In the Matter of:	**The Medicare Protection Act** RSBC c.286 and amendments thereto
And in the Matter of:	**A Health Care Practitioners Special Committee For Audit Hearings Panel established under s.4(3) of the Medicare Protection Act to hear the matter of Winston Tam M.D., Practitioner #25533 under s.37 of the Medicare Protection Act**

Decision and Reasons

Robert Musto & Kathryn Kickbush	**counsel for the Health Care Practitioners Special Committee for Audit Hearings and the Billing Integrity Program**
H.P. Swanson, Nevin Fishman & Amelja Zoehner	**counsel for Winston Tam M.D.**

Panel:
Oleg H. Tomchenko — **Chair**
Dr. Douglas Still
Dr. Janet Evans
Dr. Ezra Kwok
Jonalan Oddleifson

Hearing Dates:
January 26-29, 2015
February 2-5, 2015
March 24, 2015

The Medicare Protection Act R.S.B.C. 1996 c. 286 (the "Act") is legislation to provide medically necessary health care to residents of British Columbia as required by the *Canada Health Act*. The Act is one of the few pieces of provincial legislation that has a preamble which states:

Purpose of the Act

WHEREAS the people and government of British Columbia believe that medicare is one of the defining features of Canadian nationhood and are committed to its preservation for future generations;

WHEREAS the people and government of British Columbia wish to confirm and entrench universality, comprehensiveness, accessibility, portability, public administration and sustainability as the guiding principles of the health care system of British Columbia and are committed to the preservation of these principles in perpetuity;

WHEREAS the people and government of British Columbia are committed to building a public health care system that is founded on the values of individual choice, personal responsibility, innovation, transparency and accountability;

WHEREAS the people and government of British Columbia are committed to developing an efficient, effective and integrated health care system aimed at promoting and improving the health of all citizens and providing high quality patient care that is medically appropriate and that ensures reasonable access to medically necessary services consistent with the *Canada Health Act*;

WHEREAS the people and government of British Columbia wish to ensure that all publicly funded health care services are responsive to patients' needs and designed to foster improvements in individual and public health outcomes and ongoing value-for-money for all taxpayers;

WHEREAS the people and government of British Columbia recognize a responsibility for the judicious use of medical services in order to maintain a fiscally sustainable health care system for future generations; being paid for by the state.

AND WHEREAS the people and government of British Columbia believe it to be fundamental that an individual's access to necessary medical care be solely based on need and not on the individual's ability to pay.

Although not binding, the preamble allows us to focus our lens on what the legislation attempts to achieve. It governs the herculean task of the province providing medically necessary services to all British Columbia residents the direct cost of which is borne by the state. Not only are positive health care outcomes for individuals a priority but also is the sustainability of this scheme for all those using it now and into the future.

The Act has definitions which are relevant to this proceeding. They are:

"beneficiary" means a resident who is enrolled in accordance with section 7.2, and includes the resident's child if the child is enrolled under section 7.2;

"benefits" means

(a) medically required services rendered by a medical practitioner who is enrolled under section 13, unless the services are determined under section 5 by the commission not to be benefits,

(b) required services prescribed as benefits under section 51 and rendered by a health care practitioner who is enrolled under section 13, or

(c) unless determined by the commission under section 5 not to be benefits, medically required services performed
(i) in an approved diagnostic facility, and
(ii) by or under the supervision of an enrolled medical practitioner who is acting
(A) on order of a person in a prescribed category of persons, or
(B) in accordance with protocols approved by the commission;

"practitioner" means
(a) a medical practitioner, or
(b) a health care practitioner
who is enrolled under section 13;

The Act continues the Medical Services Commission (the "Commission") to administer the Act and whose guiding principles are set out in s.5.1 of the Act. They are:

Guiding principles
5.1 In performing its responsibilities and exercising its powers under section 5 (1) and in performing its responsibilities under section 5 (2), in addition to taking into account any broad policy issues and other matters the commission considers relevant, the commission must have regard to the following principles, as set out in sections 5.2 to 5.7:
(a) the principles established under the *Canada Health Act* as the criteria for a province to qualify for a full cash contribution for a fiscal year, those principles being public administration, comprehensiveness, universality, portability and accessibility;
(b) the principle of sustainability.

The responsibilities and powers referred to are:

Responsibilities and powers of the commission
5 (1) The commission may do one or more of the following:
(a) administer this Act on a non-profit basis;
(b) receive premiums that are payable by beneficiaries;
(c) determine the services rendered by an enrolled medical practitioner, or performed in an approved diagnostic facility, that are not benefits under this Act;
(d) determine the manner by which claims for payment of benefits rendered in or outside British Columbia to beneficiaries are made;
(e) determine the information required to be provided by beneficiaries and practitioners for the purpose of assessing or reassessing claims for payment of benefits rendered to beneficiaries;
(f) investigate and determine whether a person is a resident and, for this purpose, require the person to provide the commission with evidence, satisfactory to the commission, that residency has been established;
(g) determine whether a person is a spouse or a child;
(g.1) determine whether a person is a member of a prescribed class;
(h) determine whether a person is a medical practitioner or a health care practitioner;

