Performance Audit

Oversight of Physician Billing

// Independent Auditor's Report

Office of the Auditor General of Ontario

ANNUAL REPORT 2025

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1.0 Audit at a Glance

// Why We Did This Audit

- The Ministry of Health (Ministry) paid $19.5 billion to about 35,000 physicians through the Ontario Health Insurance Plan (OHIP) in 2024/25.

$19.5 billion
was paid to physicians through OHIP in 2024/25

- We last audited physician billing in 2016, which is almost 10 years ago. Our past audits repeatedly identified issues with physician billings. For example, in our 2016 audit on Physician Billing, we found the Ministry did not adequately review significantly high and unreasonable billings. We found similar issues in other recent audits such as the Implementation and Oversight of Ontario's Opioid Strategy in 2024.

// What We Found

The Claims Processing System Has Limited Ability to Automatically Flag High-Risk Billings

- While the Ministry's claims system performs automated checks based on some claim rules, it has limited functionality to detect high-risk billings. Our analysis of fee-for-service (FFS) billings data between 2021/22 and 2024/25 found numerous examples of physicians who billed for over 24 hours of services in a single day; provided services to an unusually high number of patients (for example, over 100) per day; or worked a high number of days (for example, 365) in a year.

» **Recommendation 1**

Ministry Is Not Using a Risk-Based Data Analysis Approach to Select Post-Payment Audits

- The Ministry primarily relies on tips and complaints, instead of proactive and independent data analysis of claims, to identify physicians for post-payment audit.

- Our data analysis identified examples of physicians in various specialties with notable billing concerns or risks that have not been audited. For example, an ophthalmologist billed $6.7 million in 2023/24, over twice as much as the next highest-billing ophthalmologist. In another example, a diagnostic radiologist reported working 364 or more days in each year from 2021/22 to 2023/24 and billed $3 million in 2023/24 alone. While these billings may be appropriate, identifying and investigating risks could result in a reduction of inappropriate billings.

» **Recommendation 1**

Lack of Progress in System Modernization Has Led to Delays in Realizing Benefits

- In Ontario's 2023 budget, the government launched a multi-year Claims Modernization initiative to upgrade business processes and IT infrastructure for managing claims for health programs. The expected benefit was estimated to be $1 billion through improving oversight of claims programs including OHIP, Ontario Drugs Benefit Program and Assistive Devices Program. We found that the Ministry has completed some early planning work on modernization but has not identified specific expectations regarding what will be improved and how.

» **Recommendation 2**

Limited Resources Are Available to Detect Inappropriate Billings

- The Ministry made a proposal in 2017 requesting additional staff to improve its oversight work on physician billing. The proposal noted that Ontario had 0.4 audit staff for every 1,000 physicians, while the average among other provinces was 5.3. Of the 22 additional staff requested and approved, the Ministry permanently reallocated 17 to other areas and assigned the remaining five to areas outside of the audit function.

- The Ministry made another proposal requesting additional staff in 2024/25. At the time of our audit, the number of post-payment audit staff, eight, had not changed since the 2017 proposal. Our 2016 audit of Physician Billing raised the same issue and recommended the Ministry strengthen its oversight work.

» **Recommendation 3**

Limited Action Has Been Taken to Reduce Billing for Medically Unnecessary Services

- In 2019, the Appropriateness Working Group (AWG), a bilateral working group between the Ministry and the Ontario Medical Association (OMA), targeted approximately $480 million in annual reductions by limiting the use of medically unnecessary services. The Ministry estimated that, as of 2024/25, only 18% ($87 million) of those reductions have been realized.

- While AWG estimated that one of its proposals, related to excessive injections for chronic pain, would result in approximately $100 million in cost reductions annually, the Ministry did not move forward with it. Our review of claims data found the top 10 billing physicians who provided pain management each billed between $4.3 and $9.9 million, for a combined total of almost $60 million in 2024/25.

» **Recommendation 5**

The Post-Payment Audit Process Involved Delays and Has Limited Follow Up

- The Ministry aims to complete post-payment audits within one year. Of the 173 audits opened and completed between 2022/23 and 2024/25, 21 audits (12%) took over a year to complete.

- The Ministry does not have any formal follow-up process to ensure physicians with past inappropriate billings have corrected or improved their billing practices. Our review of the Ministry's post-payment audits over the last five years identified cases where physicians had to repay inappropriate billings but never received any follow-up reviews.

» **Recommendation 7**

There Has Been Limited Oversight of Physicians with Payments from Multiple Sources

- In addition to billing through the FFS model, physicians may receive other lump-sum payments through an alternate funding agreement (AFA). The Ministry's post-payment audits focus on FFS billings ($7.8 billion in 2015/16 and $13.3 billion in 2024/25), without covering AFA payments ($4.1 billion in 2015/16 and $6.2 billion in 2024/25) or other forms of remuneration.

- Our 2011 audit of Funding Alternatives for Specialist Physicians also raised the issue that the Ministry had not done any comprehensive reviews to ensure that all payments to physicians were appropriate.

» **Recommendation 8**

The Complexity of Fee Codes for Billing Has Resulted in Potential Errors and Misuses

- The OHIP Schedule of Benefits lists about 5,000 services and related fee codes that a physician can bill for. Both the Ministry and OMA have recognized the complexity of the Schedule of Benefits and developed working groups to help physicians understand the appropriate use of fee codes for billing purposes.

- The Ontario Provincial Police's (OPP) Health Fraud Investigations Unit, which receives referrals from the Ministry and investigates suspected billing fraud, has also noted that the complexity of the billing system could make it challenging while conducting their investigations.

» **Recommendation 9**

There Has Been Limited Oversight to Protect Patients Against Inappropriate Charges for Insured Services

- Potential billing violation reviews completed by the Ministry since 2020 indicate confusion about insured and uninsured services. Patients are not always aware of what can and cannot be charged by a physician. Physicians have been found to have inappropriately charged patients directly for optional or unnecessary upgrades and enhancements without adequately informing them of their right to opt for services covered by OHIP.

» **Recommendation 10**

// Our Conclusion

We concluded that the Ministry does not have effective systems and procedures in place to identify, review and prevent inappropriate physician billings. The Ministry also needs to take more timely, effective and appropriate corrective actions against identified inappropriate billing practices.

The Ministry continues to use an outdated claims system that has limited functionality to automatically identify and prevent high-risk billings. In 2023, the government launched a multi-year Claims Modernization initiative but there has been limited progress on this project since the end of 2024.

The Ministry's post-payment audit work has been reactive, relying on tips and complaints instead of data analysis to select physicians for audit. Eight staff are dedicated to this audit work, a number that has not changed since 2017, creating a risk that inappropriate billings remain undetected.

Post-payment audits are not always completed on a timely basis, and little to no follow-up work has been done to confirm whether billing concerns identified by past audits have been addressed. Furthermore, the Ministry has limited abilities to directly recover overpayments from physicians who are found to have made inappropriate billings.

The Ministry uses an outdated claims system with limited functionality to automatically identify and prevent high-risk billings

While physicians charging patients inappropriately is an ongoing issue, the Ministry has not conducted any reviews to determine if there are systemic issues with certain physicians or in certain specialties.

The Ministry has agreed with all 10 of our recommendations.

2.0 Background

2.1 Overview of OHIP Billing

The Ministry provides insured health-care services to Ontario residents through OHIP. OHIP is established and governed by the *Health Insurance Act* (HIA), which defines eligible patients, insured medical services for eligible patients and providers eligible to receive payments. In summary:

- Insured services include medically necessary services rendered by physicians, hospitals, health facilities and practitioners. Approximately 5,000 fee codes are publicly funded under OHIP. Uninsured services are paid directly by patients or their private insurance.
- Eligible providers relevant to this audit are physicians licensed with the College of Physicians and Surgeons of Ontario (CPSO), with a primary practice address in Ontario and an OHIP billing number.

The Ministry paid physicians $19.5 billion through OHIP in 2024/25. The amount paid at the time of our last audit in 2015/16 was $11.9 billion. After factoring in 28% inflation since 2015/16, payments have increased by $4.3 billion or 28%.

The Ministry is responsible for overseeing payments and reviewing billing practices to ensure compliance and prevent fraud

The Ministry is responsible for overseeing payments to physicians, and the related policies and procedures. It is responsible for auditing and reviewing billing practices to ensure compliance and prevent fraud.

