**In the matter of** a notice under sections 15 and 37 of the *Medicare Protection Act* RSBC 1996, c 286, as amended (the "Act")

| | | |
|---|---|---|
| BETWEEN: | The Medical Services Commission, a body continued under the Act | MSC, or COMMISSION |
| AND: | Dr. Gustavo Jose Carvalho, a General Practitioner, Practitioner ID #09137 | ENROLLEE |
| BEFORE: | A panel appointed under section 6 of the Act | PANEL |
| DATE: | Conducted by way of oral hearing from June 20 to June 24, 2015* continued by written submissions closing on February 26, 2016. | |
| APPEARING: | For the MSC: | Kathryn Kickbush, and Shankar Kamath Counsel |
| | For the Enrollee: | Gerald J. Fahey, Counsel |

# I INTRODUCTION

## *A. Initiation and Hearing Overview*

[1] This is a decision of the Panel that arises from a hearing under sections 15 and 37 of the Act which was held at the request of the Enrollee. That hearing was initiated following an audit of the Enrollee's billing of the MSC for benefits provided under the British Columbia Medical Services Plan ("MSP"). The Panel is tasked to consider whether pursuant to the Act at:

(1) s.37, that the Enrollee be required to repay money to the MSC plus interest and surcharges mandated by the legislation;

(2) s.15, that the Enrollee's enrolment under s.13 of the Act be cancelled and that he be permanently ordered not to apply for re-enrolment; and

(3) s.37(8), that the Enrollee pay the costs of the audit and hearing.

[2] The hearing on the matter began as an oral hearing and concluded as a written hearing. In the course of it various applications were made concerning the progress of the matter. The submissions also include argument concerning admissibility and use of evidence, constitutional questions, and joined hearing of sections 15 and 37, before discussion of the merits of the case. Accordingly, this decision is broken into sections under multiple headings with the following as a table of contents:

Contents

I INTRODUCTION ........ 1
A. Initiation and Hearing Overview ........ 1
B. The Parties and Background ........ 4
i. Medical Services Commission and the Medical Services Plan ........ 4
ii. The Enrollee ........ 4
C. Hearing Basis ........ 5
i. The Audit – A Second Audit ........ 5
ii. Summary of Defence ........ 5
II Hearing: Notice to Present ........ 7
A. Preparation for Hearing ........ 7
B. Preliminary Adjournment Hearing ........ 7
C. July 2015 Commencing Hearing ........ 7
D. Application for Re-Opening ........ 7
E. Application for Recusal of Panel ........ 8
F. Receipt of Submissions and Sur-Reply ........ 8
III Procedural or Preliminary Matters ........ 8
A. Re: Admission of Evidence ........ 8
i. The Disciplinary Records ........ 8
ii. CPSBC Media Releases ........ 10
iii. Executive Committee Release ........ 10
iv. 2013 FOIPPA Release ........ 11
v. Decision: Admission of Disciplinary Records ........ 12
B. Re: Restricted Defense by HPA s.53 ........ 12
i. An Untenable Position ........ 12
ii. Created Constraint ........ 13
iii. Enrollee’s Use of Disciplinary Records ........ 13
iv. Enrollee’s Knowledge Obtained Under s.53 ........ 14
v. Finding: Detriment and Fairness ........ 14
C. Re: A Charter Argument – ........ 15
i. Demand for Documents ........ 15
ii. Constitutional Question Act Notices ........ 16
iii. Finding: Charter – Search and Seizure ........ 17
iv. Standing ........ 17
D. Re: Joined Hearing – Hearing Sections 15 and 37 in Single Proceeding ........ 17
i. Claim and Evidentiary Differences ........ 17
ii. Panel sets own Procedures ........ 18
i. Objection Raised ........ 19
IV Substantive Issues – ........ 20
A. Introduction - Audits and Proof ........ 20
ii. Audits Examine for Verification ........ 20
iii. Audits of Records vs. Prosecution and Proof ........ 20
B. Re: Act s.37(1)(b) and (c) Service Rendered ........ 21
i. Proof of No Services ........ 21
ii. “Service” as Compared to “Benefit” ........ 21
C. Re: Proof of No Service Rendered ........ 24
D. Re: The Meaning of “Misrepresented” ........ 24
E. Re: Statistical Calculation of Inappropriate Billing under s.37 ........ 25
F. Re: The Auditor’s Conclusions Should Change and Such Change Will Change the Statistical Calculations ........ 25

i. Argument and Issues ... 25
ii. Three Sets of Added Information ... 25
iii. The Records Kept at Home ... 26
iv. Affidavit Records ... 30
v. SG-2 – Lab Report Wound Culture ... 30
vi. SG-3 Pathology Report Menzies Benign Hemangioma ... 31
vii. SG-1 and 4 Pathology Reports – Skin biopsy ... 32
viii. Patient 56- Samples 2, 4, and 5 ... 32
V Repayment and Section 37(1) of the Act ... 33
A. Section 37(1) ... 33
B. Calculation of Repayment ... 35
i. Statistical Information ... 35
ii. The Batcher Report ... 35
iii. The Kovalyov Report ... 36
iv. Calculated Repayment ... 37
VI Section 15 Orders in Respect of a Practitioner ... 37
A. Notice and Order Sought ... 37
B. Cause: Proper Acts After Misconduct Discipline - Section 15(1)(a) ... 37
C. Cause: Section 15(1)(c) – Submitting Claims “Knowing” ... 39
ii. Cause: Section 15(1)(c)(i) – Knowing Benefit Not Rendered ... 40
iii. Cause: Section 15(1)(c)(ii) – Knowing Misrepresentation ... 40
D. Cause: Section 15(1)(f) ... 41
E. Section 15(2) Cancellation of Enrolment ... 42
i. Trust, Integrity: Loss and Reestablishment ... 42
i. Trust in the Enrollee ... 43
ii. 1991 ... 43
iii. 1993 ... 43
iv. 1998 ... 43
v. 2001 ... 43
vi. 2002 ... 44
vii. 2003 ... 44
viii. 2007- 2009 ... 44
ix. 2012 ... 45
x. 2014 ... 45
xi. Dis-Enrolment ... 46
F. Section 15(2) Reenrolment ... 46
i. Consideration ... 46
ii. CPSBC Regulation and Monitoring ... 46
iii. Mitigating Factors – Enrolment ... 48
VII CONCLUSION ... 48
A. Section 37 ... 48
B. Section 15 ... 49
VIII ORDER ... 49
i. Section 37 ... 49
ii. Section 15 ... 50

## *B. The Parties and Background*

### *i. <u>Medical Services Commission and the Medical Services Plan</u>*

[3] The MSC manages the MSP under the Act and deals with over 90 million billed claims each year. One of the things that the MSC does is enroll practitioners who are then eligible to be paid for delivering benefits under the Act. Submitted claims are paid under a system that relies on trust and the integrity of those billing rather than on a more expensive or slower system where pre-approval or high level scrutiny of billings is required before payment.

[4] One of the MSC departments is the Billing Integrity Program ("BIP") which seeks to detect and avoid inappropriate and incorrect billing of MSP claims. It monitors and may investigate billing patterns and practices and claims for payment. It may also audit and investigate directly. Depending on the results the MSC may seek to recover funds, and may seek restrictions on or removal of a practitioner's ability to bill.

### *ii. <u>The Enrollee</u>*

[5] The Enrollee is a physician who, in June 1990, was licensed to practice by the College of Physicians and Surgeons of British Columbia (the "CPSBC" or the "College") - which governs licensing and regulation of the practice of medicine, as opposed to billings as examined here. At that time, he was also enrolled with the MSC to be eligible for payment under the MSP.

[6] The audit that is the focus of this hearing is the second of the Enrollee's medical career. That career (and billings to MSP) has been discontinuous and affected by repeated discipline by the CPSBC.

[7] The first discipline was less than two years after the Enrollee was issued an in-good-standing license. The CPSBC ordered erasure of that license and issuance of licensure under a different class as part of that first discipline after the CPSBC found that he had improperly billed the MSC. On a subsequent discipline that lesser licensure was, itself, erased (and re-licensure blocked for a period of time) after CPSBC disciplined the Enrollee following his convictions for criminal harassment and breach of release conditions put in place to protect his victim and her family. In total the CPSBC has disciplined the Enrollee and he has withdrawn or been suspended from practice four times.

[8] The first MSC audit of the Enrollee arose after the MSC became aware of - among other things- a media release by the CPSBC (concerning that Enrollee's first CPSBC discipline). The audit report covering January 1, 1991 to December 31, 1997 found problems with completeness or existence of his medical records and that almost half of the billings were inappropriate (the "First Audit").

[9] The Enrollee and the MSC engaged in extended negotiations resulting in some of the identified errors being removed from the error list and the parties entering into a settlement and the MSC issuing a Consent Order dated November 15, 1999 (the "1999 Consent Order"). Under the settlement agreement the Enrollee repaid funds to the MSC, and the 1999 Consent Order governed the Enrollee's

future billing practices, which included compliance with medical record keeping standards for billings.

## *C. Hearing Basis*

### *i. <u>The Audit – A Second Audit</u>*

[10] The subject hearing arose from a second audit of the Enrollee that began at the Enrollee's offices on January 28, 2013. The audit was initiated after a CPSBC media release of July 3, 2012 came to the BIP's attention. The media release stated that the Enrollee was – among other things- to reimburse the MSC having:

> … admitted to unprofessional conduct in the period June to September 2009 by creating false appointments for patients, and invoicing the Medical Services Commission for attendances on patients he had not seen. Dr. Carvalho received payment of approximately $4,000 from the Medical Services Commission for medical services which he either did not provide to patients, or did not maintain any or adequate medical records.

[11] The audit report was issued March 24, 2014 (the "Audit Report") for an audit period covering December 1, 2007 to November 31, 2012 (the "audit period") - over two years of which he was not practicing in association with CPSBC disciplinary action. The audit examined a random sample of patients, which disclosed 804 benefit claims made by the Enrollee for payment and found that almost 33% of the claimed fees (by dollar) were billed inappropriately.

### *ii. <u>Summary of Defence</u>*

[12] The Enrollee argues a number of procedural or preliminary matters as follows:

(1) Re: Admission of evidence - He states that two blocks of exhibits are protected by statutory privilege under s.53 of the *Health Professions* Act, RSBC 1996, c 183 ("HPA") and as such must be excluded from evidence and use within other records. These exhibits are composed of records obtained by the BIP from the CPSBC records of disciplinary proceedings of the Enrollee – including a media release within the records specified by the Enrollee at Exhibit 1 pages 42-56 and 147-200 (the "Disciplinary Records").

(2) Re: Restricted Defense by HPA s.53 - He argues that the MSC's use and reliance upon Disciplinary Records is problematic for his defense, a problem for which he sought no express remedy. His claim is that because of that use and reliance he is in an untenable position and severely restricted in his ability to defend himself, and puts him in jeopardy of committing an offence under the HPA if he defends himself by disclosing matters protected by HPA s.53.

(3) Re: A Charter Argument - He argues that the Disciplinary Records were obtained by unreasonable search and seizure. As such he claims a breach of s.8 of the Canadian Charter of Rights and Freedoms (the

"Charter) for which he seeks a stay of proceedings or exclusion of the CPSBC discipline records.

(4) Re: Joined Hearing – The Enrollee argues that it is improper for the Panel to hear the sections 15 and 37 in the same proceeding. He maintains that they are two separate statutory proceedings that must be kept separate because they each have different evidentiary standards, specifically s.37 allows for statistical information which is not admissible under s.15.

[13] The Enrollee argues a number of substantive matters concerning the application or meaning of statutory provisions and of the merits of the evidence and ultimate conclusions as follows:

(1) Re: Act s.37(1)(b) and (c) Service Rendered - The Enrollee argues that s.37(1)(b) and (c) create a specific statutory requirement that the MSC demonstrate that a service was not rendered or that the service was misrepresented before it may seek repayment. He states that the MSC failed to produce evidence that the Enrollee had violated those sections of the Act.

(2) Re: Proof of No Service Rendered – The Enrollee argues that a finding that no service was provided may not be "deemed" based on an audit where there is an absence of substantiating records. He states that witnesses must be produced to state that they did not receive services on a given date and if not so produced then an adverse inference must be made.

(3) Re: The Meaning of "Misrepresented" – The Enrollee argues that "misrepresentation" requires that a representation be both false and that intent to misrepresent be found.

(4) Re: Statistical Calculation of Inappropriate Billing under s.37 – The Enrollee argues that the "Relative Precision" of the calculations of the inappropriate billings is not supported by an expert opinion. He states that the Panel ought to draw an adverse inference from this and find that the statistical calculations are unreliable.

(5) Re: The Auditor's Conclusions Should Change and Such Change Will Change the Statistical Calculations – The Enrollee argued that he recalled providing certain services, and submitted evidence supporting services that may have been provided. As a result, he submitted that the actual number of errors is less than the number relied upon to calculate the inappropriate billings, and thus those statistical calculations are unreliable or inflated.

(6) Re: Imposition of the Maximum Penalty under s.15 – The Enrollee argues that he has already been punished by the CPSBC and that a lifetime ban from enrolment as a practitioner under the MSP is the maximum penalty reserved for the most exceptional and egregious cases of individuals motivated by greed using a deliberate plan to defraud.

## II Hearing: Notice to Present

### *A. Preparation for Hearing*

[14] The MSC gave the Enrollee notice of what it was seeking and the Enrollee exercised his right to have a hearing. The Enrollee advised that he was "in the process of retaining a lawyer" and the parties agreed to a two-week hearing scheduled for about one year later. The MSC did not receive any communication from a lawyer and entreated the Enrollee to seek legal counsel in many of its letters after the hearing date was set for July 20-31, 2015.

### *B. Preliminary Adjournment Hearing*

[15] In the week before the hearing the Enrollee indicated that he could not attend the hearing. On July 15, 2015 an application by the Enrollee for an adjournment was heard by Chair of the Panel via teleconference. The MSC filed argument and evidence for itself, and at the request of the Enrollee filed documents that he had provided to the MSC. The Chair found that the Enrollee's primary reason for seeking an adjournment was his failure to have counsel. He found that the Enrollee was not entitled to an adjournment.

[16] During the preliminary hearing the Enrollee speculated that an adjournment would be granted if he had a heart attack, a stroke, was in a "car accident or something like that".