(i) determine for the purposes of this Act whether a person meets the requirements established in the regulations for premium assistance;
(j) determine whether a service is a benefit or whether any matter is related to the rendering of a benefit;
(k) determine before or after a service is rendered outside British Columbia whether the service would be a benefit if it were rendered in British Columbia;
(l) determine whether a diagnostic facility, or a benefit performed in an approved diagnostic facility, meets the requirements of the regulations;
(m) monitor and assess the effectiveness and efficiency of benefits;
(n) enter, with the prior approval of the Lieutenant Governor in Council, into agreements on behalf of the government with Canada, a province, another jurisdiction in or outside Canada or a person in or outside British Columbia for the purposes of this Act;
(o) establish advisory committees, including pattern of practice committees, to advise and assist the commission in exercising its powers, functions and duties under this Act, and may remunerate members of a committee at a rate fixed by the commission and pay reasonable and necessary travelling and living expenses incurred by members of a committee in the performance of their duties;
(p) authorize surveys and research programs to obtain information for purposes related to the provision of benefits;
(q) enter into arrangements and make payment for the costs of rendering benefits that will be provided on a fee for service or other basis;
(q.1) establish, subject to this Act and the regulations, rules to govern its own practices and procedures for the conduct of hearings under section 15 or 37, including the following:
(i) the conduct of negotiations or a pre-hearing conference for possible settlement of the issues before a hearing is commenced;
(ii) the means by which particular facts may be proved or the mode in which evidence may be given at a pre-hearing conference or a hearing;
(iii) the time limits for the exchange of documents, reports and affidavits in preparation for a pre-hearing conference or a hearing;
(iv) the requirements for the attendance of witnesses, the conduct of witnesses or the compelling of witnesses to give evidence under oath or in some other manner;
(q.2) require that a party to a hearing under section 15 or 37 submit a matter at issue in the hearing to non-binding mediation;
(r) provide to a person or body prescribed by the Lieutenant Governor in Council, for the purpose of an audit or investigation of a practitioner's pattern of practice or billing, information concerning claims submitted by that practitioner to the commission;
(s) apply section 26 for supply management and optimum distribution of medical care, health care and diagnostic services throughout British Columbia;
(t) establish guidelines setting the number of practitioners that a beneficiary may consult respecting the same medical condition within the period specified in the guidelines;
(u) exercise other powers or functions that are authorized by the regulations or the minister.

Thus, a practitioner who enrolls to be a provider under the act and receive payment for benefits rendered to a beneficiary, comes under the purview of and is required to do what the

Commission requires in order to receive such payment. This includes providing medically necessary services in a cost effective manner. The rules for receiving payment are set out in the Commission's Payment Schedule. This schedule not only sets out the amounts that are to be claimed for various services, divided into groupings by type of health care practitioner or medical specialty and the general requirements for payment including the necessity of having an adequate medical record of a service that is deemed a benefit under the medical services plan.

During the 2011 -2012 fiscal year the Commission paid $2.7 billion dollars to almost ten thousand practitioners for benefits they provided to some four million six hundred thousand beneficiaries. In order to do so benefit claims which, during the period in issue totalled approximately 87.6 million, are submitted by practitioners in electronic format and are paid as a matter of course unless incomplete or wrong information is submitted. The magnitude of claims submitted makes it extremely impractical to review and approve each claim made. Therefore all are paid. Thus the payment system depends greatly on the integrity of practitioners to submit only valid and proper claims.

The Commission is mandated to determine what benefits qualify for payment at what rates and what is required to be performed as set out in s. 5 of the Act set out above. This monitoring is authorized both before and after payment. Additionally s. 36(2) of the Act authorizes the commission to appoint inspectors to audit claims for payment by practitioners and the patterns of practice or billing followed by practitioners. In practice, the Commission, through the Billing Integrity Program (BIP), monitors practitioner claims. BIP staff are persons with expertise in auditing and a medical practitioner called the Medical Consultant. Initially a review is done utilizing computer programs which produce practitioner profiles that compare the claims specific payments of that practitioner to the group average. The group consists of those practitioners who are of the same profession, or in the case of medical practitioners, those of the same specialty. If the comparison shows a statistically significant deviation from the average and is without an explanation that is apparent from the records, the practitioner's records are then analyzed by qualified individuals and, if appropriate, are sent for further action. This is what occurred with Dr. Tam's billing records.

Dr. Tam's billing profile was brought to the attention of the BIP Audit and Inspection Committee in August 2010 after the profile revealed that he ranked number one in Services, Costs, Patients, Services per patient receiving the Service, and Services per 100 Total Patients as shown in Exhibits 1 to 19. The profile compared Dr. Tam to his peers, other Obstetricians and disclosed that he was 4 standard deviations above the average for Services per patient receiving the Service and 5 standard deviations above the average for Services per 100 Total Patients. During the Audit Period (2005 – 2010 fiscal years) Dr. Tam's fees for services were consistently 2 standard deviations above the group average being 330% of the group average in 2005 and 382% of the group average in 2010.

Dr. Tam's profile indicated significant anomalies that were not readily explained and so BIP, after a three level internal review, referred his file to the Audit and Inspection Committee which, because Dr. Tam is a licensed physician, is composed of a representative of:

A physician representing the College of Physicians and Surgeons of B.C;
A physician representing the Doctors of B.C.;
A physician representing the Government of B.C.; and
A member of the public representing the Beneficiaries of MSP.

Evidence was adduced to the Audit and Inspection Committee as to the anomalies the Medical Consultant observed after a review which not only raised concerns regarding the propriety of service billings, such as urinalysis, but also of the quality of patient care in that for many days Dr. Tam billed for personally attending to 70 plus and 80 plus patients in a day and for 3 days provided care to 90 or more patients.

