Chapter 2
Department of Health
Medicare
Payments to Doctors

Contents

Main Points..…………….……………….……………………………………………………. 9

Recommendations……………………………………………………………………... 19

Conclusion ……………………………………………………………………………. 19

Background on the Medicare Program ……………………………….……………… 24

Introduction to Findings ……………………………………………………………… 28

Highlights: Audit and Enforcement Functions ………...……………..………....….…... 31

Highlights: Doctor Remuneration and Public Reporting……………………………... 37

Department of Health Medicare Payments to Doctors

Main Points

Objective of our work

2.1 Medicare has a huge impact on the lives of all New Brunswickers. In the 2010-2011 fiscal year (2011), roughly 1,873 doctors were paid under this program. Medicare expenditures for 2011 were slightly more than half of a billion dollars ($553.3 million). This represented 22.3% of the Department of Health's expenditures of approximately $2.5 billion. Medicare represents one of government's highest cost programs with consistent growth.[1]

2.2 The objective of our work was: *to determine if the Department of Health (Department) is maximizing its recovery of incorrect Medicare payments to doctors, through the practitioner audit function*.

2.3 The audit function is very important for many reasons, including the following:

- In addition to monitoring compliance with legislation, agreements and policies and identifying incorrect payments to recover, a strong audit function serves as a deterrent to doctors inappropriately billing Medicare.
- The Fee-For-Service (FFS) payment system is based upon the honour system. The onus is on the doctor to accurately submit FFS claims. It is not practical for Medicare to confirm that patients received services from doctors prior to paying claims. Inherent in any such system is a risk of incorrect or inappropriate claims. This inherent risk can be mitigated via payment controls, consistent

[1] Figures from: Province of New Brunswick, *2010-2011 Annual Report - Department of Health*, September 2011, page 95.

monitoring and audit.

2.4 We found the audit coverage of payments to doctors is incomplete (which we report in the section titled, *Audit and Enforcement Functions*), and for this reason we also report observations on the different types of payments to doctors (FFS, salary and sessional). We also discuss public reporting of doctor remuneration in the second section titled, *Doctor Remuneration and Public Reporting*.

2.5 The observations on payments to doctors are intended to highlight unusual items that, in our professional opinion as auditors, may warrant further investigation by the Department (i.e. the audit unit or other monitoring groups within the Department). However, we performed no such investigations pursuant to our work.

2.6 Doctors play a vital role in the Medicare program and are essential in the delivery of health care in our Province. It is important to note our work was not intended to assess the quality of doctors' services in any way.

2.7 The Department provided full cooperation during our work. There was one instance where we requested a legal opinion which the Department did not provide; however, this had minimal impact on our findings. We are pleased to report there were cases when we verbally presented findings during the course of our work and the Department took immediate corrective action.

Highlights

2.8 ***There are three ways doctors are paid by Medicare***:

1) Fee-For-Service (FFS) - a payment is made for each service performed by the doctor (i.e. similar to piece work);

2) salary - a fixed annual remuneration according to a provincial agreement, the *Medical Pay Plan* (MPP); and

3) sessional - an hourly rate per hours of service provided.

Many doctors are paid using more than one of these methods.

2.9 ***Medicare payments to some doctors appear high when compared to budget estimates.*** Information provided by the Department for 2011 showed the following:

- Sixteen doctors were paid over $1 million each. The doctor paid the most by Medicare in 2011 was an ophthalmologist who received $1,652,786;
- 219 of 1,873 doctors (12%) were paid more than half a million dollars each; and
- 826 of 1,873 doctors (44%) were paid more than $300,000. Note if the doctors with remuneration less than $100,000 (part-time doctors) were excluded, this would increase to 56%.

2.10 According to the Department, the following figures were used while budgeting for 2011. "*The estimated annual earnings of a general practitioner is $291,418 and the average annual earnings of a specialist is $420,977 (this specialty average is the average earnings of all specialties).*" Given this, we believe remuneration greater than these figures should be considered high.

2.11 ***Only a portion of Medicare payments to doctors gets audited.*** While the Department has authority to audit all Medicare payments, only some types of payments to doctors are audited. A portion of FFS payments is audited. However, radiology, salary and sessional payments to doctors are not audited. At the time of our work, only 53% of Medicare payments to doctors were subjected to audit.

2.12 We believe although it may be more difficult to audit some types of Medicare payments, given the magnitude of the payments involved, alternate audit methods should be pursued so all types of payments (100%) are included in the audit population.

2.13 ***Monitoring of Medicare payments to doctors is inadequate.*** There is no monitoring of radiologist remuneration by the Department. Monitoring of FFS payments and payments to salary doctors is lacking.

2.14 We believe the Department should develop, document, assign and implement proper monitoring procedures for all Medicare payments (FFS, salary, sessional), including FFS payments to salaried doctors

such as the cap and the "on-call group account".

2.15 ***Public reporting of doctor remuneration is incomplete and misleading***. There is no public reporting of the total amount paid to individual doctors within the Medicare program. Currently, some salaried doctors are publicly reported, but not all. For many of those doctors who are publicly reported, only a portion of their remuneration is shown. The Department indicated only some salaried doctors were publicly reported and no FFS payments were. Publicly reporting only some of the Medicare payments to some of the doctors is incomplete reporting and could be misleading to readers.

2.16 In order for the Department to demonstrate proper accountability for over half of a billion dollars in annual spending, we believe the distribution of this spending should be publicly reported and subject to public scrutiny. Even if change to legislation is required, the Department should publicly report total remuneration for each doctor, regardless of whether the doctor is paid via FFS claims, salary, sessional or alternative payment arrangements. (This would be similar to other government reporting of employee compensation and vendor payments.) And to provide better accountability, the Department should publicly report annually summary-level information on doctor remuneration, such as: total payments for each remuneration method (FFS, salary, sessional, other – Exhibit 2.4), doctor remuneration by dollar range (Exhibit 2.7), doctor remuneration by specialty (Exhibit 2.8), etc.

2.17 ***The audit function has several strengths which include the following:***

- There is appropriate authority for auditing that is clearly documented and communicated to doctors.
- Resources are assigned to the audit function. New staff receive on-the-job training.
- A documented audit plan guides the unit's work. The annual work plan incorporates the audit plan. The audit unit issues a quarterly report to the Director.
- Documented policies and procedures guide the audit unit.

2.18 We believe the existence of an audit unit within the Medicare program is positive and very appropriate given the magnitude and complexity of the program. The strengths of the existing audit function provide a good foundation to build upon.

2.19 ***The audit function has several significant weaknesses*** which include the following:

- ***There is limited audit coverage*** of Medicare payments.
- ***Not all high earners are reviewed or audited.*** We believe the Department should identify doctors with high Medicare earnings and doctors with earnings significantly higher than their specialty average; their earnings should be reviewed to determine reasonableness and audited if suspect.
- ***Recoveries of inappropriate payments are low.*** The average annual recoveries for the ten-year period fiscals 2002 to 2011 were $72,581. The recoveries identified by the audit unit ranged from $4,492 in fiscal 2009 to $312,143 in fiscal 2011.

  For 2011, audit recoveries of $312,143 are negligible when compared to the Medicare expenditures of $553 million. The *Medicare Audit Plan 2012-2013* projects recoveries of $3.21 million (excluding WSNB [WorkSafeNB] recoveries); the plan is based on an audit team of five.
- ***We identified inefficiencies*** regarding the selection of audit projects, the time frame for recoveries, the organization of electronic information and the time consumed by auditors doing administrative tasks.

  We believe the Department should train staff and identify / develop exception reports as needed in order to implement a risk-based audit approach.
- ***Revisions to legitimate audit recoveries undermines audit's credibility***. (Sometimes the recoveries identified by audit were not collected, and sometimes recoveries that had been collected from doctors were repaid.)

  We believe there should be documented procedures for authorizing, processing, recording and reviewing the reversal / repayment of recoveries. Also there should be a log of recovery reversals / returns to allow them to be easily tracked and reported.

- ***There is limited performance reporting of the audit function.*** In our opinion, the Department should publicly report the actual performance of its audit unit in comparison with targeted recoveries and provide a rationale for any variances. Such performance information should be included in the Department's annual report.

2.20 ***Recoveries of inappropriate Medicare payments relating to WorkSafeNB (WSNB) claims are significant.*** "WSNB recoveries" is the term we use for improper Medicare payments for services (for work-related injuries covered by a WSNB claim), which are recovered from doctors. Information provided by the Department showed in fiscal 2009, Medicare recoveries relating to WSNB claims were over half of a million dollars ($503,025) and in fiscal 2006 and fiscal 2010, recoveries were over $400,000.

2.21 Other observations regarding Medicare payments relating to WSNB claims include the following:

- ***The current process for identifying WSNB recoveries is inefficient*** because it is a quarterly manual review by the audit unit of approximately 25,000 pages of information. We discussed the inefficiencies with staff of the Department and management agreed they should review the process for identifying and recovering amounts related to WSNB claims and implement changes to improve the process.
- ***Some doctors bill both Medicare and WSNB for the same service.*** We believe billing two parties for the same service is inappropriate. We believe the Department should take immediate corrective action which prohibits doctors from billing two parties for the same service.

2.22 ***The Department's enforcement of doctor compliance with legislation and Departmental policies needs strengthening***. Legislation and policies establish the rules for programs; monitoring and auditing measures compliance with the rules; and, enforcement ensures compliance with the rules. We found enforcement was lacking in the following ways:

- ***The Department does not have an enforcement policy*** for Medicare. Also, the Department does not have documented procedures regarding

enforcement.

- ***We identified situations*** where the Department's enforcement action with doctors is lacking.
- ***There are no ramifications for over-charging Medicare.*** While the Act authorizes the Department to revoke a doctor's billing privileges, the Department informed us they have never done this as an enforcement action. The Department does not use penalties such as charging interest or issuing fines.

2.23 We believe the Department should enforce existing legislation that allows for a progressive range of sanctions which could deter a doctor from wrongfully billing. There should be consequences when a doctor repeatedly submits inappropriate claims. Consequences such as fines, penalties and / or charging interest on overpayments may deter inappropriate claims. Also, staff need clearly documented procedures to allow them to perform enforcement actions confidently with no risk of interference.

2.24 ***The Professional Review Committee (PRC) is active.*** The PRC was established in 1972 to protect the interests of the public, the profession and the government in the operation of Medicare. The PRC is required by legislation and has significant authority. It consists of five doctors nominated by the New Brunswick Medical Society and appointed by the Minister. We found the PRC has documented *Terms of Reference* and a history of being active. The committee met between two and six times per year during the twelve years from 2000 to 2011.

2.25 Other observations regarding the PRC include the following:

- ***The PRC has opportunity to enhance its value.*** We believe the PRC has an opportunity to expand its value to the Department by reviewing analyses of Medicare billings and providing comments to the audit unit. As indicated by the Act, this review may identify areas where inappropriate or unneeded services have been claimed and / or misuse of the fee schedule. Both could result in recoveries, either directly or indirectly via a recommendation for an audit. Given the PRC needs only to meet approximately five times per year to review audit

cases, other monthly meetings could be held to review and analyze patterns of billing.

We discussed this with members of the PRC who were very receptive to the opportunity to expand its value to the Department by reviewing billing patterns and making recommendations regarding possible misuse of the fee schedule.

- ***The PRC does not report annually*** to the Minister as required according to their *Terms of Reference* and their *Orientation Manual*.

2.26 ***Medicare FFS payments to doctors -*** FFS payments to doctors were over $351 million in 2011, which represented 64% of total Medicare expenditures. The Department reported there were 1,060 FFS doctors in their *2010-2011 Annual Report.*

2.27 ***FFS payments to many doctors appear high when compared to budget estimates.*** Information provided by the Department for 2011 showed the following:

- There were 13 doctors who received FFS payments in excess of $1 million each.
- There were 145 doctors who received FFS payments in excess of $500,000 each.
- There were 409 doctors (25%) who received FFS payments in excess of $300,000. Note if the doctors receiving Medicare payments less than $100,000 were excluded (part-time or part-year doctors), this would increase to 47%.

2.28 ***Medicare payments to radiologists -*** Radiologists are doctors who use diagnostic imaging (X-rays, etc.) to diagnose conditions and treat patients. Although their remuneration is funded under the FFS agreement, the payment process differs from other FFS doctors. Radiologists are paid by the Regional Health Authority (RHA) for which they work. The RHA then bills Medicare to recover these payments. In 2011, total payments to radiologists were approximately $45 million.

2.29 ***Total payments to some radiologists appear high when compared to other specialties.*** Information provided by the Department for 2011 showed the following:

- There were 68 regularly paid radiologists.

- There were five radiologists who were paid more than a million dollars each.
- The radiologist with the highest Medicare remuneration was paid $1,430,121. The same radiologist was paid $6.3 million over five fiscal years.
- There were 45 radiologists (66%) who were paid more than half a million dollars each.
- The median for one zone was $821,863, which means four of the nine radiologists in the zone received payments in excess of $821,863 and four of the nine radiologists in the zone received payments less than $821,863.

Department staff agreed that payments to radiologists appear high when compared to other specialties.

2.30 ***Other observations regarding radiologists*** include the following:

- ***Most claims submitted for radiologists are not subject to regular payment controls.*** The Department's 1998 radiology project to automate billings is slow moving.
- ***The Department does not recover Medicare costs relating to radiology*** as important claim information is not available in the Department.
- ***There is no monitoring*** of radiologist remuneration by the Department.
- ***Current radiology claims do not comply*** with the *Physician's Manual* and regulations.

2.31 Current radiologist billing practices have significant risks and may lead to the loss of considerable recoveries of incorrect payments. We believe radiologists should be required to bill through the automated Medicare system like all other FFS doctors. The lack of information, controls, monitoring and auditing regarding radiologist payments requires immediate action.

2.32 ***Medicare payments to salaried doctors -*** Salary payments to doctors were over $109 million in 2011, which represented 20% of total Medicare expenditures. The Department reported there were 489 salaried doctors in their *2010-2011 Annual Report.*

2.33 ***Medicare payments to some salaried doctors appear high when compared to the salary scale.*** Information provided by the Department for 2011 showed the following:

- There was one doctor who received salary payments in excess of $1 million.
- There were 11 doctors who received salary payments in excess of $500,000 each.
- There were 136 doctors who received salary payments in excess of $300,000.

2.34 ***Other observations regarding salaried doctors*** include the following:

- ***Contracts are not filed in the Department*** for all salaried doctors. As of June 2012, the Department had received approximately 84% of the contracts.
- ***The shadow-billing requirement is not met*** by all salaried doctors. While "*shadow billing has always been a requirement of salaried physician employment*,"[2] compliance has not been enforced by the Department. In January 2012, the Department did an analysis and determined 80% of the required doctors were shadow billing.

2.35 We believe the Department should develop, document, assign and implement proper monitoring procedures for salaried doctors. Monitoring procedures should include reviewing contracts signed between the RHAs and the doctor to ensure compliance with the MPP. As well, we believe the Department should continue its efforts to monitor compliance with the shadow-billing requirement and take action with those doctors who do not comply.

2.36 ***Medicare sessional payments to doctors*** relate to designated services paid for on an hourly basis, such as doctors working in emergency rooms and those working part-time in a nursing home or a jail. Sessional-type payments to doctors were approximately $60 million in 2011, which represented 11% of total Medicare expenditures. Approximately

[2] Information provided by the Department – Memo to salaried physicians October 8, 2008.

250 doctors received sessional payments in 2011.

2.37 ***We found cases of non-compliance*** with the *Policy on Sessional Arrangements* and believe the Department should review and monitor the sessional arrangements with doctors to ensure compliance with the policy.

Recommendations

2.38 Our recommendations to the Department are presented along with their responses to each recommendation in Exhibit 2.1.

Conclusion

2.39 The objective of our work was: *to determine if the Department of Health is maximizing its recovery of incorrect Medicare payments to doctors, through the practitioner audit function.* We conclude the Department of Health is not maximizing its recovery of incorrect Medicare payments to doctors, through the practitioner audit function.

2.40 While the Department has authority to audit all Medicare payments, only some types of payments to doctors are audited. (A portion of FFS payments is audited. However, FFS payments to radiologists and salary and sessional payments to doctors are not audited.) We found the audit function has several weaknesses, which if addressed would improve the ability of the Department to maximize its recoveries of incorrect Medicare payments to doctors.

2.41 In addition to monitoring compliance with legislation, agreements and policies and identifying incorrect payments to recover, a strong audit function serves as a deterrent to doctors inappropriately billing Medicare. We believe there is significant opportunity for the Department to increase audit recoveries and / or achieve program savings. Expanding the audit unit’s coverage to include all Medicare payments, using a risk-based audit approach, strengthening monitoring and enforcement, and addressing other issues identified by our review should help the Department achieve substantial program savings.