### *C. July 2015 Commencing Hearing*

[17] This matter commenced as a hearing scheduled for July 20 -31, 2015 but it ran from July 20 to July 23 during which the Enrollee did not attend for various reasons, the first of which was cardiac in nature, and then as a result of drug impairment by overuse of anti-anxiety drugs and a minor car accident. The Enrollee was in irregular contact with the Panel about the circumstances keeping him away and the first two days of the hearing were adjourned. On the third day the hearing progressed and the MSC put in its case, completing on the fourth day. Several times during that hearing the Panel determined that fairness weighed in favour of proceeding.

### *D. Application for Re-Opening*

[18] After completion of the hearing but before a decision was rendered Counsel for the Enrollee sought delay of issuance of the decision in order to apply to reopen the hearing. On September 2, 2015 Counsel submitted that application.

[19] The Panel found that there was no violation of the Enrollee's rights and that he had been given the opportunity to be heard and that no procedural unfairness had occurred nor would it occur if the hearing was not reopened. Nevertheless, the Panel, remaining open minded, ordered re-opening in keeping with the principle that justice must manifestly and undoubtedly be seen to be done. It was ordered to re-open and continue as a written hearing under directions given.

### E. *Application for Recusal of Panel*

[20] On November 23, 2015 the Enrollee applied for the Panel to recuse itself and terminate the hearing. The application was based upon part of the reasons given in the decision to re-open the hearing where the Panel found that there was insufficient evidence of risk to prevent re-opening despite the Enrollee as having previously “admitted to engaging in fraudulent billing”.

[21] The Enrollee’s application was based on his belief that the reference to his admission was founded on his statement to that effect in the adjournment hearing teleconference. He claimed that his statement was protected by settlement privilege and as a result of its use he would not receive a fair and unbiased hearing.

[22] Without determining the source of the admission or considering the CPSBC Media Releases, the Panel examined the transcript of the adjournment teleconference in accordance with the basis of the application. It reviewed the subject admission and found, in its decision of December 17, 2015, that it was spontaneously and voluntarily made and that the Panel was not required to recuse itself.

### F. *Receipt of Submissions and Sur-Reply*

[23] The written submission of the Enrollee was received December 21, 2015 in accordance with an extension granted by the Chair of the Panel. The written reply of the MSC was received February 26, 2016.

[24] By letter dated March 8, 2016 the Enrollee applied for an opportunity to present a sur-reply. By reasons given March 11, 2016 the application was denied by the Chair of the Panel.

## III Procedural or Preliminary Matters

### A. *Re: Admission of Evidence*

#### *i.* ***The* Disciplinary Records**

[25] The Enrollee alleges that a large block of documents submitted as exhibits (defined above as the “Disciplinary Records”) ought not to have been put in the record or used in the audit because of confidentiality protections provided to Disciplinary Records under HPA s.53. He states that disclosure or use of them violates statutory privilege.

[26] The Disciplinary Records are composed of two packages of documents in the exhibits in accordance with their disclosure at different times. These packages are identified separately below. One of the disputed documents is a media release which deserves separate discussion. As such it and the other media releases revealed in this matter are also listed - thus identifying for analysis to follow, a list of three types of releases as follows:

(1) CPSBC media releases concerning the Enrollee (the "CPSBC Media Releases") which are dated as follows (with a notation that only the last one was disputed as protected by HPA s.53 due to its inclusion in another package below):

(a) June 29, 1993

(b) April 4, 2003

(c) August 24, 2011

(d) July 3, 2012 (Enrollee objects to admission as Ex 1:199, but not from the MSC records at Ex 1:231)

(2) A letter dated October 30, 1997 from the Deputy Registrar of the CPSBC to Dr. Verhulst of the MSP enclosing the February 12, 1993 *Decision of the Committee of Inquiry* (bearing redactions). It was stated to be sent on behalf of the Executive Committee of the CPSBC and advised that "the Executive Committee has agreed to release this information" (the "Executive Committee Release") (see Ex 1:42-56).

(3) A letter dated February 12, 2013 from the Registrar of the CPSBC to Ms Xu of the Audit and Investigations Branch, Ministry of Health with the subject line: "Re: Freedom of Information and Protection of Privacy Act ("FOI/the Act") Request for Information" (the "2013 FOIPPA Release") and enclosing documents bearing redactions. Some of those redactions were identified as "severed pursuant to s.22 of the Act" (see Ex 1:147-200):

(a) A CPSBC Memorandum (with attachments) dated September 22, 2009 to Dr. Maureen Piercey from Ruth Chapman, concerning a complaint against the Enrollee. It contains redactions made under s.22 of the *Freedom of Information and Protection of Privacy Act*, RSBC 1996, c 165, ("FOIPPA")

(b) A CPSBC Memorandum to File dated November 20, 2009 "Re: Dr. Gustavo J. CARVALHO Breach of Conditions/failure to meet practice standard…" concerning a meeting with the Dr. and a new complaint. It contains redactions made under FOIPPA s.22.

(c) An agreement dated May 31, 2012 (signed June 12, 2012) between Dr. J. Carvalho and the CPSBC with Schedule A: Citation, Schedule B: Admissions with CPSBC Resolution 06-197 [adopted November 23/24 2007], and Schedule C: Order.

(d) A letter dated June 22, 2012 from Arvay Finley to the Ministry of Health stating in substantive entirety: "Dr. Carvalho has been assessed to owe the Medical Services Commission $3,000 and in that regard we enclose his cheque for that amount." A photocopy of the cheques was attached. (Note: This is a MSC record.)

(e) A handwritten note to file dated June 28, 2012 documenting a telephone conversation stating: "Telephoned Tiffany at the Ministry of Health re: MSP matters. Rec'd cheque for $3,000 from Dr. Carvalho and no one seems to know what it is for. Left Message for her to follow - up w/Dr. C's counsel Mr. Arvay and provided his telephone number."

(f) A Media Release dated July 3, 2012 concerning Dr. J Carvalho. [Note this release is listed as provided here but falls under the CPSBC Media Releases.]

***ii. <u>CPSBC Media Releases</u>***

[27] The Enrollee did not argue that any of the media releases, themselves, violated confidentiality under any law or that they should be excluded from evidence of consideration by the Panel. The Enrollee did not distinguish between records that were Disciplinary Records under s.53 and those that were not covered by s.53– even if they were in the CPSBC disciplinary file. He failed to identify how a document that has been released to the public is protected by the claimed statutory privilege, whether included in a bundle of released documents or separately sourced.

[28] In the Panel's view media releases are in the public domain by their very nature. It finds that the July 3, 2013 Media Release was submitted into evidence as part of the MSC records in existence before receipt of the Executive Committee Release. The Panel finds no prohibition or limitation on admission of the CPSBC Media Releases.

***iii. <u>Executive Committee Release</u>***

[29] The Executive Committee Release was made on October 30, 1997. Contrary to the argument of the Enrollee that HPA s.53 applies it was not applicable at the time. At that time the *Medical Practitioners Act*, RSBC 1996, c 285 applied (the "MedPrac Act") to physicians and the CPSBC. The MedPrac Act was repealed and physicians (and the CPSBC) brought under the HPA on June 1, 2009 (after the Executive Committee Release).

[30] The salient provisions of the MedPrac Act (which are very similar to those that later became s.53 in the HPA) stated as follows at s.70(7) – and we draw attention to paragraph (b):

> (7) Subject to the *Ombudsman Act*, each person employed in the administration of sections 51 to 66, including a person conducting an inquiry or investigation, must preserve confidentiality with respect to all matters or things that come to the person's knowledge or into the person's possession in the course of the person's duties except
>
> > (a) as may be required in connection with the administration of sections 51 to 66 and any rules relating to those sections, or
> > (b) as may be authorized <u>by the executive committee</u> if it considers disclosure to be in the public interest.

[Emphasis added]

[31] It is explicit in the October 30, 1997 letter that the documents were provided based upon the consideration that "the Executive Committee has agreed to release this information."

[32] Under the MedPrac Act s.3(1)(b) it is the duty of the CPSBC "at all times" … "to exercise its powers and discharge its responsibilities under all enactments in the public interest." The Enrollee has not alleged that the CPSBC failed to fulfill its duties under that paragraph, nor is there any support for such a claim. Accordingly, it is clear that the Executive Committee Release was a release consistent with the terms of the MedPrac Act s.70(7)(b).

[33] The Panel finds that the Executive Committee Release was not governed by HPA s.53 when released and that it was duly released under MedPrac Act s.70(7)(b). Accordingly, it finds that the Executive Committee Release was produced without violation of either statute and is admissible as evidence.

***iv. 2013 FOIPPA Release***

[34] When the February 12, 2013 letter from the Registrar of the CPSBC was sent to Ms Xu of the Ministry of Health, Audit and Investigations Branch the salient statutes regarding disclosure were the *Health Professions* Act, RSBC 1996, c 183 ("HPA") and the *Freedom of Information and Protection of Privacy* Act, RSBC 1996, c 165, ("FOIPPA") – the MedPrac Act having been replaced by the HPA in 2009.

[35] In his submission the Enrollee argued that HPA s.53 prevented any record of a disciplinary proceeding (or any report or document prepared for one) from being admissible in this proceeding. He argued that the purpose of s.53 was to encourage reporting of complaints and to ensure full and fair investigation without fear by any participant that the documents would be used in a civil action. For this proposition he cited several cases and extensively quoted from *Beale v. Nagra* 1998 CarswellBC 2878 (BCCA) to argue that the subject section (described as a previous version of HPA s.53) must be interpreted for its "plain purpose" of insulating CPSBC discipline from civil litigation – which the Enrollee analogizes to this hearing.

[36] Such an argument about interpretation falls to the clarity of FOIPPA s.79 which creates a clear and absolute requirement for an express reference ousting the FOIPPA before any inconsistent or conflicting statutory provision will prevail. There is no express override to its application in the HPA. Accordingly, the Panel finds that the 2013 FOIPPA Release was released under the FOIPPA and the documents (and information therein) is not governed by HPA s.53.

[37] The Enrollee also cited paragraph 24 of *Beale* for the proposition that the legislature could have but did not provide for an exception within the Act to HPA s.53 so as to permit admission of CPSBC records in this proceeding. He asserted that s.53 created a statutory privilege preventing use. This argument fails to take account of the FOIPPA and the legislative intent. His argument does not displace the Panel's finding, but instead it supports that the legislature

intended that the FOIPPA govern and oust the application of HPA s.53 to the 2013 FOIPPA Release.

[38] The Panel takes comfort in its findings from the same determination of long standing in an order of the Information and Privacy Commissioner: *Records of the College of Physicians and Surgeons of British Columbia, Re*, 2000 CanLII 9491 (BC IPC) (AKA Order 00-08). In that case the Information and Privacy Commissioner conducted a review and found that that the FOIPPA overrides any confidentiality protection otherwise given to the CPSBC under s.70 of the MedPrac Act (which as seen above effectively corresponds to HPA s.53). That matter was reviewed on other grounds in an application to quash that Order 00-08, and on that point. Although no longer in dispute that reasoning of the Information and Privacy Commissioner was upheld by Owen-Flood J. in his decision: *College of Physicians and Surgeons of British Columbia v. British Columbia (Information and Privacy Commissioner)*, 2001 BCSC 726 (CanLII). We commend to the parties the decision of Owen-Flood under “Issue 3” with paragraphs 109-119. A further appeal was on other grounds without effect to that point which was no longer in dispute and accepted by the CPSBC (see *College of Physicians of B.C. v. British Columbia (Information and Privacy Commissioner)*, 2002 BCCA 665 (CanLII).

[39] Further, as to the use of the information itself as distinct from the documents, the Panel finds no support for the proposition that the parties are bound to maintain confidentiality in matters where there is no confidentiality to preserve. This is so because no person, including the MSC staff or the Enrollee is prevented by HPA s.53(2) from giving evidence concerning knowledge that came to the person in some other way. As discussed further above the Disciplinary Records have all been released in lawfully permitted manners, and as such they, and the giving of evidence based upon them, are not governed by s.53.

#### *v.* ***Decision: Admission of Disciplinary Records***

[40] The Panel finds that the Disciplinary Records are properly admitted into evidence and that the MSC and its staff may use and give evidence based upon information derived from the Disciplinary Records.

### *B.* *Re: Restricted Defense by* **HPA** *s.53*

#### *i.* ***An Untenable Position***

[41] The Enrollee argues that the MSC’s use and reliance upon the Disciplinary Records places him in an untenable position where he is severely restricted by the law and the MSC’s use of the Disciplinary Records. He says – where “Respondent” = “Enrollee”:

> 18. Any use of the College of college documents by the Respondent would be in violation of section 53 of the HPA, and may even put him in jeopardy of committing an offence under subsection 53(2) of the HPA which prohibits any "person" from giving evidence about "knowledge gained in the exercise of a power or in the performance of a duty under" the HPA. [sic]

> 19. Thus, the BIP's actions have placed the Respondent in the untenable position of violating section 53 of the HPA, and potentially committing an offence, in order to properly defend himself. By relying on the college disciplinary records, the BIP has created a situation process in which he is denied his fundamental right to make full and answer and defence. [sic]

[42] His argument is under the heading "Natural Justice and Procedural Fairness", and although not stated as made on that basis, it must be his claim that there is a breach of natural justice or fairness. Whether that is a breach by the MSC in violation of any law or by operation of the HPA is unstated. He fails to clearly identify what, if any breach was committed by the BIP, or any remedy.

[43] His argument is examined in segments below, the findings for which are individually determinative.

***ii. Created Constraint***

[44] The Enrollee argues in the context of HPA s.53 that "the BIP has created a situation process in which he is denied this fundamental right to make full and answer and defence" [sic]. The Panel finds that, if such restriction applies (however it may have arisen), any constraint upon the Enrollee is by virtue of HPA s.53 and not made by the BIP or MSC, rather it is statutory. Applying the reasoning of Southin J. in *Beale* (at para. 24), the Panel considers that if in fact s.53(1) limits the Enrollee's ability to defend himself then that "is a matter for the Legislature". As argued by the Enrollee in another context, but also applicable here, the Legislature could have but did not provide for an exception. As this is a choice of the Legislature it is not for this Panel to find that the Legislature has acted unfairly. Further, it is not for the Panel to speculate about what remedy was desired and grant a remedy not sought by the Enrollee in his argument about being constrained. Therefore, no remedy may be provided by the Panel and it makes no finding as to its ability to provide one if it had been requested.