2.2 FFS Billings and AFAs

Most physicians in Ontario are paid through either the FFS model or an AFA. Some physicians work under both models depending on their areas of practice. Specifically:

- The FFS model requires a physician to bill for each service provided to patients. This means the more services and patients being billed for, the higher the payments to the physician. Most specialists (ophthalmologists, diagnostic radiologists, cardiologists, etc.) bill under the FFS model. The FFS model represents $13.3 billion or 68% of the total $19.5 billion of physician payments in 2024/25. This compares to $7.8 billion in 2015/16. After factoring in 28% inflation since 2015/16, payments have increased by $3.3 billion or 25%.
- The AFA model typically pays a physician a set amount regardless of the number of services provided. Most primary care physicians and some other specialties (for example, emergency medicine) are paid under the AFA model. The AFA model represents $6.2 billion or 32% of the total $19.5 billion of physician payments in 2024/25. This compares to $4.1 billion in 2015/16. After factoring in 28% inflation since 2015/16, payments have increased by $0.95 billion or 15%.

2.3 Post-Payment Audits

Most physician billings under the FFS model are processed and paid automatically. As such, the Ministry's post-payment audits focus on the FFS model, which represents a higher risk of inappropriate payments than the AFA model (see **Section 2.2**). In a 2024 analysis, the Ministry noted that 3%–5% of FFS claims examined had anomalies that potentially include inappropriate billings. Based on the $13.3 billion in FFS payments in 2024/25, this translates to approximately $400–$665 million in payments that would require additional review.

3%–5%
of examined FFS claims had anomalies that could include potentially inappropriate billings

To verify the accuracy of claims and compliance with OHIP policies, the Ministry's Provider Audit and Payment Accountability group can perform post-payment audits of claims. When performing the review, some common risk areas are:

- all or part of the service was not provided;
- all or part of the service was not medically necessary; and
- the nature of the service was misrepresented, either intentionally or not.

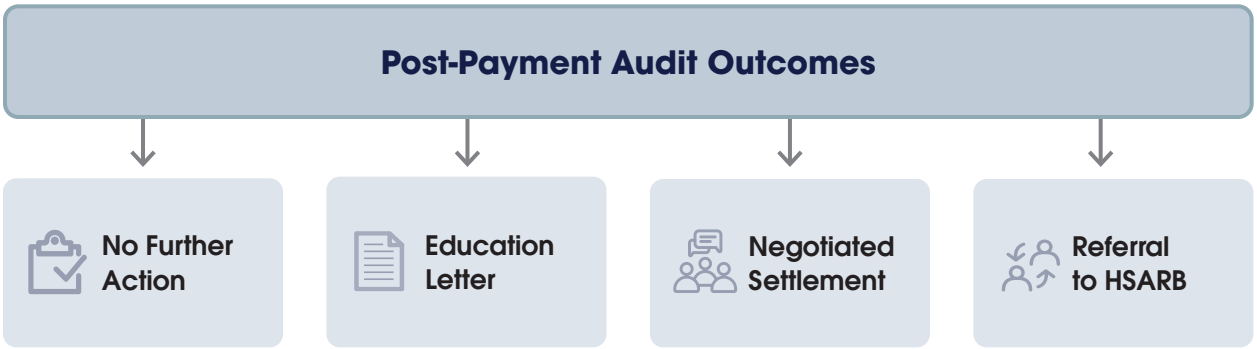
As shown in **Figure 1**, a post-payment audit can result in multiple outcomes, including:

- taking no further action if the claims and associated payments were appropriate;
- sending an education letter to notify the physician of the correct billing practices;
- negotiating a settlement agreement with the physician for paying back all or part of the inappropriate billings identified by the Ministry; and
- referring the case to the Health Services Appeal and Review Board (HSARB), an independent quasi-judicial tribunal, for a decision on repayment if a settlement agreement cannot be reached between the Ministry and the physician.

The Ministry may also, at any point during a post-payment audit, refer the case for further investigation to third parties, such as the OPP and CPSO, if the case is associated with suspected criminal or provincial offences, misconduct or quality-of-care concerns that are outside of the Ministry's purview.

Figure 1: Outcomes of Post-Payment Audits

Prepared by the Office of the Auditor General of Ontario



Note: At any point during a post-payment audit, MOH may refer the case to third parties, such as OPP and CPSO, for further investigation.

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ministry has effective systems and procedures in place to:

- identify, review and prevent inappropriate physician billings in accordance with applicable legislation, regulations and agreements; and
- take timely, effective and appropriate corrective actions against identified inappropriate billing practices.

Our audit scope focused on the Ministry's oversight activities including the prevention and detection of inappropriate physician billings, the post-payment audit process and efforts to recover overpayments. Our work included analyzing physician billings and payments to determine the appropriateness and effectiveness of the Ministry's oversight work.

We also reviewed post-payment audit files and findings, and the functionality and reporting capabilities of the Ministry's OHIP claims system. Given that the Ministry paused its oversight activities during part of the COVID-19 pandemic, our data analysis and documentation reviews primarily focused on billings and post-payment audits after the pandemic.

Our audit did not cover work performed by CPSO on the quality of care of physician services or by OPP's Health Fraud Investigation Unit, as both areas fall outside the Ministry's purview.

For more details, see our **Audit Criteria**, **Audit Approach** and **Audit Opinion**.

4.0 What We Found

4.1 Information Systems and Data Review

4.1.1 The Claims Processing System Has Limited Ability to Automatically Flag High-Risk Billings

The Ministry's claims system, which has been in use since the 1980s, allows physicians and other health-care professionals to bill OHIP for insured services provided to patients. While the system performs automated checks based on general claim rules (for example, validating a physician's OHIP billing number, restricting certain billing codes based on a physician's specialty, requiring Ministry staff to manually review claims with specific fee codes), it has limited functionality to automatically flag abnormal billings for further investigation.

The claims system automatically pays most claims submitted by physicians under the FFS model and does not have the ability to prevent payments when high-risk claims are made. This creates the risk of paying inappropriate FFS billings, for example, when physicians:

- bill for more than 24 hours of services in one day;
- bill for a high number of days a year (for example, 365);
- bill for a significant number of patients (for example, over 100) in one day; and/or
- are outliers with overall billings and/or services provided that are significantly higher than peers.

The Ministry's oversight activities typically occur after physicians have been paid. While the Ministry has identified issues related to the above risks through its oversight work (see **Section 4.2**), it has primarily relied on tips and complaints to identify billings for audit rather than performing risk-based or comprehensive data analysis.

Our analysis of FFS billings data between 2021/22 and 2023/24 found numerous examples of high-risk billings that could have been flagged automatically for review if the Ministry had used a modernized claims payment system. Most of these examples did not undergo a post-payment audit to determine if the billings were reasonable and appropriate (see **Section 4.1.2** and **Figure 6**).

Billing Over 15 Hours of Service in a Single Day

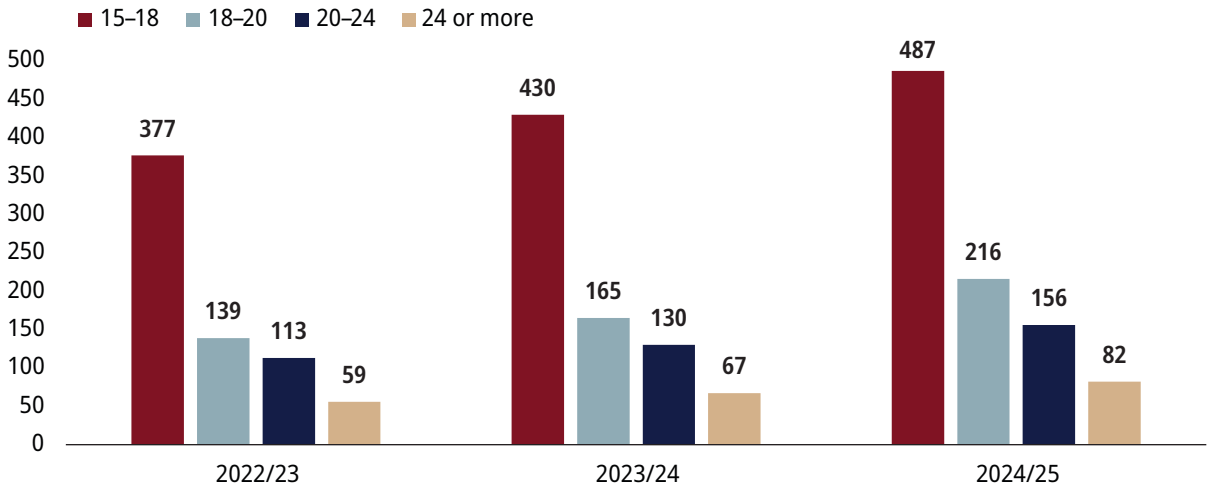
Some OHIP fee codes are time-based, meaning that payment is determined by the duration of the service provided. Service start and stop times must be documented in a patient's medical record. These codes are typically used for services with minimum time requirements (for example, counselling) and certain time-based services or procedures (for example, anaesthesiology).