Exhibit 2.1 – Summary of Recommendations

<table>
<tr><th>2.1</th><th colspan="2">Recommendations Relating to Medicare Payments to Doctors</th></tr>
<tr><td colspan="2">Recommendation</td><td>Department’s Response</td></tr>
<tr><td colspan="2">Payments to Doctors

2.42 We recommend the Department develop an action plan, with specific steps and timelines, to address the deficiencies identified by our work. The action plan is to include, but not be limited to, the following:

• Improving the monitoring of doctor remuneration, including all methods of remuneration (Fee-For-Service, salary, sessional), total payments, and the cap and the “on-call group account” for salaried doctors.</td><td>The Department has already taken the following measures to improve monitoring of all methods of remuneration:
• The previously named “Medicare Audit Team” was renamed to “Monitoring and Compliance” in the winter of 2012, and the team has been increased to 6 from 3 staff members to encompass monitoring functions.
• The Medicare Services and Physician Remuneration branch hired a staff member in the spring of 2012 to more effectively monitor the cap and on-call group accounts for salaried doctors.
• A change request was put forward to add a change to the automated system to allow the on-call stipend claims to come in electronically.

The Department will be taking the following actions to improve monitoring of all methods of remuneration:

• The Medicare Services branch will be revising the monitoring process for the on-call group account for salaried physicians.
• A change to the automated system to allow on-call stipend claims to come in electronically will be effective in the spring 2013.
• A reporting mechanism to monitor total payments to doctors on a quarterly basis will be implemented in 2013/2014.
• The Monitoring and Compliance unit will be incorporating the monitoring of all methods of remuneration as part of their annual planning process.</td></tr>
</table>

Exhibit 2.1 – Summary of Recommendations (continued)

2.1	**Recommendations Relating to Medicare Payments to Doctors (continued)**
Recommendation	***Department's Response***
• Improving the audit function by: expanding the audit coverage to include all Medicare payments; using a risk-based audit approach; ensuring the audit unit has the skill set and information needed; documenting procedures for authorizing, processing, recording and reviewing the reversal / repayment of recoveries; publicly reporting the actual performance of its audit function in comparison with targeted recoveries and providing a rationale for any variances; expanding the use of the Professional Review Committee, etc.	*The Department has already taken the following measures to improve audit coverage and process:* • *The Monitoring and Compliance unit responsible for audits has been increased to 6 from 3 staff members to encompass increase the breadth of audit functions.* • *A process was put in place in the winter of 2012 for the Department to receive all salary remunerated doctor's contracts to allow for audit of salaried physicians.* *The Department will be taking the following actions to improve audit coverage and process:* • *All specialties that have service codes are required to shadow-bill their services, of these salaried physicians, 96% of them are shadow billing. With this data, the Monitoring and Compliance unit are now in a position to audit these accounts. These will be incorporated in the team's annual planning process for fiscal 2013/2014.* • *In April 2013, the Department will be making it mandatory for all sessional remunerated physician's to provide appropriate backup for the Billing of sessional hours. The Department will also be enforcing time of day to be captured on claims to support this billing. These will be incorporated in the team's annual planning process for fiscal 2013/2014.* • *The Monitoring and Compliance unit will be enhancing their monitoring tools with exception reports to allow for a more risk based audit approach. This will include using software and skillset currently available within the Department. This process has already been initiated.* • *The Monitoring and Compliance unit will be enhancing the documented procedures and job steps to include more robust recording of all audit and monitoring projects, payments and recoveries.* • *The 2012/1013 annual report will include reporting of the Monitoring and Compliance team's performance results.* • *The role of the PRC (Peer Review Committee) will be revisited and expanded as required.* *The Department has developed accountability benchmarks for family physicians, pediatricians and psychiatrists. It will continue to develop benchmarks for the remaining specialties in the coming months.*

Exhibit 2.1 – Summary of Recommendations (continued)

2.1	Recommendations Relating to Medicare Payments to Doctors (continued)
Recommendation	***Department's Response***
• Improving the Department's enforcement of doctor compliance with legislation and departmental policies by establishing an enforcement policy and implementing ramifications for doctors who do not comply, such as those who over-charge, double bill for services relating to workplace injuries and those who do not shadow-bill.	*The Regional Health Authorities have implemented a progressive discipline process for the salaried physicians who refuse to shadow bill. This has resulted in an increase from 35% to 96% of salaried physicians shadow billing in the last two years. This percentage is based the specialties that have service codes as they are required to shadow-bill their services.* *The Department is willing to explore options to improve enforcement of compliance with legislation and policies, and implement ramifications in cases of non-compliance.*
• Ensuring claims submitted for radiology services comply with legislation and payments for those services are subject to the same payment controls, monitoring and auditing as other Fee-For-Service payments	*The Department has a Radiology billing initiative underway to automate billing by radiologists similar to other FFS physicians. Target implementation date is April 2013. In addition, there is a committee in place reviewing service codes and rules. Target completion of this work is summer 2013.*
• Improving and automating the process of recovering Medicare payments relating to WorkSafeNB claims.	*The Department has attempted over the years to improve the process currently in place to recover payments related to work safe injuries. Although data is provided to the Department, it is not standardized, nor consistent with Medicare billing data and requires extensive person hours to match the claims and effect the proper due diligence to determine if claims were billed to both WSNB and Medicare.* *Medicare has recently created a reporting mechanism to identify physicians who have and continue to bill services to both agencies and will be sending reminder letters to physicians informing them that they are non-compliant with legislation.* *In addition, the Department will continue to work with WSNB to find a better reporting mechanism for work safe related claims.*

Exhibit 2.1 – Summary of Recommendations (continued)

2.1	**Recommendations Relating to Medicare Payments to Doctors (continued)**
Recommendations	***Department's Response***
Publicly Reporting Doctor Remuneration **2.43** Similar to other government reporting of employee compensation and vendor payments, and to provide better accountability, we recommend the Department publicly report total remuneration for each doctor, regardless of whether the doctor is paid via Fee-For-Service, salary, sessional or alternative payment arrangements.	*The Department will work with the Office of the Auditor General and the Privacy Commissioner to develop the legislation and privacy requirements.*
2.44 To provide better accountability, we recommend the Department publicly report annually summary-level information on doctor remuneration, such as: total payments for each remuneration method (Fee-For-Service, salary, sessional, other), doctor remuneration by dollar range, doctor remuneration by specialty, etc.	*The Department will publish summary level information on doctor remuneration in the 2011/2012 annual report.*

Background on the Medicare Program

Medicare program – objective & delivery

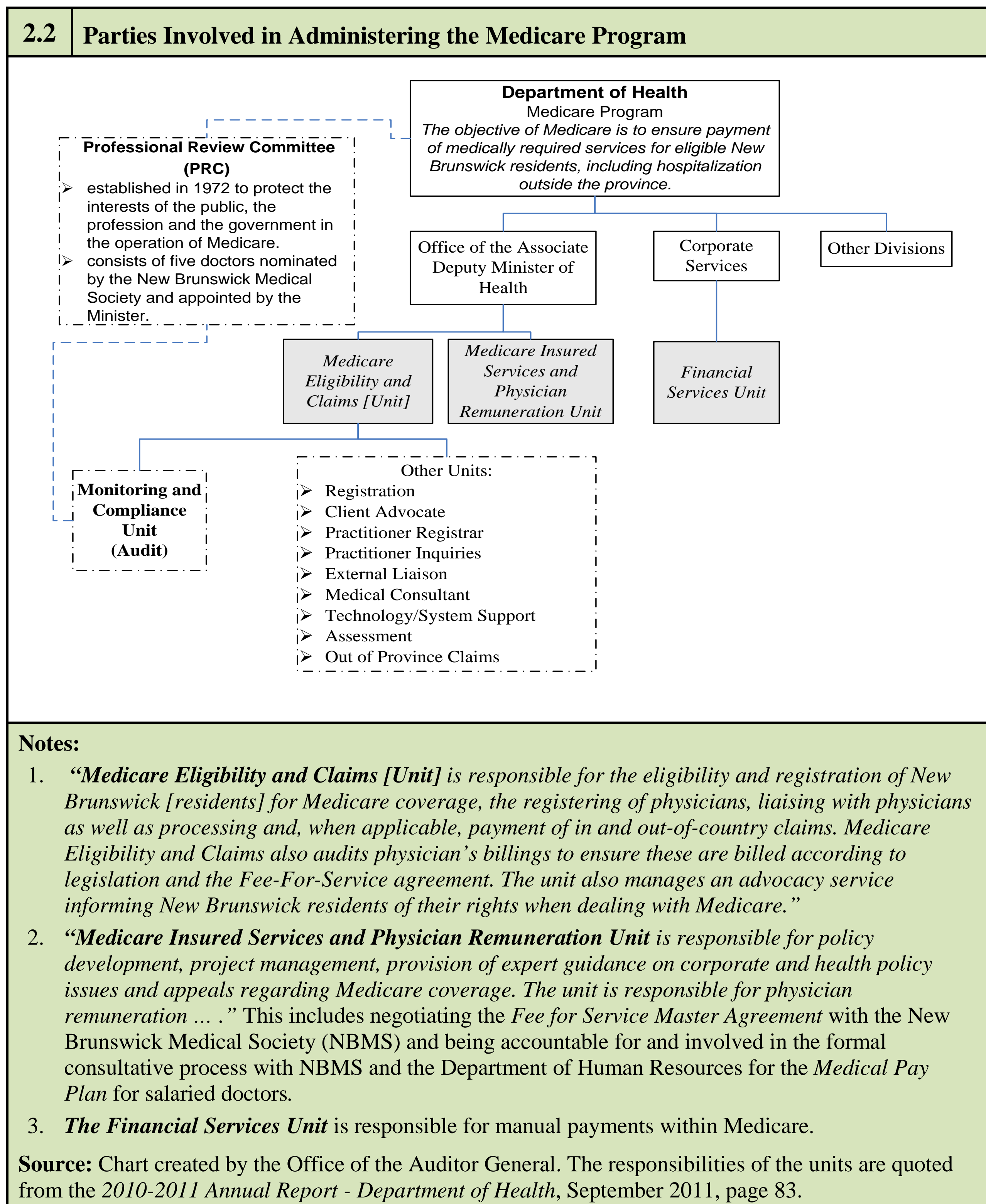
2.45 The Department of Health (Department) is responsible for the Medicare program (Medicare) under the *Medical Services Payment Act* (Act). "*The objective of Medicare is to ensure payment of medically required services for eligible New Brunswick residents, including hospitalization outside the province.*"[3]

2.46 Exhibit 2.2 shows the parties involved in administering Medicare. Within the Department, the Office of the Associate Deputy Minister of Health is responsible for Medicare. There are three units within the Department that are directly involved with delivering the program, which are shaded in Exhibit 2.2.

2.47 The Medicare program is complex. There are areas in this chapter where details have intentionally been omitted for the purpose of simplicity. For example, the number of doctors in New Brunswick may seem like a straight-forward concept. However, the number is dynamic as there is constant movement with doctors leaving the Province, new doctors entering the Medicare program, and others retiring. The number of doctors working during a time period can be different from the number of doctors paid during the same period because of the timing of submitting claims (doctors have 92 days to bill Medicare), the payment periods (every two weeks) and retroactive payments.

[3] Province of New Brunswick, *2010-2011 Annual Report - Department of Health*, September 2011, page 83.

Exhibit 2.2 - Parties Involved in Administering the Medicare Program

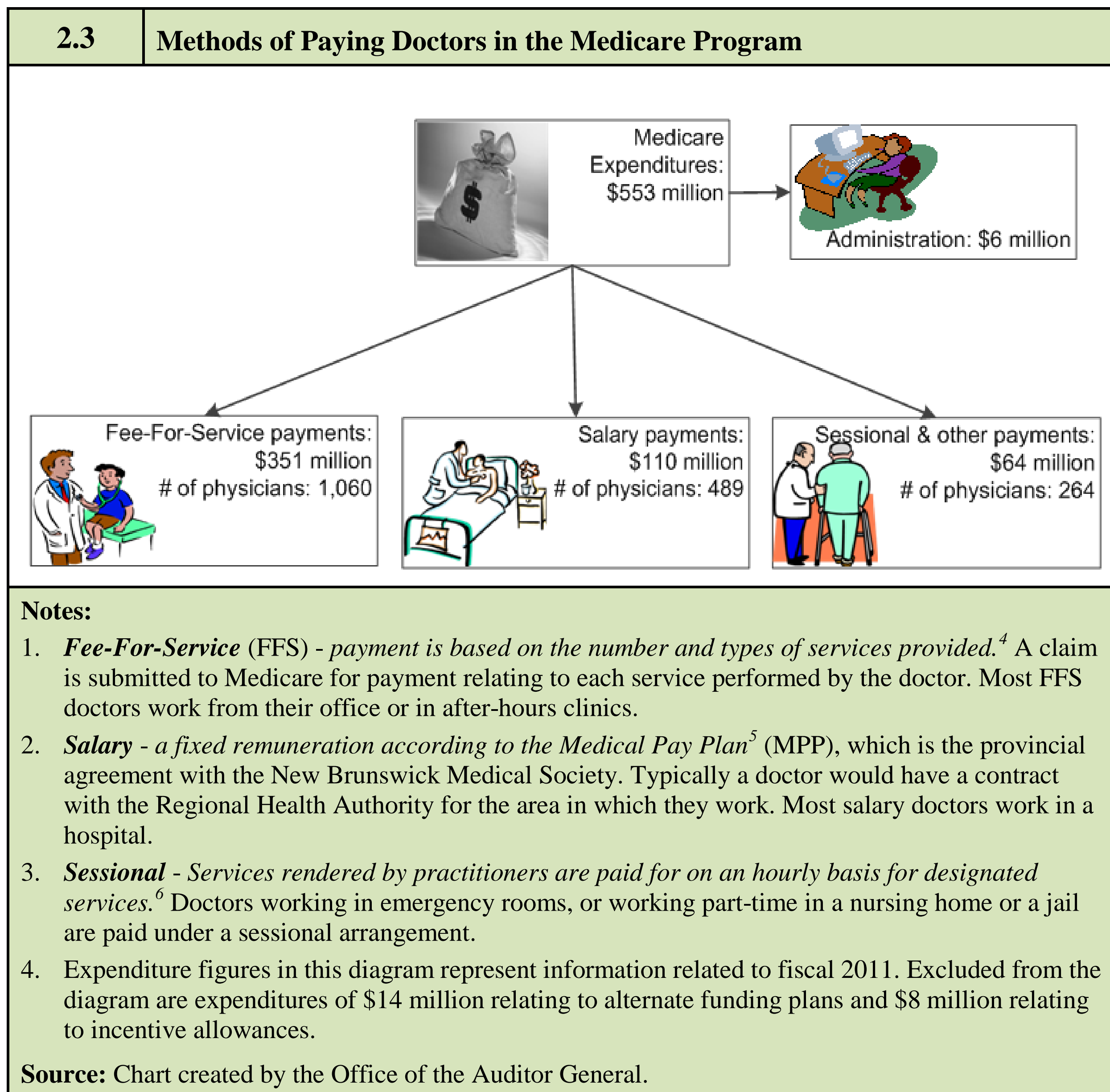


Notes:

1. *"**Medicare Eligibility and Claims [Unit]** is responsible for the eligibility and registration of New Brunswick [residents] for Medicare coverage, the registering of physicians, liaising with physicians as well as processing and, when applicable, payment of in and out-of-country claims. Medicare Eligibility and Claims also audits physician's billings to ensure these are billed according to legislation and the Fee-For-Service agreement. The unit also manages an advocacy service informing New Brunswick residents of their rights when dealing with Medicare."*
2. *"**Medicare Insured Services and Physician Remuneration Unit** is responsible for policy development, project management, provision of expert guidance on corporate and health policy issues and appeals regarding Medicare coverage. The unit is responsible for physician remuneration … ."* This includes negotiating the *Fee for Service Master Agreement* with the New Brunswick Medical Society (NBMS) and being accountable for and involved in the formal consultative process with NBMS and the Department of Human Resources for the *Medical Pay Plan* for salaried doctors.
3. ***The Financial Services Unit*** is responsible for manual payments within Medicare.

Source: Chart created by the Office of the Auditor General. The responsibilities of the units are quoted from the *2010-2011 Annual Report - Department of Health*, September 2011, page 83.

Exhibit 2.3 - Methods of Paying Doctors in the Medicare Program



Notes:

1. ***Fee-For-Service*** (FFS) - *payment is based on the number and types of services provided.*[4] A claim is submitted to Medicare for payment relating to each service performed by the doctor. Most FFS doctors work from their office or in after-hours clinics.
2. ***Salary*** - *a fixed remuneration according to the Medical Pay Plan*[5] (MPP), which is the provincial agreement with the New Brunswick Medical Society. Typically a doctor would have a contract with the Regional Health Authority for the area in which they work. Most salary doctors work in a hospital.
3. ***Sessional*** - *Services rendered by practitioners are paid for on an hourly basis for designated services.*[6] Doctors working in emergency rooms, or working part-time in a nursing home or a jail are paid under a sessional arrangement.
4. Expenditure figures in this diagram represent information related to fiscal 2011. Excluded from the diagram are expenditures of $14 million relating to alternate funding plans and $8 million relating to incentive allowances.

Source: Chart created by the Office of the Auditor General.

