[4] That's more than $26 million each hour of every day, around the clock.

The Centers for Medicaid and Medicare, the U.S. federal agency supervising the programs, is very concerned about criminal fraud. On the following page are some of the common schemes they've identified that take advantage of Medicaid.[5]

(For a more detailed explanation of fraud schemes and the U.S. system to deal with them, download a PDF file here.)

1 *https://www.medicareinteractive.org/get-answers/introduction-to-medicare/explaining-medicare/what-is-the- difference-between-medicare-and-medicaid*

2 *http://kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/*

3 *http://kff.org/medicaid/state-indicator/total-medicaid-spending/?currentTimeframe=o*

4 *https://www.cihi.ca/en/spending-and-health-workforce/spending*

5 *https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud- Prevention/FraudAbuseforConsumers/Ripoffs_and_Tips.html*

COMMON RIP-OFFS

- Payments (in cash or in kind) in return for Medicaid numbers,
- Every patient in a group setting receiving the same type of service or equipment on the same day, and
- Services listed on your medical summary notice that you don't remember receiving or didn't need.

COMMON FRAUD SCHEMES

- Billing for "phantom patients",
- Billing for medical goods or services that were not provided,
- Billing for more hours than there are in a day,
- Paying a "kickback" in exchange for a referral for medical goods or services,
- Concealing ownership in a related company,
- Using false credentials, and
- Double-billing for healthcare goods or services not provided.

THE UNSUPPORTABLE COST OF HEALTH FRAUD

The Federal Bureau of Investigation (FBI) says that health fraud costs U.S. taxpayers tens of billions of dollars a year.[6] This includes fraud in both government-funded and private insurance programs.

We cannot find a comparable statistic in relation to Canada. However, the CHLIA (Canadian Life and Health Insurance Association), reports that "All Canadians pay for healthcare fraud. In North America alone, it is estimated that 2 to 10 per cent of all healthcare dollars are lost to fraud [an average of 6 per cent]. This means higher costs for everyone."[7]

SO HOW MUCH IS BLEEDING FROM THE CANADIAN HEALTHCARE SYSTEM?

We are losing healthcare funds at an incredible rate:

- $13.7 billion per year[8]
- $37.5 million each and every day, or
- ***$1.6 million per hour***, 24 hours around the clock

There is widespread concern in the U.S. over healthcare fraud. There is major media almost daily on some company or provider being arrested, charged or convicted of such crimes.

Why not in Canada, considering the figures above?

6 *https://www.fbi.gov/investigate/white-collar-crime/health-care-fraud*

7 *https://www.clhia.ca/antifraud*

8 *Average of 6%[7] of $228 billion[4] spent in Canada*

CANADA'S PUBLIC DOUBLE SPEAK

Part of the problem appears to be rather than calling it what it is, criminal healthcare fraud, governments and media here like to use polite terms like "over-utilization," "over-billing" and other benign, nonjudgmental administrative words.

A *Toronto Star* story from December 30, 2016[9], is a case in point. The Star has been hammering at the Ontario government to release a list of the province's top billing doctors, some of whom have billed millions of dollars for their services.

"Services not rendered"
"Upcoded"
"Medically unnecessary"
"Inappropriately delegated"

...Seeing over 100,000 patients in 332 days!

The paper obtained documents relating to findings from an Ontario health ministry investigation into the top 12 billing doctors in the province.

The Star reported of those physicians, "six allegedly charged for 'services not rendered' five 'upcoded' or billed OHIP using fee codes for more expensive procedures, and three were charged for 'medically unnecessary' services, which the plan is not designed to fund, the probe found."

One doctor's billing extravaganza was seeing over 100,000 patients in 332 days!

The paper also reported:

- Three specialists "inappropriately delegated" duties — for which they billed OHIP and which they were supposed to perform themselves — to unqualified individuals to undertake.
- Six claimed to have worked between 356 and 364 days of the year.
- Eight recorded notably high volumes of claims and/or patients. One radiologist, who worked 332 days, billed for 100,000 patients, indicating that more than 300 scans were interpreted per day.

9 *https://www.thestar.com/news/queenspark/2016/12/30/ontarios-top-billing-doctors-over charged-ohip-health- ministry-audit-suggests.html*

- Eleven billed OHIP incorrectly.
- An obstetrician/gynecologist billed for seeing male patients.

This list looks suspiciously like the list of criminal fraud activities identified by the Centers for Medicaid and Medicare in the U.S.

Yet, the Star article mentions the word “fraud” once and only in relation to a list of possible actions the Ontario Ministry of Health stated it may take according to an audit document obtained by the Star.

Why isn’t the Ontario Ministry of Health more forthcoming or taking action?

ENTER THE ONTARIO MEDICAL ASSOCIATION

Dr. Virginia Walley, the president of the Ontario Medical Association, said in a statement to the Star, "The assumption that any physician has done something wrong before a formal process has been completed is detrimental and unfair. It is essential that all physicians have access to a just process."

Just because a doctor bills a lot, doesn't mean it's fraud. It can also mean he/she is an exceptional professional. In the U.S., there has been overreach in enforcing healthcare fraud by some government agencies. In some cases, bureaucrats assume that because a provider bills a lot, there must be fraud involved when in fact the provider is just very competent.[10] This ends up hurting valuable healthcare professionals.

But for "fraud" to be almost entirely absent from the Canadian healthcare lexicon means the pendulum has swung too far in the other direction, especially with such egregious violations uncovered by the Star.