The Audit and Inspection Committee, a sub committee of the Commission, determined there was sufficient cause to order an onsite audit of Dr. Tam's practice.

The audit was for the period November 1, 2005 to October 31, 2010 and the sample of patients that were audited was 44, selected at random from the 13,738 patients Dr. Tam provided services to during the audit period. This is known as a dollar unit sample and, the BIP says, on the basis of an opinion from a professional statistician, will produce a statistically valid sample of the billing practices of a practitioner. The audit team consisted of an auditor and a medical inspector. The auditor dealt with the financial aspects of the audit and the medical inspector, a licensed physician, had access to the patient charts to determine whether services provided by the practitioner to the beneficiaries were benefits under the Act and that the rules and regulations to claim payment for the benefits were followed.

During the audit, there were 3 different auditors appointed at various stages of the audit process. It was the result of staff turnover at the BIP. The evidence showed sufficient continuity and adequate record keeping and no deficiencies were noted despite the several persons attending.

There was one medical inspector throughout the entire audit process. In this instance, the inspector was Dr. Mary Lynn Simpson who is licensed to practice obstetrics and gynecology in B.C., has practised as such from 1982 to 2006 and since then has concentrated on clinical research and teaching through UBC where she is a Clinical Associate Professor in the Faculty of Medicine. She still provides surgical assistance, does locums and has a general gynecology practice. She has been an inspector under the Act since August 1996. Given the rather exclusive number of obstetric and gynecological practitioners in B.C., Dr. Simpson knows Dr. Tam meeting him first as one of his instructors and supervisors during his residency.

Dr. Tam says Dr. Simpson had an inadequate knowledge of the fee schedule and as such her findings do not stand up to scrutiny. Dr. Simpson had for many years billed the Commission for services. She displayed a good knowledge of the fee guide as well as the composition of the

services covered by the various fee items. If she was uncertain of a fee item, she sought clarification. She showed deference to Dr. Tam in that many ambiguities she resolved in his favour. Those that could not be resolved, were not just dismissed but were often reclassified under the appropriate billing code and Dr. Tam was given credit accordingly.

Dr. Simpson reviewed the charts of 44 of Dr. Tam's patients which patients were selected by BIP in order to provide a sampling to meet the objectives of the audit which were to determine whether:

1 clinical records exist to support that services were rendered as claimed;
2 there were complete and legible clinical records;
3 the services rendered were benefits under the Act;
4 Fee items claimed were consistent with the services described in the clinical records;
5 Services claimed were actually provided;
6 Whether there were any quality of care issues; and
7 Whether patterns of practice or billings were justifiable.

Dr. Simpson noted a number of discrepancies, improprieties, and errors. Those were inscribed on a document entitled "Listing of Possible Billing Irregularities" where she wrote the billing code error and made a note under Inspector Comments giving her reasons for disallowing the claim. This listing was sent to Dr. Tam and he was given an opportunity to respond to the notations and refute them. 332 possible irregularities were noted in 38 of the 44 charts examined. For some charts numerous irregularities were noted. An example is the chart of patient 42. It shows 58 irregularities between February 2009 and September 2010. This is the chart with the most errors for a single patient although others indicate multiple errors such as for patient 7 which notes 22 irregularities over a 5 month period and for patient 23 there are 27 irregularities over a 6 month period.

Dr. Tam responded to the Listing of Possible Billing Irregularities. It was not a refutation of all of the irregularities and some, such as to justify a billing of fee item 4012, he sent 25 unsigned copies of limited consultation reports. The error noted was that there was no copy of the report in the chart. As part of the follow up, BIP sent requests to the 25 referring doctors to ascertain whether they had requested and received the consultation report. All 25 replied in the negative. Notwithstanding this, the auditors, considering other evidence, such as appointment books and entries in patient charts, although scant in detail and at times, illegible, were not deemed services rendered under objective 1 above although 4 were disallowed under objective 2 of the audit and 21 were disallowed under objective 4 because they were not consistent with the services described in the records. In these 21 instances, Dr. Tam was given credit for an office visit.

Another multiple error noted was for fee items 1200, 1201, and 1202. Dr. Tam billed this item 62 times in the sample. Of the 62, in 23 of the instances, there was less than 1 hour between the call outs and for 5 of the 24, there was only a 35 minute difference. These items were, as such, disallowed.

As to the clinical records that must be maintained for billing, as required in the fee schedule, the inspector found many instances where the records were not adequate not noting material observations. Also, at times there were no clinical notes in the chart but there was a copy of a consultation letter that, although bearing a later date, referred back to the appointment. Despite these defects, the claims were not disallowed under objective 2.
Lack of clinical records were also noted in 26 instances of fee item 790, interpretation of fetal heart monitoring. Dr. Tam's evidence, supported by his expert Dr. Woo, is that the practice at his hospital was to examine the monitor tape and if it was normal, to merely initial it and that is known within the hospital and therefore is an adequate clinical record. Initialing a strip without more may be an accepted practice within a hospital but it is not a clinical record as defined in part C. 10 of the Fee Guide. The practice may be one the hospital accepts and should the practitioner proceed in that manner, that may be acceptable within the hospital but it does not entitle the practitioner to bill the fee item to the Commission.

Dr. Tam, in effect, says that adequate billing records are not required under the Act in order to receive payment. He says that s. 26(1) of the Act does not authorize the Commission to establish a Payment Schedule to specify what kind of records are required. They say at, best, the definition of adequate clinical record in Part 4 of the Regulations to the Act were met by Dr. Tam and that definition is inconsistent with the definition in the preamble to the Fee Guide.