Since the claims system cannot flag billings related to abnormal usage of time-based fee codes, we requested the Ministry to provide data that included physicians that billed time-based fee codes where the total time billed exceeded 24 hours in a single day. As shown in **Figure 2**, the analysis of claims data over the last three years (2022/23 and 2024/25) found that:

- In each of these three years, 59 or more unique physicians had at least one day where they billed 24 or more hours of services.
- During this three-year period, the number of physicians who had 24 or more hours' worth of billings in at least one day increased by about 39% from 59 in 2022/23 to 82 in 2024/25.

Figure 2: Number of Physicians by Hours Billed in a Single Day, 2022/23–2024/25

Source of data: Ministry of Health



Note: Instances of physicians billing for less than 15 hours in a single day are excluded from this figure.

The Ministry has not thoroughly reviewed these physicians' billings through a post-payment audit to determine why they billed 24 or more hours of services in a single day and whether time-based fee codes need to be updated.

While the Ministry does not analyze hourly billing data to select physician billings for post-payment audit, it has initiated a project to identify and provide education letters to physicians found to have a high number of hours of services being billed in a day. The Ministry informed us that this process may involve identifying billings for future post-payment audit.

The Ministry has also identified cases where physicians billed for more than 24 hours of services in a single day through past post-payment audits, as noted in the following examples. It could have detected further similar cases if its claims system included functionality for automatically flagging abnormal use of time-based fee codes or if it performed this data analysis to select payments for review.

The Ministry has not reviewed these physicians' billings to determine why they billed 24+ hours of services in a day

- One physician billed more than 24 hours of services on 98 days between May 2021 and April 2022. On one of these days, this physician billed 114 hours of services. The Ministry's post-payment audit found that the physician's clinical records failed to show start and stop times for services provided. The Ministry identified almost $1.4 million in overpayment. Since the Ministry and the physician could not come to an agreement on repayment, the case was referred to HSARB in 2023 and a hearing is scheduled for May 2026.
- Another physician billed over 24 hours of services on 15 days within a six-month period in 2020/21. The Ministry's post-payment audit found that the physician provided group counselling but billed as if they had seen each patient individually, which inflated the hours claimed and resulted in higher billings. This physician agreed to repay $105,000 for the amount deemed inappropriate.

There may be valid reasons for billing a large number of hours a day; however, without flagging these instances for review, the Ministry does not know if the billings are appropriate.

High Number of Days Worked in a Year

When submitting claims to the Ministry, physicians are required to specify the dates they provided the services. Our review of service days of all submitted claims over the last three years (2021/22 to 2023/24) found that between 104 and 130 physicians across many specialties claimed to have worked all 365 or 366 days in the year (see **Figure 3**). We also found that 66 of these physicians claimed to have worked all days over the three years. As discussed further in **Section 4.1.2**, we identified specific examples of physicians who submitted multi-million-dollar claims with a high number of days worked in a single year that have not been audited by the Ministry (see **Figure 6**).

Again, these may be valid claims but should be flagged as high risk for review by the Ministry.

Figure 3: Number of Physicians by Days Worked*, 2021/22–2023/24

Source of data: Ministry of Health

Days Worked	2021/22	2022/23	2023/24
365–366	118	104	130
351–364	328	270	302
301–350	2,536	2,225	2,118
261–300	4,785	4,306	4,242

* Not including physicians who worked 260 or fewer days in the year.

Billing for a High Number of Patients per Day

Our review of claims data over the last three years (2021/22 to 2023/24) found that 101 physicians billed for an average of 100 patients or more per day in each of these years. The duration of each service provided by physicians can vary from one patient to another.

We also identified numerous examples where physicians billed for services provided to over 500 patients in a single day and have not been subject to a post-payment audit. This means providing a patient service every 2.88 minutes in a 24-hour period. **Figure 4** provides anonymized examples of physicians with significantly high billings and a high reported number of patients billed for in 2023/24. For example, the top biller in the figure, who billed $4.3 million, was billing for an average of 461 patients per day or one every 3 minutes in 24 hours, with 930 patients on one extreme day.

A Ministry review would be warranted to determine if the physicians billed appropriately or in error, for example, by submitting claims on Friday for all services provided over the week.

Figure 4: Examples of Physicians with High Billing Rates per Day, 2023/24

Source of data: Ministry of Health

Physician	Specialty	Total FFS Billings ($ million)	# of Patients Billed for (per Day)[1]	
			Average	Maximum
A	Diagnostic radiology	4.3	461	930
B[2]	Paediatrics	3.1	135	764
C	Diagnostic radiology	3.0	322	728
D	Internal Medicine	1.7	60	693
E	Nephrology	1.5	86	675
F	Cardiology	1.2	42	464
G	Family practice and general practice[3]	1.3	112	523

1. The number of patients billed for in the claims system could relate to in-person visits or work done by physicians without seeing patients, such as reviewing test results.
2. A post-payment audit on this physician's billings was conducted in 2022 and found $5.7 million in overpayments. The physician disagreed with the audit findings, the case was referred to HSARB in 2024 and a hearing was pending at the time of our audit.
3. Family practice and general medicine is typically the default specialty for physicians working in areas such as addictions medicine and pain medicine.

High Billings Relative to Peers

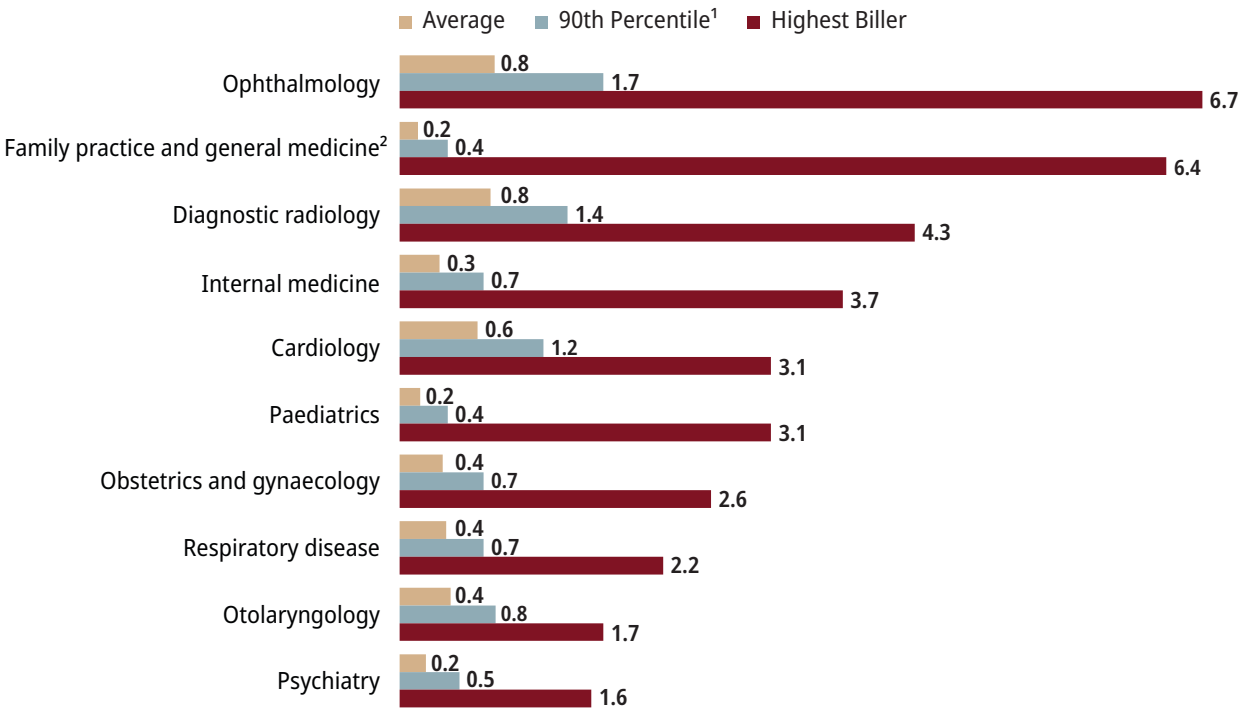
Aside from reviewing a physician's billing pattern or trend, another way to identify high-risk billings is to compare billings of different physicians in the same specialty. Physicians with significantly higher billings than their peers could indicate potential billing issues such as:

- using fee codes that pay more than the actual services being provided (upcoding); or
- billing for non-billable services (for example, services provided by a nurse or physician assistant rather than the physician).