Doctor remuneration

2.48 Exhibit 2.3 provides an overview of the different methods of paying doctors in the Medicare program (FFS, salary and sessional). It shows estimates of the number of doctors and the total Medicare dollars involved with each of the payment methods.

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[4] Department website: www.gnb.ca/0394/prw/Remuneration-e.asp#SFFS
[5] Ibid.
[6] Ibid.

Exhibit 2.4 - Medicare Expenditures (3 fiscal years)

2.4 Medicare Expenditures (3 fiscal years)			
Expenditure type	**2010-11**	**2009-10**	**2008-09**
Fee-For-Service	$ 351,508,711	$ 347,055,854	$ 333,729,380
Salaried Doctors	109,622,799	99,611,334	89,608,833
Sessional Fees	63,518,368	58,148,115	55,519,021
Alternate Funding Plans	14,291,050	12,656,605	3,073,200
Incentive Allowances	7,966,999	7,094,219	8,256,866
Administration	6,341,736	6,119,743	6,263,075
Total	**$ 553,249,663**	**$ 530,685,870**	**$ 496,450,375**

Notes:

1. ***Expenditure type*** is the high-level classification used by the Department to categorize payments made from Medicare funding.

Source: Table created by the Office of the Auditor General with information from Province of New Brunswick Oracle Financial Information System - Account Analysis Report – Fiscal 2009, Fiscal 2010, Fiscal 2011.

Medicare represents one of government's highest cost programs with consistent growth.

2.49 Medicare expenditures in 2011 were slightly more than half of a billion dollars ($553.3 million[7]). This represented 22.3%[8] of the Department's expenditures, which were approximately $2.5 billion[9]. Medicare represents one of the government's highest cost programs. Exhibit 2.4 shows Medicare expenditures for three fiscal years: 2009, 2010 and 2011. It shows Medicare expenditures increased by $34.2 million (6.9%) in fiscal 2009-10 and increased by $22.6 million (4.3%) in fiscal 2010-11.

Monitoring and Compliance Unit (Medicare Practitioner Audit)

2.50 During the course of our work, the *Medicare Practitioner Audit* unit was renamed as *Monitoring and Compliance***.** The mission of the unit is, "*Monitor Medicare expenditures through*

[7] Province of New Brunswick, *2010-2011 Annual Report - Department of Health*, September 2011, page 95.
[8] Ibid.
[9] Ibid.

investigation, education and / or recommendation of changes, to ensure physicians comply with Medicare's rules and regulations."[10] The goal of the unit is, "*To reduce the number of inappropriate billing/fraudulent activity*"[11]. Additional information on the monitoring and compliance unit is provided in Appendix 2.

Introduction to Findings

2.51 The objective of our work was: *to determine if the Department of Health is maximizing its recovery of incorrect Medicare payments to doctors, through the practitioner audit function*.

What we examined and the objective of our work

2.52 We developed five criteria to use as the basis for our work. The criteria are shown in Appendix 3.

2.53 In completing our work, we focused on Medicare payments and audit recoveries for the fiscal year ended March 31, 2011. We performed the following procedures.

- We reviewed legislation and policies for Medicare.
- We held discussions with staff from each of the three units involved with Medicare, including the Medical Consultant for the program.
- We met with members of the Professional Review Committee (PRC).
- We examined operating procedures.
- We shadowed auditors doing an on-site visit to a doctor's office to retrieve information.
- We analyzed payments to doctors and explored unusually high amounts.
- We provided the Department with a sample of doctors with high salary payments and a list of doctors with high sessional payments and asked for explanations.
- We selected a sample of doctors with high on-call payments and asked the Department for

[10] Information provided by the Department - *Audit routine procedure May 2010 for PRC.*
[11] Ibid.

explanations.

- We performed other procedures as determined necessary.

How we present our findings

2.54 Our main findings are reported in sections. The first section presents our findings on the audit and enforcement functions. Since we found the audit coverage of payments to doctors is incomplete, we are reporting observations on the different types of payments to doctors (FFS, salary and sessional) in a second section. We also discuss public reporting of doctor remuneration in the second section titled, *Doctor Remuneration and Public Reporting*. See Exhibit 2.5.

Exhibit 2.5 - Presentation of Our Findings

2.5 Presentation of Our Findings		
Finding	**Highlights**	**Details**
Audit and Enforcement Functions		
✓ The audit function has several strengths.	Page 31	Page 45
! The audit function has several significant weaknesses.	Page 32	Page 48
! There are problems with identifying inappropriate doctor billings for workplace injuries.	Page 33	Page 64
! The Department's enforcement of doctor compliance with legislation and Departmental policies needs strengthening.	Page 35	Page 68
● The Professional Review Committee (PRC) is active and has opportunity to enhance its value.	Page 36	Page 70
Doctor Remuneration and Public Reporting		
! Fee-for-service payments need more monitoring.	Page 37	Page 75
! Radiologist payments need better controls and monitoring.	Page 38	Page 83
! Salary payments to some doctors appear high when compared to the salary scale.	Page 39	Page 89
! Sessional amounts paid to some doctors appear high when compared to the policy.	Page 40	Page 94
! Public reporting of doctor remuneration is incomplete and misleading.	Page 41	Page 97

Key used in this chapter

2.55 The following key is used to classify our summary findings:

- ✓ represents a positive observation
- ! represents an area needing improvement or further consideration
- • represents other observations.

Terms used in this chapter

2.56 Appendix 1 provides a list of terms, which are frequently used in this chapter, along with their definitions.

Fiscal year 2011 and cash-basis analysis of doctor remuneration

2.57 Figures presented in this chapter relate to the 2010-2011 fiscal year (2011), unless otherwise indicated. Most figures used during our work were provided by the Department. Doctor remuneration figures for 2011 are shown on a cash basis.

Highlights: Audit and Enforcement Functions

Key Finding: The Audit Function has Several Strengths.

Background[12]

2.58 The monitoring and compliance unit (formerly the "Medicare practitioner audit" unit) performs the audit function. It has been in operation since April 1990. The role of this unit is to monitor and review the billing patterns of medical practitioners. Appendix 2 provides general information on the unit.

2.59 A specific audit or review project may involve a particular billing code(s), an individual doctor or a selected specialty (a group of doctors, an example being pediatrics). Based on audit findings, one or more of the following actions may be taken:

- provision of educational advice to doctors;
- referral of the matter to the Professional Review Committee, legal authorities or the College of Physicians and Surgeons of New Brunswick; and
- recovery of funds.

Summary of Findings

2.60 We found the following:

- ✓ There is appropriate authority for auditing that is clearly documented and communicated to doctors.
- ✓ Resources are assigned to the audit function.
- ✓ New staff receive on-the-job training.
- ✓ A documented audit plan guides the unit's work.
- ✓ The annual work plan incorporates the audit plan.
- ✓ The audit unit issues a quarterly report to the Director.
- ✓ Documented policies and procedures guide the audit unit.

2.61 For more detailed discussion of these findings please see Appendix 4.

[12] Paraphrased from information provided by the Department

Key Finding: The Audit Function has Several Significant Weaknesses.

Background

2.62 A strong audit function can yield significant program savings. The audit function may:

- serve as a deterrent to doctors inappropriately billing Medicare;
- identify incorrect payments to recover;
- monitor compliance with legislation, agreements and policies; and
- help educate doctors and their office staff on proper billing practices.

Summary of Findings

2.63 We found the following:

! Only 53% of Medicare payments have been in the audited population.

! Not all high earners are reviewed or audited.

! Recoveries of inappropriate payments are low.

! Reversing recoveries undermines the audit unit's credibility.

! We identified inefficiencies in the audit unit's processes.

! There is limited performance reporting relating to the audit function.

2.64 For more detailed discussion of these findings please see Appendix 5.

Key Finding: There are Problems with Identifying Inappropriate Doctor Billings for Workplace Injuries.

Background

2.65 Several years ago, Medicare staff observed Medicare paying high volumes of claims for "work-related injuries", which under the correct submission by the doctor, should in fact have been billed to and paid by WorkSafeNB (WSNB)[13]. Claims paid by WSNB are funded through insurance premiums paid by businesses, whereas claims paid by Medicare are funded by the taxpayer. In 1992, our Office recommended the Department and WSNB develop a procedure to recover claims billed to both the WSNB and Medicare.[14]

2.66 WSNB now provides the Department with information on claims paid. Medicare staff review Medicare payments to determine if any relate to services for work-related injuries. "WSNB recoveries" is the term we use for improper Medicare payments regarding work-related injuries which are recovered from doctors. (It is an improper Medicare payment because the doctor's service was for a work-related injury covered by a WSNB claim, and was either billed to both WSNB and Medicare or billed to Medicare when it should have been billed to WSNB.)

Summary of Findings

2.67 We found the following:

- ● Recoveries relating to WSNB claims are significant.
- ! Some doctors bill both Medicare and WSNB for the same service.
- ! Some salaried doctors get paid twice for WSNB related services they provide.
- ! The current process for identifying WSNB recoveries is inefficient.
- ✓ There are documented procedures for WSNB

[13] WorkSafeNB (WSNB), formerly Workplace Health Safety and Compensation Commission and Workers Compensation Board (WCB).

[14] Paraphrased from information provided by the Department.

recoveries.

- The WSNB recoveries are currently the audit team's responsibility.

2.68 For more detailed discussion of these findings please see Appendix 6.

Key Finding: The Department's Enforcement of Doctor Compliance with Legislation and Departmental Policies Needs Strengthening.

Background

2.69 Legislation and policies establish rules for programs. Monitoring and auditing measures compliance with rules and identifies cases of non-compliance. Enforcement ensures compliance with rules.

2.70 The Act and regulations provide authority to the Department to recover overpayments and "*revoke, suspend or cancel*" a doctor's ability to participate in the Medicare program.

2.71 The Act also lists offences. Section 11(1) states, "*A person who violates or fails to comply with any provision of the regulations commits an offence punishable under Part II of the* Provincial Offences Procedure Act *as a category B offence.*" Section 11(2) makes a similar statement with regards to the Act, and section 11(3) states, "*A medical practitioner, an oral and maxillofacial surgeon or other person providing entitled services who wilfully makes a false statement in any report, form or return required for the purposes of this Act or the regulations commits an offence punishable under Part II of the* Provincial Offences Procedure Act *as a category I offence.*"

Summary of Findings

2.72 We found the following:

- The Department does not have an enforcement policy.
- We identified situations where the Department's enforcement of doctor compliance with legislation and Departmental policies needs strengthening.
- There are no ramifications for over-charging Medicare.

2.73 For more detailed discussion of these findings please see Appendix 7.

Key Finding: The Professional Review Committee (PRC) is Active and has Opportunity to Enhance its Value.

Background

2.74 The Professional Review Committee (PRC) was established in 1972 to protect the interests of the public, the profession and the government in the operation of Medicare. It consists of five doctors nominated by the New Brunswick Medical Society and appointed by the Minister. A member is generally appointed for a term of three years and may be re-appointed for any number of terms. The PRC provides:

- support and / or recommendations to Medicare;
- experienced professional counsel to any doctor whose pattern of practice appears not to be in the best interests of the public or the medical profession; and
- opportunity to doctors to present their situation to the committee.[15]

Summary of Findings

2.75 We found the following:

- The PRC is required by legislation and has significant authority.
- ✓ The PRC has documented *Terms of Reference.*
- ✓ The PRC has a history of being active.
- The PRC does not meet regularly.
- PRC has opportunity to expand its value.
- ! The PRC does not report annually.

2.76 For more detailed discussion of these findings please see Appendix 8.

[15] Paraphrased using information provided by the Department.

Highlights: Doctor Remuneration and Public Reporting

Key Finding: Fee-For-Service Payments Need More Monitoring.

Background

2.77 Medicare FFS payments are based on the number and types of services provided. A claim is submitted to Medicare for payment relating to each service performed by the doctor. Most FFS doctors work from their office or in after-hours clinics. The following facts relate to FFS payments in 2011:

- FFS payments were over $351 million and represented 64% of total Medicare expenditures.
- Over 1,600 doctors received FFS payments. Most were full-time FFS doctors. The Department reported 1,060 FFS doctors in their *2010-2011 Annual Report*. However, salaried doctors also have a FFS account for services they provide outside normal working hours.

2.78 ***The FFS payment system is based upon the honour system.*** The onus is on the doctor to accurately submit FFS claims. It is not practical for Medicare to confirm that patients received services from doctors prior to paying claims. Inherent in any such system is a risk of incorrect or inappropriate claims. This inherent risk can be mitigated via payment controls, consistent monitoring and audit.

Summary of Findings

2.79 We found the following:

- FFS payments to many doctors appear high when compared to budget estimates.
- There is limited monitoring of FFS payments.
- Monitoring of the FFS cap for salaried doctors is inadequate.
- There is no monitoring of the “on-call group account” for salaried doctors.
- The use of a wrong account may cause overpayment.
- Radiologist payments need better controls and monitoring. (This is reported as a separate finding in the next section.)

2.80 For more detailed discussion of these findings please see Appendix 9.

Key Finding: Radiologist Payments Need Better Controls and Monitoring.

Background

2.81 Radiologists are doctors who use diagnostic imaging (X-rays, etc.) to diagnose conditions and treat patients. Although their remuneration is funded under the FFS agreement, the payment process differs from other FFS doctors. Radiologists are paid by the RHA for which they work. The RHA then bills Medicare to recover these payments. In 2011, total payments to radiologists were around $45 million.

Summary of Findings

2.82 We found the following:

- Total payments to some radiologists appear high when compared to other specialties.
- Claims submitted for radiologists are not subject to regular payment controls.
- The Department does not recover Medicare costs relating to radiology as important claim information is not available in the Department.
- There is no monitoring of radiologist remuneration by the Department.
- Current radiology claims do not comply with the *Physician's Manual* and regulations.
- The Department's radiology project to automate billings is slow moving.

2.83 For more detailed discussion of these findings please see Appendix 10.

Key Finding: Salary Payments to Some Doctors Appear High when Compared to the Salary Scale.

Background

2.84 Medicare payments to salaried doctors relate to *a fixed remuneration according to the Medical Pay Plan.*[16] Typically a doctor would have a contract with the RHA for the area in which they work. Most salary doctors work in a hospital. The following facts relate to salary payments in 2011:

- Salary payments were over $109 million and represented 20% of total Medicare expenditures.
- The Department reported there were 489 salaried doctors in their *2010-2011 Annual Report*.

Summary of Findings

2.85 We found the following:

- Salary payments to some doctors appear high when compared to the salary scale.
- ! Contracts are not filed in the Department for all salaried doctors.
- ! The shadow-billing requirement is not met by all salaried doctors.
- ! Monitoring of payments to salaried doctors is lacking.
- ! There are three significant FFS issues involving salaried doctors that were discussed earlier in this report: 1) FFS payments to salaried doctors are not audited regularly; 2) monitoring of the FFS cap for salaried doctors is inadequate; and 3) there is no monitoring of the "on-call group account" for salaried doctors.

2.86 For more detailed discussion of these findings please see Appendix 11.

[16] Department website: www.gnb.ca/0394/prw/Remuneration-e.asp#SFFS

Key Finding: Sessional Amounts Paid to Some Doctors Appear High when Compared to the Policy.

Background

2.87 Medicare sessional payments to doctors relate to designated services paid on an hourly basis. For example, doctors working in emergency rooms and those working part-time in a nursing home or a jail are paid under a sessional arrangement. The following facts relate to sessional payments in 2011:

- Sessional payments were approximately $60 million and represented approximately 11% of total Medicare expenditures.
- Approximately 250 doctors received sessional payments.

Summary of Findings

2.88 We found the following:

- Sessional amounts paid to some doctors appear high when compared to the policy.
- There is non-compliance with the *Policy on Sessional Arrangements*.

2.89 For more detailed discussion of these findings please see Appendix 12.

Key Finding: Public Reporting of Doctor Remuneration is Incomplete and Misleading.

Background

2.90 Typically, employees for government, Crown Corporations, and other government organizations whose compensation exceeds $60,000 during a particular calendar year are publicly reported on the internet in the publication "*Unaudited Supplementary Employee Lists.*" "*The salary reported includes regular earnings, overtime, personal service contracts and any other employee remuneration.*" Also, each supplier whose total payments by all government departments exceed $25,000 during the fiscal year is publicly reported on the internet in the publication "*Unaudited Supplementary Supplier Lists*".

Summary of Findings

2.91 We found the following:

- There is no public reporting of FFS payments to individual doctors.
- Public reporting for salaried doctors is incomplete and misleading.
- There is no public reporting of sessional payments to individual doctors.

2.92 For more detailed discussion of these findings please see Appendix 13.

Appendix 1 – Frequently Used Terms

Terms Used in this Chapter

Act is the *Medical Services Payment Act*.

Claim refers to the documentation submitted to Medicare on a service provided by a doctor. A claim contains information such as: the patient's Medicare number, the date of service, a diagnosis, a code representing the service provided, etc.

- ***A Fee-For-Service (FFS) claim*** serves as a billing that results in a payment to the doctor.
- ***Shadow billing*** – claims are submitted by salaried doctors and they serve as a record of service provided. This does not prompt a payment.