S. 26 of the Act does not consider records but. S.27 states:

Submission, assessment and payment of claims
27 (1) A practitioner who renders a benefit to a beneficiary **must**, for the purpose of assessing or reassessing the claim for payment, **provide particulars of services and accounts to the commission that are required under this Act in the manner the commission specifies.**
(2) The commission must assess and, if appropriate, reassess the particulars of claims for payment and determine the amounts payable for them in accordance with this Act, the regulations and the appropriate payment schedule.
(3) The Lieutenant Governor in Council may prescribe the period of time within which
(a) a claim for payment must be submitted to the commission,
(b) a practitioner or beneficiary may request reassessment of a previously submitted claim, or
(c) the commission can assess or reassess a claim.
(4) The commission must, to the extent authorized by the appropriation, pay for claims for benefits that the commission has assessed or reassessed and that comply with this Act, the regulations and the appropriate payment schedule.
(5) The commission is not liable for payment if a claim is submitted outside the period prescribed under subsection (3) but, in its discretion, may pay the claim.
(6) For the purposes of this section
(a) a practitioner must provide the commission with any record that the commission considers relevant to substantiate a claim, including any medical or clinical record, in the care or control of the practitioner, and

(b) a practitioner must retain records, including medical or clinical records, for a period specified by the appropriate licensing body or, if the appropriate licensing body has not specified a period, for a period the commission specifies. (our emphasis).

It is clear that s. 27 authorizes the Commission to set standards including what constitutes an Adequate Clinical Record. Dr. Tam goes on to say that the Commission exceeded that authority by not repeating the definition of Adequate Clinical Record in the Regulations. The difference is that in the regulations, the words: "together with the beneficiary's clinical records from previous encounters" are not included. But in the Payment Schedule the words: "at hand" are used. These words appear to be interpreted as the patient's chart which contains the clinical record of the service being billed plus the records of all previous encounters. The Clinical Inspector treated them as such and confined her error listing to errors on the record dealing with the specific service in light of the records in the entirety of the chart. The guidelines and their interpretation are consistent with the definition of Adequate Clinical Record in the Regulations.

Under Objective 4 of the Audit, a determination of whether fee items claimed were consistent with the services described in the clinical records, 223 services were found to be not consistent with the services provided. These claims were not disallowed but were valued for the more appropriate claims which were for a lesser amount. One of the items was for urinalysis. Dr. Tam consistently claimed for 15142, Microscopic urinalysis rather than 15130, urinalysis even though his office was not equipped to perform a microscopic urinalysis since it had no microscope. At the hearing Dr. Tam conceded that he billed urinalysis incorrectly during much of the audit period and agreed that all monies overpaid for that billing item are owing to the Commission. Dr. Tam testified that it was an innocent mistake as he switched his billing practice when he was supplied with "advanced" urinalysis strips that produced a wider range of results and did not realize that a microscopic analysis was required. He said he learned of his error during discussion with the Medical Inspector at the onsite audit which was conducted from December 6, 2010 to December 10, 2010. However, an examination of the statistical profile graph comparing the 2 urinalysis codes, 15130 and 15142 show that during June and July 2008 Dr. Tam switched from claiming 15130 to the higher fee, code 15142 but that in October 2010, changed to billing 15130. This was before the onsite audit but after he was notified by BIP that an onsite audit would be conducted. When Dr. Tam was asked why the change was made during the last month of the audit period but before the on site audit, Dr. Tam's response is almost unintelligible. He dissembled. The inference to be drawn is that Dt. Tam had the requisite knowledge and knew that his billing for code 15142 could not be supported.

Additionally, the audit noted a number of concerns regarding the quality of care. Scantiness of records and their illegibility, notwithstanding this is a core requirement for billing, was noted along with omissions. There were also delays in conducting requested pelvic examinations. There were also very high daily patient volumes. Dr. Tam's long hours of work and high patient volumes should not be discouraged because of the prime objective of the *Canada Health Act* as adopted by the Act, which is to provide all British Columbians with reasonable access to, inter alia, medical care. However, the medical care that is provided, to be billable, needs to comply

with the rules and regulations proscribed by the commission, including the requirements to chart the service adequately and to ensure that it was provided and the diagnoses are correctly stated. It was noted that Dr. Tam's urine tests were always recorded as negative, even when there was record of a related issue, such as a urinary tract infection.

Dr. Tam says that in considering the Audit Report as revised, we are limited to considering those errors listed under objectives 1, 2, and 4 of the original Audit Report as amended as to amount only in the Revised Audit Report of April 10, 2014 because of s.37(2)(b) of the Act and the notice given in the letters of July 26, 2012 and August 16, 2012. This ignores the specific wording of sub paragraph number 2 of the second paragraph in the August 16, 2012 notice which states:

> 2. The circumstances giving rise to the Commission's intended action are outlined in the audit report dated June 6, 2012 **and such additional circumstances as counsel may advise**. (our emphasis)

The aforesaid notice contemplates that as advancing to the hearing, the process is dynamic and that other matters may arise and would be relied on and which was done. The Revised Audit Report is just such a document and it was provided to Dr. Tam with sufficient time to consider its findings and be prepared to answer them. Dr. Tam received adequate notice of the findings and the allegations contained therein.
In considering the evidence, the practice profile of Dr. Tam which were initially examined and which led to the audit, the notice and subsequently the hearing, are a comparison of is billing practices to those of his peers.