Figure 5 shows the results of our analysis of FFS claims data for 10 specialties. We found that in 2023/24, the total payments to each specialty's top biller were significantly higher than the 90th percentile billings of other physicians in the same specialty.

Figure 5: Billings by Specialty, 2023/24 ($ million)

Source of data: Ministry of Health



1. Means 90% of physicians in each specialty billed at or below the stated amount, and only 10% billed higher.
2. Family practice and general medicine is typically the default specialty for physicians working in areas such as addictions medicine and pain medicine.

The 90th percentile represents the top 10% of physicians' billings. For example, the total payment to the physician with the highest billing in ophthalmology was $6.7 million. This was almost three times higher than the 90th percentile billings of physicians in this specialty. Another example is in family practice and general medicine where the 90th percentile of billings was $0.4 million but the highest-billing physician billed $6.4 million. As discussed in **Section 4.1.2**, we identified specific examples of physicians with high-risk billing patterns, including significantly higher-than-peer billings, that have not been audited by the Ministry (see **Figure 6**).

Figure 6: Examples of Notable Billing Concerns Not Audited by the Ministry of Health, 2021/22–2023/24

Source of data: Ministry of Health

Physician	Specialty	Total Billing 2021/22–2023/24	Billing Concerns or Risks		
			Most # of Days Worked/Year	Most # of Patients/Day	High Billings Relative to Peers
A	**Diagnostic radiology**	$7.6 million	364+ days each year	428 in 2021/22 574 in 2022/23 728 in 2023/24	$3 million in 2023/24, compared with $1.4 million or less for 90% of peers
B	**Respiratory disease**	$6.4 million	363+ days each year	98 in 2021/22 104 in 2022/23 114 in 2023/24	$2.2 million in 2023/24, compared with $700,000 or less for 90% of peers
C	**Ophthalmology**	$19 million	n/a	232 in 2021/22 220 in 2022/23 233 in 2023/24	$6.7 million in 2023/24, over twice as high as the next highest-billing peer
D	**Diagnostic radiology**	$9.6 million	300+ days in 2022/23 and 2023/24	580 in 2021/22 701 in 2022/23 930 in 2023/24	$4.3 million in 2023/24, compared with $1.4 million or less for 90% of peers
E	**Cardiology**	$7 million	364+ days each year	123 in 2021/22 118 in 2022/23 113 in 2023/24	$2.4 million in 2023/24, compared with $1.2 million or less for 90% of peers
F	**Internal medicine**	$11.5 million	288+ days billed each year	71 in 2021/22 72 in 2022/23 81 in 2023/24	$3.7 million in 2023/24, $566,000 higher than the next highest-billing peer
G	**Family practice and general medicine***	$4.9 million	365+ days each year	731 in 2021/22 692 in 2022/23 600 in 2023/24	$1.7 million in 2022/23, compared with $383,000 or less for 90% of peers

* Family practice and general medicine is typically the default specialty for physicians working in areas such as addictions medicine and pain medicine.

4.1.2 Ministry Is Not Using a Risk-Based Data Analysis Approach to Select Post-Payment Audits

The Ministry primarily relies on tips and complaints to identify physicians for post-payment audit. The number of tips and complaints received by the Ministry's payment oversight groups increased from 74 in 2019/20 to 180 in 2024/25.

In total, 440 post-payment audits were completed between 2022/23 and 2024/25, some of which were opened prior to those years. Approximately, 60% of those completed identified billing concerns and resulted in either an education letter, an overpayment recovery and/or a referral to HSARB. The remaining 40% resulted in no concerns being identified. We noted that the Ministry was able to make overpayment recoveries of $8.1 million between 2022 and 2025 by conducting post-payment audits primarily based on tips and complaints (see **Section 4.2.1**).

60% of post-payment audits completed between 2022/23 and 2024/25 identified billing concerns

While tips and complaints provide value in detecting inappropriate billings, they do not replace the need for performing analysis of claims data proactively and independently as we did in **Section 4.1.1**.

Through our own data analysis, we identified specific examples of physicians in various specialties with notable billing concerns or risks that had not been audited (see **Figure 6**). These anonymized examples were based on billing data between 2021/22 and 2023/24. The Ministry had not conducted any audit work on these physicians' billings for two or more years despite the data being available to identify these risks.

Why It Matters

Relying on tips and complaints to conduct oversight work is a reactive approach. The lack of proactive data analysis to identify and select physician billings to audit is poor financial management and creates a risk that inappropriate billings remain undetected. Using a proactive approach could save millions of dollars for Ontario taxpayers.

Recommendation 1

We recommend that the Ministry:

- utilize data analytic tools to flag high-risk payments for review while the Claims Modernization project is being implemented; and
- develop and implement a risk-based approach that includes data analysis to identify and select physicians for post-payment audit.

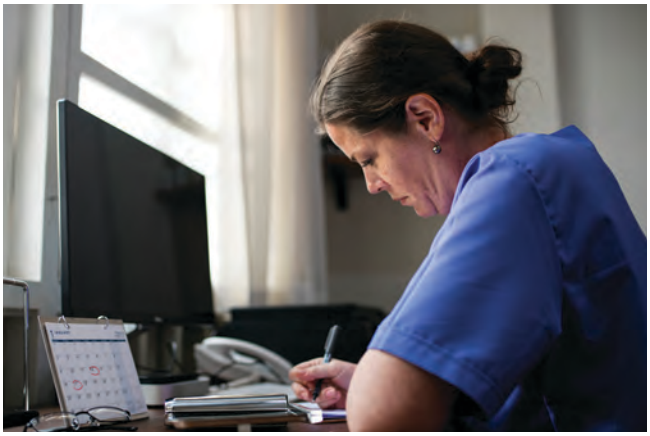
For the auditee responses, see **Recommendations and Auditee Responses**.

4.1.3 Lack of Progress in System Modernization Has Led to Delays in Realizing Benefits

The Claims Modernization initiative is on hold awaiting government approval to move forward

In Ontario's 2023 budget, the government launched a multi-year Claims Modernization initiative to upgrade the business processes and IT infrastructure that manage claims for three health programs, including OHIP, the Ontario Drug Benefit Program and the Assistive Devices Program. The Ministry was directed to develop a strategy for modernization. While some early planning work and analysis was completed, we found that the Ministry has not started its work on modernizing the claims system.

We reviewed documentation related to the Claims Modernization initiative and noted that the expected benefit was estimated to be over $1 billion annually once fully implemented. This estimate was based on an analysis done by an external consultant, which identified that approximately 3%–5% of claims ($1–$1.4 billion) among the three health programs had anomalies. The estimated benefit would primarily result from detecting high-risk billings and claims before payment, reducing the need for post-payment work and avoiding the challenges of recovering overpayments. As noted in **Section 2.3**, additional analysis by the Ministry found that 3%–5% of FFS claims reviewed had anomalies that could include potentially inappropriate billings. Based on the $13.3 billion in FFS payments in 2024/25, this translates to approximately $400–$665 million in FFS payments that would require additional review.



The Ministry noted that system modernization would take approximately six to eight years to complete. By December 2024, the Ministry had completed early planning work, which included identifying current system challenges and potential solutions. We found that the project has since been on hold awaiting government approval to move forward.

We also found that the Ministry has not identified what needs to be improved, nor how and when it will be done. For example, the preliminary work done by the Ministry to date does not indicate whether a modernized system would include functionality to either flag or prevent payment for high-risk billings, as noted in **Section 4.1.1.**

Why It Matters

OHIP is the second-largest payment program in the province. Identifying high-risk billings for review prior to payment may help stop inappropriate billings and eliminate the need to recover overpayments. This could save, as estimated above, $1 billion in taxpayers' money that could go toward other health-care expenditures like attaching people to family physicians and practitioners.

Recommendation 2

We recommend that the Ministry:

- identify and incorporate high-risk indicators of potentially inappropriate billings into the modernized claims system; and
- update the Claims Modernization timeline and expectations, such as by identifying specific functionality that will help strengthen the modernized system's ability to automatically detect high-risk billings.