In fact, a Google search on "healthcare fraud in Canada" uncovers little current media or public debate on the subject. If it weren't for the Star going after these high billers in Ontario, there would be almost nothing.

Furthermore, there used to be a private, non-profit organization called the Canadian Health Care Anti-Fraud Association (CHCAA). It operated for more than 14 years, holding annual meetings on the topic. It was also quoted on the subject.[11]

Now it is gone. It was recently taken over by the Canadian Life and Health Insurance Association which has buried the topic of healthcare fraud on its website. There is only one webpage[12] on the topic and it can't be reached from the website's menu–only from a search from Google.

10 *http://www.expressnews.com/news/local/article/In-Medicaid-docs-guilty-until-proven-innocent-4832728.php*

11 *http://www.benefitscanada.com/benefits/health-benefits/cchaa-raises-fraud-awareness-64443*

12 *https://www.clhia.ca/antifraud*

ATTENTION, MINISTER OF JUSTICE: IT'S TIME FOR A FEDERAL CRACKDOWN

Surprisingly, the Canadian Medical Association Journal published a three-part series of articles in 2013 about healthcare fraud in the U.S.[13], Canada[14], and Europe[15]. The article on Canada was re-published by U.S. National Institutes of Health and is very sympathetic to the idea that healthcare fraud in Canada is at least as great as in the United States and Europe.

The author, Adam Miller, found, as we have, that there is a vast difference between the handling of fraud in the United States and Canada, and is convinced that it would be wrong to think it doesn't happen in Canada.

Lack of oversight justification #1:

"...an intrusion into provincial jurisdiction over health."

Miller wrote: "But it would be entirely erroneous for Canadians to smugly assume that every doctor is squeaky clean, or that the problem of health care fraud is non-existent north of the 49th parallel, as the aggregate level of fraud by physicians, pharmacies and patients probably doesn't differ much, whether it's the US, Canada or any other nation on the planet, according to the Canadian Health Care Anti-fraud Association"–the now defunct group we just mentioned.

The former director of CHCAA told Miller that the lack of investigation and action is due to the fact that there is no federal oversight of such activities.

Health Canada told Miller that "the notion that there is a need for some manner of federal involvement or federal mechanism to crack down on healthcare fraud... would be an intrusion into provincial jurisdiction over health." Miller, indeed,

13 *http://www.cmaj.ca/content/185/1/E19*

14 *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3537805/*

15 *http://www.cmaj.ca/content/185/1/16*

found there is no coordination between provinces or the federal government to track healthcare fraud.

When Miller interviewed key bureaucrats from Manitoba, Ontario and Alberta, they simply told him that there is little fraud in their systems.

ONTARIO'S ANTI-RACKETS UNIT

But an investigator with the Ontario Provincial Police's Anti-Rackets Branch which investigates healthcare fraud in Ontario told Miller, "Things that happen in the US happen in Canada, happen in Europe, and happen anywhere, and in any kind of fraud where there is a way for people to exploit a service or a system—people will do that."

He went on to say that "We don't quantify it. We really don't track that. What we know is that there's sufficient work out there for our unit to keep going every year with referrals from the ministry and referrals from other sources to justify the fact that we're here. I think there's a deterrent effect as well when our unit lays charges... But obviously I don't have that crystal ball to be able to quantify it."

IS THE SYSTEM SET UP TO HIDE FRAUD?

So, Canadians are being bamboozled by their own health agencies into a false sense of security that there is little or no healthcare fraud here.

Why would this be the case?

Here are two possible reasons:

1. Charitably we can chalk it up to public relations. In Canada, the governments run the whole health care system. So, to uncover and find fraud is an admission of incompetence and makes them look bad as administrators. Therefore, they are reluctant to uncover it and to discuss it. This mentality is detrimental to Canadians and the healthcare system.

2. More cynically, the Canadian system is set up to hide fraud. The fact that there is no co-operation between provinces and no federal oversight even to the extent of providing statistics on the problem, means it is a porous system and it continues this way despite public exposure. Who benefits is a key question here.

If you need further evidence that fraud is a problem in Canada, please review our additional resource of articles in the appendix at the end of this paper.

Exposing criminal fraud within our healthcare system must become both an open topic of discussion and a priority for action by governments in this country. Citizens must lead the way.

We hope you are sufficiently shocked to raise your voice.

Let us know what you think

What do you think of what's going on? What do you feel should be done? We are conducting an anonymous survey and would like your opinion. Please click here to take the survey.

APPENDIX – ONLINE CANADIAN FRAUD ARTICLES

The $100 Million Operation

Rip-off of the Ontario Health Insurance Plan.

http://herman.strijewski.com/w5.htm

... While Ontario's bureaucrats and politicians - past and present - are stuck in the throes of collective amnesia, south of the border NME (National Medical Enterprises) has been giving in to the crushing weight of evidence against it.

W5 correspondent: "In 1993 National Medical Enterprises settled out of court with a group of American insurance companies for 214 million dollars. A few months later it was the U.S. federal government's turn. They collected 379 million dollars to repay Medicare and Medicaid. The largest fraud settlement in U.S. history."

Texas lawyer James Moriarty can't understand why even today the conservative government of Ontario isn't flying on down to try to get it's money back.

James Moriarty: "Well, OHIP doesn't have sense to pour piss out of a boot. This is *the* best example of fraud in healthcare that there is ever going to be. You are never going to see it this clearly with this many witnesses, with this many people who acknowledged the fraud in that. I believe that just like if you owned a bank and somebody robbed the bank you would say 'I want the money back'."