***iii. Enrollee's Use of Disciplinary Records***

[45] The Enrollee's complaint that he is constrained in defending himself involves his use of the Disciplinary Records. The Enrollee would be in the same position as a MSC staff member to use the records in evidence. The MSC has rightful possession of the Disciplinary Records and these have been made available to the Enrollee without the Enrollee having to rely upon those same documents no matter how obtained otherwise. Independent of any other method of receipt his receipt of the Disciplinary Records from the MSC was without any violation of HPA s.53.

[46] Even if the Enrollee was considered as constrained before receipt of the Disciplinary Records he has had possession of them for a substantial period of time before he objected. His objection and claim of being constrained arose well after that disclosure prior to the hearing.

[47] The CPSBC is equally available to both parties as a witness or holder of documents. It is clear from the record that the MSC sought and lawfully obtained documents from the CPSBC and found some of its documents in the public

domain. The Enrollee has not shown that he has sought or been denied access to witnesses, information or documents that he needs to defend himself and has lawful right to seek. The Panel does not give weight to a claim that some sort of inappropriate disadvantage applies to him where he has not shown that he has sought, but been unable, to overcome the claimed constraint.

### *iv. __Enrollee's Knowledge Obtained Under s.53__*

[48] The Enrollee's argument is broad and not clearly focused concerning the scope of his alleged constraint. His broad description loosely includes the Enrollee's ability to use his knowledge gained in the course of his discipline by the CPSBC. The issue is the Enrollee's right to use confidential matter or things that are not part of the Disciplinary Records that came to his knowledge while exercising a power or performing a duty under the Act.

[49] The MSC argues that s.53 only applies to those who perform a duty or exercise a power under the HPA and thus it does not apply to the Enrollee. Whether this is a correct interpretation need not be decided because the Panel finds that the Enrollee was not shown that he, as the subject of the discipline, was exercising a power or performing a duty that would bring him under HPA s.53. Given that it is the Enrollee who is claiming that the HPA ousts evidence or restricts him in his circumstances it is he who bears the burden of showing that he falls under the provisions as he cites them. This he has not done. He has not expressly sought any remedy and not shown how any restriction should – if found- change the hearing or determinations.

[50] The MSC argued that by his actions the Enrollee has acknowledged that he is not bound by any confidentiality provision under the HPA. It also argues that he has acted inconsistently by providing information and documents that the Enrollee states is from the CPSBC concerning his discipline while later seeking to exclude evidence and argue that he is obligated to remain silent about his discipline.

[51] In the course of this matter the Enrollee has voluntarily provided and referred to information and documents from CPSBC investigations. Significantly, on July 7, 2015 he sent to the MSC a bundle of documents with correspondence copying CPSBC resolutions concerning the CPSBC discipline and his practice restrictions, along with other documents related to the discipline and his compliance. Those same disciplinary terms and conditions with practice limitations and reporting requirements are referred to by the Enrollee in his submission to this Panel. While the Enrollee says that disciplinary documents are not to be used and that he is bound to keep silent, elsewhere he has not maintained that secrecy or silence. The Enrollee cannot have it both ways.

### *v. __Finding: Detriment and Fairness__*

[52] The Panel finds that to the extent that the Enrollee has been restricted in defending himself it arose voluntarily, or by self-imposed restriction, and not from a breach of natural justice or fair process. The Enrollee has also submitted information and argument based upon the CPSBC discipline contrary to his position of silence and for exclusion of evidence. The Panel finds that, in terms of

the presentation of either party's case, to the extent that there is any detriment it would be to the MSC having provided the documents before the hearing and having already put in its case at the hearing before any objection arose. If the Enrollee's position is accepted by this Panel, it would be fundamentally unfair to exclude lawfully obtained evidence and still allow the Enrollee's information on the same matters to be introduced as evidence or be considered. Accordingly, the Disciplinary Records will not be excluded from evidence. However, where noted below the Panel has first considered and may make determinations without consideration of the Disciplinary Records, or before making any other or additional determinations after consideration of those records.

## *C. Re: A Charter Argument –*

### *i. <u>Demand for Documents</u>*

[53] The Enrollee has claimed infringement of his rights under the Charter. Neither party has argued that the Panel is unable to hear and consider this issue, and the Panel finds that it is able to do so because it is not disabled from doing so under the *Administrative Tribunals* Act, SBC 2004, c 45.

[54] The Enrollee argues that the Disciplinary Records were obtained by the BIP in a manner that infringes his right under section 8 of the Charter to be secure from unreasonable search and seizure." Specifically, the allegation hangs on the word "requires" as set out in his argument that:

> 21. The College sent the records to the BIP in response to the BIP's letter to the College dated January 24, 2013 in which the inspector appointed pursuant to section 36 of the Act 'requires' information about the College's discipline process. The law provides that such a demand constitutes a seizure …

[55] In support of his proposition that the January 24, 2013 letter was a demand amounting to a search, and the production of the documents as a seizure, the Enrollee cites *College of Physicians and Surgeons (British Columbia) v. Bishop* 1989 CarswellBC 10 (BCSC), and an unnamed "recent Saskatchewan case" which could not be ascertained. The *Bishop* case did involve a demand for production but it fails to support the proposition of the Enrollee. Instead it supports the opposite, which is that an order to a physician to deliver patient records to the CPSBC under its rules was not an unreasonable search and seizure in breach of s.8 of the Charter.

[56] There was, however, no demand akin to *Bishop* in this case. To characterize the MSC's January 24, 2013 letter as a demand mischaracterizes the evidence and in any event the word "requires" – cited above in the Enrollee's argument - cannot be found in that letter. While the word "require" is found it is only used in one relevant place and it relates to what the inspector needs to accomplish her job; and her statement is followed expressly by a form of the word "request". The letter states:

> In order to conduct our examination, I *require* information under the authority of the Act regarding the disciplinary action taken by the College in regard to Dr. Carvalho, as outlined in the College's media release of July 3, 2012.

> With respect to that disciplinary action, I am *requesting* the following information:
> …
> I would appreciate you providing us with the requested information as soon as possible…
>
> [Emphasis by italics added]

[57] That request followed on an earlier email thread starting on January 15, 2013 in which the Ms Xu stated "… I would like to request detailed information …", and on January 15, 2013 "… we would like to know…".

[58] In response to the MSC request the CPSBC replied with its 2013 FOIPPA Release under the subject line "Re: Freedom of Information and Protection of Privacy Act ("FOI/the Act") Request for Information". Whether or not the Panel found that the response was under the FOIPPA, it is clear that the response was voluntary and thus neither search nor seizure, so as to found the s.8 claim.

### *ii. Constitutional Question Act Notices*

[59] The Enrollee seeks "a stay of proceedings pursuant to section 24(1) of the Charter" or, alternatively, exclusion of the Disciplinary Records from evidence. As a stay of proceedings is not "a remedy consisting of the exclusion of evidence or consequential on such exclusion" s.8 of the *Constitutional Question Act*, RSBC 1996, c 68 (the "CQA") requires that due notice be served upon the Attorneys General of Canada and British Columbia. Unless that is done – and done in accordance with the requirements for notice are set out in s.8(4) of the CQA - no law may be held invalid or inapplicable by any decision.

[60] The Enrollee has provided no documentation that he has served the required notice on the Attorney General of Canada.

[61] As for the notice to the Attorney General of British Columbia, a notice -of sorts - was apparently provided (although proof of service was absent) however the notice fails to fulfill the basic requirements for notice. The Enrollee's notice advised the Attorney General that the constitutional question would be heard by the Panel at 800 Smithe Street, Vancouver on a date to be set. It was wrong on those fundamental details. The hearing was known to the Enrollee as being conducted by submissions in writing so it would not be held at the place stated nor is it likely that the court would be obligated to provide space for the Panel to hold one there. The Enrollee also knew the date of the hearing, specifically that February 26, 2016 was the deadline for the last of the submissions, which is effectively the commencement of the hearing. As such the date for submission was known to be other than "to be set".

[62] The Enrollee has failed to comply with the CQA on two grounds, the failure to give notice to the Attorney General of Canada, and the deficient notice to the Attorney General of British Columbia. As such no law may be held invalid or inapplicable in any form by the Panel. Notwithstanding this, it is arguable that the Panel may still exclude evidence but the Panel has no need to decide that matter

as based upon the following determination that no evidence will be excluded. The parties also did not separately argue the impact of failed notice upon such a right.

#### ***iii. Finding: Charter – Search and Seizure***

[63] The Panel finds that there was no demand for production of the Disciplinary Records so as to constitute possession by the MSC to be as a result of a search and seizure. Separately, the Panel also finds that there was no search and seizure because the documents were provided voluntarily. It is also of the view that it is a prerequisite for a challenge as presented by the Enrollee that there be a search and seizure and finds no factual basis upon which the Enrollee's Charter challenge is based.

[64] The Panel also finds that there was no search or seizure of any of the Disciplinary Records given that they were all lawfully obtained as found above.

[65] Based upon each of these findings there is not, and could not be, a violation of s.8 of the Charter. Thus there is no basis for a Charter challenge, for exclusion of the Disciplinary Records from use in the proceeding, or for a grant of a stay of proceeding. The latter is found without any determination of whether the Panel has the authority to grant a stay.

#### ***iv. Standing***

[66] Further, although it was not argued by either party, the Panel is concerned about whether the Enrollee had standing to complain about a search and seizure of another person's documents from that person's office and apply for a remedy under s.24. The application of the Charter to any situation is not automatic. The party who alleged a violation has the obligation to show that it is applicable in the circumstances, which necessarily includes showing standing.

[67] The Panel commends to the parties: *R. v. Edwards*, [1996] 1 SCR 128, 1996 CanLII 255 (SCC) and *R. v. Belnavis,* [1997] 3 SCR 341, 1997 CanLII 320 (SCC) where it is clear that if a person cannot establish that he or she had a personal reasonable expectation of privacy then a s.24(2) remedy is not available to be claimed. The criteria to establish that are not found in this matter and the Enrollee failed to show that he had standing to claim violation of s.24(2) of the Charter in this matter.

### ***D. Re: Joined Hearing – Hearing Sections 15 and 37 in Single Proceeding***

#### ***i. Claim and Evidentiary Differences***

[68] The Enrollee argues in his submission that it is improper for the Panel to hear the Act's sections 15 and 37 in the same proceeding. The argument is based on each having different evidentiary standards, specifically:

(1) s.37 creates a cost recovery process that does not require a finding of fault and which allows for statistical analysis; while

(2) s.15 requires proof of intent by "knowing" for which statistical evidence "is not admissible".

[Enrollee's emphasis]

[69] His argument is that after consideration of statistical analysis under s.37 "the statistical evidence will undoubtedly influence the Panel's decision under section 15" and prejudice to the Enrollee would result. For this proposition he cites *K v. College of Physicians & Surgeons* (Saskatchewan) (1970), 13 DLR. (3d) 453 (Sask QB), 1970 CanLII 597 (SK QB) sub nom. *Kerster v. College of Physicians and Surgeons of Saskatchewan.* That case involved assessment of credibility concerning allegations that a physician engaged in indecent conduct involving multiple women. There the concern was the credibility of one would be used to bolster the credibility of another. By hearing the testimony of the women in a common hearing the rule against similar fact evidence was breached. That cross-over of credibility from one person to another and similar fact evidence concerning separate allegations based on separate events is wholly unlike the current matter.

[70] It is also noted that while the Enrollee claims that statistical evidence is not admissible under s.15 and that it would prejudice him, he nevertheless cites it and bases arguments upon it in defence concerning the s.15 decision. He seeks to show a disparity between findings arising before and after his discipline by the CPSBC and the effects of the terms and conditions of his discipline. He states under the heading "Section 15":

> 62. The statistical model used by the BIP extrapolates the findings from the sample of files that were audited to all of the Respondent's files to arrive at an estimate of possible billing errors. The BIP calculated the "stratified" estimate of errors by location, to reflect the fact that the error rate was much higher for Hycroft (37%) than it was for MCI/Richmond (13%), but accepted Mary Batcher's* conclusion that the "unstratified" estimate was more accurate. The striking difference between the Hycroft and MCI/ Ackroyd files was also repeatedly alluded by the auditors in their audit report.
> [* Added Note: The MSC's expert Batcher Report is discussed below]

[71] The Enrollee does not make his case to show why the matters must be heard in separate hearings and implicitly accepted a contrary position later in his argument by his use of statistical evidence. The Panel finds that the Enrollee has failed to show any statutory exclusion or any prejudice to hearing the matters together.

***ii. Panel sets own Procedures***

[72] It is a long accepted principle that tribunals are the masters of their own procedures provided that the rules of natural justice are applied. (See, for example: *Cambie Hotel (Nanaimo) Ltd. v. B.C.*, 2006 BCCA 119, at para. 38 and at para. 28 where Rowles J. cites Lord Denning in *T.A. Miller Ltd. v. Minister of Housing & Local Government*, [1968] 1 WLR 992, [1968] 2 All ER 633 (CA).) The scope of this is broad and in no way narrowed under the Act which states at s.5(1)(q1):

> 5 (1) The Commission may do one or more of the following:
> …
> (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:
>
> > …
> > (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;

[73] The MSC exercised its discretion to draw up and provide the notice under the Act's section 37(2) and 15(2) as it did. It chose to present the matter for hearing in one proceeding, presumably because of the information in common to both and for avoidance of delay and cost to both parties. The Panel has discretion as to how it proceeds and to split, or hear together, related matters as appropriate for the circumstances. The Act does not require separate hearings, and there was nothing inherently unfair in the Panel hearing the s.15 and s.37 matters together. As expressed in *McNaught v. Toronto Transit Commission*, 2005 CanLII 1485 (ON CA) at para. 61 by Gillese JA:

> [61] I see no basis upon which it could be maintained that the Board decision to consolidate the two proceedings was unreasonable. The Board gave careful consideration to the question of consolidation on several occasions and determined that there was sufficient overlap in the issues and evidence to be adduced that the matters would be most thoroughly, efficiently and fairly dealt with if heard together. It is clear that there was a factual connection between the two matters …

[74] It is clear that in this case there is a factual connection between the two matters. At the same time, it is also clear to the Panel that the statutory provisions that apply to its decision under s.15 are different from that of s.37 in the Act. The distinction between those provisions in its home statute are clear to the Panel. The Enrollee has not shown that the Panel would misapply its statute or the evidence. The mere allegation of prejudice is insufficient, and as found above, no prejudice has been shown or found to arise. The Enrollee has shown no other basis to cause the Panel to change from hearing the matters in the same hearing.