Department is the Department of Health.

Doctor / physician are terms used interchangeably to mean all healthcare providers paid by the Medicare program, which includes licensed practitioners, dentists and oral maxillofacial surgeons.

Fee-For-Service (FFS) is a type of remuneration where payment is based on the number and types of services provided.

GNB is the government of New Brunswick.

RHAs are the Regional Health Authorities: Horizon Health Network and Vitalité Health Network.

Locum is a replacement doctor performing services for a minimum of three consecutive days. For example, a locum replaces a doctor who is taking a vacation.

Medicare is the term applied to the medical services plan, established under the *Medical Services Payment Act.* The purpose of Medicare is to ensure payment of medically required services for eligible New Brunswick residents.

MPP is the *Medical Pay Plan*, which sets a fixed remuneration for doctors paid a salary. Salary is another type of remuneration for doctors.

Appendix 2 – General Information on the Monitoring and Compliance (Audit) Unit

General Information on the Monitoring and Compliance Unit of Medicare

Mission:

- *To monitor Medicare expenditures by ensuring that physicians conform to Medicare's rules and regulations through investigation, education and/or recommendation of changes.*

Goal:

- *To reduce the number of inappropriate billing / fraudulent activity.*

Role:

- *To monitor and review billing patterns of practitioners (medical / oral maxillofacial surgeons) either on a random or non-random basis, as required.*

Audits:

- *Legislative authority for conducting an Audit is provided by the* Medical Services Payment Act. *The 1994 legislation appointed "inspectors" authority to "full access" to physician billing information. (Section 8.1(1) to (6) of the* Medical Services Payment Act*).*
- *Audits are initiated by internal and/or external tips (i.e. practitioner/patient calls/letters; law enforcements agencies), review of profiles and exception reporting.*
- *A routine audit procedure is followed. This procedure may change according to the specifics of each case.*

Ramifications:

- *The Department has the right to suspend a practitioner's billing number at the discretion of the Minister. If the practitioner refuses to reimburse the Medicare branch for overpayment, it is forwarded to the Financial Services Branch who is authorized under the* Financial Services Act *to recuperate any outstanding monies owed to the province. When this process fails or there is unquestionable fraud, the case is sent to the Department of Justice [and Attorney General] for appropriate action.*
- *The Department has the right to go back 7 years but generally looks at 1 or 2 quarters or up to 2 year periods, then utilizes statistical inference and applies the percentages of inappropriate billings or any over billings for the fiscal period reviewed. This depends on the exact nature and extent of the errors found. No interest or penalties are assessed on over billings discovered, as the* Medical Services Payment Act *does not provide authority in this area.*

Relationships:

- *The audit team would have direct relationships/communication with many of the other Medicare teams as well as the Medical Consultant, Medicare Program Support and the Director.*
- *There would also be a relationship between Audit and Medicare payments in Financial Services, Extra Mural Hospitals, Hospital Services and Administration, the NB Medical Society (NBMS), the Professional Review Committee (PRC), Canadian Medical Protection Association (CMPA), College of Physicians and other similar branches across Canada and most importantly the practitioners themselves.*

Source: Information provided by the Department, excerpts from the *Medical Practitioner Audit Overview – updated 2010.*

Appendix 3 – Criteria Used in Our Work

Criteria Used in Our Work
Criterion #1: The Department should ensure the practitioner audit group has the ability to audit any fee for service payment.
Criterion #2: The Department should use a risk-based approach to identify work to be done by the practitioner audit group.
Criterion #3: The Department's practitioner audit group should perform work in accordance with documented procedures.
Criterion #4: The Department should collect incorrect payments to doctors, identified by the audit group, in accordance with documented procedures.
Criterion #5: The Department should measure and report the effectiveness of its practitioner audit group.

Appendix 4 – Detailed Findings: The Audit Function has Several Strengths.

There is appropriate authority for auditing that is clearly documented and communicated to doctors.

2.93 The authority for auditing is granted through section 8.1(1) of the *Medial Services Payment Act*, which provides the authority to appoint auditors to "*inspect, examine and audit books, accounts, reports and medical records maintained in offices of [physicians]…*". Section 11(2.3) of the regulation supports the audit function by requiring a doctor to permit an audit of his or her books and records, retain documentation for a period of seven years, and submit documentation when requested by Medicare.

2.94 Medicare policies also document the authority to audit. *The Policy on Salaried Physicians*, under section C. Roles and Responsibilities states, "Any arrangements regarding a salaried physician must be approved by Medicare and services provided by salaried physicians are subject to reviews by the Audit section of Medicare." Similarly, the *Policy on Sessional Arrangements* under section B. Remuneration states, "All payments are subject to monitoring and audit."

2.95 Section 08: Audit of the *Medicare Policy Manua*l consists of two policies: Policy 1 - *On-Site Audit, Physician's Office* and Policy 2 - *The Professional Review Committee.*

2.96 In addition to legislation and Medicare policies, the authority to audit is communicated to doctors via documents provided to them. The *Physician's Manual* is provided to each doctor when they are registered with Medicare. It contains a two-page description of "Practitioner Audit" which begins with a statement that "*accounts paid by NB Medicare to either doctors or patients are subject to verification*". Also, FFS doctors sign a *Medicare Teletransmission Agreement,* which allows them to electronically submit their claims for payment. Section 7 of the agreement requires the practitioner to permit Medicare or its authorized representatives to audit their records and take extracts or make copies.

2.97 These authorities appear to apply equally to FFS, salaried and sessional payments to doctors. Therefore, the Department (through the monitoring and

compliance unit) has the authority to audit all Medicare payments to doctors.

Resources are assigned to the audit function.

2.98 The audit function is resourced to have a maximum of six members. We reviewed documentation indicating that over the ten-year period of fiscal 2002 to 2011, the number of auditor positions varied from a low of two in fiscals 2005 and 2006 to a high of six in fiscal 2004.

New staff receive on-the-job training.

2.99 The audit unit has a documented training plan. New staff receive on-the-job training which enhances their competency and the consistency of audit work performed by the unit. The audit unit holds regular team meetings and the auditors frequently consult with each other when doing their work, both of which also promote consistency.

A documented audit plan guides the unit's work.

2.100 Starting in 2011, the audit unit began preparing an annual *Medicare Audit Plan*. At the time of our work, two *Medicare Audit Plans* had been completed, one for fiscal 2012 and a second for fiscal 2013. The *Medicare Audit Plan* guides the unit's work.

2.101 We examined the *Medicare Audit Plan 2012-2013* dated March 13, 2012 and discussed it with Department staff. It contained a summary of audit projects (providing a brief description of the project along with the staff assigned to the project), a project schedule (a chart fitting the projects into a calendar), a time table (listing start and end dates for each project), a chart of forecasted recoveries, and a list of assumptions.

The annual work plan incorporates the audit plan.

2.102 The audit unit has a history of preparing an annual team work plan. We reviewed work plans for the past several years. Work plans list job functions along with their objective, timeframe and performance indicators. The annual work plan for 2012 incorporated the *Medicare Audit Plan 2012-2013*. In addition to the audit projects, the work plan contained items relating to training and administration.

The audit unit issues a quarterly report to the Director.

2.103 The audit unit reports to the Director each quarter. Reporting consists of a memo (summarizing key activities for the period such as staffing, progress on projects and Professional Review Committee activity) and a one-page report of audit activities and recoveries (providing statistics such as the number of activities completed during the period, the number of doctors

involved, the number of on-site audits, and dollar recoveries).

Documented policies and procedures guide the audit unit.

2.104 Medicare has two policies for audit as previously noted.

2.105 The audit unit has "job steps" which provide documented direction and specific procedures for identifying, substantiating, reporting and documenting recoveries. The unit also has templates for letters and standard forms which enhance both efficiency and consistency in their work.

2.106 The audit unit's role stops with documenting recoveries. There is proper segregation between identifying and collecting audit recoveries. Audit recoveries are collected by either the assessment unit, who collects the recovery amount by adjusting / reducing future payments to the doctor, or by the financial services unit, who receives a manual cheque from the doctor for the recovery amount.

Summary

2.107 We believe the existence of an audit unit within the Medicare program is positive and very appropriate given the magnitude and complexity of the program. The strengths of the existing audit function provide a good foundation to build upon.

Appendix 5 – Detailed Findings: The Audit Function has Several Significant Weaknesses.

Exhibit 2.6 - Audit Unit's Coverage of Medicare Payments

2.6 Audit Unit's Coverage of Medicare Payments		
Doctor remuneration category	**2010-11 Medicare payments to doctors**	**Audited?**
FFS – doctors (note 4)	$ 291,725,033	partially
FFS – radiologists (note 5)	42,357,617	no
Salaried doctors	109,622,799	no
Sessional doctors	63,518,368	no
Alternate funding plans	14,291,050	no
Other	31,734,796	no
Total Medicare payments to doctors	**$ 553,249,663**	

Notes:

1. ***Doctor remuneration category*** refers to the remuneration category that the Department uses to report Medicare payments.
2. ***2010-11 Medicare payments to doctors*** are the actual payments as recorded in the accounting records of the Province.
3. ***Audited?*** indicates if Medicare payments to doctors in the noted category are audited by the Department.
4. ***FFS – doctors*** include all fee-for-service payments from Medicare in 2011 to doctors practicing in all specialties except diagnostic radiology and nuclear medicine.
5. ***FFS – radiologists*** include all fee-for-service payments from Medicare in 2011 to doctors practicing diagnostic radiology or nuclear medicine.
6. ***Salaried doctors*** include all payments to all doctors receiving salary as remuneration during the period.
7. ***Sessional doctors*** include all payments to all doctors who have received sessional (hourly) remuneration during the period.
8. ***Alternate funding plans*** include all payments to all doctors who are employed or contracted under an alternate funding plan as defined by the Department and / or Health Authority.
9. ***Other*** includes items such as administration and incentive allowances.

Source: Table created by the Office of the Auditor General with information from Province of New Brunswick Oracle Financial Information System Account Analysis Report –Fiscal 2011.

Only 53% of Medicare payments have been in the audited population.

2.108 Only some types of Medicare payments to doctors are audited. The audit unit's coverage of Medicare payments is shown in Exhibit 2.6. Until recently, the population of payments audited has been limited to the automated FFS payments, which was $291,725,033 (53% of total Medicare payments to doctors).

2.109 ***FFS payments to salaried doctors are not audited regularly.*** The New Brunswick Policy on Salaried Physicians states, "*Fee-for-service and sessional billings are monitored and subject to audit by the [Department].*" While the Department has authority to audit FFS payments to salaried doctors, they currently do not do so regularly. Staff from the Department indicated they are not easily able to audit FFS payments to salaried doctors because they do not have access to the information required to audit, such as copies of the doctors' contracts, complete shadow-billing information, and doctors' working schedules.

2.110 The Department provided us with information indicating their intent to collect the required information and commence auditing FFS payments to salaried doctors. The Department is in the process of collecting outstanding doctor contracts from the RHAs, and the Department is insisting upon compliance with the shadow-billing requirement. We also noted the *Medicare Audit Plan 2012-2013* includes a project involving salaried doctors with high payments. The Department will be able to complete this project only once the information is provided.

2.111 ***Payments to radiologists have never been audited.*** The audit unit's work focuses on claims paid by Medicare's automated claims payment system. While most FFS doctors are paid in this manner and hence subject to audit, radiologists are not. The audit unit confirmed they have never audited payments to radiologists. "*These physicians are paid via manual FFS mechanism. [The Department] is now looking at a plan to better manage this billing scenario. As it stands now, without on-line data, the Audit (now Monitoring & Compliance) Unit would be unable to effectively review these services billed.*"[17]

2.112 ***Salary payments to doctors are not audited.*** *The New Brunswick Policy on Salaried Physicians* states, "*Services provide by salaried physicians are subject to review by the department's Audit section. Salaried physicians must provide shadow billing or history only billing as required by the department.*" While the

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[17] Documented response from the Department – Monitoring & Compliance Unit, May 2012

Department has authority to audit salary payments to doctors, they currently do not do so.

2.113 ***Sessional payments to doctors are not audited.*** The Department's *Policy on Sessional Arrangements* states, "*All payments are subject to monitoring and audit.*" The *New Brunswick Policy on Salaried Physicians* states, *"Fee-for-service and sessional billings are monitored and subject to audit by the department.*" While the Department has authority to audit sessional payments to doctors, they currently do not do so.

2.114 We believe although it may be more difficult to audit some types of Medicare payments, given the magnitude of the payments involved, alternate audit methods should be pursued so all types of payments (100%) are included in the audit population.

Exhibit 2.7 - 2010-11 Doctor Remuneration

2.7	**2010-11 Doctor Remuneration**	
Remuneration range	**# of doctors**	**% of total # of doctors**
Greater than $1,000,000	16	0.9%
$900,001 to 1,000,000	5	0.3%
$800,001 to 900,000	24	1.3%
$700,001 to 800,000	31	1.6%
$600,001 to 700,000	47	2.5%
$500,001 to 600,000	96	5.1%
$400,001 to 500,000	216	11.5%
$300,001 to 400,000	391	20.9%
$200,001 to 300,000	390	20.8%
$100,001 to 200,000	256	13.7%
Less than $100,000	401	21.4%
Total # of doctors	1,873	100.0%

Notes:

1. ***Remuneration*** is the total remuneration paid to doctors under the Medicare program and includes fee-for-service, sessional and salary payments to doctors.
2. ***Remuneration range*** is the range of remuneration selected by OAG for comparison purposes.
3. ***# of doctors*** refers to the number of doctors that fall into each range.
4. ***Less than $100,000*** may include doctors working part-time, as locums (replacement doctors), and those working only a portion of the year due to new employment or retirement.
5. ***Total # of doctors*** is the total of all doctors presented in the report.

Source: Table created by the Office of the Auditor General with information provided from the Department – Consolidated Practitioners Cumulative Earnings Report IR3542 (unaudited) for the period 2010-11 [IR3542 – CER 2010-2011].

Not all high earners are reviewed or audited.

2.115 Exhibit 2.7 shows doctor remuneration by range for 2011. It indicates the number and the percentage of doctors within each range. It shows the total remuneration paid to doctors under the Medicare program, which includes fee-for-service, sessional and salary payments.

2.116 Our observations for 2011 from Exhibit 2.7 include the following:

- Sixteen doctors were paid over $1 million each.
- 219 of 1,873 doctors (12%) were paid more than half a million dollars each.
- 826 of 1,873 doctors (44%) were paid more than $300,000. Note if the doctors with remuneration less than $100,000 (part-time doctors) were excluded, this would increase to 56%.

2.117 According to the Department, the following figures were used while budgeting for 2011. "*The estimated annual earnings of a general practitioner was $291,418 and the average annual earnings of a specialist was $420,977 (this specialty average is the average earnings of all specialties).*" Given this, we believe remuneration greater than these figures should be considered high.

Exhibit 2.8 - Doctor Remuneration by Specialty

2.8	**Doctor Remuneration by Specialty**						
Specialty	**# of doctors**	**Doctor's remuneration (# and %) within $ ranges:**					
		> $250,000		**> $500,000**		**> $1,000,000**	
		#	**%**	**#**	**%**	**#**	**%**
General Practice	846	416	49%	45	5%	1	0%
Radiology[1]	136	61	45%	47	35%	5	4%
Psychiatry	96	58	60%	3	3%	0	0%
Anesthesia	94	57	61%	0	0%	0	0%
General Surgery	79	39	49%	13	16%	0	0%
Obstetrics/Gynaecology	73	40	55%	6	8%	0	0%
Pediatrics	66	39	59%	4	6%	1	2%
Internal Medicine	62	34	55%	11	18%	0	0%
Orthopedic	50	29	58%	4	8%	0	0%
Anatomical Pathology	34	21	62%	2	6%	0	0%
Ophthalmology	29	23	79%	18	62%	7	24%
Cardiology	27	21	78%	13	48%	1	4%
Otol-Head & Neck Surgery	22	15	68%	4	18%	0	0%
Urology	22	20	91%	6	27%	0	0%
Oncology[2]	21	17	81%	4	19%	1	5%
Plastic Surgery	20	12	60%	3	15%	0	0%
General Pathology	18	11	61%	3	17%	0	0%
Neurology	16	12	75%	1	6%	0	0%
Emergency Medicine	13	3	23%	0	0%	0	0%
Dermatology	12	10	83%	4	33%	0	0%
Gastroenterology	12	9	75%	6	50%	0	0%
Nephrology	12	10	83%	5	42%	0	0%
Respirology	12	7	58%	2	17%	0	0%
Physical Medicine	11	10	91%	0	0%	0	0%
Rheumatology	11	7	64%	0	0%	0	0%
Neurosurgery	10	9	90%	9	90%	0	0%
Other[3]	69	41	59%	6	9%	0	0%
	1,873	**1,031**	**55%**	**219**	**12%**	**16**	**1%**

Notes:

Remuneration refers to total Medicare payments to a doctor, regardless of payment type.

Specialty refers to a doctor's practice concentration as identified in the Cumulative Earnings Report.