Jim Wilson is the Ontario Minister of Health: "We've had three legal opinions who say it may not be the best advice to spend another million dollars of tax payers' money to take the chance to get the money back."

Sandy Rinaldo: "But so far no one from the Ontario government has contacted any of the American law firms who successfully collected millions on behalf of their American clients."

When that's story first appeared on W5 last fall it stirred an immediate fury in the Ontario Legislature. The opposition liberals were eager to tell the Health Minister all about the rip-off.

Opposition speaker: "I will tell him that the W5 story raised some serious questions regarding the management of OHIP, and frankly the minister's incompetence."

Jim Wilson (Health Minister): "As I told W5 in a 20 minute interview I'd be happy to have any law firm in the world take on this case."

Sandy: "Happy perhaps, but certainly not hasty. Seven months after we first brought you that story, the Ontario government has still not launched legal action to recover it's share of the 100 million dollars. The province insists that it is considering a law suit but so far *nothing* has been done."

MDs get jail terms, fines as new police squad targets health fraud

http://www.cmaj.ca/content/163/5/591.2.full.pdf

Physicians are among the targets as Canada's first health care fraud squad operated by police officers starts cracking down on swindles that have cost Ontario taxpayers millions of dollars. Since 1998, more than 500 cases have been referred to the Ontario Provincial Police (OPP) Health Fraud Investigation Unit. The vast majority — 395 cases — involved alleged fraud by people who use the Ontario Health Insurance Plan (OHIP) illegally. There were also cases of double doctoring in which patients used several doctors to obtain controlled drugs by prescription, as well as 60 alleged cases of fraudulent billing by health care practitioners, including physicians. If a physician is convicted of fraud, the provincial college automatically deems it discreditable conduct and has the option of, among other things, suspending or revoking the doctor's licence to practise.

Before 1998, health fraud in Ontario was investigated by a civilian unit within the Ministry of Health, but results from 2 independent audits caused the ministry to ask the antirackets section of the OPP to conduct all investigations of fraud involving the use of and payment for health services. The officers had to study the Health Insurance Act and its regulations, as well as in the schedule of benefits

The fraud unit's largest case to date involves 62-year-old Stephen Kai Yiu Chung, who is alleged to have posed as a physician in Hamilton and is charged with defrauding OHIP of $4.5 million. Other physicians have already pleaded guilty to defrauding OHIP. Dr. Alexander Scott of Kingston was sentenced to 30 months in penitentiary after defrauding OHIP of almost $600 000; he also forfeited $124 000 in an RRSP portfolio. Dr. Donald MacDiarmid of Ajax, who had false billings worth $150 000, received an 18-month conditional sentence to be served at home and was ordered to repay the money. He was also fined $100 000 and repaid the clinic where he worked $150 000. Dr. Gustavo Tolentino, a Toronto general practitioner who practises psychotherapy, pleaded guilty to defrauding OHIP of $55 000 between 1995 and 1998. He repaid the money and received a 12-month conditional sentence. (So far, only Scott has been referred to the Ontario college for a disciplinary hearing.) The most complex case to date is ongoing. It involves 12 doctors at a Mississauga walk-in clinic who are charged with defrauding OHIP of about $2 million between Jan. 1 and Dec. 31, 1997.

Health Care Fraud: Who's Problem is it?

http://www.cgib.ca/linkedpages/CHCAA.pdf

Fraud Myth #1 “Canada Doesn’t Have a Fraud Problem!” Where there is money, there is someone that wants to get that money even if not entitled No verifiable statistics but studies suggest could be 2 – 10% of healthcare dollars

What is Fraud? A working definition: “Health care fraud is an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party.” (National Health Care Anti-Fraud Association)

Only a few actual types... υ Billing for Services Not Rendered υ Treating outside of Scope of Practice υ Allowing Unlicensed Persons to Treat υ Kickbacks or Referral Payments υ If illegal υ Over-utilization/over treatment

Common Frauds: • Identity Theft • Fabricated Receipts • Misrepresented Claim Details • Unauthorized Alterations of Receipts

Other Fraud Schemes in Canada ¬ Double doctoring ¬ Office staff fraud ¬ Drug trafficking / diversion

“Health care fraud remains uncontrolled, and mostly invisible. … … this problem represents one of the most massive and persistent fiscal control failures in their history.” “For those who profit from it, health care fraud is not seen as a problem, but as an enormously lucrative enterprise, worth defending vigorously.” Malcolm K. Sparrow Professor, Harvard University - Kennedy School of Government

Fraud Myth #2 “The Insurance Company Just Doesn’t Want to Pay The Claim!” Insurance carriers are obligated, contractually and legally, to process claims as your patient’s employers directs them Increasing utilization of benefits, especially in tight economic times, forces your patient’s employers to make tough decisions about what they can offer in employee benefit plans

Fraud Myth #3 “Insurance Carriers Always Think It Is the Provider Committing Fraud!” Absolutely Not! The carriers have seen so many types of fraud by so many different people that they do not assume anything

CBC TV Investigative report - dental ¬ A woman from Brampton charged with 234 counts of double doctoring and fraud for prescription narcotics ¬ A pharmacist charged with obtaining prescriptions for high priced drugs and paying the patient a percentage of the total prescription – not dispensing the meds however billing ON Gov. for the prescription. ¬ A US citizen charged who was receiving insured medical services for which he was not entitled

Some Case Studies ¬ Foot care practitioners charged with submitting fraudulent claims to OHIP ¬ A Pharmacy case – fake Norvasc medication being dispensed to clients and the coroner investigating if this contributed to the deaths of multiple patients ¬ A Canadian pair who were

charged over their fake Cancer clinic – this affected over 800 patients in Mexico totaling 12 million dollars

The Consequences Premium increases Decrease in the quality of coverage Inability to continue to provide insurance coverage Things (goods and services) cost more...