### *i. Objection Raised*

[75] The Enrollee argument that the Act's sections 15 and 37 proceedings must be held separately was first raised in his December 21, 2015 submission. The Panel has no evidence that the Enrollee had previously objected to the hearing of the matters together. Had he wished to challenge this his remedy was to move for division of the proceeding before that point. He has given no reason for his delay.

[76] The Panel has no need to determine that failure to object in a timely fashion constituted consent. This is because of the effects of the delay. The delay if allowed to now vitiate the proceeding up to this point would cause substantial delay and affect procedural fairness. The delay would, also, no longer be within the bounds of being considered "modest" as contemplated in the decision to re-open the hearing and amount to an abuse of process. These latter grounds alone support the Panel finding that the s.15 and s.37 matters may be heard in one hearing.

## IV Substantive Issues –

### *A. Introduction - Audits and Proof*

[77] The requirements from both parties in the conduct of an audit and the proof required under the Act for benefits underscores much of the parties' argument. As such clarity about the function of inspectors, audits and finding of proof within an audit are important and discussed here.

#### ***ii. Audits Examine for Verification***

[78] The subject audit was conducted by the BIP under the Act's Part 7 which allows for examination of records to audit claims for payments and the patterns of practice or billing of the Enrollee (see s.36(2)). Claims for MSP payment may only be made when they are supported by adequate medical records (as examined below – see "benefits" vs "services"). In short, an audit seeks to determine whether the medical records provide the proof needed for payment.

#### ***iii. Audits of Records vs. Prosecution and Proof***

[79] Auditing to determine whether records meet a standard requires the record to prove itself against a standard, which is the opposite of a prosecutorial standard where no fault is found in the absence of proof to the contrary.

[80] In argument the Enrollee correctly identifies the primary purpose of the medical inspector as follows: "The medical inspector's function in the audit was to determine whether the clinical records supported the billings claimed." Elsewhere, however, the Enrollee's argument inverts what an audit is all about by applying a prosecutorial standard of proof. He alleges that the Audit Report is faulty as it did not prove that a service was not provided because the inspector "did not speak directly with any patients nor did he discuss any specific files with the Respondent." He also states that witnesses should have been produced to state that they did not receive services. These arguments misconstrue what an audit is, what is required of the Enrollee, and what the requirements are for MSP billing.

[81] The first issue is discussed above and it is the Panel's view that an audit is to determine whether the medical records are adequate and accurate for the purposes of billing as a benefit. As such, an audit is not automatically deficient if no information beyond the medical record is sought, and it is not the auditor's obligation to prove whether a service was provided.

[82] The Enrollee argues that the audit is deficient in proof because the inspector did not seek answers from the Enrollee. The Panel sees no basis upon which this claim is made, and the allegation is contrary to the facts.

[83] In terms of access to information for use in the audit, it is clear that under the Act the Enrollee has the obligation to provide all the requested records, and to answer questions. As seen under section s.36(8) and (9), a person must be responsive to requests from an inspector for records and answers.

[84] In terms of the facts, it is inaccurate to suggest that the inspector did not seek answers from the Enrollee. Without explanation the Enrollee failed to attend the review with the inspectors, or the rescheduled review made at his request, at the conclusion of the initial records review in his offices. The Enrollee failed to provide all the records upon request and only after receipt of the error list did he respond with some documents that he claimed to have kept at his home. He failed to respond to two requests of the inspector seeking explanations or other records. He did not respond by the deadline nor afterward to the ongoing obligation to respond even if the deadline had passed. He cannot now suggest that the inspectors failed to discuss matters with him when it was his obligation to respond and, independent of that, he failed to take the opportunities afforded him to fully inform the BIP. The records from his home (per his October 2013 Letter) are discussed below.

[85] The standard of proof to be applied for the audit (to verify that they fairly, accurately, and adequately document or represent the transactions they claim to represent) is found in and under the Act in the identification of what is a “benefit” as discussed below.

### *B. Re: Act s.37(1)(b) and (c) Service Rendered*

#### ***i. <u>Proof of No Services</u>***

[86] The Enrollee argues that s.37(1)(b) and (c) creates a specific statutory requirement that the MSC demonstrate that a service was not rendered or that the service was misrepresented before it may seek repayment. Before proceeding further, it is important to identify that there is a distinction under the Act and the payment rules between a “service” and a “benefit”. This is important here because the terms are not interchangeable.

#### ***ii. “Service” as Compared to “Benefit”***

[87] Under the Act s.37(1) it is “benefits” that are the issue. The word “service” does not appear in s.37 at all. Further, to the extent that the word appears elsewhere in Part 7 it is not relevant to the audit of the Enrollee as the term applies to audits of diagnostic facilities.

[88] Under the Act a service is not a benefit unless all the ‘inherent components’ (or deliverables) are provided as specified in the applicable MSC Payment Schedule (B.1.a.) which include required service and documentation components. Accordingly, it is insufficient to argue that if a service was provided it is a benefit and therefore billable and payable. Instead, it is only a benefit if it is both for a

provided service that was eligible as a benefit, and was documented as required, in order to qualify as a benefit.

[89] What is required to constitute a “benefit” follows from the Act through the regulations and rules with increasing particularity. The last document is the MSC Payment Schedule which is one that should also be particularly well noticed and adhered to by the practitioners as it contains all the Fee Item descriptions and the greatest particularization of rules. This thread of increasing particularity is described below.

[90] Under the Act, the word "benefits" is defined as certain authorized “medically required services rendered by a medical practitioner”. Section 5 of the Act allows the MSC to determine whether a particular service is or is not a benefit and the information required to “claim for payment of benefits rendered”. Under s.13(6) of the Act a practitioner is not entitled to be paid for services provided contrary to directions or prohibitions imposed on the practitioner:

> (a) by the appropriate disciplinary body,
> (b) under the Act, or
> (c) by rules that regulate services provided by the practitioner.

[91] Under the regulations applicable throughout the audit period, specifically BC Regulation 426-97 at s.31, a practitioner must submit claims by the system approved by the MSC and is responsible for accuracy of the information, maintenance of the source information, and to make it available to the MSC when required. This information is to include details of the benefit in an “adequate clinical record”. That clinical record must include “the location where the benefit was rendered, the length of time spent rendering the service and the diagnosis” (see s.31(b)(iii)).

[92] Further particularity is found in the MSC Payment Schedule as authorized by the Act at s.26. The MSC Payment Schedule that applied during the audit period states at B.1.a. (B. Terms and Definitions 1.a. General) that all benefits (with a few exceptions not applicable here) include the following, with a clear statement:

> vii) Making and maintaining an adequate medical record of the encounter which appropriately supports the service being claimed. <u>A service for which an adequate medical record has not been recorded and retained is considered not to be complete and is not a benefit</u> under the Plan.
>
> [underlining added]

[93] Then at B.2. under the heading “Adequate Medical Records of a Benefit under the Plan” it states that:

> … a medical record is not considered adequate unless it contains all information which may be designated or implied in the MSC Payment Schedule for the service unless another physician of the same specialty, who is unfamiliar with both the patient and the attending physician, would be able to

readily determine the following from that record and/or the patient's medical records from previous encounters:

a. Date and location of the service.
b. Identification of the patient and the attending physician.
c. Presenting complaint(s) and presenting symptoms and signs, including their history.
d. All pertinent previous history including pertinent family history.
e. The relevant results, both negative and positive, of a systematic enquiry pertinent to the patient’s problem(s).
f. Identification of the extent of the physical examination including pertinent positive and negative findings.
g. Results of any investigations carried out during the encounter.
h. Summation of the problem and plan of management.

[94] From the foregoing home statute, regulation and rules of the MSC it is clear to see that even if a service is provided it is not a benefit and thus also not payable unless: a) an adequate medical record has been created and retained; and b) it is available upon demand by the MSC. The Panel finds that adequacy of a medical record has a temporal element in that it must exist at the time of the billing in order for it to be a benefit, and it must be available (and exist) when demanded by the MSC. (Notwithstanding this the inspectors in the current matter have given credit after inadequate records were subsequently completed, supplemented, or otherwise validated – that is an administrative remedy preceding the notice of this hearing and has no effect upon the decision of this Panel.)

[95] A determination of whether a practitioner may be ordered to repay funds comes down to a review, or audit, of the practitioner’s documentation and billings against standards unless the MSC alleges that, notwithstanding documentation being adequate and the billing being in accord with it, the underlying service was not provided. Only in case of the latter must the MSC disprove the records. It would have to prove, on a balance of probabilities, that the service was not provided – or not provided at all- as documented in the applicable medical record and thus not a rendered benefit. With that exception it is not incumbent upon the MSC to prove that a service was not rendered or that the service was misrepresented before it may seek repayment. Instead the MSC must prove that the Enrollee has not met documentation standards that – if met and a service provided – would constitute a benefit as billed.

[96] In terms of records and standards, the Panel notes that in BC Regulation 426-97 at s.31 the reference to adequate documentation refers to a “clinical record” whereas later in the MSC Payment Schedule the term “medical record” is used. This has no impact to reduce or alter the obligations of a practitioner to adequately document benefits because under the Act s.31(b) the practitioner is obligated to “maintain and make available to the commission such sources of information as may be required by it” and which includes items which are described with greater particularity in the MSC Payment Schedule’s description of an adequate medical record.

### *C. Re: Proof of No Service Rendered*

[97] The Enrollee argues that the Audit Report deemed some services to have not been provided based upon an absence of substantiating records without sufficient additional evidence. He states that witnesses must be produced to state that they did not receive services on a given date and if not so produced then an adverse inference must be made.

[98] The Enrollee correctly points out that the Audit Report does state that services were deemed not provided under Objective 1 of the report. But Objective 1 is about the existence of records and is not about whether services were provided. The objective in the audit is stated as:

> Objective 1: To determine whether medical records existed to support that services were rendered for the dates of service that claims were paid.

[99] For this objective the report findings are clear and expressed in the first sentence of analysis as: "We identified 140 service units, with a total value of $4,359.94 where a medical record was not found to substantiate the visit."

[100] The Audit Report does go on to make a statement that is irrelevant to an assessment of Objective 1. It said: "As no medical record was found to substantiate the visit, in all 140 instances, the services were deemed not to have been rendered." This statement is outside the parameters of the objective and given no weight by the Panel. The Objective 1 was about whether medical records existed, not whether a service was, or was not, rendered. While the objective uses the words "services were rendered" rather than "benefits were rendered" this is of no effect. Based upon a finding of irrelevancy above and giving of no weight, the Panel finds that the MSC was not required to produce witnesses to prove that a service had not been rendered.

[101] The Panel reviewed the evidence and the Audit Report and accepts the Audit Report finding under Objective 1 that out of 804 service units 140 did not have a medical record. The Panel finds that, contrary to s.37(1)(b), a substantial number of claims had been made by the Enrollee for payment in respect of benefits (vs. services) that had not been rendered.

### *D. Re: The Meaning of "Misrepresented"*

[102] The Enrollee argues that the term "misrepresentation" in Act s.37(1)(c) "requires a finding that a representation be false and that there be a component of intent regarding the representation." Misrepresentation may be a misstatement of fact and may be fraudulent, negligent or innocent. (See, in the tort context, *Hedley Byrne & Co. Ltd. v. Heller & Partners Ltd*, [1964] AC 465, [1963] 2 All ER 575 (H.L.)) The Panel finds that the term "misrepresentation" in s.37(1) includes fraudulent, negligent or willfully blind representations.

[103] As to 'innocent misrepresentations' the Panel notes that under s.46 of the Act "A … practitioner who misrepresents the nature or extent of the benefit in a claim for payment commits an offence." This raises the issue of whether the legislature intended to create an absolute liability offence for misrepresentation. However, it

is unnecessary for the Panel to resolve that issue for the current matter because, as seen below, the Panel finds that the Enrollee's misrepresentations were not innocent.

### *E. Re: Statistical Calculation of Inappropriate Billing under s.37*

[104] The Enrollee argues that the "Relative Precision" of the calculations of the inappropriate billings is not supported in the report of the MSC's expert. He argues that the Panel should draw an adverse inference from the claimed failure of that expert to opine that the Audit Report conformed with her opinion that:

> "relative precision of 23% is not optimal although at a level generally acceptable in the context of billing audits which involve a combination of zero billing errors and some relatively large overbilled amounts."

[105] The Panel finds that the data did involve a combination of zero billing errors and some relatively large overbilled amounts and that the expert was relating the acceptability of the relative precision to data having the characteristics as found in the audit. This report is discussed further below as the "Batcher Report".

### *F. Re: The Auditor's Conclusions Should Change and Such Change Will Change the Statistical Calculations*

#### *i. Argument and Issues*

[106] The Enrollee states he provided additional clinical records and explanations supporting his billing that were not accepted to reduce the list of billing errors in the audit. He also argued that the BIP failed to provide evidence that he violated s.37(1)(b) or (c); and as a consequence of these things the statistical calculation for repayment would be unreliable or significantly inflated.

[107] The first issue of who bears the burden of providing evidence is discussed above. It is clear that the Enrollee has the obligation to create and maintain medical records that meet the standards for adequacy to document and constitute a benefit that should be well known to any physician. Medical record keeping is taught from the beginning of medical school, and every physician in BC is regulated by the CPSBC which sets standards for creating and maintain medical records. The MSC standards are not an onerous imposition. Indeed, the Enrollee should be more keenly aware of his obligations, having been disciplined by the CPSBC for his record keeping on three occasions, having been audited previously by the MSC, and being obligated to comply with the 1999 Consent Order.

#### *ii. Three Sets of Added Information*

[108] The second issue is whether the information provided should have been accepted to reduce the identified billing errors in the audit or in this Panel's consideration. The Enrollee provided three sets of information or explanations addressing relatively few of the identified billing errors. The Enrollee argues that those documents and his explanations should be accepted and, accordingly,

would change the underlying calculations for the amount of repayment, thereby making the MSC's calculations unreliable or inflated. The three sets of information or explanations are considered in turn below.

***iii. The Records Kept at Home***

[109] On September 3, 2013 the BIP provided the Enrollee with the preliminary list of billing errors and enquired about other records that may have bearing on the assessments and an explanation as to why they were not previously available. The Enrollee was reminded of his obligation to provide all requested records and that even after the deadline for response that the obligation continued. He was given a reply deadline, which was extended upon request.