Below we deal with individual billing items in issue not discussed above. In considering all of the billing items we considered the audit report and all that went into the report. We also considered the evidence of Dr. Tam and his expert Dr. Woo.

Dr. Tam began his practice in Obstetrics and Gynecology in 2001. For the early part of his career, his billings to the Commission were not brought to the attention of BIP since they were within the parameters considered normal. That is, his practitioner profile appeared to be his within the averages of his peers. It was not until 2005 and subsequent years that that profile showed a marked departure from that of his peers. Our impression of the BIP witnesses was that of professionals within their fields doing their jobs in a competent and dispassionate manner. They were led to Dr. Tam by billing programs that had monitored practitioner billings to the Commission for several years and when they observed the anomalies, they logically followed up.

Dr. Tam did not impress us as a wholly credible witness. He attempted to portray himself as a victim whose extreme hard work and dedication to his patients was not appreciated. During his examination in chief, he displayed an incredible recollection of the several patients whose charts were audited and to explain away the very large number of billing errors noted. However, during much of his cross examination he dissembled and did not coherently answer fairly straight forward questions. His incredibly detailed memory suddenly faded into an

incoherent jumble. An example touched on above is his billing for 15142. In addition, when he made the billing change from15130, he claimed he or his administrative assistant contacted the Commission to confirm that he was billing correctly. This does not ring true since he did not allow his administrative assistant to do his billings but he did them at home in the evening on a lap top computer. There is also the example of the found referral letters, unsigned and undelivered. To claim that all of the purported recipients are in error is unreasonable and not believable. Where there is a contradiction between the evidence of Dr. Tam and witnesses proffered by BIP, we believe the latter.

Dr. Woo was presented as an expert witness. Dr. Woo is also an Obstetrician – Gynecologist. He examined the Audit Report, Dr. Tam's replies, and the charts. His evidence to a large part was to support Dr. Tam's position. However, Dr. Woo did not display an infallible knowledge of the billing codes. His position on item 790 is not accepted for the reasons stated above. Dr. Woo's assertions as to the propriety of billing fee item 4007 is discounted since he was confused on his comparisons to fee item 4717 which was not in existence during the audit period.

Although Dr. Woo's evidence and opinions may have certain weight in court, this is not a court but an administrative tribunal where the hearing panel is deemed to have expertise with the matters in issue. This is especially true for this panel where the majority are licensed practising physicians who have or have had extensive experience rendering billings to the Commission and, as such, we are entitled to rely on this expertise when weighing the evidence. To that end, while we find Dr. Woo's evidence interesting and informative, it, like the evidence of Dr. Simpson, is not determinative.

FEE ITEMS

15142
Discussed above. All items were wrongly billed during the audit period.

790
As we have found that Dr. Tam did not keep an adequate clinical record of this service, it cannot be billed.

4118 & 4119
While it is generally accepted that direct attendance is not required during an oxytocin infusion it is expected that the provider be readily available otherwise the words in the code: "where constant attendance by the physician in attendance is required" would have no meaning. Frequently Dr. Tam billed several other services while billing 4118, and 4119, in circumstances that would have made it impossible to be "readily available" as required by the billing code. While Dr. Tam says there is no evidence, there is evidence. It is found at:

sample 7-23, Exhibit3-288;
sample 15-8, Exhibit 4-20;
sample 39-4, Exhibit 7-266;

sample 40-21,22, Exhibit 7-423-424;
sample 42-35, Exhibit 817.

4010

The billing code is clear. To qualify as a full consultation, the physician must do a complete patient history and perform a gynecological examination which Dr. Simpson says includes a pelvic examination, and noting such in the clinical record as well as providing a written report. The record did not note a pelvic examination was performed in 30 instances. In giving evidence, Drs. Tam and Woo opined that a pelvic examination is not always medically necessary to do a gynecological examination and, at times, would be, inappropriate. Dr. Simpson also said that there are rare exceptions to the pelvic examination. Dr. Tam says Dr. Woo's view of when a pelvic examination is required is preferred to Dr. Simpson's view because of her limited practice over the last 8 years and as such she is not up to date on modern preferred practice. This ignores that Dr. Simpson's practice is limited but she supervises the training of residents in her specialty as a professor at the University of British Columbia. As such, she undoubtedly would be very aware of the modern approach to gynecological examinations as she is responsible for the training of those working toward their specialist certification.

When examining the evidence of all three doctors, it appears that a pelvic examination is an integral part of a gynecological examination and not performing it is an exception to the general rule. Therefore, it follows that if an exception is to be made and a pelvic examination is not performed, such would be noted in the clinical record along with the reasons for not performing the examination yet no such notations appear. During the hearing, Dr. Tam was asked by the panel about a specific error where no pelvic examination was performed but the foetus was breech, something that would have been discovered had the examination been performed. Dr. Tam had no reply to this question.

Additionally, the code requires a written report unless the consultation is done during labour. The Commission sent out requests to 30 referring physicians as to whether they received the reports. Ten replied in the negative. Dr. Tam says that this is hearsay evidence and is very unreliable. He does acknowledge that this is an administrative hearing and while we are entitled to admit the evidence, to rely on it would be very dangerous. However, the requests were to physicians who also bill MSP to check their relevant patient charts to ascertain whether a report was in the chart. As participants in MSP, these physicians are required to keep adequate medical records and so merely checking the records is not a task that is fraught with uncertainty or ambiguity. As fully one third of those to whom the question was posed answered in the negative it mitigates against error and unreliability. To say that all of the physicians would be in error while, Dr. Tam, who especially in regard to code 4012 (discussed more fully below), could only produce unsigned copies at a later date, is an unsupportable assertion. We are of the view that the physician replies are reliable evidence.