Ontario's top-billing doctor charged OHIP $6.6M last year

https://www.thestar.com/news/queenspark/2016/04/22/ontarios-top-billing-doctor-charged-ohip-66m-last-year.html

-An eye specialist who charged the Ontario Health Insurance Plan a "staggering" $6.6 million last year is one of 500 doctors on a secret list billing more than $1 million annually

-Hoskins said he's willing to consider arbitration but insisted many fees, such as for methadone testing and assessing CT scans and MRIs, are outdated given that technological advances mean tasks and treatments can now be performed much more quickly.

-The system is "badly out of balance" with two per cent of doctors — mostly a small cadre of specialists — taking 10 per cent of the $11.6 billion set aside to pay doctors for their services, offices, staff and equipment, he added.

-The top-billing doctor was an ophthalmologist — one of three specialties that take in the most cash, with 85 of them billing more than $1 million.

-Diagnostic radiologists led the pack, with 154 billing $1 million or more. Another 57 cardiologists hit or surpassed the same threshold.

-"When they bill more than the budget, the money has to come from elsewhere in the health-care system, limiting our ability to invest in home care, hospitals, mental health and other services."

-The fee cuts for doctors last September were on top of a 2.65 per cent across-the-board cut the previous February. There have also been fee cuts targeted at different specialties, and taken together they add up to 6.9 per cent in cuts, the OMA has said.

-The government cut fees because it is trying to cap the annual physician services budget at $11.6 billion.

Healthcare Anti-Fraud

https://www.clhia.ca/antifraud

All Canadians pay for healthcare fraud. In North America alone, it is estimated that 2 to10% of all healthcare dollars are lost to fraud. This means higher costs for everyone.

CLHIA member companies provide important supplementary health coverage to 24 million

Canadians and pay over $30 billion annually for healthcare services delivered to Canadians.

Canada's life and health insurers work hard to reduce healthcare fraud but we need your help! Reducing healthcare fraud is a team effort. Everyone has an important role to play, whether you are a patient, healthcare provider or work in law enforcement.

Mississauga doc charged with OHIP fraud

http://www.torontosun.com/2016/09/01/mississauga-doc-charged-with-ohip-fraud

A Mississauga doctor is accused of defrauding OHIP.

OPP say 57-year-old Essam Samy Michael is charged in relation to billings that were submitted to the Ontario Health Insurance Plan for services that were allegedly either not provided or billed inappropriately.

Michael is charged with one count of fraud over $5,000.

OPP say the case remains under investigation and police are reviewing evidence to determine the total loss to OHIP.

Web of deceit: Pharmacist billed province for dead patients- several case examples here

https://www.thestar.com/news/canada/2015/10/03/web-of-deceit-pharmacist-billed-province-for-dead-patients.html

Billing the province for dead patients and creating fake prescriptions from deceased and retired doctors — all part of a Toronto pharmacist's web of deceit.

Using these and other schemes, Amany Hanna bilked more than $200,000 from Ontario's drug benefit program and was disciplined by the provincial pharmacy regulator.

Hanna is one of 107 health-care professionals found guilty of fake billing during the past five years. Like almost all of them, she kept her licence.

A Star investigation has found that most health-care providers sanctioned by the province's health regulatory colleges for false and misleading billing are allowed to continue practising, even in cases that resulted in criminal fraud convictions. The 25 regulatory colleges the Star reviewed also include bodies that oversee chiropractors, dentists and optometrists.

Following a provincial health ministry audit and a police investigation, Hanna pleaded guilty in 2012 to fraud over $5,000, was given a 12-month conditional sentence and was ordered to pay $60,000 in restitution to the province.

The Ontario College of Pharmacists discipline panel did not revoke her licence. Instead, in Nov. 2014, it issued an 18-month suspension, a reprimand and a requirement to take an ethics course. She was also ordered to pay $20,000 in costs. The discipline panel called Hanna's conduct "disgraceful, dishonourable and unprofessional."

Hanna will be eligible to continue working as a pharmacist next year.

Hanna did not respond to the Star's numerous attempts to contact her, including two detailed letters left at her home and Highland Creek Pharmacy, the pharmacy in Scarborough her husband operates.

At Hanna's court sentencing hearing in 2012, her lawyer, Marie Henein, said her client's actions were "financially motivated offences" and came shortly after Hanna's daughter was diagnosed with relapsing-remitting multiple sclerosis. Henein said treatment for the disease was costing Hanna and her husband more than $40,000 a year.

Here are the highlights of the provincial health ministry's audit of Hanna's pharmacy:

65 claims were made for dispensing products to seven dead patients.

More than 3,500 claims with "incorrect" identifying information about the prescribing medical practitioner, including 16 claims from a doctor whose licence to practise had been revoked six years earlier.

Two drug refill claims that came from a doctor who died 10 years earlier.

118 claims for Pico-Salax, a medication used to clean the bowels before a colonoscopy, for a patient who had not been prescribed the drug.