For the auditee responses, see **Recommendations and Auditee Responses**.

4.2 Detection of Inappropriate Billings

4.2.1 Limited Resources Are Available to Detect Inappropriate Billings

The Ministry primarily relies on tips and complaints from various sources, for example, the public, other physicians and clinic employees, to detect and investigate billing concerns. As discussed in **Section 4.1.1**, its outdated claims system has limited functionality to automatically flag high-risk billings and there is a limited number of staff working on analyzing billing data.

The Ministry's Audit and Adjudications team has a sub-group of eight staff, including a physician as medical consultant, that are responsible for conducting post-payment audits on FFS billings. They determine inappropriate billings and recover overpayments. While these audits have identified inappropriate billings and resulted in the recovery of $8.1 million between 2022 and 2025, the audit work has been reactive rather than proactively directed by a data-driven, risk-based approach to identify billings for potential audit.

In our 2016 audit of Physician Billing, we recommended the Ministry strengthen its oversight and monitoring of FFS payments. The Ministry made a proposal in 2017 requesting additional staff to improve oversight and its ability to conduct more post-payment audits on high-risk billings.

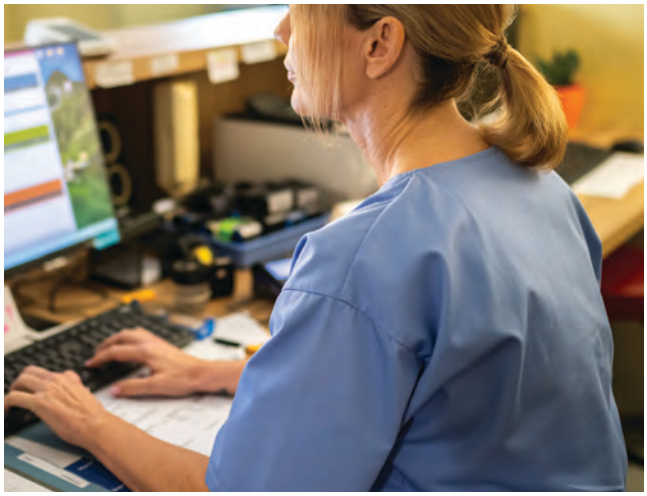
The 2017 proposal noted that:

- Ontario had 0.4 audit staff for every 1,000 physicians, while the average among other provinces was 5.3 staff for every 1,000 physicians.
- Increasing oversight staffing would provide the Ministry with significant financial benefits by way of preventing or recovering inappropriate billings, with each $2 million staffing investment resulting in $8–$10 million in benefits. For example, the Ministry estimated that increasing the number of payment accountability staff from 13 to 40 would provide $40 million in net benefits through additional detection of inappropriate billing overpayment and recovery.

$40 million

The Ministry's estimate of net benefits from increasing payment accountability staff from 13 to 40

The Ministry received approval to hire 22 additional payment accountability staff, with the expectation that some would be assigned to conducting post-payment audit work. We noted that 17 of these additional staff were permanently reallocated to other areas of the Ministry and only five stayed within the payment accountability team. At the time of our audit, the number of staff conducting post-payment audits (eight) specifically had not changed from the staffing level that existed prior to the proposal in 2017.



In 2024/25, the Ministry made another proposal requesting 15 additional payment accountability staff, with the expectation of using some of those staff to work on post-payment audits. This proposal was still pending with no decision made at the time of our audit.

Why It Matters

Ontarians expect the Ministry to have approaches in place to ensure payments made to physicians are valid, including dedicating the appropriate number of skilled staff for this purpose. Without using data analytic tools or updating systems to automate the process of detecting inappropriate billings and overpayment, the Ministry has to continue relying on staff to manually identify high-risk billings and conduct post-payment audits. However, it has not assigned additional resources for this work since 2017. Without performing more payment oversight activities, including post-payment audits, there is a risk that potentially millions of dollars in inappropriate billings continue to be paid, reducing the value for money for Ontario taxpayers.

Recommendation 3

We recommend that the Ministry look at its internal staffing complement and re-assess its staffing and technology resourcing needs to conduct physician billing oversight work such as post-payment audits.

For the auditee responses, see **Recommendations and Auditee Responses**.

4.2.2 The Random Verification Letter Review Process Was Suspended in 2019

In February 2019, the Ministry suspended its random verification letter process due to its outdated system and staffing challenges. We noted that, as of September 2025, the Ministry has not set a timeline to reimplement the process.

Historically, the Ministry proactively identified potentially inappropriate billings through the random verification letter process. This process involved selecting a random set of patients and sending them letters to verify whether they received the services that their physicians had billed for.

We reviewed past results of this process and found that the Ministry did identify minor savings after sending education letters that improved billing practices.

We found there is an opportunity to improve the process's efficiency and effectiveness. For example, instead of sending letters to a random set of patients, the Ministry could select patients who received services from physicians with past billing issues or risks, including those noted in **Section 4.1.1**.

Reimplementing the process of sending verification letters to specific patients would help the Ministry identify physicians who warrant selection for further review as part of the post-payment audit process.

In 2022, the Ontario Internal Audit Division (OIAD) conducted an audit of the OHIP Medical Claims Process Internal Controls and noted similar findings. As part of its audit, OIAD indicated that suspending the random verification letter process was a high-risk control weakness and recommended the Ministry restart the process. OIAD noted that the discontinuation of the process may hinder the Ministry's ability to identify, deter and potentially recover inappropriate billings.

Why It Matters

By suspending the random verification letter process, the Ministry lost an important patient-focused control that historically resulted in cost savings. It also lost an opportunity to proactively identify physicians with potentially inappropriate billings by verifying services provided and claims with patients directly and independently.

Recommendation 4

We recommend that the Ministry resume the verification letter process and identify ways to improve its efficiency and effectiveness, such as using a risk-based approach and data analytics for selecting patient letter recipients.

For the auditee responses, see **Recommendations and Auditee Responses**.

4.2.3 Limited Action Has Been Taken to Reduce Billing for Medically Unnecessary Services

As part of the 2017–2021 physician services agreement between the Ministry and OMA, an arbitrator approved the establishment of the bilateral AWG. The AWG was mandated to use evidence and best practices to improve the quality of patient care by reducing the use of medically unnecessary or inappropriate services.

The arbitrator noted there is evidence that fewer than 4% of Ontario's family physicians are responsible for ordering nearly 40% of tests that are considered "low value." Choosing Wisely and the Canadian Institute for Health Information together estimated that as much as 30% of medical services in Canada are unnecessary and inappropriate.

In 2019, the AWG targeted $480 million in annual reductions of medically unnecessary services. According to the Ministry, the AWG paused some of its work during the COVID-19 pandemic. As of 2024/25, 18% ($87 million) of the targeted reductions have been realized. We noted that the Ministry has not implemented some of the AWG proposals that were intended to result in further reductions.

One proposal related to inappropriate or excessive use of injections for chronic pain. For example, the Ministry's audits identified multiple cases where a physician delegated pain management services to non-physicians that are not eligible for OHIP billing or where a physician potentially billed inappropriately for pain management services.

The AWG explored a proposal to transfer patients who received more than 48 nerve block injections for chronic pain a year to a Ministry-funded multidisciplinary chronic pain clinic. While the AWG estimated that this proposal would reduce inappropriate services by approximately $100 million annually, the Ministry has not moved forward with this proposal.

Our review of FFS claims data noted that the top 10 billing physicians who provided pain management services billed a combined total of almost $60 million in 2024/25. Each billed between $4.3 million and $9.9 million in that year. Two of these physicians had been selected by the Ministry for post-payment audits that were ongoing at the time of our audit.

$60 million
billed in 2024/25 by the top 10 billing physicians providing pain management services

Another AWG proposal related to cardiac testing, which included an opportunity to reduce medically unnecessary repeat echocardiograms costing around $40 million. At the time of our audit, this initiative was still outstanding.

In addition to excessive billing for pain management services and cardiac testing, our past audits also raised concerns with billing for medically unnecessary services in other specialities. For example, our 2024 audit on the Implementation and Oversight of Ontario's Opioid Strategy identified cases of excessive billing for addiction medicine services. The Ministry did limited reviews of these cases to determine whether the services provided were medically necessary and the related billings were appropriate. For example:

- **Billing for medically unnecessary services:** A physician billed for an excessive number of urine tests for patients in stable condition.
- **Seeing a significantly high number of patients per day:** A physician saw an average of 113 patients in person and 74 virtually each day in 2023/24 and billed almost $1.8 million.