1. "Radiology" includes both diagnostic radiology and nuclear medicine.
2. "Oncology" includes both radiation oncology and medical oncology.
3. "Other" includes all specialties with less than 9 doctors, such as geriatrics.

# of doctors refers to the total # of doctors in the report that were included in the specialty.

Doctor's remuneration (# and %) within $ ranges

"> $250,000", "> $500,000", " > $1,000,000" – refers to the number (**#**) of doctors in the specialty and the percentage (**%**) - expressed as a percentage of the total number in the specialty - of doctors whose total Medicare earnings exceeded the specified dollar value.

Source: Table created by the Office of the Auditor General with information provided from the Department - Consolidated Practitioners Cumulative Earnings Report IR3542 (unaudited) for the period 2010-11 [IR3542 – CER 2010-2011].

2.118 Exhibit 2.8 presents doctor remuneration for 2011 by specialty. Specialties are listed according to the number of doctors in each specialty; the specialty having the greatest number of doctors is listed first. Exhibit 2.8 also shows for each specialty the number and percentage of doctors that were paid more than $250,000, $500,000 and $1,000,000.

2.119 Exhibit 2.8 indicates the following:

- There are substantially more doctors specializing in general practice than any other specialty; there were 846 general practitioners paid by Medicare in 2011.
- There were 219 doctors who were paid more than half of a million dollars and this represented 12% of all the doctors receiving payments from Medicare.
- Seven ophthalmologists (24%) were paid over a million dollars during 2011.
- There were only four specialties with no doctors earning more than $500,000 from Medicare (anesthesia, emergency medicine, physical medicine and rheumatology).

Exhibit 2.9 - 16 Doctors Each Paid More than $1 Million in Fiscal 2010-2011 (Doctors Listed by their Specialty)

2.9 16 Doctors Each Paid More than $1 Million in Fiscal 2010-2011 (Doctors Listed by their Specialty)

Specialty	Total remuneration	Specialty average	Remuneration > specialty average
Ophthalmology	$1,652,786	$667,516	$985,270
Radiology	1,430,121	335,155	1,094,966
General Practice	1,364,489	255,623	1,108,866
Ophthalmology	1,342,005	667,516	674,489
Ophthalmology	1,318,853	667,516	651,337
Ophthalmology	1,144,401	667,516	476,885
Radiology	1,125,367	335,155	790,212
Radiology	1,116,342	335,155	781,187
Ophthalmology	1,104,288	667,516	436,772
Oncology	1,077,693	391,200	686,493
Radiology	1,076,198	335,155	741,043
Cardiology	1,075,866	440,493	635,373
Ophthalmology	1,069,452	667,516	401,936
Radiology	1,067,345	335,155	732,190
Ophthalmology	1,039,540	667,516	372,024
Pediatrics	1,036,053	245,088	790,965

Notes:

1. ***Specialty*** refers to a doctor's practice concentration as identified in the Cumulative Earnings Report. *Radiology* refers to a doctor practicing diagnostic radiology or nuclear medicine. *Oncology* refers to a doctor practicing medical oncology or radiation oncology.
2. ***Total remuneration*** is the total payments to a doctor regardless of payment type.
3. ***Specialty average*** is the average of the total payments greater than zero of all doctors in the specialty listed as calculated from the Cumulative Earnings Report.
4. ***Remuneration > specialty average*** is the excess of the doctor's total Medicare payments over the specialty average.

Source: Table created by the Office of the Auditor General with information provided from the Department - Consolidated Practitioners Cumulative Earnings Report IR3542 (unaudited) for the period 2010-11 [IR3542 – CER 2010-2011].

2.120 In 2011, 16 doctors were each paid more than one million dollars under the Medicare program. Exhibit 2.9 lists the 16 highest paid doctors by their specialty, rather than their name. The *Total Remuneration* figures represent the total Medicare payments to the doctors, which includes fee-for-service, sessional and salary payments. Exhibit 2.9 also shows the amount of the doctor's total remuneration over their specialty average.

2.121 Regarding the 16 doctors in Exhibit 2.9, our observations include the following:

- Seven (44%) were practicing ophthalmology, representing approximately 24% of the 29 ophthalmologists listed in the Department's report. The audit unit is currently working on an audit of this specialty. The audit involves all doctors in this specialty and specific codes are being examined.
- Five (31%) were practicing radiology (diagnostic radiology or nuclear medicine). Payments to the radiology specialty are not monitored by the Department and are not currently auditable. None of these five radiologists have had earnings audited by the Department.
- Four were practicing pediatrics, cardiology, oncology and general practice respectively. None of these four doctors have had earnings audited recently by the Department. (Payments to two of the four doctors were audited in 2002 and recoveries were made from both doctors.)

2.122 For each of the 16 doctors, we compared their total remuneration to the average total remuneration of their specialty; our observations include the following:

- One doctor, a general practitioner, earned $1,364,489 - which exceeded the specialty average of $255,623 by $1,108,866 (434%).
- Two doctors exceeded their specialty average by 323% and 327%. One was in pediatrics and earned $1,036,053 - which exceeded the specialty average of $245,088 by $790,965 (323%). The other was in radiology and earned $1,430,121 - which exceeded the specialty average of $335,155 by $1,094,966 (327%).
- Four other doctors in the radiology specialty

exceeded their specialty average by over 200%.

- Four other doctors exceeded their specialty average over 100%. Two were in ophthalmology, one in cardiology, and one in oncology.
- Five other doctors exceeded their specialty average by 56% to 100%. All were in the ophthalmology specialty.

2.123 We believe the Department should identify doctors with high earnings and doctors with earnings significantly higher than their specialty average; their earnings should be reviewed to determine reasonableness and audited if suspect.

Exhibit 2.10 – Audit Unit's Recoveries over a 10-year Period

2.10 Audit Unit's Recoveries over a 10-year Period

Fiscal period	Adjusted recovery	Adjusted recovery / auditor
2010-2011	$ 312,143	$ 78,036
2009-2010	109,819	36,606
2008-2009	4,492	1,497
2007-2008	21,539	7,180
2006-2007	15,868	5,289
2005-2006	35,528	17,764
2004-2005	63,877	31,939
2003-2004	65,019	13,004
2002-2003	75,023	25,008
2001-2002	22,504	7,501
Average	**$ 72,581**	**$ 20,726**

Notes:

1. ***Fiscal period*** is the financial reporting period for GNB (April 1 through March 31).
2. ***Adjusted recovery*** is the amount identified by Medicare from incorrect payments to doctors based on audit work only. It may or may not have been actually collected. Where possible, the gross recoveries were adjusted to reflect actual recoveries only, excluding such items as WorkSafeNB recoveries and projected savings.
3. ***Adjusted recovery / auditor*** is the adjusted recovery amount divided by the number of full-time equivalent positions filled and available for work during the fiscal period as indicated by the Department. Over the 10-year period, the number of auditor positions varied from a low of two in 2004-05 and 2005-06 to a high of six in 2003-04.

Source: Table created by the Office of the Auditor General with information provided by the Department:

- Fiscal Summary of Audit Activities and Recoveries (unaudited): each fiscal period noted above
- Quarterly Summary of Audit Activities and Recoveries (unaudited): each fiscal period noted above.

Recoveries of inappropriate payments are low.

2.124 The audit unit's recoveries over the past ten-year period are shown in Exhibit 2.10. (These figures do not include recoveries relating to WSNB, which we report later in Exhibit 2.11.)

2.125 In reviewing identified recoveries during the ten-year period, we made the following observations:

- The recoveries identified by the audit unit ranged

from $4,492 in fiscal 2009 to $312,143 in fiscal 2011. The average annual recoveries for the period were $72,581, and the average annual recoveries per auditor for the period were $20,726.

- The number of auditors varied during the period. The calculated average recovery amount per auditor position ranged from $1,497 in fiscal 2009 to $78,036 in fiscal 2011. The average recovery amount per auditor position was less than $8,000 for four years and greater than $25,000 for four years during the ten-year period.
- The recovery amounts reported by the audit unit are the amounts identified as incorrect payments to doctors, and may or may not have been actually collected. Recovery amounts that were collected and then later reversed (and the money given back to the doctor) are also included in the amounts reported. Therefore actual net financial recoveries are typically less than those shown in Exhibit 2.10.
- Staff from the Department told us that for a period involving fiscals 2009 and 2010, the Department ceased all auditing due to a legal opinion advising such action until a formal appeals process could be created. This provides an explanation for the low recovery figure in fiscal 2009.

2.126 We believe the recovery amounts are low, given Medicare expenditures for 2011 were over half of a billion dollars. For 2011, audit recoveries of $312,143 are negligible when compared to the Medicare expenditures of $553 million. The *Medicare Audit Plan 2012-2013* projects recoveries of $3.21 million (excluding WSNB recoveries); the plan is based on an audit team of five.

2.127 In addition to monitoring compliance with legislation, agreements and policies and identifying incorrect payments to recover, a strong audit function serves as a deterrent to doctors inappropriately billing Medicare. We believe there is an opportunity for the Department to increase audit recoveries and / or achieve program savings. Expanding the audit unit’s coverage to include all Medicare payments, using a risk-based audit approach, and addressing the issues identified by our review should help the Department achieve some of these program savings.

Reversing recoveries undermines the audit unit's credibility.

2.128 Recoveries identified by the audit unit are substantiated and well documented. Therefore, we were surprised to find that sometimes the recoveries identified were not collected. Further, in some cases recoveries initially collected were subsequently repaid to doctors.

2.129 In reviewing reversed and returned recoveries, we made the following observations:

- Documentation supporting non-collection or return of recoveries already collected is inadequate. Also, there are no documented procedures regarding the authorization needed or the process to follow in reversing or returning recoveries.
- Reversed / returned recoveries are not tracked.
- Audit recoveries are overstated in management reports because reversed recoveries are not netted off recoveries shown in the quarterly and fiscal reports prepared by the audit unit.
- It is a waste of staff resources, and demoralizing to audit staff, when substantiated recoveries are not collected, or are collected but then returned to doctors. It also undermines the audit unit's credibility. We were told that recovery reversals / returns occur when there is a lack of clarity in the *Physician's Manual*, or a difference of opinions regarding the interpretation of information in the *Physician's Manual*. When this occurs, often the Department decides not to pursue collection of recoveries.

2.130 We believe there should be documented procedures for authorizing, processing, recording and reviewing the reversal / repayment of recoveries. Also there should be a log of recovery reversals / returns to allow them to be easily tracked and reported.

2.131 We reviewed a report titled *Medicare Internal Control Review* prepared by the Office of the Comptroller in 2000. It contained several recommendations "*for improving the management of Medicare audit recoveries*". One of the recommendations not implemented by the Department was, *"that Medicare formally document guidelines supporting staff activity to recover physician overpayments. Exceptions from the guidelines should*

be documented in physician audit files for third party inquiries." While the Department has implemented the first part of this recommendation, the documentation of "exceptions" is still unresolved.

We identified inefficiencies in the audit unit's processes.

2.132 In meeting with staff of the Department and reviewing the audit unit's work, we identified the following areas where we believe improvements are needed:

- The source of audit project ideas should be expanded to include analytical review procedures and regular review of standard exception reports, which would identify doctors or billing codes having a high risk of overpayment and / or misuse. This could lead to greater recoveries. While documentation of the audit unit states, "*Audits are initiated by internal and/or external tips (i.e. practitioner/patient calls/letters; law enforcements agencies), review of profiles and exception reporting,"* currently the source of audit projects is mostly internal and external tips. Staff of the Department confirmed that regular analytical review of specific reports and regular review of standard exception reports is not done for audit purposes.

  We believe the Department should train staff and identify / develop exception reports as needed in order to implement a risk-based audit approach.

  We identified reports which we believe would be useful for this purpose and confirmed they are not regularly used by the audit unit. Many of the findings in this chapter resulted from our analysis of these reports.

  Another one of the recommendations by the Office of the Comptroller in 2000 "*for improving the management of Medicare audit recoveries*" not implemented by the Department was, "*that audit review each full-time practitioner using the 'Practitioner Profile by Individual Service Code' report over a 12 month period.*" We believe the recommendation is both relevant and practical. If an annual review of each doctor is not practical, the Department could select a longer period of three to five years and do all doctors on a rotational basis. Currently audit reviews the *Practitioner Profile* report for only the doctors involved in an audit.

- The unit is authorized by legislation to review doctor billings for the past seven years. Typically, the audit unit examines only a few months. The audit unit could maximize recoveries by expanding the time frame when they believe there is a high probability of identifying recoveries.
- It is time-consuming to prepare and submit the audit unit's quarterly management reports. We reviewed several years of reports and found inconsistencies and a few errors. Pertinent information was not provided. For example, recoveries are reported by fiscal year rather than by audit project, making it difficult for management to identify the work yielding the highest recoveries. Management agreed the audit unit's reporting practices should be reviewed.
- Electronic documentation prepared by the audit unit is not well organized. On several occasions staff from the Department told us they frequently cannot find information in the electronic file management system. We reviewed the audit unit's shared folder and found it contained over 200 subfolders (many of which were not clearly labeled) and most of the 200 subfolders also contained subfolders. We noticed the naming of folders and files is not standardized. We also noticed cases where the same document was stored in multiple folders.
- In addition to audits, post payment review projects and audit related work (such as: preparing cases for the Professional Review Committee , providing support on legal cases, conducting team meetings, participating in the appeal process, reporting on the unit's work, updating job steps, etc.), there were several non-audit responsibilities on the audit unit's annual work plan. Given that the priority for audit unit staff should be to identify recoveries through their audit work, spending significant time performing other administrative responsibilities does not appear to be the best use of their time. In order to maximize the time available to identify recoveries, the Department should review, and where possible reassign, the non-audit responsibilities of the auditors.
- The process for identifying recoveries related to WorkSafeNB claims is inefficient because it

includes a manual review of paper reports which are thousands of pages in length. This issue is discussed in more detail in Appendix 6.

There is limited performance reporting relating to the audit function.

2.133 Currently the audit unit prepares an annual audit plan with projected recoveries and reports quarterly to the Director on the actual identified recoveries. However the performance of the Medicare audit unit is not reported publicly.

2.134 In our opinion, the Department should publicly report the actual performance of its audit unit in comparison with targeted recoveries and provide a rationale for any variances. Such performance information should be included in the Department's annual report.

Summary

2.135 The recovery amounts of incorrect Medicare payments are low. Given the magnitude of the payments involved, we believe all types of Medicare payments to doctors (100%) should be included in the audit population. We believe the Department should train staff and identify / develop exception reports as needed in order to implement a risk-based audit approach. For example, doctors with high earnings should be identified, their earnings reviewed to determine reasonableness and audited if suspect.

2.136 Expanding the audit unit's coverage to include all Medicare payments, using a risk-based audit approach, and addressing the issues identified by our review should help the Department achieve program savings.

Appendix 6 – Detailed Findings: There are Problems with Identifying Inappropriate Doctor Billings for Workplace Injuries.

Exhibit 2.11 - Medicare Recoveries Relating to WorkSafeNB Claims over a 10-year Period

2.11 Medicare Recoveries Relating to WorkSafeNB Claims over a 10-year Period

Fiscal year	Recoveries	Recoveries identified by:
2010-2011	$ 246,918	Audit Unit
2009-2010	415,752	Audit Unit
2008-2009	503,025	Audit Unit
2007-2008	190,760	Audit Unit
2006-2007	-	-
2005-2006	400,260	Assessment Unit
2004-2005	359,727	Assessment Unit
2003-2004	-	-
2002-2003	362,267	Liaison & Assessment Unit
2001-2002	218,086	Liaison & Assessment Unit
Total recoveries	**$ 2,696,795**	

Notes:

1. ***WorkSafeNB*** refers to the Workplace Health, Safety and Compensation Commission.
2. ***Fiscal year*** is the financial reporting period for GNB (April 1 through March 31).
3. ***Recoveries*** are payments recouped from doctors by Medicare due to 1) duplicate billing by the doctor to both Medicare and WSNB for the same service and 2) improper billing by the doctor to Medicare for a service relating to an injury under a WSNB claim.
4. ***Recoveries identified by:*** refers to the Medicare unit responsible for completing the WSNB recovery process in the specified period.

Source: Table created by the Office of the Auditor General with unaudited information provided by the Department.

Recoveries relating to WSNB claims are significant.

2.137 Medicare recoveries relating to claims paid by WorkSafeNB (WSNB) are shown in Exhibit 2.11. Exhibit 2.11 provides information for a ten-year period - fiscal years 2002 to 2011. It indicates in fiscal 2009, Medicare recoveries relating to WSNB claims were over half of a million dollars ($503,025) and in fiscal 2006 and fiscal 2010, recoveries were over $400,000. Medicare recoveries relating to WSNB claims are significant. (Exhibit 2.11 shows no

recoveries for fiscal years 2004 and 2007. Staff from the Department indicated recoveries were not identified during these periods due to a lack of human resources.)

Some doctors bill both Medicare and WSNB for the same service.

2.138 The Medicare program is a payer of last resort, meaning if the patient has other medical insurance then the insurer pays, not Medicare.