55 claims for the antibiotic Biaxin XL for a patient who had been prescribed the drug just three times.

12 claims for Enbrel, a drug used to treat rheumatoid arthritis and other diseases, over a four-month period after the patient had stopped taking the medication.

More than $31,000 worth of claims for prescription reviews with patients without any supporting documentation, such as signatures or dates. In one case, Hanna told inspectors she was "sure" she had conducted a review session with a patient two weeks after the patient had died.

Mina, a dental surgeon in St. Thomas, Ont., billed more than $32,000 for surgery that was "not justified by the records over the course of four months, was aggressive and was done for his own financial gain," according to the Royal College of Dental Surgeons.

Arcuri, a chiropractor in Niagara Falls, was first disciplined in 2010 after his clinic submitted 374 claims, amounting to $24,000, for massage therapy that was never provided. His initial 12-month suspension was reduced to six months when he completed a record-keeping workshop and an ethics exam.

When a patient had one appointment with Toronto optometrist Frank Stepec, he billed OHIP twice. Stepec did that with 32 patients, according to court documents. For another 25 patients, Stepec billed OHIP for multiple minor assessments that were not provided.

In total, Stepec improperly billed OHIP about $30,000 between Jan. 2007 and Nov. 2009.

He pleaded guilty in criminal court to two counts of fraud under $5,000, was given three months house arrest and nine months probation. He was also ordered to pay $30,000 in restitution to

OHIP, which he did. Two of his employees were also charged in relation to the fraud, but those charges were dropped.

In one case, the College of Physiotherapists of Ontario disciplined one of its members because of what she did privately.

Blumfald, a Thornhill physiotherapist, forged the signatures of other health-care providers on fake claims for health services and products for herself that she never received. Blumfald received more than $10,000 in payments from her insurance company, Chambers of Commerce Group Insurance Plan, for these false claims between 2009 and 2011.

While she submitted the claims for herself outside her physiotherapy practice, the college discipline panel stated that it felt it "had an obligation to deter the profession at large" and to show the public that the profession "takes its role as a regulator seriously."

Discipline: Reprimand; six-month suspension, which was lowered to three months when Blumfald took an ethics course, paid $3,000 in costs to the college and allowed the college to monitor her practice for three years.

Doctor charged in alleged $2M OHIP fraud

http://toronto.ctvnews.ca/doctor-charged-in-alleged-2m-ohip-fraud-1.2371582

A Brampton doctor is facing several charges after submitting a series of bills to the Ontario Health Insurance Plan for services police say were not provided.

Ontario Provincial Police said Dr. Gloria Chudnow submitted fraudulent bills between 2011 and 2014 that investigators allege amounted to a $2 million loss for OHIP.

As a result of the investigation, Chudnow, 56, has been charged with two counts of fraud over $5,000, one count of fraud under $5,000 and one count of making a false statement.

She will appear in a Brampton courthouse on June 19.

Doctor not going to jail for OHIP fraud

http://www.cbc.ca/news/canada/doctor-not-going-to-jail-for-ohip-fraud-1.291316

A Toronto doctor who cheated the province's health plan of almost $1 million has been sentenced to two years of community service.

Dr. Michael Bogart pleaded guilty last year to billing OHIP for more than $920,000 over six years for services he never provided. Bogart says he regrets what he did and wants to continue to practise so he can pay the money back. He claims he over billed because he was trying to please a former lover who demanded he take him on luxury trips around the world.

During sentencing Wednesday, Ontario Court Justice Peter Grossi acknowledged Bogart is a gifted physician, but nevertheless sentenced Bogart to 100 hours of community service and three years probation. Bogart has ten years to repay the money.

Sudbury doctor defrauded OHIP of $800,000: Crown

http://www.thesudburystar.com/2013/09/16/sudbury-doctor-defrauded-ohip-of-800000-crown

Alfred Nkut got his Ontario Health Insurance Plan billing codes from the Ministry of Health in 2004.

Five years later, he was the top filing doctor in the province, a Superior Court trial in Greater Sudbury heard Monday.

“He went from being a low biller to one of the highest-ranked billers in the province,” testified Dr. Laura Amweiler, a medical adviser with the Ministry of Health and Long-Term Care's Integrity Unit.

The unit is responsible for reviewing claims made from doctors.

“From 2008-2009, he was the top-ranked non-psychiatrist for time-based services in the province.” Amweiler was testifying on the first day of the fraud trial of Nkut, a Val Caron doctor who is facing a charge of fraud over $5,000.

The Crown is alleging that out of close to $1.5 million in OHIP billings Nkut, 48, made to the ministry from April 1, 2003 to late March 31, 2010, about $800,000 were overpayments.

“The billing codes generated more income than the patient volumes would justify,” alleged assistant Crown attorney Philip Zylberberg.

Two former Mount Sinai dental surgeons charged in $200K fraud

https://www.thestar.com/news/gta/2016/03/16/two-mount-sinai-doctors-charged-in-200k-fraud.html

Criminal fraud allegations against two dentists are just the latest kick in the teeth for the prominent dental surgeons.

As well as facing several charges of fraud over $5,000, the men have been dogged over the past 10 years by allegations against one or the other of a sexual relationship with a patient, a complaint that one of them threw a plastic skull during a consultation, and extradition from Finland.

Provincial police allege that Dr. George Sandor and Dr. Cameron Clokie charged OHIP more than $200,000 for dozens of surgeries they didn’t attend and tacked on extra services to bills on numerous occasions for work performed at Mount Sinai Hospital.