4007

Dr. Tam says that the billing of this was due to an ambiguity in the description that was not corrected until mid 2009 when the descriptor was modified to state that the code referred to

gynecological services only. However it appears that Dr. Tam switched from billing for follow up visits for pregnant patients (14091) to accommodate his concept of "shared care". This involved a pregnant patient being referred to Dr. Tam by a general practitioner and the patient then receiving routine pregnancy care by both her general practitioner and Dr. Tam. Under 14091, the number of visits for routine care are limited and visits to 2 doctors would not be billable for the entire course of pregnancy unless there were medically necessary reasons that would have to first be approved by the Commission. By using an inappropriate billing code, Dr. Tam was able to circumvent the necessity of obtaining permission to have two doctors providing essentially the same care to one patient which, in the event the case was complex, approval for both doctors sharing the care should have been sought. This is not a judicious use of medical services and to allow it would lead to fiscal unsustainability. Dr. Tam further tried to justify his use of this code by stating that he confused it with billing code 4717 which code was not introduced until mid 2011 which was outside the audit period.

4012

Initially, the concern was the lack of referral letters. Although unsigned copies were produced later, it became clear from all of the evidence that Dr. Tam scheduled a regular post partum visit outside the 6 week window to obscure that he was providing post partum care that should have been billed under code 14094. Dr. Tam stated in evidence that discussion of contraception warranted the fee code yet later admitted that discussing contraception with a patient shortly after delivery is integral to post partum care.

4000

This fee is intended for a complicated vaginal delivery and is not intended as a bonus to be billed in conjunction with 14014 other than as allowed. The change to the code made during the audit period is not, as alleged by Dr. Tam, a material change but merely done to clarify the general usage of the code.

4005

This fee code is intended to cover a special call out of the office. A requirement is to chart the time of the service. This was not done. Additionally it appears that Dr. Tam was already in the hospital. See:

sample 7-20, Exhibit 3-288;
sample 9-21, Exhibit 3-434;
sample 40-20, Exhibit 7-325; and
sample 42-33, Exhibit 8-216.

Furthermore, Dr. Tam also billed under 1211 for the same service even though 4005 is not to be billed as an additional surcharge. In responding to a question from the panel, Dr Tam said that because his office was only 10 minutes from the hospital, he would provide the service and return only to be called out again. But, we see instances where there was less than 30 minutes between call outs billed, thereby giving only 10 minutes to provide services and it is very doubtful they could be completed in that time.

1200 & 1201

Many of the call in's were less than an hour apart and some less than 35 min. It is just not plausible or reasonable to have so many call backs in such a short time period. Additionally, there were numerous instances of a lack of an adequate clinical record to support the charges.

14560

A review of the clinical record (Exhibit 1, Book 6-293) shows that a general pelvic exam was performed and nothing else so this code ought to have been billed rather than 4007.

4516

A review of the Inspector's work sheet (Exhibit 1, Book 5-198) addresses the notion that the procedure was elective and not an emergency including that the patient had a known cervical incompetence. There is nothing in the clinical record to indicate why the surgery was an emergency. On the contrary, the record, in this instance, the OR report states that the patient arrived, scheduled for the specific surgery. Her scheduled surgery time was delayed because of other emergencies that had to be attended to in priority.

808

A review of all of the records indicate that the services were performed by Dr. Tam notwithstanding the lack of an adequate clinical record, in that they are illegible. As the inspector relied on consult reports to confirm other services were rendered and therefore allowed, it should be the same for this service.

14108

The sole record dealing with the time frame this service could have been provided is found at Exhibit 1, Book 3-159. There is no indication that post natal care was provided. Given that a family doctor was involved, it is a service that physician would provide.

1205

There are no records to support this charge. It is for stand by in the second stage. Because there were records of delivery, it cannot be inferred that this charge was incurred.

4032

There is a lack of adequate records and after reviewing the same, it is not possible to determine from other material in the chart if the service was rendered. Since an integral part of requesting payment for a service is for the billing physician to have an adequate clinical record and provide proof when requested, the failure to do so is all the Commission needs to show to prove that the billing is improper.

Patients 41 & 36

Dr. Tam also argues that the charges for 2 patients that were disallowed, Patients 41 and 36, are outliers and because Dr. Tam and the other physicians involved "did the right thing", the Commission is not out any money and therefore, the billings should be allowed.
In respect of Patient 41, because he was too busy to attend to this patient's surgery, Dr. Tam called in another physician who performed the surgery but billed it as if he had done it and when payment was received, he paid over those monies to the physician.

In respect of patient 36, Dr. Tam was observing another physician perform a surgery on Dr. Tam's patient as a training exercise. The physician performing the surgery did not charge for his services despite also dictating the report. If this is not the case, the clinical records are so bereft and the meager notes there are, unintelligible and as such, the claim should be disallowed.