Why It Matters

Physicians providing medically unnecessary or inappropriate medical services increases the cost of care that is funded by taxpayers. The Ministry also loses an opportunity to use taxpayer money more efficiently to improve quality of care.

Recommendation 5

We recommend that the Ministry reduce the use of medically unnecessary or inappropriate medical services by:

- reviewing excessive billings for these services; and
- resuming work on the AWG's proposals.

For the auditee responses, see **Recommendations and Auditee Responses**.

4.3 Post-Audit Actions and Overpayment Recovery

4.3.1 The Ministry Lacks Authority to Recover Overpayments

While the Ministry can request a physician to repay billings deemed inappropriate after a post-payment audit, it has no legislative authority to directly recover overpayments if a physician refuses.

When the Ministry and a physician cannot agree on a negotiated settlement, the Ministry may refer a case to HSARB, which has the legislative authority to issue orders relating to physician billings, including ordering the physician to make repayment.

Historically, when the Ministry identified inappropriate billings, it typically negotiated a settlement with physicians for repayment, which was often less than what it initially found as being inappropriate. For example, of the post-payment audits completed between 2015/16 and 2021/22, the Ministry identified $18 million of overpayments and recovered $7.7 million (43%) after negotiated settlements. This is a usual process when it comes to a negotiated settlement.

The Ministry referred 29 cases, representing $22 million in overpayments, to HSARB

In 2021, as part of changes to the HIA, the post-payment audit process was changed, enabling the Ministry to refer cases to HSARB. For the 32 audits that were completed with a settlement between April 2022 and March 2025, the Ministry identified approximately $8.9 million in overpayments and recovered $8.1 million (91%). An additional 29 cases, representing $22 million in overpayments, were referred to HSARB because physicians disagreed with or refused to repay the Ministry. As noted in **Section 4.3.2**, these 29 cases with HSARB are still open. Some were referred to it as early as April 2023.

The Ministry noted that some ministries in other Canadian jurisdictions can make final determinations about the value of overpayments and directly recover this money by deducting future payments to physicians. The Ministry also informed us that the Ontario government proposed this method of recovering overpayments in the *Plan to Build Ontario Together Act, 2019*, but amendments were made to remove this proposal in response to concerns raised by stakeholders.

While we noted examples where the Ministry was able to recover overpayments through deducting future physician billings, the deduction was based on a negotiated settlement that required physician approval. For example, one physician was unable to provide support for numerous claims and agreed to repay over $900,000. This was part of a negotiated settlement, approved by the physician, to allow the Ministry to deduct this amount over 24 months of future billings.

Why It Matters

Not recovering overpayments from physicians represents a waste of taxpayer's money. Stronger payment recovery mechanisms would enable the Ministry to use taxpayer funds more effectively and efficiently, including the possibility of directing those recovered funds to providing more patient care.

Recommendation 6

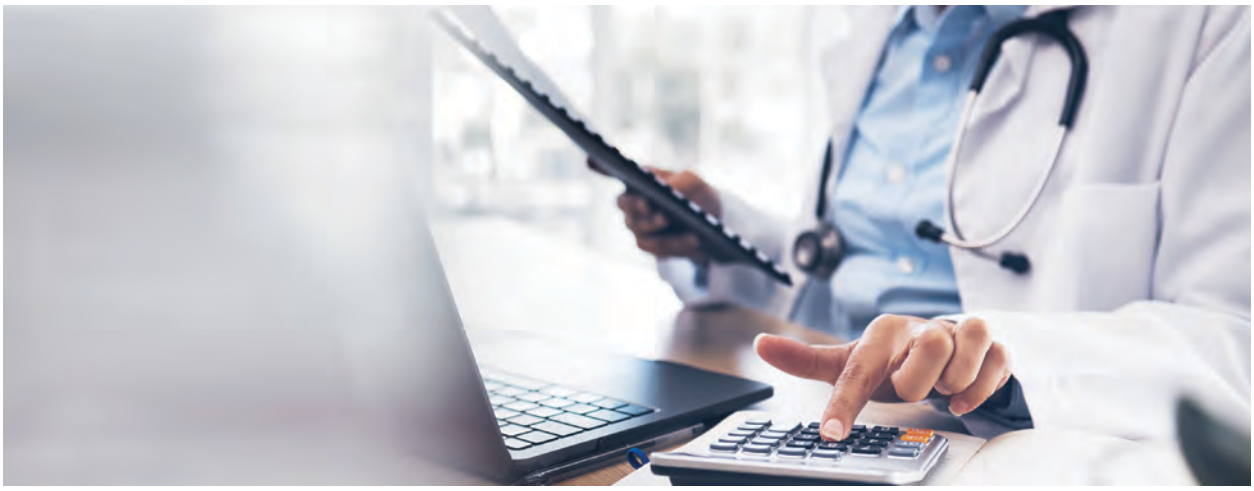
We recommend that the Ministry review its existing payment recovery mechanisms and strengthen processes to increase recovery of physician billing overpayments.

For the auditee responses, see **Recommendations and Auditee Responses.**

4.3.2 The Post-Payment Audit Process Involves Delays and Has Limited Follow-Up

We found that post-payment audits and related requests for repayment could take years to complete, despite the Ministry's aim to complete audits within a year. Significant delays in audits create a risk that the Ministry continues paying for potentially inappropriate billings until audit completion. A longer period also makes recovery harder to pursue.

When the Ministry identifies a physician for a post-payment audit, it begins the process by issuing a letter notifying the physician that they have been selected for an audit. This letter requests supporting documentation from the physician to verify that the specific claims submitted and paid were provided according to the HIA and Schedule of Benefits requirements. From that point, there is typically back-and-forth communication about the claims and supporting documentation.



Once the Ministry has received and reviewed all supporting documentation, it notifies the physician of its findings and provides an opportunity for the physician to respond. The Ministry then issues its final decision. This may include an education letter, a request for repayment or a closure of the audit with no finding of inappropriate billings.

We reviewed the timelines of all 173 post-payment audits opened and completed between 2022/23 and 2024/25. We found that 21 audits (12%) took over a year to complete, representing a risk that a physician may continue to inappropriately bill during that time and that recoveries may be more difficult to obtain.

We identified several reasons for the Ministry not completing audits on a timely basis. Specifically, additional time was spent on the following activities:

- multiple requests for information and delays in receiving documentation;
- negotiations between the Ministry and the physician on repayment amounts or refusal by the physician to repay; and/or
- referral to HSARB for a final decision.

Among these reasons, a referral to HSARB particularly added significant time to some post-payment audits. At the time of our audit, 35 cases had been referred for an HSARB review. Of those, 29 were still open. Some of these open cases were referred to HSARB as early as April 2023.

We also found that the Ministry does not have any formal follow-up process to ensure physicians with past inappropriate billings have corrected or improved their billing practices and to help deter reoccurrence of the same or similar billing issues.

We selected a small sample of physicians that were audited by the Ministry in the last five years that had to repay inappropriate billings. Our review of those physicians found that:

- Although there is no formalized follow-up process, the Ministry did select four physicians to be audited again, indicating a risk that these physicians have continued to bill inappropriately following their first audit. Three of these physicians had also received an education letter after the first audit.
- Five physicians with past overpayment issues had not undergone any additional review or audit since their last post-payment audit. Two of these physicians billed over $1 million each in 2023/24.

Why It Matters

Having a follow-up process to review billings of past audited physicians is an important preventive measure to deter reoccurrence of inappropriate billing practices. Conducting timely follow-up on past audit subjects would help the Ministry determine whether physicians have corrected or improved their billing practices and if billing concerns or risks continue to exist that warrant more thorough review.

Recommendation 7

We recommend that the Ministry:

- implement measures that it can control, such as setting a deadline for compliance with requests, to complete post-payment audits within an expected timeline of one year; and
- develop a formal process and timelines for conducting follow-up reviews on all physicians that have been found to have inappropriate billings.

For the auditee responses, see **Recommendations and Auditee Responses.**

4.3.3 There Has Been Limited Oversight of Physicians with Payments from Multiple Sources

As noted in **Section 2.1**, in addition to billing for each service provided to patients through the FFS model, physicians may receive other lump-sum payments based on contracts with predetermined requirements through the AFA or other models. For example, most primary care physicians receive an individual AFA payment, while most emergency department physicians share a group AFA payment.