In 2010, the year the OPP launched its investigation, Sandor left his posts at the University of Toronto and Mount Sinai hospital and, police say, moved to Finland, where he had defended his PhD.

He left behind a pending disciplinary hearing for false-billing charges stemming from work at the Hospital For Sick Children, said Irwin Fefergrad, the registrar of the Royal College of Dental Surgeons of Ontario.

“He skipped town,” Fefergrad told the Star. “We still suspended him because he didn’t pay his fees, but we will have a hearing.”

(Sandor’s licence to practice was revoked by the college in 2013 for the nonpayment of fees.)

“Dentists, like physicians, at Mount Sinai are independent contractors. OHIP billings are their individual responsibility and they bill directly to OHIP,” said hospital spokesperson Sally Szuster.

She declined to comment further with the case before the courts and the surgeons no longer affiliated with the hospital.

The charges against Sandor stem from alleged incidents that occurred between January 2006 and December 2009.

In January he was arrested in Oulu, Finland, and escorted back to Canada in February to face three counts of fraud over $5,000 — two for defrauding OHIP, and one for defrauding Sick Kids.

The total value police allege he gained from the scheme was over $68,000.

Clokie was arrested on March 10 in Toronto. He is facing two counts of fraud over $5,000, amounting to over $139,000 in value.

Police allege Clokie charged for 75 surgeries he did not attend between January 2007 and December 2009.

Both men were released on bail. The bail conditions do not include restrictions on practicing, according to OPP investigator Marc Duval.

Sandor is set to make a court appearance on March 31 and Clokie on March 21.

Divide and conquer

Ontario doctors want binding arbitration. The Wynne government wants a war

http://www.torontosun.com/2016/04/23/divide-and-conquer

f Ontario Health Minister Dr. Eric Hoskins has evidence ophthalmologists, diagnostic radiologists and anesthesiologists are ripping off OHIP for millions of dollars every year, he should charge them with fraud.

If he's suggesting an ophthalmologist he singled out Friday for billing OHIP for over $6.6 million in 2015 committed a crime, he should haul that doctor before the courts.

Same goes for the diagnostic radiologist he said billed over $5.1 million and the anaesthesiologist who billed over $3.8 million.

Ditto for the 500 doctors Hoskins said billed OHIP for over $1 million each last year.

In fact, none of these doctors, whom Hoskins refused to name, broke the law.

Instead, he used them to argue the "staggering" billings of some medical specialists to OHIP is the reason family doctors are underpaid and the fee-for-service billing system needs to be changed.

In other words, Hoskins is using the politics of envy to turn family doctors against specialists and the people of Ontario against their doctors.

He was also promoting class warfare, just as Ontario's social services minister would be doing were she, for example, to single out alleged welfare abusers for bleeding the system dry in order to argue for unilateral government action to cut welfare costs.

Premier Kathleen Wynne's government is locked in a long, bitter dispute with the Ontario Medical Association, representing Ontario's 28,000 doctors, over how and how much doctors should be paid.

Hoskins says Ontario's doctors are the best paid in Canada, billing OHIP for an average of $368,000 (less expenses) per year.

By contrast, the Medical Post magazine says an apples-to-apples comparison of family doctors working in Ontario to other provinces shows they are in ninth and last place (PEI was excluded), with an average income of $245,972 annually, and that specialists are no higher than the fourth-best paid in a wide variety of categories.

Disagreements of this nature with essential service workers are typically settled through binding arbitration.

In January, Wynne agreed to binding arbitration to settle contract disputes with the province's 6,000 jail guards and probation and parole officers, in return for them giving up the right to strike.

Toronto doctor charged in alleged OHIP fraud

http://www.citynews.ca/2016/08/24/toronto-doctor-charged-in-alleged-ohip-fraud/

A Toronto doctor has been charged with fraud in an alleged scheme involving Ontario health insurance billings.

Provincial police say the charge stems from OHIP billings for services that were either not provided or billed inappropriately.

They say Dr. Ranjit Kumar Chandra, 78, is charged with fraud over $5,000 and an arrest warrant has been issued as he is believed to be out of the country.

The case is still under investigation and police say they can't yet specific the total value of the alleged fraud.

Mississauga doctor Carlo Meola facing fraud charges: OPP

http://www.cbc.ca/news/canada/toronto/mississauga-doctor-carlo-meola-facing-fraud-charges-opp-1.3391860

A Mississauga doctor is facing fraud charges after an investigation by Ontario Provincial Police.

The OPP anti-rackets branch says the investigation centred on the AIMS Multispecialty Clinic.

The provincial health ministry referred the case to the OPP's health-fraud investigation unit after it received complaints about patients being unnecessarily referred to doctors at the clinic.

Dr. Carlo Meola, 59, is charged with fraud over $5,000.

Police did not estimate a value of the fraud other than to describe it as "significant" and to say it had been occurring regularly.

Meola appears on the College of Physicans and Surgeons of Ontario public register as practicing at an address on Queensway near Hurontario in Mississauga, listed as the Multi-Specialty Walk-In Clinic.

Meola is scheduled to appear in court on Mar. 1.

Patients should know what doctors are billing OHIP

http://www.torontosun.com/2012/11/15/patients-should-know-what-doctors-are-billing-ohip

Patients never get to see the what doctors are billing.

Not only that, we've no idea how much we're paying for hospital services or trips to walk-in clinics.