[110] In October 2013, four days after that extended deadline the BIP received the Enrollee's letter response (dated for five days prior to the deadline). It enclosed some documents and a brief explanation as follows (the "October 2013 Letter"):

> These clinical records were kept at my home along with other records not involved in this audit as part of the legal case with the College of Physicians of BC and their disciplinary action against me. During the period from 2007 to 2009, I utilized many papers records as well as an EMR. This was all disclosed to the College during legal deliberations and the reasons for having two types of medical records. Personal issues also played a role and were considered by the College during their assessment.

[111] The documents provided were a combination of the following covering dates from December 5, 2007 to June 19, 2012:

(1) Loose handwritten clinical records for individual patients with dates that fit discontinuously into the electronic records, some marked "rough" or "draft".

(2) A printed laboratory test result.

(3) Handwritten notes to the inspector by the Enrollee with recollections and suggestion of where the inspector might look for records.

(4) Several handwritten lists of patient names under a certain date, most containing a billing code and a brief note (such as "Percocet Rx" and "work stress / coffee shop / supp psych Rx". The sheets were dated December 15, 2007, December 31, 2007, August 12, 2008, and December 16, 2008,

[112] Following receipt of the October 2013 Letter a BIP inspector wrote to the Enrollee asking questions, and twice sought additional records. (Under s.36(8) of the Act, practitioners are obligated to provide records and answer questions upon demand.) Without explanation, the Enrollee failed to respond to either solicitation by the deadline or within his continuing obligation. The final Audit Report was prepared without considering the supplied documents.

[113] The Enrollee argues that “for the unusual reason that he did not respond to a few questions they had asked of him on December 3, 2013” the audit did not include consideration of the records he provided with his October 2013 Letter. He stated in argument that they supported his billing for benefits covering 11 of the 15 identified billing errors for his MCI/Ackroyd billings. He also argued that BIP failed to provide evidence that he violated s.37(1)(b) or (c); and as a consequence of these things the statistical calculation for repayment would be unreliable or significantly inflated.

[114] The first issue of who bears the burden of providing evidence is discussed above and elsewhere in this decision concluding that, in general, the medical records must speak for themselves disclosing an adequate record to constitute a payable benefit. The second issue is whether the information provided in the October 2013 Letter should have been accepted against identified billing errors in the audit or in this Panel’s consideration.

[115] The BIP is entitled to have its questions answered under the Act (see s.36(8)). It had a standing request for all records, which was made on the first day of the investigation at the Enrollee’s offices and repeated through to its February 2014 letter. The questions asked in the December 3, 2013 letter were not isolated from the ongoing obligation and were substantive in nature. They also were highly relevant because the provenance, reliability and authenticity of records provided is clearly part of the concern to the BIP before using the records in the audit.

[116] The BIP concern on this count is well founded. Keeping medical records at one’s home for a clinic that you do not own is an unusual practice, as is extracting medical records from a file without leaving a copy in the patient record at the clinic. Doing so presents a risk to the patient and leaves an inadequate medical record, because adequacy includes being complete, accurate and accessible.

[117] Another of the concerns was about the authenticity of the records provided. The clinic kept electronic records but the Enrollee claim amounts to him also running his own physical record system at the same time. His records show patient visits not seen in the electronic records. This means that, for an admittedly disorganized record keeper, he would have to be organized enough to keep and retrieve his own written medical record across many visits without the assistance of the support staff while also inconsistently using the electronic system for the same patient. Such a system does not provide a single complete, accurate or accessible medical record. It also calls into question the bona fides of the medical records and whether they were created at some point after the audit. These are concerns that underlay the inspector’s questions to the Enrollee.

[118] It is pervasive throughout the evidence that the Enrollee is prone to avoidance or delay, manipulation and deception. Court judgements concerning the Enrollee are damning, as seen in *Carvalho v. College of Physicians and Surgeons of British Columbia* [1993] 8.C.J. No. 887 (BCSC) per Preston J., and per Bruce J. in *R. v. Carvalho* [2002] BCJ No. 2322 and *R. v. Carvalho* [2002] BCJ No. 2819. It is also clear from the evidence that the Enrollee has been publicly and privately disciplined and identified as creating false records. Bruce J. in his criminal case described him as conducting an “incredibly sophisticated and devious plan”. The Enrollee’s record also shows that he has been confronted repeatedly with

misdeeds that he admitted and committed to stop but then repeated – sometimes within days even when aware that he is being monitored or at least under continued suspicion. In these circumstances, irrespective of whether all of the accusations are true, the BIP is entitled to require answers to reasonable satisfaction within the context of an audit (with verification at its heart) before considering records.

[119] The records that the Enrollee provided were, by his own explanation, separated from the medical record making the record at the original location and the separated sheets both incomplete. Also by his own admission the documents are or may be recreations that are not reliable. He states in his affidavit – regarding when he was working at the Hycroft Clinic which was from about March 1, 2007 to July 9, 2009:

> 8. I fully acknowledge and understand that my record-keeping practices during the period I worked at Hycroft were very poor. I was disorganized, and trying to do too much, and not catching up on my record-keeping. Eventually, I resorted to trying to recreate my medical records well after I had delivered medical services. I do not doubt that in so doing I made mistakes…

[120] The CPSBC Memorandum to File dated November 20, 2009 contains reported statements of the Enrollee in a meeting of that same day, statements that are consistent with his affidavit, although it may be seen as involving only a portion of the audit period. It states at Exhibit 1 pages 171-173:

> Dr. Carvalho explained that, as he was sorting through his notes in June/July 2009, there were several notes regarding examinations or visits which lacked detail. He indiscriminately applied the notes to patients … When asked to quantify how many patients he may have mistakenly billed, he estimated the number at around 50 patients. Dr. Carvalho had also added to the day sheets but could not identify these records as his notes were very disorganized. ...
> Ms. Peaston asked if the College would find discrepancies if it were to examine his medical charts. Dr. Carvalho agreed that this was likely…
> …Dr. Carvalho admitted that he may have billed for patients he never saw at all; where he had a scrap of paper with a name, date or brief note attached, he would bill for a visit. He conceded he was never entirely sure about the context of the notes he had made. …
> … he added information from his paper notes, even when he was not entirely sure what the notes read. He said that, once the record was updated, he would throw away his scrap of paper. When asked if this meant there was no "original" record to correspond with the day sheet, he agreed that this was the case. …
> Ms. Peaston asked Dr. Carvalho to estimate how many patients he had billed who would say that they had never seen him. Dr. Carvalho guessed in excess of 100 patients but then revised this figure to upwards of 130 patients … When asked if all the records he had entered could be wrong, he said that this was indeed possible.

[121] In the Panel's view a medical record is not adequate if it has been disassembled or was kept in a distributed and disassembled state when it should be

assembled. A record in such a disassembled or disorganized state is neither accessible for proper patient evaluation and treatment, nor is it reliable if prone to mistakes as admitted by the Enrollee. The Panel also finds that some of the records are not medical records but compilations in the form of lists of patients with billing data. At best these would be extracts of records and thus not medical records themselves. They also clearly lack most of the criteria needed to be considered adequate medical records under the MSC Payment Schedule. The deficiencies are substantial.

[122] The Panel notes that there is no evidence that the provided records were – when provided or since – correctly inserted into each patient's medical records to make them complete. Further, given that some of the records were compilations of patient records it should be clear that any insertion was done only when accurate and without intermingling the records of other patients to disclose the medical information of other patients within another's file.

[123] The Panel finds that an inspector conducted a preliminary review of the documents provided with the October 2013 Letter. The inspector gave them no weight, determining that the documents could not be considered against identified errors without certain questions being answered, and sufficiently answered so as to validate them for the purposes of the audit.

[124] In its review of the records the Panel notes the Enrollee's explanation that he had the records at his home as part of the legal case by the CPSBC and its disciplinary action against him. The dates do not all line up. It is clear from the evidence that the CPSBC investigation at issue was settled by the Enrollee in an agreement dated May 31, 2012 and bearing the Enrollee's signature dated June 12, 2012. The dates of the records should all precede those dates if, as he stated, that was the reason for holding the records at the Enrollee's home. Only some do, with many outliers. One of the records is for June 19, 2012 which is after the date that he settled the matter with the CPSBC. His stated reason for possessing it at his home does not align with the applicable date. It is also clear from the evidence that the CPSBC investigation was initiated by discoveries of false attendance records and medical reports being created by the Enrollee in the period of June 2009 to September 2009. There is no evidence that the CPSBC investigated outside that period. The records provided, however, span from about a year and a half before then (December 5, 2007) to almost three years afterward (June 19, 2012) – which is after he had withdrawn from practice and then returned to practice at a different clinic. Again the dates, and the clinics, do not align with the stated purpose for holding them outside either clinic's medical record system.

[125] In his submitted argument the Enrollee states – as opposed to in his affidavit - that the billing error identified for sample 54-4 was among those that the Enrollee provided information. The inspector found that sample was not an MSP benefit stating in his notes: "Clinic notes shows "Talk Re: form" only/not a MSP benefit". The Enrollee states that he provided a service recalling that he had "met with this patient … about his ongoing streptococcus, and filled out a form for him … located at page 179 … Exhibit 7."

[126] A non-contemporaneous recollection is not an adequate medical record in support of a billable benefit, even if it might provide some guidance where the writer or reader knows that it may be fallible.

[127] This particular recollection is difficult to reconcile with the record and given little weight. The clinical record merely states “Talk Re: Form”. Such a record is inadequate as it fails to provide the information required for “benefits”. It is also clear that under the MSP, filling out forms is not a benefit that is claimable. If a physician wishes to be paid for such service, they are allowed to charge the patient directly. They are not allowed to bill, or to double bill. However, looking at the form in question at Exhibit 7 pg. 179 it is clear to see in handwriting at the bottom an indication of a charge “$30.00” followed by a checkmark and initial. This indicates that a charge was levied to the patient for the completion of the form. While the Enrollee now states that he recalls meeting with the patient “about his ongoing streptococcus, and filling out a form for him” this is not part of the record and no less suggestive of double billing than the documents by themselves.

[128] For its review the Panel gives little weight to that information given these discrepancies and the lack of the Enrollee’s response to the BIP’s questions. The Panel also finds that given the circumstances of the Enrollee and the information, the BIP was entitled not to rely upon the information in the October 2013 Letter, absent a response (or an adequate response) to the inspector’s questions. The Panel finds that the inspector committed no error in not using the information in the audit, and that the audit is not in error due to those unvalidated documents not being considered or applied against identified errors.

### *iv.* ***Affidavit Records***

[129] The Enrollee submitted his affidavit with some documents attached which appear to be, but are not stated to be, in respect of additional errors found by the BIP and for which an inspector requested medical records on February 7, 2014 (Ex 1:37-39). All but one (re SG-2) were attached without explanation or attestation, and all are only a small portion of the medical record of a patient. Three of them related to patients billed out of the Hycroft clinic and five relate to patients billed out of the MCI clinic.

### *v.* ***SG-2 – Lab Report Wound Culture***

[130] One record was regarding sample SG-2 for which the audit finding was “Patient record not found”. For this the Enrollee provided an explanation by way of his sworn recall of the patient visit. To substantiate his recall and billing as a benefit he provided a lab result for a wound culture of the same patient’s left shin that was ordered by a different doctor on a different day. Recall may provide some explanation but is not a substitute for an adequate medical record as required to constitute a benefit.

[131] The explanation applies to performing “a single flap skin closure on a severe laceration location on [the patient’s] tibia on or about September 2, 2011”. The explanation does not address the error found on sample SG-2. That error identifies a plastic surgery skin flap procedure (Fee Item 06019) for a wound that

is not on a limb as per the International Classification of Diseases (“ICD”) code “879” applied to the billing.

[132] The Enrollee does not provide a clinical record of the visit but provides a laboratory report ordered by a different physician on a different day, without any declaration of provenance or authenticity. That laboratory report may hint that a service was provided by the Enrollee in prior days that became infected and was followed by a wound culture of the shin, assuming that it was the same wound, although -as noted – the culture was from a limb and the billing was for a wound not on a limb. However, again, the issue is not whether there was a service – which this evidence is far from adequate to substantiate – it is whether there is a benefit that is billable.

[133] The Enrollee charged $155.32 for Fee Item 06019 (skin grafts/advancement flaps), which is essentially plastic surgery, whereas if it was a laceration repair the correct Fee Item would have been under the “Minor Procedures” heading and be either Fee Item 13611 (for a minor laceration requiring anesthesia, which pays about 1/3 of what he charged), or Fee Item 13612 (for extensive laceration repair, greater than 5 cm (maximum 35 cm) operation only, payable per cm) if it was a laceration over the tibia and longer than 10 cm. All this information is lacking and must be present to be a benefit.

[134] There is no evidence or explanation before the Panel to suggest that the Enrollee performed only one procedure on the patients on the relevant day or that the Enrollee had accidentally billed for a procedure that was distinctly different and more expensive than that provided (and which was a Fee Item specifically referenced in the 1999 Consent Order to be provided and billed only when medically required and properly documented). There is no adequate medical report of the billed benefit identified by the inspector. If a service was performed but it was billed improperly it is impossible to tell what was done and the correct billing in order to constitute it a benefit. A benefit, as seen above, is by definition supported by an adequate medical record. One does not exist here, irrespective of whether the ICD was correct or an error.

### *vi. SG-3 Pathology Report Menzies Benign Hemangioma*

[135] The Enrollee also provided three other laboratory records, by attachment to his affidavit, without any explanation, and without any declaration of provenance or authenticity other than by way of inclusion of fax coversheets of recent days. (The Panel makes no determination as to whether such records may be accessed and provided under rules of patient confidentiality in these circumstances.) These records were not previously part of the record, and there is no evidence that they were provided to the inspector.

[136] One laboratory report ordered by a different physician correlates to the date for audit sample SG-3 for which the audit finding was “no notes made” in the medical record. Under SG-3 the Enrollee charged a plastic surgery procedure Fee Item 06019 at $124.00. The pathology report provided is in regard to a substantially less expensive and different procedure. That report, ordered by a different physician (although copied to the Enrollee), concerned a small benign hemangioma collected on the date of the identified billing error, the excision of

which would be Fee Item coded as either 13620 or 13600. The correct charge of that physician, or any physician, would only be known by looking at an adequate medical record. The laboratory report is not an adequate medical record for the determination, or that the Enrollee was involved and did anything.