While the Ministry can identify total AFA payments to physicians who receive an individual payment, it does not have data on payments made to each physician within a group.

Post-payment audits only focus on FFS billings, without including any AFA payments in the scope of work. As noted in **Section 2.2**, AFA payments were $6.2 billion in 2024/25, although lower than the $13.3 billion of FFS payments in 2024/25. In our 2011 audit of Funding Alternatives for Specialist Physicians, we recommended the Ministry track the total amount paid to individual physicians through all payment models.

The Ministry still has not tracked the total amount paid to physicians through all payment models

At the time of our current audit, the Ministry still has not tracked this information and has not done any comprehensive review to ensure that all payments, including group payments, to physicians are appropriate and aligned to policy and contract expectations.

Why It Matters

Focusing on FFS payments only and excluding specific payment sources (for example, AFA payments) in the Ministry oversight creates a risk of not detecting situations where physicians are getting payments from multiple sources that could be high risk. It is important for the Ministry to consolidate payments received by physicians through various payment models when performing data analysis and selecting physicians for post-payment audit.

Recommendation 8

We recommend that the Ministry review payments to physicians through different sources such as FFS, AFA or others when identifying potentially inappropriate billings and selecting physicians for post-payment audit.

For the auditee responses, see **Recommendations and Auditee Responses.**

4.4 Understanding of Billing Codes and OHIP Coverage

4.4.1 The Complexity of Fee Codes for Billing Has Resulted in Potential Errors or Misuses

The OHIP Schedule of Benefits lists approximately 5,000 services and related fee codes that a physician can bill for. The complexity of this Schedule could contribute to inappropriate billings and make it difficult for the Ministry and other parties (for example, OPP) to determine whether inappropriate billings are made intentionally or accidentally.

~ 5,000
fee codes in the OHIP Schedule of Benefits

Both the Ministry and OMA have recognized the complexity of the Schedule of Benefits and developed working groups to help physicians understand the appropriate use of fee codes for billing purposes. Despite this, as discussed in **Section 4.3**, inappropriate billing continues to be an issue, indicating that training and education may not be meeting these needs.

Through discussion with the OMA, we noted that the lack of fee code clarity and transparency in OHIP interpretation could lead to inconsistency or disagreement in billing code interpretation between physicians and the Ministry. This, in turn, could lead to denied billing claims, reduced payment amounts and/or payment delays.

Through our discussion with OPP's Health Fraud Investigation Unit, which receives referrals from the Ministry and investigates suspected billing fraud, we heard that the complexity of the Schedule of Benefits can also make it challenging for the OPP while conducting its investigations. Examples of risk areas include using fee codes that pay more than the actual services being provided (referred to as upcoding) or purposely providing and billing for services that are not medically necessary.

Why It Matters

The complexity of fee codes in the OHIP Schedule of Benefits presents an opportunity for both unintentional errors and intentional misuses for the purposes of increasing billings. It is important to adequately educate and train physicians on the use of fee codes to prevent or minimize potential errors and misuses.

Recommendation 9

We recommend that the Ministry work with the OMA to:

- continue to review cases where it is well known that codes are confusing and being incorrectly interpreted in order to clarify and correct the codes;
- provide more education and training to increase physicians' understanding of the appropriate use of fee codes to bill for services provided; and
- determine the feasibility of requiring physicians to attest to the completion of the relevant training on the Schedule of Benefits.

For the auditee responses, see **Recommendations and Auditee Responses.**

4.4.2 There Has Been Limited Oversight to Protect Patients Against Inappropriate Charges for Insured Services

As discussed in **Section 2.1**, the HIA ensures the provision of insured (that is, free to the patient) health-care services to Ontarians through OHIP. We identified examples, in both past and current audits, where physicians or clinics charged patients for insured services but the Ministry has not done enough work to prevent these practices. In these examples, patients paid for services already covered by OHIP, either out of pocket or through private insurance.

When patients bring forward a concern that relates to a potential billing violation, the Ministry may initiate a review under the *Commitment to the Future of Medicare Act* (CFMA) to determine whether a billing violation did occur. Our examination of the CFMA reviews completed by the Ministry since 2020 found that there was often confusion about insured services (where physicians bill OHIP) and uninsured services (where physicians charge patients). For example:

- **Patients are not always aware of what can and cannot be charged by a physician:** While OHIP covers new and refill drug prescriptions issued by physicians as part of a patient visit, a physician can charge patients for prescriptions if there is no associated visit.
- **Patients are not always adequately informed by their physicians about OHIP coverage:** Cataract surgeries are considered an insured service for which physicians bills OHIP. We noted cases where physicians charged patients directly for optional or unnecessary add-ons (for example, upgraded or enhanced eye lenses) without informing patients about their right to opt for a basic, free-of-charge cataract surgery entirely covered by OHIP.

Of the 452 CFMA reviews by the Ministry since 2020, the majority (377, or 83%) were related to potential patient billing violations. About one-third (148) of these cases were for eye-related services such as cataract surgeries. We previously raised this issue in our 2021 audit of Outpatient Surgeries, which found no provincial oversight to protect patients against inappropriate charges for OHIP-funded services or physicians that may mislead and charge patients for unnecessary add-ons.

The Ministry has often been able to work with service providers including physicians to address patient billing violations, requiring physicians to refund patients for inappropriate charges when made for an insured service. However, the Ministry did not consistently conduct reviews to determine if these CFMA reviews indicated systemic issues with certain physicians or specialties. For example:

- Over the last five years, 27 providers had multiple CFMA reviews. The Ministry did not conduct a thorough review of these providers, which included physicians, to determine whether they consistently charged their patients for insured services.
- Three CFMA reviews were related to one ophthalmologist for wrongfully charging patients. The first review found wrongful patient charges, the second review found no issue and the third review is ongoing. Our data analysis also identified the same ophthalmologist (see **Figure 6**) as having the highest billings in the specialty, almost twice as much as the ophthalmologist with the next-highest billing. This physician had not been audited, although these CFMA reviews and our data analysis indicated the physician could have potentially charged patients improperly and billed OHIP inappropriately.

Why It Matters

Physicians charging patients inappropriately for insured services has been an ongoing issue because many patients are unaware or uninformed of their rights and coverage under OHIP. It is important for the Ministry to conduct thorough reviews of the physicians involved in potential billing violation reviews to protect patients from potentially inappropriate charges and to determine if the physicians also made potentially inappropriate billings to OHIP.

Recommendation 10

We recommend that the Ministry develop a formal process to refer cases where physicians were found to have inappropriately charged patients for insured services to the post-payment audit group for further review and audit if warranted.

For the auditee responses, see **Recommendations and Auditee Responses.**

Recommendations and Auditee Responses

Recommendation 1

We recommend that the Ministry:

- utilize data analytic tools to flag high-risk payments for review while the Claims Modernization project is being implemented; and
- develop and implement a risk-based approach that includes data analysis to identify and select physicians for post-payment audit.

Ministry Response

The Ministry agrees with the recommendation.

The Ministry will better utilize data analytic tools to flag high-risk payments for review while the Claims Modernization project is being implemented. The claims system limitations do not directly impact the Ministry's ability to identify concerns for post-payment audits.

The Ministry remains committed to ensuring accountability for the use of OHIP funds. The Ministry currently performs some data analysis to flag high-risk claims for review on a limited basis and will continue to review ways to expand these activities.

Recommendation 2

We recommend that the Ministry:

- identify and incorporate high-risk indicators of potentially inappropriate billings into the modernized claims system; and
- update the Claims Modernization timeline and expectations, such as by identifying specific functionality that will help strengthen the modernized system's ability to automatically detect high-risk billings.

Ministry Response

The Ministry agrees with the recommendation to identify and incorporate high-risk indicators of potentially inappropriate billings into the modernized claims system and to update the Claims Modernization timeline and expectations.

The Ministry is actively reviewing the current claims system and is developing a comprehensive Benefits and Claims Modernization strategy.

Recommendation 3

We recommend that the Ministry look at its internal staffing complement and re-assess its staffing and technology resourcing needs to conduct physician billing oversight work such as post-payment audits.

Ministry Response

The Ministry acknowledges the work undertaken by the Auditor General and agrees with the recommendation.

The Ministry remains committed to ensuring accountability for the use of OHIP funds. The Ministry will explore additional resourcing opportunities for payment accountability and specifically post-payment audit, subject to government approvals.