We don't value something when we don't know how much it costs.

And how do we know we're getting good value for our dollars when we don't even know the cost of the service?

That simple measure of sending out a statement to patients at the end of the year for services they've received would do more to lower health costs than the piddly $100 million in savings the government claims to have negotiated with the Ontario Medical Association (OMA) in its latest deal.

The only thing we do know is that the deal adds $100 million to doctor salaries, but that will be offset by $100 million in supposed “savings.”

We know precious little about this deal and with the legislature prorogued, there’s no mechanism for us to find out the details.

Whitby-Oshawa Tory MPP Christine Elliott is troubled by the lack of accountability.

“I’m concerned that we’re adding another $100 million to the overall physician compensation package at a time when we have a $15-billion deficit,” she told me in an interview.

Health Minister Deb Matthews says the $100 million will be made up by savings to the system — but those savings aren’t from the $11.2 billion we spend on doctor salaries. It’s from the rest of the $49-billion health budget — a drop in the bucket. And again, no accountability as to where they’re coming from.

Elliott says sending out health statements is a good idea.

“Members of the public need to understand what the real cost is of the health services they receive,” she said.

“I think we really need to do something to give members of the public a realistic idea of how much the cost is of services that they individually receive because it is a very scarce resource and we need to make sure that everybody uses that resource appropriately.”

New Democrat health critic France Gelinas says she’s “fuming” that she knows none of the details of OMA deal because the House is shut down, no committees are operating and there’s no question period so opposition parties can hold the government accountable for their actions.

“You’re talking about an $11.2-billion deal in my portfolio, and I know nothing about it,” she said.

At one time, sending out a yearly statement to the estimated seven million Ontarians who use the health system every year would have been a nightmare, she says.

Now, with e-mail and secure websites, she says technology has made it simpler.

“There are huge parts of the health-care system where we have no idea how much anything costs,” she said.

Look, who hasn’t opened a credit card or utility bill that’s had an error in it?

Mistakes happen. But without the fail-safe check of the consumer checking his or her bill, how do we know OHIP is being billed accurately for the services we’re using?

Give doctors binding arbitration

http://www.torontosun.com/2016/04/28/give-doctors-binding-arbitration

In that context, we're at a loss to understand what Health Minister Eric Hoskins' point was last week in throwing gasoline on the fire by implying high-priced medical specialists in Ontario are the reason other parts of the health care system are starved for necessary funds.

Especially so since Hoskins did not claim any of the 500 specialists he cited for billing the system for more than $1 million annually (out of 28,000 doctors) were committing fraud.

In fact, many doctors must pay out of their gross billings to OHIP for the costs of maintaining a practice — things like office rent, hiring staff and purchasing equipment — which lower their take-home pay.

It would appear the solution to the two-year deadlock in negotiations between the province and the Ontario Medical Association, is relatively easy to resolve.

Because doctors cannot strike, they want their contract dispute with the government sent to binding arbitration if an agreement cannot be reached at the bargaining table.

Given that this is the norm for other essential workers in Ontario such as police, firefighters and TTC employees, why is the province refusing to agree to binding arbitration for doctors?

Doctor payments in Canada reach $25B

http://www.cbc.ca/news/health/doctor-supply-cihi-1.3732029

-Physicians in Canada were paid a total of $25 billion in 2014–2015, up from $24.1 billion during the previous period, according to a new report.

The average payment per physician remained virtually unchanged at $339,000 nationally, the Canadian Institute for Health Information(CIHI) said Tuesday in its annual report.

Total gross payments to physicians represent an increase of 3.7 per cent over the previous year — the second-lowest increase since 1999–2000.

To put the $25 billion in total gross payments to doctors into perspective, Canada spends $18 to $20 billion a year on defence.

The average gross clinical payment per physician varied across the country. The average gross payment per physician was $339,000, ranging from $258,000 in Nova Scotia to $366,000 in Alberta. Ballinger said 2015 was the first year Alberta topped the country in average gross clinical payment per doctor.

For the first time, the institute provided a breakdown of the average amount by physician speciality. For example, nationally:

- Family physicians — $271,000.
- Medical specialists — $338,000.
- Surgical specialists — $446,000.

CBC INVESTIGATES

Millions of Canadians don't have to be told if health information breached

http://www.cbc.ca/news/health/health-records-privacy-breaches-1.3780963

The personal health information of hundreds of patients is breached every year, but most Canadians live in provinces where health-care providers don't have to tell victims.

A CBC News investigation found six provinces, which have a combined population of about 20 million, have no legislation in place requiring hospitals, doctors and other health-care providers notify patients of a breach of their medical files.

The legislative landscape across the country is uneven.

B.C., Alberta, Saskatchewan, Manitoba, Quebec and P.E.I. don't have legislation that requires health-care providers to notify patients of a breach.

In the jurisdictions that do have some form of notification requirement, the legislation often has a minimum harm threshold. In Yukon, for example, the bar for notification is "risk of significant harm as a result of the security breach."

The information CBC News gathered from privacy watchdogs and health authorities from across the country suggests there were more than 1,300 breach reports in 2015, compared to 922 in 2014. The numbers include provinces where custodians of health information don't have to report breaches to their respective privacy watchdogs.