### ***vii. SG-1 and 4 Pathology Reports – Skin biopsy***

[137] Two other laboratory reports, also attached to the Enrollee's affidavit, correlate to dates for audit samples SG-1, and SG-4, were provided without explanation. On those dates billing errors were noted where the Enrollee billed at $124 and $115.79, respectively, for a plastic surgery procedure Fee Item 06019. In each case the inspector found that no clinical notes substantiated the billing and none were provided by the Enrollee to substantiate such a procedure.

[138] The pathology reports concerned small skin biopsies submitted for laboratory examination and would form part of a medical record but for a procedure that is totally unlike a local tissue shift plastic surgery procedure Fee Item 06019. The removal of such growths, if benefits, would be billed as either Fee Item 13600 biopsy of skin or mucosa operation only, or as Fee Item 13620 excision biopsies, both of which pay about 1/3 to 1/2 of what was claimed. Some are not claimable at all. Removal of clinically diagnosed benign skin lesions (like seborrheic keratosis) is cosmetic and not a benefit. The correct charge, if a benefit, would only be known by looking at an adequate medical record, but one was not provided by the Enrollee.

[139] There is no evidence or explanation before the Panel to suggest that the Enrollee performed one or two procedures on the patients on the relevant day or that, if only one, the Enrollee erroneously billed for an unlike procedure. There is no adequate medical report of the billed benefit for SG-1 or SG-4.

### ***viii. Patient 56- Samples 2, 4, and 5***

[140] The Enrollee also provided some documents in his affidavit in regard to patient 56, for whom additional billing errors had been found and for which an inspector requested documents on February 7, 2014, as discussed above (Ex 1:37-39). They, too, were attached as exhibits without explanation. These records were not previously part of the record, and there is no evidence that they were provided to the inspector.

[141] In his counsel's argument these documents for patient 56 were linked to errors under the heading "MCI/Ackroyd Errors". The total argument concerning this patient and the documents is as follows directly:

> 50. The inspector found a total of 15 errors for the MCI/Ackroyd files. The Respondent has reviewed these 15 errors (listed on page 261 of BIP Exhibit 1) and notes the following:
> …
> d) [patient 56's first and last names]: There were three instances where the inspector found that there were no clinical records to support office visits.
> …
>
> [Patient name replaced here]

[142] If accepted on their face the documents correspond to the additionally identified billing errors for patient 56 and although they contain sparse clinical notes might be considered as adequate if found within an otherwise complete medical record in the normal course. The circumstances are far from the normal course. These records were not previously part of the record, and there is no evidence that they were provided to the inspector. The Panel was not advised whether the documents are now in the patient's medical record or whether they remain apart.

[143] The Enrollee provides no explanation or declaration of provenance or authenticity. There is no explanation as to why the document was missing from the medical record when inspected, from where it was recovered, or whether it is a recreation from other notes or memory. The paucity of explanation provides no enlightenment and this is unfavourably compared to the inspector's questions in response to the Enrollee's October 2013 Letter (discussed above and found to not be sufficient for the submission of other documents regarding other errors).

[144] The Panel was provided two pages entitled "Patient Follow-Up Sheet" bearing the patient's name with notes corresponding to sample errors 56-2, 56-4 and 54-5 and a laboratory report stated as ordered by the Enrollee for a blood sample taken on the date of sample error 56-2. Comparing the notes on one page to the samples, not all of them have an entry or date match. There is no entry for sample 56-3 recorded as a no charge referral on September 19, 2011 and for which an entry should appear sandwiched between those shown. The Enrollee provides no explanation whatsoever for this.

[145] The documents and the argument provided by the Enrollee are for the purposes of the review of the audit and determination by this Panel under s.37. For this the Panel expects substantial explanation for the Enrollee's failure to comply with s.36(8) and answers addressing outstanding questions of the inspector or answers to questions that equally apply to much belatedly provided documents. The Panel finds that the Enrollee has not provided the Panel with sufficient information for it to determine that the audit was in error concerning samples under patient 56 or that, independently of that, an adequate medical record then or now exists for the identified billing errors to constitute benefits.

## V Repayment and Section 37(1) of the Act

### *A. Section 37(1)*

[146] In this hearing under s.37(1) of the Act the Panel sits in the position as the MSC for the purpose of determining whether the repayment is due by the Enrollee.

[147] Under s.37(1) the Panel must determine whether the Enrollee has engaged in the following such that repayment is due and for which it issues an order:

> (a) an unjustifiable departure from the patterns of practice or billing of practitioners in the practitioner's category,
> (b) a claim for payment in respect of a benefit that was not rendered, or
> (c) a misrepresentation about the nature or extent of benefits rendered,

[148] The Panel has reviewed the audit and the exhibits, and without reference to any of the exhibits in dispute, finds no operative error in the conclusions of the audit. The one possible insubstantial error – which the Panel has no need to resolve- is in respect of sample 54-4, discussed above, for which the Panel notes appears to be an instance of double billing but which does not change the rejection of payment for the claimed benefit.

[149] The audit discloses, and the Panel finds (in respect of just over 800 sample service units examined) as follows:

(1) The Enrollee billed for 140 service units which did not constitute benefits because they were not supported by any medical record, and that in those instances there were no medical records existing.

(2) The Enrollee billed for a plastic surgery procedure Fee Item 06019 (skin grafts/advancement flaps) for which no benefit was found, given that in every one of four instances claimed no medical records existed or the medical records were inadequate.

(3) The Enrollee billed for 92 service units for which medical records were incomplete to the point of being inadequate medical records and unable to substantiate the billing, and therefore did not constitute benefits.

(4) The Enrollee billed, as a benefit, for a service which is not a benefit under the MSP.

(5) The Enrollee billed for 18 benefits of one type but for which the medical records supported and thus constituted benefits for a different, and lesser paid, benefit. These included billing for complete physical examinations, and individual prolonged counselling sessions when the medical records only support a lesser billing as constituting the benefit.

(6) There is a significant quality of care concern arising from the Enrollee maintaining incomplete, inaccurate, inaccessible, and non-sequential medical records that were kept apart from the normal clinic records and either knowingly false or made while being willfully blind to their accuracy.

(7) The Enrollee has provided no reasonable justification for his pattern of practice, or for his billings to account for the nature or extent of the identified billing errors and his record keeping.

(8) The Enrollee has not complied with the 1999 Consent Order in that he did not:

(a) maintain adequate clinical records in his patient files, sufficient to support each service he billed to MSP in conformity with that Order which required compliance with the record-keeping requirements of the MSC Payment Schedule and any protocols or guidelines implemented by the Commission; nor did he

(b) only bill for complete physical examinations, prolonged counselling, or skin grafts/advancement flaps when the service was medically necessary, actually rendered, adequately documented in the beneficiary patient's file, and in conformity with the provisions of the Act, the regulations, the requirements of the Payment Schedule and any protocols or guidelines implemented by the MSC.

[150] The Panel finds that in respect of s.37(1)(a), (b) and (c), respectively, that the Enrollee has:

(a) engaged in "an unjustifiable departure from the patterns of practice or billing of practitioners in the practitioner's category";

(b) made many claims for payment in respect of a benefit that was not rendered; and

(c) misrepresented the nature or extent of benefits rendered.

[151] The Panel shall issue an order for repayment. The Panel is expressly able to come to this conclusion without reliance on the Disciplinary Records not in the public domain, without considering any statements in the audit concerning those matters not in the public domain, and without considering any version or conclusion of "services deemed not rendered" in the Audit Report.

### *B. Calculation of Repayment*

#### *i. __Statistical Information__*

[152] Under s.37(6) the Panel may consider statistical information for the purposes of calculating the appropriate amount of money be repaid to the MSC by the Enrollee. The Panel does so and has the benefit of expert opinion on the appropriate calculation and result.

#### *ii. __The Batcher Report__*

[153] The MSC presented the expert opinion of M. K. Batcher, Ph.D. (Statistics), who is the National Director, Statistics and Sampling for Ernst & Young LLP (United States). In her report (the "Batcher Report") she set out her qualifications, outlined the purpose of her report, confirmed the foundation and commitment to acting as an independent and objective expert, the scope of work and data reviewed, instructions and assumptions. The Enrollee did not contest any of this, nor did he contest the report or the results other than to express the mathematical certainty that if billing error data changed then the resulting calculation would change.

[154] The Batcher Report concluded that the proper calculation to estimate billing errors was the unstratified calculation in this matter, and she also found that at a 90% confidence interval that the relative precision was 23.3%, adjusted for outliers. She cited an objective standard, briefly referred to above, stating that:

> … the United States Department of Health and Human Services ("US HHS"). US HHS guidelines indicate that if relative precision of 25% or smaller at 90% confidence is achieved, it is acceptable to rely on the extrapolated results for their purpose of estimating the amount of overpayment by government for healthcare services.

[155] Applying the data to calculate the amount due in response to the salient question "What is the best estimate of billing errors given the sample selected in this audit?" she stated that "If a single value is desired, the best estimate is the standard dollar unit sampling estimate adjusted for the fee outliers" which she found to be $184,138 ($186,689 before adjustment). The MSC seeks that $184,138, plus interest and surcharges as mandated by s.37(1.3)-(1.6) of the Act.

***iii. The Kovalyov Report***

[156] The Enrollee disputed the statistical calculations for repayment. He presented an expert report by G. Kovalyov, CA (the "Kovalyov Report"). The MSC made no objection to its late filing and it has been received into evidence.

[157] Mr. Kovalyov is a Chartered Accountant and principal in his own firm. His report is brief, composed of a single page letter with his resume attached setting out his qualifications in accounting and conducting audits of public companies. His report sets out that he reviewed the 8 pages of audit summary and aggregate data – which presented both stratified and unstratified data and calculations.

[158] His report lacked the expected statement about being independent and objective, what his instructions were, or what was the objective of the report. It also failed to include a review or comment on the Batcher Report or conclusions in it.

[159] The Kovalyov Report considered the stratified data to the exclusion of the unstratified calculations – only the latter being validated in the Batcher Report. No explanation was provided as to why only one was considered or any basis to conclude that one was more accurate than the other. He stated in reference to the stratified data that:

> In my professional opinion, the error rate of 37% and 13% is significantly high compared to the sample size tested. It is generally good audit practice to increase the sample size during testing when the error rate is significant compared to the norm or expectations.

[160] The Enrollee's expert failed to specify an objective standard or comparison in support of this statement. The suggestion that the sample size should be increased if the "error rate is significant compared to the norm or expectations" does not address what is to be considered the norm or what the expert considered as expected. More significantly, it failed to address that the sample size of the audit undertaken had been increased to 50% higher (by number of patients, which then determines the service units examined) than was the BIP's normal practice because of an anticipated high error rate.

[161] While the Enrollee's expert expresses that to increase the confidence level "one would expect to increase the sample size" he fails to identify what is an acceptable confidence level, or that the 90% confidence level found in the Batcher Report was insufficient or in error.

[162] The Panel finds the Kovalyov Report to be seriously flawed and gives it little weight. To the extent that it can be relied upon it supports the increase by the auditors to the sample size as appropriate in the circumstances.

#### *iv. Calculated Repayment*

[163] The Panel gives the Batcher Report the most weight and finds that the amount due by the Enrollee to repay the MSC under s.37 of the Act is appropriately based on the standard dollar unit sampling estimate adjusted for the fee outliers based upon the unstratified data. The Panel finds that this produces the best estimate of the Enrollee's billing errors across the audit period. It duly takes into account the long periods of no errors where the Enrollee was not working, and the differential error rates in the different clinics from which he operated.

[164] The Panel finds that because of the Enrollee's departure, claim or misrepresentation referred to in paragraphs (a) to (c) of s.37(1), as discussed above, it considers it appropriate that the Enrollee pay $184,138.00 to the MSC, plus interest and surcharges under s.37 of the Act.

## VI Section 15 Orders in Respect of a Practitioner

### *A. Notice and Order Sought*

[165] The Enrollee was given notice that the MSC intended to seek an order for cause, under section 15 of the Act, to cancel his enrolment in the MSP, and an order that he be permanently barred from applying for re-enrolment because he cannot be trusted to bill the MSP in accordance with the law.

[166] The cause for dis-enrolment, under s.15 of the Act, was stated as arising from the Audit Report findings including that he failed to comply with the 1999 Consent Order. The relevant provisions of s.15(1) sought to be applied are s.15(1)(a), (c), and (f).

### *B. Cause: Proper Acts After Misconduct Discipline - Section 15(1)(a)*

[167] Under s.15(1)(a) the Panel may order cancellation of the Enrollee's enrolment in the MSP under s.13 of the Act for cause as follows:

> **15** (1) In this section, "**cause**", in respect of a practitioner, includes, but is not limited to,
>
> > (a) a determination by the commission that, as a result of a finding by the appropriate disciplinary body that a practitioner has inadequate skills or knowledge or has been guilty of infamous conduct or repeated

> instances of serious misconduct, the practitioner is no longer able to provide proper care or treatment to beneficiaries,

[168] The Panel interprets this section of its home statute as applying within the purpose of s.15 of the statute which is in the context of billing and the operation of the MSP. This is based upon consideration that it is within the jurisdiction of the CPSBC, under the HPA, to determine the ability of a person to practice medicine and the Act is not directed to that purpose. Support for this is found in the Act where “appropriate disciplinary body” is defined as “person or body that may cancel or suspend the right to practise under … an enactment as … a medical practitioner…”.

[169] It is the Panel’s view that s.15(1)(a) must be interpreted as applying to the ability of the practitioner to appropriately bill MSP without necessarily usurping the powers of the CPSBC. Thus because record keeping and billing is part of the proper care and treatment and in keeping with the purpose of the Act the Panel interprets “proper care or treatment” as including that the enrollee be trusted to maintain adequate medical records and appropriately bill for benefits as part of that care or treatment. This interpretation is in keeping with the purpose of the Act and the fact that s.15(1) is not a closed list of what may constitute “cause” because it states in the opening sentence of s.15(1) that it “includes, but is not limited to,” the detailed examples that follow.