- This is stated in the regulations. Exclusions of entitled services are listed and WSNB claims are one of the listed exclusions.
- The *Fee For Service Master Agreement* in section 9 states the Medicare payment is to be the sole payment for services provided.
- Doctors are reminded of this when they sign the *Participating Practitioner's Agreement* (see Exhibit 2.12) on the *Medicare Practitioner Registration Form*.

Exhibit 2.12 – Participating Practitioner's Agreement

2.12	Participating Practitioner's Agreement
If you wish to become a participating practitioner under Medicare, please sign below. I, a duly registered medical practitioner / a duly registered oral and maxillofacial surgeon, apply to practise my profession in accordance with the *Medical Services Payment Act* and the regulations under that Act. In particular, I agree to accept payment by the Medicare Branch for any entitled service provided by me for which I will submit an account to the Medicare Branch as payment in full for that service and I shall not make any further claim against any person with respect to that service. Signature of Practitioner________________________________ Date_________________	
Source: *Medicare Practitioner Registration Form*	

2.139 Some doctors bill both Medicare and WSNB for the same service. Given the regulations, this is not permitted under the *Participating Practitioner's Agreement* and the *Fee For Service Master Agreement*. The Department should take immediate action to address such double billing.

2.140 When the Department identifies Medicare payments for the same services that have been paid by WSNB, they recover the payment. These are a portion of the recoveries identified in Exhibit 2.11**.** Staff of the Department told us there are many doctors who repeatedly appear on the recovery listing.

2.141 Department staff also told us there are cases where a

doctor bills Medicare, later learns the service relates to a WSNB claim and informs Medicare of the situation so their previous payment can be reversed. Given the Medicare program is based upon doctor honesty and integrity in submitting FFS claims, it is reassuring to hear of these cases.

Some salaried doctors get paid twice for WSNB related services they provide.

2.142 Salaried doctors submit shadow-claims for services provided, which allows patient records to be complete. We learned the Department sometimes identifies shadow-claims for the same services that have been paid by WSNB. This means some salaried doctors get paid by WSNB as well as Medicare for the same service; the doctor gets paid twice for the WSNB-related service. We believe doctors should be paid once, and only once for services provided.

The current process for identifying WSNB recoveries is inefficient.

2.143 After receiving information from WSNB regarding paid claims, Medicare produces a report which is reviewed to identify WSNB recoveries. This report is manually reviewed each quarter by the audit unit. We examined the two most recent reports and noted they contained 25,745 and 24,741 pages respectively.

2.144 For statistical purposes, a record of total dollar amounts reversed and the number of claims adjusted is maintained in a log. This documented evidence demonstrates, to both the staff members and the Department, that the WSNB recoveries are significant.

2.145 Identification of WSNB recoveries is included in the *Medicare Audit Plan 2012-2013.* The projected WSNB recoveries are $547,291 and it is estimated to take twenty audit weeks to complete (i.e. all five auditors one week, each quarter).

2.146 The same general process has been used for many years. Staff have identified concerns, such as:

- the inefficient process ("*present system of identifying and adjudicating WHSCC claims relies on copious paper thereby adding to a slow and inefficient process*"[18]); and
- the risk that not all recoveries are being identified

[18] Information provided by the Department – *WHSCC & Medicare … Information Sharing*

due to the lack of detailed descriptions provided to Medicare by doctors and WSNB. (For example, sometimes the description of the bodily injury is ambiguous such as "multiple systems", "multiple body parts" or "lower extremities".)

2.147 Another one of the recommendations made by the Office of the Comptroller in 2000 "*for improving the management of Medicare audit recoveries*" not implemented by the Department was, "*that Medicare request the WHSCC to consider providing additional information on treatment reports for audit purposes.*" We believe the recommendation is both relevant and practical.

2.148 We discussed these inefficiencies with staff of the Department and management agreed they should review the process for identifying and recovering amounts related to WSNB claims and implement changes to improve the process.

There are documented procedures for WSNB recoveries.

2.149 Documented procedures typically provide direction and guidance which promote consistency in work performed. There are documented procedures for WSNB recoveries. We reviewed the *WSNB Job Steps* and found them to be comprehensive.

The WSNB recoveries are currently the audit unit's responsibility.

2.150 The process for identifying Medicare payments relating to paid WSNB claims to be recovered is straight-forward. It is a simple comparison of a patient's history of paid Medicare services to the paid WSNB claims to identify Medicare services relating to the work-related injury (WSNB paid claim).

2.151 Currently, identifying WSNB recoveries is the audit unit's responsibility. This exercise does not need to be done by the audit unit. Exhibit 2.11 shows that within the past ten years, the work actually has been done by various Medicare units. If the responsibility for identifying WSNB recoveries was reassigned, then the audit unit would have time available to perform additional audits. This would likely increase overall recoveries of inappropriate Medicare payments.

Summary

2.152 Medicare recoveries relating to WSNB claims are significant at $400,000 annually. Some doctors bill both Medicare and WSNB for the same service. Given the regulations, this is not permitted and we believe the Department should take immediate action to address such double billing. Some salaried doctors get paid twice for WSNB related services they provide. We

believe doctors should be paid once, and only once for services provided.

Appendix 7 – Detailed Findings: The Department's Enforcement of Doctor Compliance with Legislation and Departmental Policies Needs Strengthening.

The Department does not have an enforcement policy.

2.153 Typically, an enforcement policy describes the sanctions exercised to bring about compliance with the Act, regulations, policies, etc. and states the ramifications of not complying. Documented enforcement procedures usually specify the roles and responsibilities of the individuals involved, along with the timing of actions. The Department does not have an enforcement policy for Medicare. And, the Department does not have documented procedures regarding enforcement.

We identified situations where the Department's enforcement of doctor compliance with legislation and Departmental policies needs strengthening.

2.154 We identified the following situations where the Department's enforcement action with doctors is lacking:

- *The Department does not enforce the Act with doctors who inappropriately bill the Medicare program.* Earlier in this report we commented that some doctors double bill and inappropriately bill Medicare in addition to WSNB. Staff of the Department told us there are many doctors who repeatedly do so. Based on our interpretation of section 11 of the Act, we believe billing two parties for the same service is not permitted.

  Aside from recovering the Medicare payments for the services that were paid by WSNB, the Department does nothing. By allowing doctors to bill Medicare in addition to WSNB, the Department is not enforcing the Act.

- *The Department does not enforce their Policy that requires shadow billing.* Another example of the Department's lack of enforcement involves salaried doctors and shadow billing. Although shadow billing has always been a requirement for salaried doctors, compliance was not enforced by the Department. We noted even though in 2006 the Department took action to address non-compliance, there was still 20% non-compliance as of September 2011. It appears that doctors who do not comply are not penalized; the Department is not enforcing the Policy.

- *Current radiology claims do not comply with the "Physician's Manual" and regulations*. We noted

the *Physician's Manual* states, "*Since Spring 1992, Medicare fee-for-service claims must be submitted by electronic means.*" Twenty years later, most radiology claims are still being submitted manually. And, most radiology claims do not comply with the requirements stated in the regulations, which are shown in Exhibit 2.17 later in this chapter.

There are no ramifications for over-charging Medicare.

2.155 Currently there are no ramifications for failing to comply with Medicare legislation and policies. The Act authorizes the Department to revoke a doctor's billing privileges. However, the Department indicated they have never done this as an enforcement action. The Department also informed us they have never used penalties such as charging interest or issuing fines.

2.156 Department staff commented the Department needs stronger enforcement action with doctors.

- There is no incentive for a doctor to bill appropriately. However, there is a monetary incentive to bill inappropriately.
- Since auditing is based on sampling, an audit may or may not find inappropriate billings.
- In the event an audit identifies inappropriate billings, the scope of the audit covers only a few months. Potentially recoverable amounts outside the period under audit would not be identified.
- If an amount is required to be repaid by the doctor, there are no associated penalties such as fines, interest, or administration charges levied.

Summary

2.157 We believe the Department should enforce existing legislation that allows for a progressive range of sanctions which could deter a doctor from wrongfully billing. There should be consequences when a doctor repeatedly submits inappropriate claims. Consequences such as fines, penalties and / or charging interest on overpayments may deter inappropriate claims. Also, staff need clearly documented procedures to allow them to perform enforcement actions confidently with no risk of interference.

Appendix 8 – Detailed Findings: The Professional Review Committee (PRC) is Active and has Opportunity to Enhance its Value.

The PRC is required by legislation and has significant authority.

2.158 The Professional Review Committee (PRC) is required by legislation and has significant authority. Upon the recommendation of the PRC, the Department can suspend a doctor from participating in the Medicare program pursuant to section 5.5(6) of the Act.

The PRC has documented "Terms of Reference".

2.159 Documented direction is provided to the PRC via the Act, the regulations, a documented *Terms of Reference* and an *Orientation Manual*.

2.160 The PRC's mandate is stated in section 5.7(2) of the Act, as follows:

5.7(2) The Professional Review Committee shall
(a) conduct reviews and make recommendations to the provincial authority on any matter referred to it under subsection 5.5(1),

(b) examine and study all matters and material forwarded by the provincial authority and make recommendations related to such matters, and

(c) perform such other duties as are prescribed by regulation.

2.161 The objectives of the PRC are stated in section 26 of the regulations, as follows:

- *To enhance the standards of medical service*
- *To protect the interests of the public, government, the medical profession…*
- *To provide experienced professional counsel to a medical practitioner or oral and maxillofacial surgeon whose pattern of practice under the medical services plan appears not to be in the best interest of the public, the medical profession or the oral and maxillofacial surgery profession.*

2.162 The Act also provides members with protection against legal action taken as a result of their participation in the PRC. The regulations state the composition and appointment of the members; their term of service and remuneration; the rules and procedures for conducting its business; and the responsibilities of the Department.

2.163 The PRC's *Terms of Reference* are consistent with legislation. They paraphrase the committee's mandate,

scope, authority, membership, remuneration and explain the committee's reporting requirements.

2.164 The *PRC Orientation Manual* is dated 2004 and needs updating. However, most of the information provided is relevant and the manual should be useful to members. We found the ten-page manual to be comprehensive. It includes topics such as: a history of the committee, a summary of the relevant legislation, the work of the audit unit, the stipend and legal protection, a glossary, and meeting preparation and procedures.

The PRC has a history of being active.

2.165 We saw documented evidence that the PRC has been active since 1998. However, Department staff told us the committee has been active since at least 1990, when the audit unit was created.

2.166 The PRC's meetings are scheduled and agendas and minutes are prepared.

The PRC does not meet regularly.

2.167 The PRC's *Orientation Manual* indicates the committee meets "*each month, September through June" and "The schedule for the year, including storm dates, is provided to the members in early August.*" Given this, we expected the PRC would meet ten times each year.

2.168 We reviewed the committee's documentation for the calendar years 2000 to 2011, including the annual meeting schedules, minutes of meetings, meeting cancellation notifications, etc. We found the committee met between two and six times per year during the twelve-year period. The committee met five times in 2011. Exhibit 2.13 presents a summary of our review of the PRC's documentation.

2.169 Staff of the Department told us the PRC met when the audit unit had a case to submit to them for examination. If the audit unit did not have a case needing PRC's examination, the PRC meeting was cancelled. (Not all audit cases are submitted to the PRC for review. The audit unit decides when this professional review is needed.)

Exhibit 2.13 - Professional Review Committee (PRC) Meetings and Annual Reports

2.13	**Professional Review Committee (PRC) Meetings and Annual Reports**		
Period	**# of meetings scheduled**	**# of meetings held per minutes**	**Annual Report (date issued)**
2011	10	5	No report
2010	10	4	No report
2009	10	4	No report
2008	10	5	No report
2007	10	3	No report
2006	10	5	Report dated June 8, 2006 for period of October 2003 to May 2005.
2005	10	2	
2004	10	6	
2003	10	5	Report (undated) for period of October 2001 to October 2003
2002	10	4	No report
2001	9	3	No report
2000	8	4	3 reports for 2000, 1999 & 1998

Notes:

1. ***Period*** refers to the calendar year in which the meetings were scheduled.
2. ***# of meetings scheduled*** refers to the meetings planned and scheduled at the beginning of the period.
3. ***# of meetings held per minutes*** is a measure of the number of meetings held during the period based on the number of approved meeting minutes identified for the period.
4. ***Annual Report*** refers to a document identified in the *PRC Orientation Manual* that requires annual submission to the Minister by the committee Chair.

Source: Table created by the Office of the Auditor General using information provided by the Department.

PRC has opportunity to expand its value.

2.170 The Department values the expertise of the PRC. The examination of an audit case by the PRC adds credibility to the work of the audit unit and provides assurance to both the Department and the doctor involved that the recovery claim is appropriate.

2.171 Reviewing audit cases is part of the PRC's mandate. Section 5.7(2) of the Act states, "*the Professional Review Committee shall…examine and study all matters and material forwarded by the provincial authority and make recommendations related to such matters...*" The PRC also has authority to review billing patterns and make

recommendations as stated in sections 5.5(1) and 5.7(2)(a) of the Act. Specifically, section 5.5(1) of the Act states the Department may refer to the PRC and it shall review patterns of billing for:

(a) quality of service (below minimum standards)
(b) level of service (in excess of requirements)
(c) misuse of the fee schedule

Based on the results, the PRC shall make recommendations to Health. In addition to the legislation, these two functions are listed in both PRC's *Terms of Reference* and the *Orientation Manual*.

2.172 We believe the PRC has an opportunity to expand its value to the Department by reviewing analyses of Medicare billings and providing comments to the audit unit. As indicated by the Act, this review may identify areas where inappropriate or unneeded services have been claimed and / or misuse of the fee schedule. Both could result in recoveries, either directly or indirectly via a recommendation for an audit. Given the PRC needs only to meet approximately five times per year to review audit cases, other monthly meetings could be held to review and analyze patterns of billing.

2.173 We discussed this with members of the PRC who were very receptive to the opportunity to expand its value to the Department by reviewing billing patterns and making recommendations regarding possible misuse of the fee schedule.

The PRC does not report annually.

2.174 The PRC has not prepared an annual work plan or report to the Minister in recent years. According to the PRC's *Terms of Reference* and *Orientation Manual,* annual reporting to the Minister is required.

2.175 The PRC's *Terms of Reference* states the following in the section labeled "Reporting": "*The Professional Review Committee reports to the Minister of Health or his/her designate. In collaboration with the Department of Health, the PRC shall prepare an annual work plan and report to the Minister annually on the status and outcome of work plan items.*"

2.176 The PRC's *Orientation Manual* states, "*The Chairperson is responsible for the preparation of any correspondence necessary on behalf of the Committee, as well as, the Annual Report to the Minister…*"[19]

2.177 We reviewed the PRC's documentation for the calendar years 2000 to 2011. The PRC did not prepare an annual work plan for any of the twelve years. The PRC prepared three reports to the Minister during this twelve-year period, the last of which was dated 2006 (as was shown in Exhibit 2.13). We believe the Professional Review Committee should report to the Minister as required in their *Terms of Reference* and *Orientation Manual*.

Summary

2.178 The PRC has documented *Terms of Reference* and has a history of being active. However, the PRC does not report annually to the Minister as required according to its *Terms of Reference* and *Orientation Manual*. We believe the PRC has an opportunity to expand its value to the Department by reviewing analyses of Medicare billings. As indicated by the Act, this review may identify areas where inappropriate or unneeded services have been claimed and / or misuse of the fee schedule. Both could result in recoveries, either directly or indirectly via a recommendation for an audit.

[19] *The Professional Review Committee Orientation Manual*, October 2004, page 10.

Appendix 9 – Detailed Findings: Fee-For-Service Payments Need More Monitoring.

Exhibit 2.14 - Medicare FFS Payments to Doctors (fiscal year 2010-11)

2.14 Medicare FFS Payments to Doctors (fiscal year 2010-11)		
FFS payment range	**# of doctors**	**% of total # of doctors**
Greater than $1,000,000	13	0.8%
$500,001 to 1,000,000	132	8.1%
$400,001 to 500,000	111	6.8%
$300,001 to 400,000	153	9.4%
$100,000 to 300,000	468	28.8%
Less than $100,000	746	46.0%
Total # of doctors	1,623	100.0%

Notes:

1. ***FFS payment range*** is the range of FFS payments to doctors selected by OAG for comparison purposes.
2. ***# of doctors*** refers to the number of doctors that fall into each range.
3. ***Total # of doctors*** is the total of all doctors presented in the report (and excludes doctors with FFS payments of $0).
4. ***Less than $100,000*** which includes amongst other items doctors whose primary income is from salary or sessional arrangements with limited FFS billings as well as doctors working part-time, as locums (replacement doctors), and those working only a portion of the year due to new employment and retirements.
5. There is no differentiation of the data by doctor specialty. (There are 44 specialties.)

Source: Table created by the Office of the Auditor General with information provided from the Department – Consolidated Practitioners Cumulative Earnings Report IR3542 (unaudited) for the period 2010-11 [IR3542 – CER 2010-2011].