Health Care Cost Drivers: The Facts.

https://secure.cihi.ca/free_products/health_care_cost_drivers_the_facts_en.pdf

In total, public-sector spending on health care reached $121 billion in 2008, an average annual increase of 7.4% since 1998. According to the latest forecasts presented in National Health Expenditure Trends, 1975 to 2011, 1 an annual report from the Canadian Institute for Health Information (CIHI), public-sector health spending as a share of gross domestic product (GDP) is projected to be 8.1% in 2011 (Figure 1).

It is helpful to examine the story of health spending after adjusting for inflation and population growth. As the following figure illustrates, there have been three phases in the growth of public-sector health spending since 1975: a growth phase from 1976 to 1991; a second period of retrenchment and disinvestment from 1992 to 1996; and a third phase of growth that averaged 3.5% per year from 1997 until 2008.

Actually, Canada, health care isn't 'free'

http://www.theglobeandmail.com/life/health-and-fitness/health/actually-canada-health-care-isnt-free/article4230286/

Last year in Canada, we spent an estimated $200.5-billion on health services. About 70 per cent of the total, $141-billon, was paid from public coffers and the other $59.5-billion with private insurance and out-of-pocket.

The "free" part, presumably, is the public piece of the pie

Canadian health care is high price yet low quality

http://www.torontosun.com/2016/10/29/canadian-health-care-is-high-price-yet-low-quality

One out of every four dollars spent by governments in Canada goes to maintaining our "free" health care system. It is far and away the provinces' largest expense.

Of our total GDP – nearly $2 trillion – almost 11% is directed by governments towards health care. That works out to well over $200 billion every year. Of the 28 industrialized countries in the world with universal health care system (the U.S. doesn't count), Canada ranks third in health care spending. Only the Netherlands and Switzerland devote greater percentages of their GDP to hospitals, doctors, health workers, diagnostic machinery and drugs.

For instance, of the 28 countries surveyed, Canada is dead last in the number of hospital beds per 1,000 residents. We have fewer than two beds per 1,000 residents. That puts us behind Slovenia, Estonia and the Slovak Republic.

Leaders Korea and Japan have more than six per 1,000.

The number of acute care beds isn't always a direct sign of a failing health care system.

We are 24th in the number of doctors per 1,000 population, 13th in the number of nurses and 20th or lower in the number of MRIs, CT scanners, PET scanners, mammography equipment and other high-tech diagnostic tools.

So what is the problem?

It's not money, obviously. We pump plenty of money into health care – about $5,700 per man, woman and child. The amount spent on health is nearly four times the amount spent on all new homes and buildings constructed across the country in a year.

And it is not those who work in the system. Canada's doctors, nurses, physios, lab techs and so on rank highly on most international measures of training, skill and competence.

Health-care savings are complete fiction

http://www.kelownadailycourier.ca/opinion/columnists/article_a390c084-9d6a-11e6-8b7d-1797d34a29a7.html

Less lovely is a report, from B.C., that Canadians with broken hips are more likely to die if they seek treatment at a small- or medium-sized community hospital, compared with large or teaching facilities.

For every 1,000 patients admitted with a hip fracture, 14 more die at medium-sized centres. That number increases to 43 more at small community hospitals.

Small hospitals have fewer than 50 beds, medium community hospitals have between 50 and 199 beds while large community hospitals have more than 200 beds, according to the study.

Fewer beds, staff and less equipment are cited as reasons for the outcomes.

Physician Assistants Could Result In Significant Savings For Canadian Health Care System: Report

http://www.inews880.com/syn/60/177190/physician-assistants-could-result-in-significant-savings-for-canadian-health-care-system-report

In 2015, the health care system cost Canadians $219M, with physician services, hospitals and drugs making up 60% of the spending.

The report says the PAs could step in and complete more routine tasks, to free up the physicians' time. The Board says if PAs are able to relieve more than 30% of physicians' time in all areas, this could represent $620M in costs savings for the health care system

Canada one of highest spenders among universal health-care countries, but performance ranks modest-to-low

http://www.marketwired.com/press-release/canada-one-highest-spenders-among-universal-health-care-countries-but-performance-ranks-2170164.htm

Canada spends more on health care than almost every other comparable country with universal care, with only middling to poor performance to show for it, finds a new study released today by the Fraser Institute, an independent, non-partisan Canadian public policy think-tank.

he study compares 28 universal health-care systems in developed countries, spotlighting several key areas including cost, use of resources, access to care and treatment, clinical performance and quality, and the health status of patients.

In 2012, the most recent year of readily comparable cost data, Canada's health-care spending as a share of GDP (10.6 per cent) ranked third highest-after adjusting for age -- behind only the Netherlands and Switzerland.

But despite the high cost, Canada ranked poorly on a number of important indicators. For example, Canada ranked 24 out of 28 countries for number of physicians (2.59 per 1,000 people), and last for the number of acute care beds (1.77 per 1,000 people).

When it comes to critical technological resources, Canada ranked 18 out of 26 for the number of Magnetic Resonance Imaging (MRI) machines with 9.2 MRIs per million people. Japan ranked first with 36.7 MRIs per million people.

As for wait times, Canada ranked last for the percentage of patients (29 per cent) who waited two months or more for a specialist appointment. Canada ranked second-last for the percentage of patients (18 per cent) who waited four months or longer for elective surgery. Switzerland, the Netherlands and Germany all reported significantly shorter wait times.

"Despite Canada's high health-care spending, wait times remain a defining characteristic of Canadian health care," Barua said.

"To improve Canada's health-care system, policymakers should learn from other successful universal health-care countries, for the benefit of Canadians and their families," Barua added.