[170] As early as February 1993 the Enrollee was disciplined for infamous conduct for improperly billing the MSP with the majority of the billings being found to be made where he had not seen the patient. This is in the public record in *Carvalho v. College of Physicians and Surgeons of British Columbia* [1993] 8.C.J. No. 887 (BCSC) where Preston J. unheld the finding of the CPSBC Inquiry Committee that the Enrollee was guilty of infamous conduct rather than simply unprofessional conduct. At paragraph 6 Preston J. quotes from a long section of the Inquiry Committee’s decision including the following:

> 24. In the facts as found before us, Dr. Carvalho has been given the privilege of practising medicine in this province and has been given the privilege of billing his medical fees to the Medical Services Plan. The plan can obviously not operate nor can the public afford to operate it if physicians are permitted to bill the plan for services not rendered. We see very little distinction between the sort of activity carried on in this case by Dr. Carvalho and the activities of someone who would steal from or defraud any other third party. We do feel as well, however, that Dr. Carvalho has indeed learned from this experience and is indeed repentant for his wrongdoing.

[171] On August 24, 2001 a media release of the CPSBC shows that the Enrollee again admitted to and was found guilty of unprofessional conduct by the CPSBC in relation to maintaining confidentiality, and disposition, of patient records. The media release says that he “will be formally reprimanded by the Council of the College. His future professional conduct is expected to be beyond reproach in every respect.”

[172] In a media release of April 4, 2003 the CPSBC announced that the Enrollee's name was erased from the CPSBC register due to his criminal conviction for harassment of another person and breach of conditions of sentence (see *R. v. Carvalho* [2002] BCJ No. 2322 and *R. v. Carvalho* [2002] BCJ No. 2819). He would, however, be permitted to re-apply for registration after November, 2004. The erasure was pursuant to s.50 of the *Medical Practitioners* Act which only permitted erasure of a person's name from the register -per s.50(3)- for an offence that could "disqualify the person from practising under this Act." Accordingly, in the view of the disciplinary body his offence disqualified him from practice. That assessment places the findings by that appropriate disciplinary body under s.15(1)(a) as distinct from s.15(1)(b) which is not considered by the Panel here.

[173] In a media release of July 3, 2012 the CPSBC announced that the Enrollee was suspended for three months, must pay a $50,000 fine and do other things including "Reimbursement of the Medical Services Commission". Such discipline clearly shows it to be "serious misconduct" as does the statement in the release that the Enrollee:

> … admitted to unprofessional conduct in the period June to September 2009 by creating false appointments for patients, and invoicing the Medical Services Commission for attendances on patients he had not seen…

[174] The Panel finds that cause is found under s.15(1)(a). The Panel has determined that, as a result of a finding by the appropriate disciplinary body that the Enrollee has been guilty of infamous conduct or repeated instances of serious misconduct, the practitioner is no longer able to provide proper care or treatment to beneficiaries.

### *C. Cause: Section 15(1)(c) – Submitting Claims "Knowing"*

[175] Under s.15(1)(c) the Panel may order cancellation of the Enrollee's s.13 enrolment in the MSP for cause which "includes, but is not limited to" the following:

> (c) the submission of a claim by the practitioner to the commission for payment knowing that
>
> > (i) the benefit had not been rendered, or
> > (ii) the nature or extent of the benefit that was rendered had been misrepresented,

[176] The Enrollee argues that under s.15 the word "knowing" means that intent must be proven. The Enrollee did not address the media releases in which he was stated as admitting to falsification of records for which he billed the MSP. Such falsification, if true, could not be made unknowingly.

[177] In his affidavit to this Panel the Enrollee admitted to knowingly making medical records that were recreations that he did not doubt contained mistakes.

[178] In the Panel's view "knowing" includes all ways of knowing or disregarding truth or accuracy, and avoidance of the truth of facts represented as true. Even if he maintained that "knowing" did not include negligent error, willful blindness, or submitting claims without knowing whether they were false or true, it is the Panel's view that the non-exclusive nature of the list of causes under s.15(1) captures such acts as "cause".

### *ii. <u>Cause: Section 15(1)(c)(i) – Knowing Benefit Not Rendered</u>*

[179] In the present case it is clear that the Enrollee billed at least 140 instances where he knew – because he was responsible for creation of the medical record – that he did not have adequate medical records so as to constitute a benefit. Also, of the four separate samples of Fee Item 06019 examined one had no medical record (the others being inadequate). Thus, in those 141 cases found in the sample audit, no benefit was rendered.

[180] If the Executive Committee Release is considered it is noted that the Enrollee admitted in 1991 that he did "bill the Plan falsely and agreed to not do it again" and that in 1993 he agreed that in a 2-month period in 1991 he had made 32 claims for services to patients that he had not seen on the dates which he claimed he rendered benefits. If the 2013 FOIPPA Release is considered it is noted that the Enrollee admitted that he created false appointments (backdated about three months) for 27 patients that he had not seen on those dates but for which he invoiced the MSP. Clearly, if there was no service the benefit had not been rendered and the Enrollee submitted claims knowing that fact in both those cases where he was investigated and disciplined by the CPSBC.

[181] The Panel finds that the Enrollee submitted claims to the MSC for payment knowing that the benefit had not been rendered. This applies to the fact that he claimed for payment knowing that the medical records were inadequate to constitute a benefit (and thus that it was not rendered) and also to the fact that where no service is provided no benefit is rendered irrespective of whether there is a medical record to substantiate the falsehood.

### *iii. <u>Cause: Section 15(1)(c)(ii) – Knowing Misrepresentation</u>*

[182] The Panel accepts the findings in the Audit Report that there were 92 instances found where the medical records were incomplete and unable to substantiate the claim made, and that there were 18 instances found where the claims were not consistent with the services in the medical records. Accordingly, the claims were a factual misrepresentation of the benefit rendered. The question is whether they were knowing.

[183] With regard to the incomplete records the Enrollee could not fail to know the requirements for keeping adequate records. Keeping of adequate medical record is a basic requirement and taught in medical school. The Enrollee's records have been scrutinized by MSC audit previously and the Enrollee was provided with directions and placed under the 1999 Consent Order which made adequate record keeping a central issue. He has also been disciplined several times by the CPSBC for his record keeping practices and been obligated to understand the requirements and fulfill them.

[184] Of the 92 instances of incomplete medical records it is clear that 77 bore only a service date attached to the patient's record without any clinical notes for the claimed benefit. The remaining 15 claimed for benefits where there was insufficient evidence, or even evidence to the contrary, that the benefit was claimable. Of the 18 instances of claims inconsistent with the services the Panel accepts the findings in the Audit Report that anticoagulant therapy by telephone was billed as units of office visits, that office visits were being billed as complete examinations, extended counselling was billed instead of office visits, and minor abscess draining was billed as a laceration. Also, three of the four separate Fee Item 06019 samples examined (one having no medical record, above) lacked any, or substantiating, clinical notes. Each of the records was in conflict with or inadequate to support the claimed benefit. In all these circumstances submitting a claim for payment while knowing that the medical record is inadequate to support the billing is a knowing misrepresentation of the nature or extent of the benefit rendered, and not merely an innocent misrepresentation.

[185] The Panel finds that the Enrollee submitted claims to the MSC for payment knowing that the nature or extent of the benefit that was rendered had been misrepresented. The Panel also finds that, in respect of the claims found in violation of s.15(1)(c)(i) for payment knowing that the benefit had not been rendered, these too are claims made in breach of s.15(1)(c)(ii).

### *D. Cause: Section 15(1)(f)*

[186] Under s.15(1)(f) the Panel may order cancellation of the Enrollee's enrolment in the MSP under s.13 of the Act for cause in respect of a practitioner due to:

> (f) failure to comply with a written order made under section 37 (1) (e) to adopt an appropriate pattern of practice or billing…

[187] The Enrollee was obligated to adhere to the terms of the 1999 Consent Order which was issued in accordance with s.37(1)(e).

[188] The Panel finds from the Audit Report, and the facts found above that the Enrollee failed to adhere to the 1999 Consent Order provisions that he:

(1) maintain adequate clinical records in his patient files sufficient to support each service billed to the Medical Services Plan which was provided by him; and

(2) bill for complete physical examinations, individual prolonged counselling, and advancement flap surgery (fee item 06019) only when such a service is medically necessary, actually rendered, documented in the patient's file, and in conformity with the provisions of the Act, the regulations made thereunder, the requirements of the appropriate MSC Payment Schedule, and any protocols or guidelines implemented by the MSC.

[189] The Panel finds that the Enrollee has failed to comply with the 1999 Consent Order by failing to adopt the appropriate pattern of practice and billing specified.

## E. Section 15(2) Cancellation of Enrolment

### *i.* ***<u>Trust, Integrity: Loss and Reestablishment</u>***

[190] The Enrollee's argument summarized above under description: "Imposition of the Maximum Penalty under s.15" is addressed below.

[191] As stated near the start of this decision, trust in the integrity of those billing the MSP is essential to how it operates because it is impossible – in practical terms – to review each medical and billing record and to validate that all criteria have been met before payment is issued. In such a trust based system the payor (whether public or private) should not be required to continue doing business with a provider or supplier who demonstrates a clear pattern or practice of billing non-compliance or abuse such that the trust is broken. That trust is broken by the magnitude or repetition of a failing, or a failing to adhere to directed corrective action.

[192] In the Panel's view the Act s.15 is about whether to continue doing business, not punishment as claimed by the Enrollee. If there is dis-enrolment, it is an end to an existing contractual and statutory relationship in which the practitioner's integrity is required, and the trust by the MSC in that integrity is also required. It is the Panel's view that when the MSC has lost the requisite trust on good grounds then disenrolment must follow.

[193] As for the opportunity to re-enroll, this also has to be taken on a case-by-case basis. There is no set number of chances at reform, and no set number of chances to regain trust. The MSP is a single payer system and disenrolment narrows the options for work as a physician in British Columbia to a substantially smaller number of employment type positions. As such where circumstances exist that trust may be regained that opportunity must be given in keeping with the length of time or conditions for re-enrolment needed for the MSC to trust that the enrollee will act with integrity and fulfill all obligations under the MSP.

[194] The Panel finds no support for the Enrollee's suggestion that a lifetime ban from enrolment is reserved for cases where individuals are motivated by greed or that *Medical Services Commission v. Milorad Stokic*, May 3, 2000 sets the threshold of the types of cases and facts that justify a lifetime ban. The Panel finds that the tribunal in *Stokic* found in its conclusions at page 22 that "The consistent and repetitive conduct without any remorse for or insight into the harm caused justifies the lifetime prohibition of his enrolment." It is the Panel's view that consistent or repetitive conduct is relevant to the consideration but having remorse or insight is irrelevant. Trust is the basis here, which the tribunal in *Stokic* equated to a breach of trust in an employment situation where dishonesty is sufficient to terminate employment. Continuing that 'employment' analogy, a ban on a form of re-employment with the former employer will depend upon whether trust can be regained as discussed above. Although, greed or a lack of remorse or insight may support a determination that trust cannot be regained.

### *i. Trust in the* Enrollee

[195] The Panel has found cause for disenrolment. In doing so its considerations were about actions or circumstances and not about credibility. They were also not about whether the Enrollee has integrity now or at any other particular time, but about whether for cause under s.15(1) the MSC has, or does not have, the requisite trust in the Enrollee. The Enrollee has been repeatedly reminded of the trust in his integrity and his privileged position. His actions and the surrounding circumstances provide a factual basis upon which an assessment of whether it is reasonable that the MSC has or lacks trust in the Enrollee for the purposes of the Act. His actions since the inception of his career do not engender trust, and perhaps even lesser trust from the MSC with its public service mandate.

### *ii. 1991*

[196] Regarding his false or improper billings of the MSP in 1991: "After his office staff confronted him about this practice on June 7, 1991, he promised to desist. He did not. …[more] instances took place after this confrontation." (*Carvalho v. College of Physicians and Surgeons of British Columbia* [1993] BCJ No. 887 (BCSC))

### *iii. 1993*

[197] In 1993 the Enrollee was disciplined by the CPSBC for infamous conduct for those improper billings in 1991. He was fined by the CPSBC, had his license status changed and suspended for a short time. While finding his actions bore little distinction from stealing the CPSBC Inquiry Committee stated that:

> 24. …We do feel as well, however, that Dr. Carvalho has indeed learned from this experience and is indeed repentant for his wrongdoing.
> [*Carvalho v. College of Physicians and Surgeons of British Columbia* [1993] BCJ No. 887 (BCSC) at para 6.]

### *iv. 1998*

[198] In 1998 at the conclusion of the First Audit of the Enrollee he was found to have a significant number of improper billings. He settled with the MSC and repaid an agreed sum and agreed to the 1999 Consent Order. That Consent Order was particular in detailing the service and billing requirements in keeping with the deficiencies found in the First Audit – which while stated were no more than already required of any enrollee. The MSC did not change the Enrollee's enrolment and he was allowed to continue billing.

### *v. 2001*

[199] In August 2001 by CPSBC media release the public, and the MSC, learned that again the Enrollee had admitted to and was found guilty of unprofessional conduct by the CPSBC in relation to maintaining confidentiality, and disposition, of patient records. The media release said: "His future professional conduct is expected to be beyond reproach in every respect."

***vi. 2002***

[200] In June 2002 the Enrollee was found guilty of criminal harassment after he had "terrorized" a woman and her family for months. Bruce J. established a 'no-go' type area and imposed many conditions on his release. In his decision he stated:

> You have abused the trust in your family by engaging them unwittingly in your incredibly sophisticated and devious plan to blame [the victim] for the harassment. You have used your position as a professional to great advantage and to great harm…
> … there is no doubt ... whatsoever in my mind that you have hit rock bottom and you must recognize that the only place to go is up.
> [*R. v. Carvalho* [2002] BCJ No. 2322 at paras 5 and 6]

[201] Eight days later the Enrollee was observed in the 'no-go' area outside the victim's dwelling which he denied until informed that he had been under police surveillance. He was charged again. In that case (*R. v. Carvalho* [2002] BCJ No. 2819) Bruce J. clearly had no trust in the defendant. He stated of the Enrollee, at paragraph 5, that:

> He is skilled enough to tell the doctors what they want to hear, not because he believes it but because he knows it will bring the desired result for him. In frustrating treatment, Dr. Carvalho appears to be his own worst enemy, and this I think underlines the substantial risk he poses to the community.

***vii. 2003***

[202] In April 2003 by CPSBC media release the CPSBC announced that the Enrollee's name was erased from the CPSBC register due to his crimes. The CPSBC was only entitled to do so, under the law, if his acts had disqualified him from practice.