Recommendation 4

We recommend that the Ministry resume the verification letter process and identify ways to improve its efficiency and effectiveness, such as using a risk-based approach and data analytics for selecting patient letter recipients.

Ministry Response

The Ministry agrees with the recommendation to resume the verification letter process and identify ways to improve its efficiency and effectiveness, such as using a risk-based approach and data analytics for selecting patient letter recipients.

The Ministry is actively working on the implementation of a random verification program for patients.

Recommendation 5

We recommend that the Ministry reduce the use of medically unnecessary or inappropriate medical services by:

- reviewing excessive billings for these services; and
- resuming work on the AWG's proposals.

Ministry Response

The Ministry agrees with the recommendation to reduce the use of medically unnecessary or inappropriate medical services by reviewing excessive billings for these services.

The Ministry currently performs some data analysis to flag high-risk claims for review and will continue to review ways to expand these activities.

As part of the 2021 Physician Services Agreement (PSA), the Ministry and the OMA agreed to continue the work of the AWG. The AWG has resolved 10 of 12 proposals identified in the 2021 PSA. The Ministry will explore opportunities to resume work on the outstanding proposals and seek approval to implement recommendations for all outstanding AWG proposals.

Recommendation 6

We recommend that the Ministry review its existing payment recovery mechanisms and strengthen processes to increase recovery of physician billing overpayments.

Ministry Response

The Ministry agrees with the recommendation.

Based on recommendations from the 2016 audit on Physician Billing regarding recovery of overpayments, the Ministry enacted legislative changes to the HIA in December 2019 and correspondingly updated its post-payment audit process. These included fundamental improvements to how the Ministry could recover overpayments.

Recovery is only one outcome of the post-payment audit process. A large component is to provide billing education to physicians to improve future claim submission accuracy.

The Ministry will continue to look for opportunities to increase recovery of overpayments. Any changes to the Ministry's recovery authority would require legislative amendments.

Recommendation 7

We recommend that the Ministry:

- implement measures that it can control, such as setting a deadline for compliance with requests, to complete post-payment audits within an expected timeline of one year; and
- develop a formal process and timelines for conducting follow-up reviews on all physicians that have been found to have inappropriate billings.

Ministry Response

The Ministry agrees with this recommendation.

The Ministry currently has operational procedures that include standard response times for physicians to provide information requested, accommodations to physicians for reasonable extension requests, and actions the Ministry can take when a physician does not provide the requested information in the time or form specified. The Ministry will continue to work towards completing all post-payment audits within one year.

The Ministry will develop and implement a process that uses a risk-based approach to determining which physicians will be subject to follow-up reviews.

Recommendation 8

We recommend that the Ministry review payments to physicians through different sources such as FFS, AFA or others when identifying potentially inappropriate billings and selecting physicians for post-payment audit.

Ministry Response

The Ministry agrees with the recommendation.

The Ministry will expand its work to centralize the collection of physician remuneration data from all sources, including FFS, AFA, hospitals and others.

The Ministry will explore opportunities to expand the post-payment audit process to capture additional payment modalities such as alternative funding plans when identifying potentially inappropriate physician billings.

Recommendation 9

We recommend that the Ministry work with the OMA to:

- continue to review cases where it is well known that codes are confusing and being incorrectly interpreted in order to clarify and correct the codes;
- provide more education and training to increase physicians' understanding of the appropriate use of fee codes to bill for services provided; and
- determine the feasibility of requiring physicians to attest to the completion of the relevant training on the Schedule of Benefits.

Ministry Response

The Ministry agrees with the recommendation.

Ministry staff will continue working with OMA representatives through the Education and Prevention Committee (EPC) to bring forward topics and case examples where there are known instances of confusion or incorrect interpretation. Together, the Ministry and the OMA prepare educational materials to provide physicians with additional clarification and appropriate interpretation of billing issues through publishing the Billing Briefs and other physician billing resources on the **Ministry website**.

In the 2024–28 PSA, the Ministry and the OMA agreed to modernize the Schedule of Benefits. The parties have assigned this work to the Physician Payment Committee (PPC). The PPC is a standing bilateral committee that makes recommendations to the parties on how to make investments in physician services. The PPC considers the evolution of clinical practice as well as opportunities to make the Schedule of Benefits easier to understand. The PPC has made significant changes to the Schedule in 2020 and 2023, and will be making additional changes in 2026 and 2027.

In addition to online billing resources, the Ministry sends targeted letters to physicians to promote appropriate billing. The Ministry will provide more education and training to increase physicians' understanding of the appropriate use of fee codes to bill for services provided. The Ministry remains committed to:

- working with the OMA to develop billing education materials and to improve physician awareness and access to these materials; and
- providing more education and training to increase physicians' understanding of the appropriate use of fee codes to bill for services provided.

The Ministry requires new physicians to attest that they are responsible for reading and understanding the Schedule of Benefits, regulations under the HIA and INFOBulletins prior to registering to bill OHIP. The Ministry will explore this requirement for physicians already in practice.

Recommendation 10

We recommend that the Ministry develop a formal process to refer cases where physicians were found to have inappropriately charged patients for insured services to the post-payment audit group for further review and audit if warranted.

Ministry Response

The Ministry agrees with this recommendation and will develop a formal process to refer cases where physicians were found to have inappropriately charged patients for insured services to the post-payment audit group for further review and audit if warranted.

Audit Criteria

In planning our work, we identified the audit criteria we would use to address our audit objectives (outlined in **Section 3.0**). These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management at the Ministry reviewed and agreed with the suitability of our objectives and associated criteria:

1. The Ministry has controls in place to ensure that physician payments are for eligible and medically appropriate services rendered to patients according to the OHIP Schedule of Benefits and fee codes.
2. The Ministry has processes in place to ensure that different billing models for physicians are evaluated to determine the reasonableness of related payments, and that total payments to each physician through different billing models are tracked and monitored.
3. The Ministry has controls in place to ensure that post-payment audits of FFS billings are conducted consistently and completed in a timely manner, and to follow up on physicians with history of inappropriate claims when necessary to prevent further risk.
4. The Ministry has processes in place to ensure that appropriate enforcement actions are taken and overpayments are recovered in a timely manner to deter repeat inappropriate billings.
5. The Ministry has mechanisms in place to monitor payments to physicians on contracts, such as AFAs, to determine whether payments are reasonable and services are provided to patients as stipulated in applicable policies or contracts.
6. The Ministry has controls in place to ensure that patients are protected from being charged inappropriately by physicians for medically necessary services covered by OHIP and are informed about their OHIP coverage and rights.
7. The Ministry has processes in place to ensure that systems and tools used for monitoring physician billings detect and analyze high-risk, irregular or inappropriate claims and payments for further review and enforcement.

Audit Approach

We conducted our audit between January 2025 and October 2025. We obtained written representation from the Ministry's management that, effective November 24, 2025, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

As part of our audit work, we:

- interviewed relevant staff from the Ministry;
- obtained and analyzed physician billings and payments;
- reviewed supporting documentation for the Ministry's oversight work, such as post-payment audits;
- reviewed the Ministry's information systems and tools, including its claims processing system; and
- spoke with external stakeholders including CPSO, OPP's Health Fraud Investigation Unit and OMA.

Audit Opinion

To the Honourable Speaker of the Legislative Assembly:

We conducted our work for this audit and reported on the results of our examination in accordance with Canadian Standard on Assurance Engagements 3001—*Direct Engagements* issued by the Auditing and Assurance Standards Board of the Chartered Professional Accountants of Canada. This included obtaining a reasonable level of assurance.

The Office of the Auditor General of Ontario applies Canadian Standards on Quality Management and, as a result, maintains a comprehensive system of quality management that includes documented policies and procedures with respect to compliance with rules of professional conduct, professional standards and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the Code of Professional Conduct of the Chartered Professional Accountants of Ontario, which are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

We believe the audit evidence we have obtained is sufficient and appropriate to provide a basis for our conclusions.

December 2, 2025

Shelley Spence, FCPA, FCA, LPA
Auditor General
Toronto, Ontario

Acronyms

Acronym	Definition
AFA	alternate funding agreement
AWG	Appropriateness Working Group
CFMA	*Commitment to the Future of Medicare Act*
CPSO	College of Physicians and Surgeons of Ontario
FFS	fee for service
HIA	*Health Insurance Act, 1990*
HSARB	Health Services Appeal and Review Board
OHIP	Ontario Health Insurance Plan
OIAD	Ontario Internal Audit Division
OMA	Ontario Medical Association
OPP	Ontario Provincial Police

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