FFS payments to many doctors appear high when compared to budget estimates.

2.179 Exhibit 2.14 shows FFS payments to doctors by range. It indicates the number and the percentage of doctors receiving payments within each range. (It shows only FFS payments to doctors and does not include sessional and salary payments.) According to the Department, the following figures were used while budgeting for 2011. "*The estimated annual earnings of a general practitioner was $291,418 and the average annual earnings of a specialist was $420,977 (this specialty average is the average earnings of all specialties).*" Given this, we believe

remuneration greater than these figures should be considered high.

2.180 Our observations from Exhibit 2.14 include the following:

- There were 13 doctors who received FFS payments in excess of $1 million.
- There were 145 doctors (9%) who received FFS payments in excess of $500,000.
- There were 409 doctors (25%) who received FFS payments in excess of $300,000. Note if the doctors with FFS payments less than $100,000 (salaried, sessional and part-year doctors) were excluded, this would increase to 47%.

There is limited monitoring of FFS payments.

2.181 Consistent monitoring of FFS payments is crucial. There is significant risk of overpayment given the complexity of the system, the fact services are not confirmed as received by the patient and there is no penalty for overcharging.

2.182 There is very limited monitoring of FFS payments. Our observations include the following:

- No one is assigned primary responsibility for monitoring FFS payments. While the *Medicare Insured Services and Physician Remuneration* unit has monitoring responsibilities, staff indicated their oversight of FFS payments is limited to monitoring the “FFS cap” for salaried doctors.
- No analytical review procedures are done on a regular basis. For example, there is no regular review of the doctor payment register. FFS payments are made once every two weeks. Individual doctor totals are not reviewed to identify unusually high amounts, which then could be explored further to determine if they are reasonable.
- No standard exception reports are generated and reviewed on a regular basis. For example, it may be worthwhile to have an exception report listing doctors with claims for more than a reasonable number of patients per day. These could be explored further to determine if the cases are realistic.
- There are no documented monitoring procedures.
- There are no regular monitoring practices to identify and analyze claims of high earners.
- The automated FFS payment system has a monitoring component which has not been

developed and enabled.

2.183 We observed two specific areas where monitoring is lacking and consequently doctor overpayments may be occurring.

Monitoring of the FFS cap for salaried doctors is inadequate.

(Example 1)

2.184 The *New Brunswick Policy on Salaried Physicians* (Policy) and the *Medical Pay Plan* (MPP) state a salaried doctor is permitted to bill FFS in the following situations:

- services performed outside the scope of the salaried arrangement and outside the normal hours of work, which are 37.5 hours weekly between 8:00 a.m. and 6:00 p.m. Monday to Friday. (These are billed through a doctor's account using the automated FFS payment system.)
- mandated on-call services outside of normal working hours (These are billed through a separate "on-call group account" using the automated FFS payment system.)

2.185 While there is no limit to claims made to a salaried doctor's mandated "on-call group account", there is a limit to other FFS earnings for salaried doctors. The Policy and the MPP consistently state there is a "Fee-for-Service income threshold". FFS billings outside the mandated on-call program are paid at 100% up to a maximum amount stated in the MPP for a fiscal year. Once the threshold is reached, subsequent claims are paid at 50% of their listed value. The threshold for 2011 was $48,438. This threshold or FFS billing maximum for salaried doctors is commonly referred to as "the cap".

2.186 Responsibility is assigned to a staff member in the *Medicare Insured Services and Physician Remuneration* unit to monitor the FFS billings of salaried doctors and responsibility is assigned to a staff member in the *Financial Services* unit to reduce payment to 50% for claims submitted by salaried doctors who have been identified as having reached "the cap".

2.187 We reviewed the Department's process for monitoring the FFS cap for salaried doctors and found the following:

- Monitoring of the cap was done for only the first three quarters of 2011. Therefore, doctors reaching

the cap in the fourth quarter were not identified and the 50% payment rule was not applied. This likely resulted in the overpayment of some doctors.

- Some doctors were identified as having reached the cap but the 50% payment rule was not applied. The Department could not provide documentation to substantiate the reason for providing this exemption.
- Monitoring the cap is done in isolation, excluding any review of a doctor's "on-call group account" balance or claims. Doctors could mistakenly or intentionally submit FFS claims subject to the threshold to the "on-call group account", which is not monitored, and those claims would not be included in the doctor's total FFS payments for cap purposes. This could result in an overpayment of 50% on claims.

2.188 We selected a small sample of five salaried doctors with FFS payments greater than $120,000 to determine if their payments had been capped. We found the following:

- Two had been identified as having reached the cap and their subsequent FFS claims were adjusted as per the 50% payment rule.
- Three had been not been identified as having reached the cap. Further review indicated the high FFS payments were because of significant billings to the doctors' "on-call group account" and billings to their FFS accounts were below the cap. Without the audit unit doing substantially more work, the Department could not indicate whether there were inappropriate billings to the "on-call group accounts." We make observations regarding the "on-call group account" for the three doctors in the next section.

There is no monitoring of the "on-call group account" for salaried doctors.

(Example 2)

2.189 A salaried doctor will have an "on-call group account" if the doctor participates in a mandated on-call program at a hospital. An "on-call stipend" is a payment made to a doctor for being available to provide patient services after-hours, on weekends and on holidays according to a schedule prepared for a hospital. Should the doctor be called into the hospital and perform urgent or emergency services, the doctor may also bill for those services. Both the stipend and the emergency services are billed through the doctor's "on-call group account" which is part of the

automated FFS payment system.

2.190 While there is no "cap" on claims made to a salaried doctor's mandated "on-call group account", monitoring this account is still important to ensure only eligible emergency services are billed. The Department is aware some doctors inappropriately submit claims relating to other services, which should be submitted to the doctor's FFS account that is subject to the cap.

2.191 The Department informed us of the following:

- The Department has no controls to prevent the inappropriately submitted claims from being paid.
- The only method of identifying wrongfully submitted claims is via an audit, which is a very involved and time-consuming process.

Exhibit 2.15 - Review of 3 Doctor "on-call group account" Payments and Other Remuneration (2010-11)

2.15	Review of 3 Doctor "on-call group account" Payments and Other Remuneration (2010-11)					
	Doctor A		Doctor B		Doctor C	
	#	Payment	#	Payment	#	Payment
Services billed to the "on-call group account" on the date of a stipend payment	475	$149,887	479	$86,922	540	$114,802
Services billed to "on-call group account" on dates with no stipend payment	219	95,762	69	16,917	93	24,068
Total on-call services (excluding stipends)	**-**	**$245,649**	**-**	**$103,839**	**-**	**$138,870**
Stipend payments	97	13,618	112	14,767	47	6,598
Total on-call payments	**-**	**$259,267**	**-**	**$118,606**	**-**	**$145,468**
Other FFS	-	-	-	1,977	-	4,556
Total FFS payments	**-**	**$259,267**	**-**	**$120,583**	**-**	**$150,024**
Salary	-	329,291	-	321,165	-	275,763
Sessional and other	-	27,001	-	30,744	-	27,399
Total remuneration	**-**	**$615,559**	**-**	**$472,492**	**-**	**$453,186**

Notes:

1. Under each doctor column:

   "#" refers to the number of services the doctor billed to their "on-call group account" and the number of stipend payments made to the doctor.

   "Payment" refers to the total payments made to the doctor for the services provided and for stipends.
2. ***Services billed to the "on-call group account"*** were separated based on whether they occurred within a 24-hour stipend period for mandatory on-call coverage or were outside of this period.
3. ***Stipend payments*** refer to the payments made to doctors participating in the mandated on-call / second call program for remaining "on-call" in case an approved facility (typically hospitals) requires them to provide patient services after-hours and on weekends and holidays. Stipends are only paid once in a 24-hour period.
4. ***Other FFS*** refers to FFS payments to the doctor for FFS billings to accounts other than the "on-call group account".
5. ***Salary*** refers to the total salary remuneration paid to the doctor per the Department's report.
6. ***Sessional and other*** refers to any sessional remuneration paid to the doctor as well as other payments such as benefits and adjustments per the Department's report.

Sources: Table created by the Office of the Auditor General with information provided from the Department – Consolidated Practitioners Cumulative Earnings Report IR3542 (unaudited) for the period 2010-11 [IR3542 – CER 2010-2011], and an associated analysis by the Department – "Monitoring and Compliance Overview of Supplied Data".

2.192 Exhibit 2.15 presents a review of three doctor "on-call group account" payments and other remuneration. Without the audit unit doing substantially more work, the Department could not indicate whether there may have been inappropriate billings to the "on-call group accounts".

2.193 Our observations from the analysis of the three

doctor's remuneration in Exhibit 2.15 include the following:

- Two doctors had limited other FFS billings. Other FFS billings were $1,977 for doctor B and $4,556 for doctor C. Since the other FFS payments were below the threshold of $48,000, the cap was not applied.
- While only mandated on-call stipends and claims are acceptable in the "on-call group account", each of the accounts contained FFS billings without stipends. Payment of a stipend confirms the doctor was on-call that day and was permitted to bill claims through their "on-call group account". Absence of a stipend payment indicates their claims may have been inappropriate – they should have been billed as regular FFS claims subject to the cap.
- Using doctor A as an example, there were 219 (32%) FFS billings without stipends that may have been inappropriately billed. The total payment for these claims was $95,762. For doctor A, had the claims without stipends that were billed to the "on-call group account" been billed to the other FFS accounts, the billings would have been subject to the $48,000 cap. Paying claims in excess of the cap at 50% would have resulted in FFS payments of approximately $72,000 rather than $95,762.

The use of a wrong account may cause overpayment.

2.194 All doctors registered with Medicare are provided with a service provider number and a FFS personal account. Salaried doctors are also provided with a shadow-billing account and an "on-call group account". Some doctors also have a corporate account. We were told many doctors have several accounts and we observed an example of a doctor with six accounts.

2.195 The use of a wrong account may cause overpayment. For example, a salaried doctor may incorrectly post their shadow billings to their FFS personal account, rather than their shadow-billing account. Claims submitted to their shadow-billing account are for Departmental tracking purposes only and are not paid. Claims submitted to their FFS personal account are paid at 100% up to approximately $48,000 (the cap) and then at 50%. Department personnel informed us of cases where salaried doctors have been paid in error for services provided during their regular salaried hours.

2.196 The problems with "on-call group account" billings, as previously discussed, also provide an example of

potential overpayment through use of the wrong account.

Summary

2.197 We believe the Department should develop, document, assign and implement proper monitoring procedures for all FFS payments, including FFS payments to salaried doctors such as the cap and the “on-call group account”.

Appendix 10 – Detailed Findings: Radiologist Payments Need Better Controls and Monitoring.

Exhibit 2.16 - Methods of Paying Doctors in the Medicare Program

2.16 Radiologist Remuneration by Range (fiscal year 2010-11)		
Remuneration range	**# of radiologists**	**% of total # of "full-time" radiologists**
Greater than $1,000,000	5	7.35%
$750,000 to 1,000,000	19	27.94%
$500,000 to 749,999	21	30.88%
$250,000 to 499,999	14	20.59%
Less than $250,000	9	13.24%
Total # of radiologists (status codes 11, 15, 31)	**68**	**100.00%**
# of radiologists with all other status codes	66	
Total (all radiologists)	134	

Notes:

1. ***Radiologist*** refers to a doctor practicing diagnostic radiology or nuclear medicine.
2. ***Remuneration range*** is the range of remuneration selected by the OAG for comparison purposes. ***Remuneration*** is the total of all payments of all types by Medicare.
3. ***# of radiologists*** is the total number of radiologists practicing diagnostic radiology or nuclear medicine in the specified range.
4. ***"full-time" radiologists*** refers to those with the following status ("status" of a radiologist refers to the categorization under which the radiologist is originally registered by Medicare):
   - Status 11 – Full-time fee for service
   - Status 15 – Full-time salaried with other remuneration
   - Status 31 – Full-time salaried with no other remuneration
5. ***# of radiologists with other status codes*** is the number of radiologists with a status not specifically listed above. These would include short-term locums, retirees, out of province practitioners, etc.
6. ***Total (all radiologists)*** figure of 134 includes one radiologist paid salary; remaining 133 radiologists were paid FFS.
7. This information includes only radiologists practicing diagnostic radiology or nuclear medicine in valid zones with total payments exceeding $0.

Source: Table created by the Office of the Auditor General with information provided by the Department – Radiology - Comparative Practitioners Cumulative Earnings Report IR3567 for the period April 2010 to March 2011 (unaudited).

Total payments to some radiologists appear high when compared to other specialties.

2.198 The number of radiologists within a specified payment range is shown in Exhibit 2.16**.** The chart indicates there were 68 regularly paid radiologists during 2011. Of these, 45 radiologists (66%) were each paid more than half of a million dollars, which includes five radiologists who were each paid more than a million dollars. Department staff agreed that payments to radiologists appear high when compared to other specialties.

2.199 Other observations regarding payments to radiologists include the following:

- *Status 13* is used for "short-term fee for service locums". (A locum is a replacement doctor.) We included status 13 in Exhibit 2.16 in the "# of radiologists with all other status codes" figure. There were 17 radiologists with status 13. Most of these radiologists (16) had total payments of $72,474 or less, which seems reasonable given locums do part-time / replacement work. However, one status 13 radiologist was paid $651,406 which appeared high and unusual.
- There were only five other radiologists with payments over $100,000 in the "# of radiologists with all other status codes" group. Three had payments between $100,000 and $199,999; the fourth radiologist was paid $213,730 and the fifth radiologist was paid $851,955 and had a status "not in active practice NB". Given the amounts paid to most "radiologists with all other status codes", the payment of $851,955 to one radiologist appeared high and unusual.
- The radiologist with the highest remuneration was paid $1,430,121. We also noted over the five-year period 2006-07 to 2010-11, $6.3 million was paid to this one radiologist. A Department staff member agreed that the payments to this radiologist appear high. The staff member explained some radiologists are "certified" and are paid a higher rate; however, it was confirmed this was not the case for this specific radiologist.

2.200 We did an analysis of radiologist remuneration by zone for 2011 and found the following:

- For seven of the eight zones, the zone average was more than half of a million dollars.
- The median for one zone was $821,863, which means four of the nine radiologists in the zone received payments in excess of $821,863 and four of the nine radiologists in the zone received payments less than $821,863.

  These figures appear high when compared to other specialties.

Claims submitted for radiologists are not subject to regular payment controls.

2.201 While radiologists are part of the FFS group of doctors paid under the FFS agreement, claims submitted for radiologists are not subject to regular payment controls. The payment process for radiologists is distinct from other FFS doctors in the following ways:

- *An indirect manual payment process is used.* Radiologists are paid by the RHA, which in turn is repaid by Medicare through a manual payment process. Typically, FFS doctors are paid using the automated FFS payment system; the doctor submits claims electronically and is paid directly by Medicare via direct deposit to their bank. The indirect manual process for radiologists may be more costly, given the amount of staff time involved, than the direct automated process for typical FFS doctors.
- *Important claim information is not provided, which results in fewer payment controls and no recoveries.* Radiologists are the only FFS doctors that do not submit claims using the automated FFS payment system, which has several built-in edits, validation checks and payment controls. With the exception of two zones, radiologists are paid without submitting patient information which is required for every claim paid under the FFS agreement. Without adequate claim information, Medicare is unable to validate the charge prior to payment or audit the payment afterwards.
- *Very limited adjudication rules for electronic radiology claims means fewer controls.* Department staff indicated there are two zones which do submit electronic claims for radiologists via the FFS automated payment system. Although this is better

than the manual payment system, it is still not as controlled as other FFS payments because there are fewer adjudication rules applied to radiology claims than those applied to other FFS claims. (Adjudication rules are conditions that must be met in order for the claim to be paid. For example, a claim for examining an X-ray of a uterus must be made with a Medicare number for a female.)

The Department does not recover Medicare costs relating to radiology as important claim information is not available in the Department.

2.202 Because radiologists are not using the automated FFS payment system, important claim information is not provided and the Department does not recover Medicare costs relating to radiology.

2.203 Typical FFS payments with claim information allow the Department to recover payments relating to out-of-province patients and third-party billings such as WSNB. Typical FFS payments with claim information are also subject to audit, which often results in recoveries. Since radiologists are paid without providing important claim information, none of these typical recoveries are possible.

There is no monitoring of radiologist remuneration by the Department.

2.204 None of three units within the Department that are involved with radiologists monitor their remuneration.

2.205 Also, given payments to radiologists are a flow-through cost to the RHAs, there is no incentive for the RHAs to monitor payments or control costs.

Current radiology claims do not comply with the Physician's Manual and regulations.

2.206 The *Physician's Manual* states, "*Since Spring 1992, Medicare fee-for-service claims must be submitted by electronic means.*" It is now twenty years later, and radiology claims are still being submitted manually by most zones.

2.207 The regulations under the *Medical Services Payment Act* state the requirements for all claims. See Exhibit 2.17. Current radiology claims do not comply with the stated requirements because information on the patient, diagnosis and treatment are not submitted.