***viii. 2007- 2009***

[203] In 2007, from the 2013 FOIPPA Release (admission disputed) evidence shows that the CPSBC granted the Enrollee a temporary license to practice with conditions that included being supervised by another physician and that his future professional conduct "be beyond reproach in every respect."

[204] It also shows that in September 2009 office staff alerted the CPSBC to apparently falsified records and billings made by the Enrollee. He was interviewed in November 2009 by the CPSBC and the heavily redacted memorandum of that interview says that he stated that he was disorganized and that when he was sorting through his notes in mid-2009 he "indiscriminately applied the notes to patients". He did so even when he was not entirely sure what the notes said and couldn't remember the context of the note. Then, after entry from scraps of paper he would destroy the note, thus destroying the original. He agreed that one of the factors in his actions was "financial pressure". His estimate of how many patients he had billed for, but had not seen, migrated from 50, to over 100, and then to over 130 during the course of the interview. He said that all of the patient's medical records could be wrong.

***ix.*** ***2012***

[205] On June 22, 2012 the MSC received an unexpected and vague letter enclosing a cheque regarding the Enrollee, which the MSC did not understand until almost a fortnight later. The letter was from the Enrollee's Counsel and simply stated, without context, that:

> Dr. Carvalho has been assessed to owe the Medical Services Commission $3,000 and in that regard we enclose his cheque for that amount.

[206] On July 3, 2012 a CPSBC media release disclosed that the Enrollee was again subject to CPSBC discipline that was linked to the cheque. The media release stated that the Enrollee had admitted to unprofessional conduct and was – among other things- to reimburse the MSC approximately $4,000 for medical services which he billed but either did not provide to patients, or did not maintain any or adequate medical records.

[207] From the 2013 FOIPPA Release (admission disputed) it is clear that the Enrollee was required to do more with regard to his dealings with the MSC. He both agreed to and was ordered by the CPSBC Inquiry Committee as follows:

> Dr. Carvalho will reimburse the Medical Services Commission for all sums which he has billed for medical services provided by Dr. Carvalho for the treatment of patients [for whom he had made false appointments and not seen at all or as claimed] and such other amounts as may be owed by Dr. Carvalho to the Medical Services Commission, such amounts and the schedule for payment of same to be determined by agreement between Dr. Carvalho and the Medical Services Commission, by proceedings before the Medical Services Commission, by arbitration, or by Order of the Supreme Court of British Columbia.
> [Ex 1:179; Parenthetic insert replaces the words "referred to in Schedule B"]

[208] The Enrollee did no such thing with the MSC and merely paid a lesser amount than stated in the media release.

[209] The CPSBC records show that it was aware that only $3,000 was sent to the MSC. They also show that the CPSBC was aware of the MSC confusion upon receipt of the cheque. There is no evidence that the CPSBC followed up or acted other than as if the Enrollee had complied with the provision requiring agreement and repayment.

***x.*** ***2014***

[210] On March 24, 2014 the BIP released the Audit Report of its second audit of the Enrollee. Having two audits during one's career is unusual, although not rare. During the audit the Enrollee failed to provide all documents in a timely manner, failed to attend an interview at his workplace (even after rescheduling to an agreed time), and failed to provide answers to written questions. The Enrollee could not be described as fully cooperative or forthcoming. It was not argued and the Panel need not determine whether the failures were a hindrance to the inspectors, or were refusals to reply.

### *xi. Dis-Enrolment*

[211] The Panel has considered the magnitude and frequency of the failings during the audit period and finds that the Enrollee has acted as he has while necessarily being aware that the MSP is a trust based system and of its reliance upon his integrity. The Panel finds, without consideration of the Disciplinary Records, that there is cause under s.15 of the Act to cancel the Enrollee's enrolment. The Panel also finds that if the Disciplinary Records are considered that the conclusion is no different. The Panel Orders disenrolment.

## *F. Section 15(2) Reenrolment*

### *i. Consideration*

[212] Under s.15(2)(a) the Panel may "order that the practitioner not apply under s.13(1) for a period specified" by it.

[213] The Panel has considered the same factors that have gone into determining whether to cancel the Enrollee's enrolment as well as his past failings commencing from almost the start of and spanning the Enrollee's 26-year career in British Columbia.

[214] The Panel first considered the evidence without consideration of the Disciplinary Records and found that the evidence is overwhelming that there are good grounds for the MSC to have lost trust in the Enrollee as requisite for his enrolment in the MSP, and that this loss is permanent and cannot be regained in the circumstances.

### *ii.* CPSBC *Regulation and Monitoring*

[215] The Enrollee argues that he has changed and is repentant for his past poor judgement and mistakes. In his affidavit he states that he has:

> …worked hard on the problems identified by the College in its disciplinary process, and though I am not perfect, I am a much improved physician today. I most definitely have not and will not attempt to receive payment for services I have not rendered as putting my licence to practice and ability to earn a living in jeopardy would have a devastating impact on my family and I.
>
> [Enrollee affidavit at para 9.]

[216] Throughout his career the Enrollee has admitted to intentional misdeeds – although it is noted that in this matter he has not admitted an intention – and agreed to stop or been told to do no more, either by specific direction or general direction for his future actions to be beyond reproach. The MSC and the Panel is entitled to give his statement of future intention little weight based upon this past behaviour, independent of whether the Enrollee is being truthful about his intentions.

[217] The Enrollee also states in his argument (at para 64) that the last CPSBC discipline has been working to reduce identified billing errors. He states:

> 64. … since the College's disciplinary order, the Respondent has practiced under the strict terms and conditions imposed by the College including practising under a medical supervisor, not having any involvement in billing matters and continuing to seek treatment for his psychiatric illness and reporting to the College as required. The evidence clearly demonstrates that the regulatory model is working and the Respondent's billing practices have produced few if any errors in the past six years.

[218] His argument is not about the magnitude of errors but about numbers and suggests that the Enrollee is entitled to some billing errors. The errors identified since his return to work in June 2011 are significant in nature, and not merely clerical, with many for billings found to have "no record" and still with a 100% error rate on every billed Fee Item 06019 procedure. While the numbers are fewer, since his last discipline by the CPSBC, it is clear that the Enrollee claims that a significant basis of this is due to the conditions imposed by the CPSBC.

[219] The Enrollee provides no support for what those conditions are and objected to acceptance of the 2013 FOIPPA Release which would reveal something about them. The Panel finds that, without consideration of the 2013 FOIPPA Release, any of the stated involvement of the CPSBC does not displace cause for cancelling enrolment or that in the circumstances that the enrolment of the Enrollee shall be cancelled. Nor does it displace or shorten the period in which the Enrollee is ordered not to apply for re-enrolment.

[220] If the 2013 FOIPPA Release is excluded the Panel puts little weight on the CPSBC discipline conditions and ongoing actions to restore the MSC's trust in the Enrollee or to ameliorate any inadequacy of medical reports and claims for benefits to the standard required.

[221] Oversight by the CPSBC does not address cause under s.15 or the factors that apply for determination of the duration of any order not to re-apply for re-enrolment. This is because it is the trust of the MSC in the Enrollee that is applicable, not the trust of the MSC in the CPSBC and its ability to control the Enrollee. The relationship is between the MSC and the Enrollee, and the MSC has no ability to control the CPSBC. The CPSBC has no obligation to report any changes in its regulation of the Enrollee, and no relevant duty to report failings of the Enrollee to the MSC.

[222] If there was a level of reliance of the MSC upon the CPSBC this would be inappropriate. The role of the CPSBC is not to monitor billings, that is the role of the MSC. In this regard it would be inappropriate – and potentially illegal – for the MSC to delegate its regulatory responsibility to the CPSBC.

[223] Further, the Panel also finds that the CPSBC media release stated that the Enrollee was to reimburse the MSC "approximately $4,000" but there is no evidence that the CPSBC ensured compliance with this or the other parts of its disciplinary order. There is, however, evidence that it did not do so, specifically the Enrollee only paid $3,000 to the MSC.

[224] If the 2013 FOIPPA Release is considered it is then clear that the CPSBC disciplinary order was more extensive and required reimbursement for all sums

identified in the order (which was significantly over $3,000) and "and such other amounts as may be owed by Dr. Carvalho to the Medical Services Commission, such amounts and the schedule for payment of same to be determined by agreement between Dr. Carvalho and the Medical Services Commission".

[225] There is no evidence that the CPSBC monitored or sought to enforce these terms. It did have proof that $3,000 was tendered to the MSC by the Enrollee but also was aware that the MSC was unaware of what it was for and thus that there was no agreement between the MSC or even opening of discussions between them as to any other amounts owing.

[226] While the regulatory model may be working for the CPSBC it is not working, or intended to work, for the MSC.

[227] Finally, in the 2013 FOIPPA Release there is evidence that the CPSBC changed, or revoked and replaced, the resolution so as to alter the terms and conditions imposed on the Enrollee. The effect has not been determined, but it is clear the MSC has no control over such changes.

[228] After considering the 2013 FOIPPA Release the Panel's findings are unchanged from those that resulted from consideration without it.

#### *iii. Mitigating Factors – Enrolment*

[229] The Enrollee plead, in essence, factors to mitigate the outcome. The Panel was asked to take account that he had been punished by the CPSBC and that a lifetime ban would have a devastating impact on the Enrollee.

[230] Any decision to order repayment or to terminate the business relationship is not punishment. The fact that the Enrollee has been punished by the CPSBC – the terms of which the Enrollee sought to exclude from evidence – is not relevant in two ways. First, the basis of repayment is debt and the basis for termination is loss of trust by the MSC, both of which are unaffected by the CPSBC's punishment of the Enrollee. Second, the regulatory purpose of that punishment is unlike and does not address the purpose of the MSC in this matter.

[231] As for the very human impact on the Enrollee, the decision here is not made lightly or without consideration of the impact to both parties. The Panel has considered and finds that its decisions are not disproportionate and that the MSC has good grounds for its permanent loss of trust. The grounds and the consequences are of the Enrollee's making.

## VII CONCLUSION

### *A. Section 37*

[232] The Panel has determined that the Enrollee, as a practitioner, has made:

> (a) an unjustifiable departure from the patterns of practice or billing of practitioners in the practitioner's category,

> (b) multiple claims for payment in respect of a benefit that was not rendered by him, and
> (c) multiple misrepresentations about the nature or extent of benefits rendered by him;

[233] As a result, the Panel has also determined that the Enrollee has been paid an amount for which repayment should be made to the MSC and it has determined the amount that it considers appropriate to be repaid arising out of the departure, claim or misrepresentation under s.37(1)(a) to (c) of the Act.

### *B. Section 15*

[234] The Panel has determined, pursuant to s.15(1)(a) of the Act, that as a result of a finding by the CPSBC that the Enrollee has been guilty of infamous conduct and has repeatedly been found guilty of instances of serious misconduct, that the practitioner is no longer able to provide proper care or treatment to beneficiaries in accordance with the Act.

[235] The Panel also finds that, pursuant to s.15(1)(c) of the Act, the Enrollee has made many submissions to the MSC for payment knowing that:

> (i) the benefit had not been rendered, and
> (ii) the nature or extent of the benefit that was rendered had been misrepresented,

[236] The Panel also finds that, pursuant to s.15(1)(f) of the Act, the Enrollee has failed to comply with the 1999 Consent Order made under section 37 (1) (e) to adopt an appropriate pattern of practice or billing.

[237] In respect of each paragraph above, considered independently, the Panel finds that the Enrollee's enrolment should be cancelled and that he be prohibited from re-enrolling for life.

## VIII ORDER

### *i. <u>Section 37</u>*

[238] The Panel Orders that:

(1) pursuant to s.37(1)(d) of the Act, the Enrollee pay to the MSC the amount of $184,138.00;

(2) pursuant to s.37(1.1) the Enrollee pay the prescribed surcharge of 5% in the amount of $9,206.90;

(3) the Enrollee shall be given credit for payment of the $3,000 tendered by letter dated June 22, 2012 provided the cheque was deposited by the MSC and was honoured;

(4) pursuant to s.37(1.3) the Enrollee pay interest on the balance of the above calculated at the rate, and compounded, as prescribed by the Act; from the last day of the audit period until paid; and

(5) pursuant to s.37(8) the Enrollee pay the costs of the audit in respect of which this hearing called, and costs in the cause.*

[239] Subject to a demand by either party for a hearing by the full Panel, the Chair of the Panel shall determine any dispute between the parties as to the calculation of interest and determination of costs under this Order. Costs for such a hearing shall be determined separately from those of this hearing.

[240] A copy of this Order shall be provided to the Registrar of the CPSBC in accordance with s.37(4) of the Act.

***ii. Section 15***

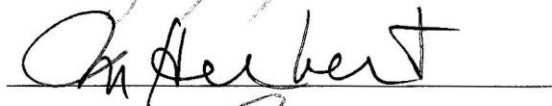
[241] The Panel Orders, pursuant to s.15(2)(a) that the enrolment of the Enrollee be cancelled as a practitioner under s.13(1) of the Act, and that the Enrollee not apply for enrolment or be enrolled under s.13 of the Act for the period of his lifetime.

April 20, 2016

Mr. Kent Ashby, Panel Chair

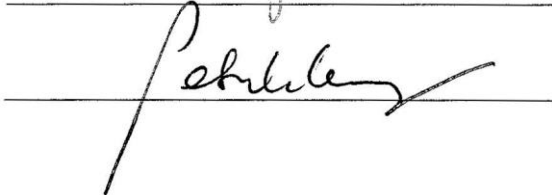
Dr. Szu-Yang Chen, Panel Member

Dr. Melodie Herbert, Panel Member



Dr. Ezra Kwok, Panel Member

Mr. Patrick Wong, Panel Member



## Corrigendum

A corrigendum was issued by the Panel on May 6, 2016 as part of a decision on an application of Dr. Carvalho as follows but without the underlining shown here to indicate the corrections (the corrections have not been made to the text above but are marked by " * ":

(1) In the date section of the style of cause on the first page the dates "June 20 to June 24, 2015" is to be replaced by "July 20 to July 23, 2015"; and

(2) paragraph [238] subparagraph (5) is replaced by:
(5) pursuant to s.37(8) of the Act, the Enrollee pay the costs of the audit in respect of which this hearing was called, and costs of the hearing with those awarded in the cause.

**On behalf of the Panel**

Kent Ashby, Panel Chair

May 6, 2016
Date