Dr. Tam's assertion that he "did the right thing" in both of these instances is troubling. As set out above, because of the sheer number of claims, integrity of those using it and benefiting from it is of utmost concern. Without that integrity, the payment system and Medicare as designed and the principles on which it is founded could not be sustained. Individual claims cannot possibly all be vetted by the Commission and so the professionals who are entitled to send in claims for payment must scrupulously follow the prescribed rules for payment. S. 37(1)(b) allows us to order repayment when that claim is for payment in respect of a benefit that was not rendered. These are two instances in a sample of 44 patients where Dr. Tam did not render the benefit for which he claimed. Dr. Tam says these are but outliers. By his own admission Dr. Tam has an extremely busy practice and his billing was done by him sometimes long after the service was delivered and errors were made. One instance, perhaps, could be considered an outlier but given Dr. Tam's lack of candor and the cavalier way that Dr. Tam practices, his inadequate charting and his propensity to cut corners while maximizing his billings are sufficient for us to find that, on the balance of probabilities, these patients are not outliers but are indicative of Dr. Tam's method of practice.

We therefore find that the Commission has proved the errors set out in the audit save for fee item 808.

S.37(6) of the Act says:

In making an order under subsection (1), the commission may consider, and base the order on, any relevant source of information, including a source created on a statistical basis or by a comparison between benefits provided by the practitioner or diagnostic facility and corresponding benefits provided by other practitioners or diagnostic facilities, but it is not necessary for the commission to consider any particular benefit that the practitioner or owner of the diagnostic facility provided.

BIP has proffered a statistical report based on the dollar unit sample. They compiled it and it was reviewed and approved by their statistician Dr. Mary Batcher who provided an expert report.

Paragraph 7.5 of Dr. Batcher's report states that dollar unit samples are used by statisticians and other quantitative experts. They are particularly effective in improving the precision of the estimates derived from the sampling process with financial data where there are relatively few high dollar amounts and many smaller amounts, which is what we have in this case. They are frequently used in audit sampling.

Paragraph 8.5 explains that sampling methodologies and extrapolation techniques are based on the premise that a complete examination of the population would identify, with certainty, the true value of the exception.

The report indicates that the single point of estimated value of billings in error is $1,692977.76 with a margin of error of $391,759.18 which amounts to 23.1% of relative precision. This is generally acceptable as the extrapolation of the value of billings in error is depending on sampling. At a 90% confidence interval, relative of precision of less than 25% is acceptable for the purpose of estimating the amount of billings in error for recovery.

Dr. Tam had Dr. Berkowitz, also a statistician testify on his behalf. Dr. Berkowitz raised several issues. These are:

1. Dollar Unit Sampling and Sample Size

Dr. Berkowitz says that "a large margin of error means that the single-value point estimate provided by the Weighted Dollar Error calculation may be a long way from the truth. That is, there is low precision in the estimate. A large margin of error calls into question the adequacy of the sample size" (p2.Berkowitz report). In the practise of billing by physicians, the system expects a high degree of integrity and the billing by physicians usually follows a general pattern that has been communicated from physician to physician, in addition to the instructions from the MSP fee schedule. That means in general, physicians would have similar understanding of different billing codes. Therefore, a random audit of any physician should yield no irregularity in the billing in an ideal situation, and only yield very low error rate as a result of minor misunderstanding or negligence. But a review of Dr. Tam's billings, even a ample of 44 patients yielded a high percentage of billing irregularities. On one hand, the large margin of error could be because of the small sample size, on the other hand, the high percentage of billing irregularities even from a small sample shows a high probability of billing irregularities for the overall population.

Dr. Berkowitz further said that "To put this into context, survey sampling for applications such as opinion polling is designed to achieve margins of error of plus or minus three percentage points 19 times out of 20; that is, a 95% Bound on Estimate of +/- 3%". His example is for survey sampling which has finite questions and the responses that are clearly restricted by a set of pre-defined choices. For financial audits, the population generally contains large amount of samples with varying dollar figures. That's why Dollar Unit Sampling has been recommended by Dr. Batcher as a better tool for financial audits. This method, according to Dr. Batcher, "is a commonly used audit sampling method".

2. Confidence Intervals and Point Estimates

It is agreed by both experts that any value within the confidence interval may be the true value, and the true value doesn't have to be in the mid point of the confidence interval. It is also agreed that "the low end of the 95% confidence interval is as valid an estimate as any other". While the lower bound and upper bound of a confidence interval vary at different confidence interval estimate (i.e. 95% confidence interval will have a wider span from lower to upper bound than a 90% confidence interval.) For audit purposes, one still needs to have a point estimate for the amount of recovery. Because the confidence interval bounds change according to the confidence percentage limit, the most reasonable point estimate for recovery is still the unbiased estimate from the estimation formula for dollar unit sampling.

BIP has referred us to a previous decision of this board, that of Russell Schulter. We agree with the submissions of Dr. Tam that this decision is not binding on us, but its logic is impeccable. Statistically it may not matter where within the confidence interval may lie the true value but if we choose the high point, there may be injustice to Dr. Tam. Using the same reasoning, the low point would be equally inappropriate unless there is some justification, which we do not find. Therefore, the midpoint is the fairest choice.

3. Comments on sample selection

Dr. Berkowitz identified three potential outliers that may have skewed the distribution resulting in a biased extrapolation in the total weighted dollar error. The three top outliers are patients 41, 36, and 31.

We have dealt with the first 2 above and it is our conclusion that they should remain in the sample. As to patient 31, the letters to the family doctors were not provided within the reasonable time expected from the fee schedule. Hospital notes were not legible. Therefore, for the same reasons as for patient 36, the dollar value appears to be an outlier but the reasons for identifying these as billing errors is consistent with many of the other billing errors. Therefore, the billing errors from patient 31are not outliers.

Therefore, we consider the sample size to be adequate.