Exhibit 2.17 - Medicare Claim Requirements per Regulations under the Medical Services Payment Act

2.17	Medicare Claim Requirements per Regulations under the *Medical Services Payment Act*

The regulations under the *Medical Services Payment Act* require that all claims must be submitted with the following information:

- whether the practitioner or beneficiary is to be paid;
- patient's name;
- patient's Medicare number;
- patient's date of birth;
- patient's sex;
- practitioner's name and practitioner number;
- practitioner's role i.e.: the surgeon, assistant, collaborating surgeon or anaesthetist;
- time spent by practitioner on service(s) if required to determine amount of payment;
- transferring or referring practitioner's name and practitioner number;
- diagnosis;
- date(s) of services charged;
- number of services charged or hospital days;
- date of admission to and date of discharge from hospital if in-patient care is involved;
- whether services are provided at practitioner's office, patient's home, hospital (inpatient), hospital out-patient or emergency department, nursing home, or elsewhere;
- site code must be provided for services rendered in location 3, 5, 6 and telemedicine services and walk-in clinic services;
- service code(s) and fee charges;
- total line count;
- treatment information or remarks;
- date of completion of form;
- signature of the patient in the case of services for which the practitioner is opted-out.

Source: Excerpt from the *Physician's Manual* 27/03/08 available on Department's website.

The Department's radiology project to automate billings is slow moving.

2.208 The Department started a project to automate radiology billings in 1998. We reviewed a project proposal for standardized automated radiology billing dated February 4, 2011 which stated the following:

> *In the fall of 1998, the Department of Health and Wellness initiated a project to bring the radiology billings into the computerized FFS payment system. Medicare had promised each region a maximum amount of $25,000 to enhance their system to accommodate this change. It was expected this amount could be recovered in the first year as Medicare will no longer be*

responsible for services billed to them erroneously nor those of third party (RCMP, DND, etc…). Medicare will also be able to recover the cost from other provinces for radiology services rendered to their residents while in New Brunswick. To date only two Zones (…) have made changes to allow the radiologists billings to come in as automated FFS billings with individual services and patients reported. Information is captured but no formal adjudication (assessment rules) are in place - Rules will be introduced during FFS distribution discussions this year – a working group will need to be formed with NBMS/Medicare Experts.

2.209 All staff with whom we spoke regarding radiology agreed with the need for "something" to be done. Many believe the recent Department interest in automating radiology billing will result in success. However, as of May 2012, fifteen months following the proposal, only the two original zones were using automated billing for radiology services.

Summary

2.210 Current radiologist billing practices have significant risks and may lead to the loss of considerable recoveries of incorrect payments. We believe radiologists should be required to bill through the automated Medicare system like all other FFS doctors. The lack of information, controls, monitoring and auditing regarding radiologist payments requires immediate action.

Appendix 11 – Detailed Findings: Salary Payments to Some Doctors Appear High when Compared to the Salary Scale.

Exhibit 2.18 - Methods of Paying Doctors in the Medicare Program

2.18	**Medicare Salary Payments to Doctors (fiscal year 2010-11)**
Salary payment range	**# of doctors**
Greater than $1,000,000	1
$500,001 to 1,000,000	10
$400,001 to 500,000	17
$300,001 to 400,000	108
$200,001 to 300,000	187
$100,000 to 200,000	104

Notes:

1. ***Salary payments*** refer to salary related payments including benefits.
2. ***Salary payment range*** is the range of salary payments to doctors selected by OAG for comparison purposes.
3. ***# of doctors*** refers to the number of doctors that fall into each range.
4. There is no differentiation of the data by doctor specialty.

Source: Table created by the Office of the Auditor General with information provided from the Department – Consolidated Practitioners Cumulative Earnings Report IR3542 (unaudited) for the period 2010-11 [IR3542 – CER 2010-2011].

Salary payments to some doctors appear high when compared to the salary scale.

2.211 Exhibit 2.18 shows salary payments to doctors by range for 2011. (It shows only salary payments to doctors and does not include FFS or sessional payments.) Salary payments are shown in ranges, indicating the number of doctors receiving payments within each range.

2.212 According to the *Medical Pay Plan* (MPP) agreement for salaried doctors, the base salaries for 2011 ranged from $151,658 to $266,292 [20] (salary scale). Salaried doctors get benefits in addition to their base salary, and for some doctors, market

[20] *Medical Pay Plan – April 1, 2010*. Note: there was a market adjustment for oncologists and pathologists which increased their salary. There were approximately 75 oncologists and pathologists in fiscal 2011.

adjustments for specific specialties need to be added to the base salary figure in order to determine the total contract maximum figure.

2.213 Salary payments to some doctors appear high when compared to the salary scale; our observations from Exhibit 2.18 include the following:

- One doctor received salary payments in excess of $1 million.
- There were 11 doctors who each received salary payments in excess of $500,000.
- There were 136 doctors who each received salary payments in excess of $300,000.

2.214 We did an analysis and observed some salaried doctors appeared to be paid more than the salary scale. We provided the Department with a sample of these doctors. The Department provided supporting documentation showing payments to the identified doctors were reasonable. Reasons for the higher amounts included: market adjustments for some specialties, supervising pay, contracts for special qualifications and retroactive pay.

Contracts are not filed in the Department for all salaried doctors.

2.215 Although salaried doctors are paid under the MPP agreement, typically salaried doctors have a contract with the RHA. Contracts are kept at the RHA, which provides information to the Department.

2.216 The Department cannot fully audit payments to a salaried doctor unless they have a copy of their contract. At the time of our review, the Department was in the process of obtaining copies of all salary contracts. A memo was issued to the RHAs dated January 2012 requesting copies of all doctors' contracts by the end of February. As of June 2012, six months later, the Department had received approximately 84% of the salaried doctor contracts and was still in the process of obtaining others.

The shadow-billing requirement is not met by all salaried doctors.

2.217 The *New Brunswick Policy on Salaried Physicians* states, "*Salaried physicians must provide shadow billing or history only billing as required by the department.*" Shadow billing (also commonly called "history-only billing") is the process used by salaried doctors to submit information on services provided during their salaried hours of work. Shadow claims are similar to FFS claims except shadow claims do not get paid.

2.218 Shadow billing is important to the Medicare program because it provides information used for many purposes including the following:

- maintaining historical measures of service provision and tracking numbers and demographics of patients and types of services rendered;
- maintaining complete and accurate patient histories;
- epidemiology studies such as diabetes, mumps, cancer;
- public health initiatives such as immunizations;
- resource planning, performance measurement and accountability; and
- monitoring and audit.

2.219 Shadow-billing information is needed in order to properly monitor salaried doctors and audit payments to them. For example, information regarding the services provided during the salaried hours of a doctor allows the Department to monitor compliance with their contract. Shadow-billing information is also needed to audit FFS claims submitted by salaried doctors to ensure the doctor is not FFS billing for services provided during their salaried hours.

2.220 While "*shadow billing has always been a requirement of salaried physician employment*,"[21] compliance has not been enforced by the Department. Our observations include the following:

- In October 2006, the Department created a working group with the Medical Society to address doctors' resistance to shadow billing and facilitate compliance with the requirement. It was identified that many doctors did not have the time or support to shadow bill, so the Department transferred funding to the RHAs for administrative resources dedicated to shadow billing for doctors. Also a staff member of the Department visited all doctors' offices to train the staff and identify and track those complying.

[21] Information provided by the Department – Memo to salaried physicians October 8, 2008.

- In 2008 the Department issued a memo to salaried doctors reminding them of the shadow-billing requirement; stating while many salaried doctors were shadow billing, the majority were not; and requesting they begin by March 2009.
- In May 2011, the Department issued a memo to all salaried doctors as a directive to shadow bill by August 19, 2011 or the Department would "*initiate steps to ensure compliance.*" And in October 2011, the Department sent shadow-billing profile reports to the doctors that had complied. Non-compliant doctors received a letter of non-compliance.
- The Department is now tracking compliance. In January 2012, the Department did an analysis and determined 80% of salaried doctors were shadow billing. (The Department indicated some doctors do not shadow bill because there are no fee codes for their specialty work. These doctors were not included in the analysis.)

Monitoring of payments to salaried doctors is lacking.

2.221 While there are payment controls for salary, sessional and FFS payments to most doctors, there is no monitoring of total remuneration to salaried doctors. While the total payments for each type of remuneration may appear reasonable when examined individually, it is important to examine total remuneration in order to identify risk of overpayment to a doctor.

2.222 We reviewed the doctor cumulative earnings report for 2011 and observed there were several salaried doctors with high other remuneration payments (FFS and / or sessional). For example, one doctor had salary payments of $218,437, sessional payments of $216,799 and FFS payments of $9,654. Another doctor had salary payments of $305,198, FFS payments of $150,839 and sessional payments of $80,603. A third example had salary payments of $287,056, sessional payments of $113,061 and FFS payments of $58,071. This is allowed per Medicare policies; however, the total payments should be monitored.

Summary

2.223 We believe the Department should develop, document, assign and implement proper monitoring procedures for salaried doctors. Monitoring procedures should include reviewing contracts between the RHAs and the doctor to ensure compliance with the MPP. In addition, we believe the

Department should continue its efforts to monitor compliance with the shadow-billing requirement and take action with those doctors who do not comply.

Appendix 12 – Detailed Findings: Sessional Amounts Paid to Some Doctors Appear High when Compared to the Policy.

Sessional amounts paid to some doctors appear high when compared to the policy.

2.224 We reviewed the doctor cumulative earnings report for 2011 and observed there were several doctors with high sessional payments when compared to the policy. We also noted that many doctors also received FFS and / or salary payments. For example:

- One doctor had sessional payments of $475,703 and FFS payments of $825,253. We questioned the Department about this general practitioner who had received payments of over $1.3 million. The Department indicated this doctor had a special arrangement with the RHA. We examined a copy of the agreement between the RHA and the doctor. The agreement is dated May 2007, supports the sessional payments to the doctor, and provides for termination by either party with six months written notice. Based on discussions with Department staff, we believe the agreement may not be in the best financial interest of the Province.
- Another doctor had sessional payments of $342,198 and FFS payments of $461,913. The Department informed us the sessional payments related to the emergency department in a hospital and were reasonable. In order to determine the appropriateness of the FFS payments the audit unit would need to do more work.

2.225 We provided a list of doctors with high sessional earnings to the Department and asked for an explanation. The Department provided us with the following information:

- Several of the doctors who received high sessional payments worked in emergency. The Department's *Policy on Sessional Arrangements* states exclusions to the policy; emergency and intensive care departments are two examples. Doctors working sessional in emergency are paid a higher hourly rate.
- Nine of 16 doctors who received sessional payments exceeding $400,000 were coded as sessional for record-keeping purposes. However, these doctors had *Alternate Payment Plan* arrangements with the Department. We did not do further work relating to these doctors.

- Three doctors had special arrangements, which are discussed next.

There is non-compliance with the Policy on Sessional Arrangements.

2.226 The Department's *Policy on Sessional Arrangements* states, "*Sessional payment arrangements are intended for physicians who are retained on a part-time basis and for services which do not lend themselves to the fee for service remuneration. ... Sessional arrangements are paid for clinical care up to the maximum salary of the applicable classification.*"

2.227 Our understanding is the policy is intended to allow compensation to a doctor to be made in the most economic manner. In facilities such as nursing homes and jails, a full-time doctor is not required. Hence, paying the doctor an hourly rate (sessional) makes economic sense. The clause *"up to the maximum salary of the applicable classification,"* means that paying the doctor with an hourly rate should not exceed the amount the doctor would be paid under a salary agreement (MPP).

2.228 We identified three doctors who had been paid more than they would have been paid under the contracted salary for their classification. The Department provided us with the following explanations:

- One doctor "*has an approved arrangement with the RHA dating back to 2002. This was approved by the Department….*"
- One doctor "*had a sessional arrangement since April 2003 for up to 45 hours a week, which is beyond the policy. The physician retired in [fiscal] 2012.*"
- One doctor had three sessional arrangements. The Department said their interpretation of the *Policy on Sessional Arrangements* was that the maximum salary clause was per sessional arrangement. Since none of the three individual arrangements exceeded the salary maximum, they felt this doctor was in compliance with the policy. However, we believe this is non-compliance since the total of the doctor's sessional payments exceeds the amount the Department would pay under a salary arrangement.

Summary

2.229 Medicare sessional payments to doctors relate to designated services paid for on an hourly basis, such as doctors working in emergency rooms and those working part-time in a nursing home or a jail. Sessional-type payments to doctors were approximately $60 million in

2011, which represented 11% of total Medicare expenditures. Approximately 250 doctors received sessional payments in 2011. We found cases of non-compliance with the *Policy on Sessional Arrangements* and believe the Department should review and monitor the sessional arrangements with doctors to ensure compliance with the policy.

Appendix 13 – Detailed Findings: Public Reporting of Doctor Remuneration is Incomplete and Misleading.

There is no public reporting of FFS payments to individual doctors.

2.230 There is no public reporting of FFS payments to individual doctors. FFS doctors and their remuneration is not reported in *Public Accounts – Supplementary Information.*

Exhibit 2.19 - Medicare Fee for Service [FFS] Expenditures for 3 Fiscal Years

2.19 Medicare Fee for Service [FFS] Expenditures for 3 Fiscal Years

FFS payment distribution	# of doctors (2010-11)	2010-11	2009-10	2008-09
Doctors (note 3)	1,490	$ 291,725,033	$ 284,571,876	$ 271,812,348
Radiologists (note 4)	133	42,357,617	43,003,792	42,513,682
Other		17,426,061	19,480,185	19,403,350
Total FFS payments		**$ 351,508,711**	**$ 347,055,853**	**$ 333,729,380**

Notes:

1. ***FFS payment distribution*** identifies the dispersion of Medicare payments between radiologists and all other doctors.
2. ***# of doctors (2010-11)*** includes any doctor that received a FFS payment during the period regardless of amount, other forms of payment received, or specialty. Source: Fiscal 2011 - Consolidated Practitioners Cumulative Earnings Report IR3542 (unaudited).
3. ***Doctors*** include all specialties with the exception of diagnostic radiology and nuclear medicine.
4. ***Radiologists*** include all doctors practicing in diagnostic radiology or nuclear medicine during fiscal 2011. In addition to full time radiologists, this figure would include short-term locums, retirees, out of province practitioners, etc. Exhibit 2.16 provides additional information regarding radiologists.
5. ***Other*** refers to payments to dentists, CMPA, etc. that are not specifically linked to doctors and radiologists in the data reviewed.

Source: Table created by the Office of the Auditor General with information provided by the Department and Province of New Brunswick Oracle Financial Information System Account Analysis Report – Fiscal 2009, Fiscal 2010, Fiscal 2011

2.231 Exhibit 2.19 shows FFS expenditures for three fiscal years: 2009, 2010 and 2011. It also shows the number of doctors who received payments in 2011. There are many salaried doctors included in this figure because they do on-call work, which is paid as FFS.

2.232 Total FFS payments in 2011 were over $351 million, a significant amount. In order for the

Department to demonstrate proper accountability, we believe the distribution of these millions of dollars should be publicly reported and subject to public scrutiny.

2.233 We discussed public reporting of FFS doctor remuneration with Department staff. We were told under the *Medical Services Payment Act* (Subsection 8.1), the Department cannot legally publish fee-for-service doctor remuneration. The Department informed us they have a legal opinion as substantiation. We requested the legal opinion and the Department indicated they could not share it with us.

2.234 The Department did not disagree with our suggestion that to demonstrate proper accountability FFS doctor remuneration should be publicly reported. They simply informed us it is non-compliance with legislation to publicly report FFS remuneration and section 8.1 of the Act would have to be amended to allow for the publication of doctor billings.

Public reporting for salaried doctors is incomplete and misleading.

2.235 Total salary payments to doctors in 2011 were approximately $110 million. We reviewed the Employee and Supplier Lists for 2011 and found only some doctors were reported. For many of those listed, only a portion of their remuneration was shown. The Department indicated only some salaried doctors were publicly reported and no FFS payments were included in amounts shown.

2.236 Publicly reporting incomplete, inaccurate information on doctors' remuneration is misleading. As with FFS payments, we believe the distribution of salary payments to doctors should be publicly reported.

There is no public reporting of sessional payments to individual doctors.

2.237 Total sessional-type payments to doctors in 2011 were approximately $60 million. There is no public reporting of the distribution of these payments. Again, in order for the Department to demonstrate proper accountability, we believe the distribution of these millions of dollars should be publicly reported.

Summary

2.238 In order for the Department to demonstrate proper accountability for over half of a billion dollars in annual spending, we believe the distribution of this spending should be publicly reported and subject to public scrutiny. Even if change to legislation is required, the Department should publicly report total

remuneration for each doctor, regardless of whether the doctor is paid via FFS, salary, sessional or alternative payment arrangements. (This would be similar to other government reporting of employee compensation and vendor payments.) In addition, to provide better accountability, the Department should publicly report annually summary-level information on doctor remuneration, such as: total payments for each remuneration method (FFS, salary, sessional, other), doctor remuneration by dollar range, doctor remuneration by specialty, etc.