Item 15142 was conceded by Dr. Tam to be billed in error and should have been be billed under code item 15130. All the billings for this item during the audit period are identified. The difference is to be repaid. Unless BIP can readily quantify the difference since the amount payable under the 2 billing codes varied during the audit period, the use of the average between the 2 codes of $3.35, as proposed by Dr. Tam, is appropriate and the calculation therefore yield the amount of $45,342.25.

Since the total of misbillings of item 15142 are quantified, it would be wrong to include them in the statistical calculation.

In summary, in addition to the amount owing for fee item 15142, BIP are to recalculate the Estimated Values of Billings in Error using the statistical methods in their report minus the alleged billing errors under cords 15142 and 808.

Dr. Tam has made submissions of proposed pattern of practice orders and requested submissions for costs. BIP has requested that in the event a recovery order is made, that they make submissions as to pattern of practice orders and costs.

Since we have made a recovery order, we invite submissions as to both pattern or practice orders and costs.

Dated: December 7th, 2015

Oleg H. Tomchenko

"See attached"

Dr. Douglas Still

Dr. Janet Evans

Dr. Ezra Kwok

Jonalan Oddleifson

Dated: December 5, 2015

Oleg H. Tomchenko

Douglas Keith Still

Dr. Douglas Still

Dr. Janet Evans

Dr. Ezra Kwok

Jonalan Oddleifson

No.
Victoria Registry

IN THE MATTER OF the *MEDICARE PROTECTION ACT*
R.S.B.C. c. 286 and amendments thereto

BETWEEN:

THE MEDICAL SERVICES COMMISSION, a body continued under the *Medicare Protection Act*, R.S.B.C. 1996, C. 286, as amended, with an address of 1515 Blanshard Street, Victoria, British Columbia, V8W 3C8

AND:

DR. WINSTON TAM, Practitioner #25533, with an address, of 31 – 15300 105th Avenue, Surrey, British Columbia, V3R 6A7

ORDER

THIS matter coming on for hearing at Victoria, British Columbia, from January 26, 2015 to February 5, 2015, and continuing on March 24, 2015, and on hearing Robert Musto, counsel for the Ministry of Health and the Billing Integrity of Program, and on hearing Peter Swanson, Nevin Fishman, and Amelja Zoehner, counsel for Dr. Tam:

THE PANEL ORDERS that Dr. Tam pay to the Medical Services Commission ("MSC") $1,673,215.06 in repayment of certain medical services billed by Dr. Tam from November 1, 2005 to October 31, 2010, inclusive.

THE PANEL FURTHER ORDERS that Dr. Tam pay to the MSC $369,173.06, being the prescribed surcharge and interest.

THE PANEL FURTHER ORDERS that Dr. Tam pay to the MSC the costs of the audit and the hearing in the amount of $58,174.82.

THE PANEL FURTHER ORDERS that Dr. Tam adopt a pattern of practice or billing that is in accordance with the payment schedule as established by the MSC under s. 26 of the *Medicare Protection Act*, R.S.B.C. 1996, c. 286, and amended from time to time. Subject to such amendments, Dr. Tam will:

a) Make and maintain adequate medical records in accordance with the preamble to the payment schedule;

b) Bill Fee Item 4007 only for a subsequent office visit (for gynecology visits only, all pregnant patients and routine pre-natal patients billed under fee item 14091);

c) Bill Fee Item 00790 only for antepartum fetal heart monitoring (not to be charged for intrapartum fetal heart monitoring nor when done in conjunction with a consultation, and only bill fetal heart monitoring strip when it has been reviewed in a clinically relevant timeframe and a written interpretation provided;

d) Bill Fee Items 01200 to 01202 only extra to consultation or other visit, or to procedure if no consultation or other visit is charged, and such claims must state the time the service was rendered. Call-out charges apply only when the physician is specially called to render emergency or non-elective services and only when the physician must travel from one location to another to attend the patient(s);

e) Not bill Fee Item 04005 in addition to the out-of-office hours premium; nor will Dr. Tam bill Fee Item 04005 for emergency visits as the attending surgeon (or his/her substitute) within 10 post-operative days from a surgical procedure (except "operation only") procedures. Such claims must state the time the service was rendered and be claimed only when specially called;

f) Bill fee item 04000 in compliance with the payment schedule;

g) Bill Fee Item 04516 only for cervical incompetence – emergency repair;

h) Bill Fee Items 04118 and 04119 only for induction or stimulation of labour by oxytocin intravenous drip, where attendance by physician is readily available - response time by telephone is immediate and response time on the unit is within minutes; and the maximum charge for above service to be 10 hours per pregnancy;

i) Bill Fee Item 04032 only for biopsy of vulva, excisional lesion > I= 2 cm;

j) Bill Fee Item 15142 only for urinalysis – complete diagnostic, semi-quant and micro, upon use of a microscope for microscopic examination;

k) Bill Fee Item 04010 only when doing a complete history and gynecological examination, review of x-ray and laboratory findings, if required, and a written report or consultation during labour; and

l) Bill Fee Item 04012 only where a consultation is repeated for the same condition within six months of the last visit by the consultant or where in the judgment of the consultant the consultative services do not warrant a full consultative fee.

DATED in Victoria, British Columbia, this 05 day of May, 2016.

Oleg Tomchenko, Chair
Audit Hearing Panel

Approved as to form and content:

ROBERT MUSTO.

Robert Musto
Counsel for the Billing Integrity Program

Lee Mauro
Counsel for Dr. Winston Tam