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Health Insurance Act

R.S.O. 1990, CHAPTER H.6

Consolidation Period: From June 1, 2011 to the e-Laws □urren□y date.

Last amendment: 2009, □ 33, S□hed. 18, ss. 11, 17 (2).

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Definitions

1. In this Act,

"Appeal Board" means the Health Services Appeal and Review Board under the *Ministry of Health and Long-Term Care Appeal and Review Boards Act, 1998*; ("Commission d'appel")

"business day" means a day on which Canada Post ordinarily delivers lettermail; ("jour ouvrable")

"Deputy Minister" means the Deputy Minister of Health and Long-Term Care; ("sous-ministre")

"future cost of insured services" means the estimated total cost of the future insured services made necessary as the result of an injury that will probably be required by a patient after the date of settlement or, where there is no settlement, the first day of trial;

("coût futur des services assurés")

"General Manager" means the General Manager appointed under section 4; ("directeur général")

Note: On a day to be named by proclamation of the Lieutenant Governor, section 1 is amended by adding the following definition:

"general requisition number" means the unique identifying number issued by the General Manager to a practitioner or health facility to identify that a service rendered by another practitioner or health facility or by a physician, hospital or independent health facility was requested by the practitioner or health facility; ("numéro de demande général")

See: 2009, c. 26, ss. 11 (1), 27 (2).

"health card" means a document in a prescribed form issued by the General Manager; ("carte Santé")

"health facility" means an ambulance service, a medical laboratory and any other facility prescribed by the regulations as a health facility for the purposes of this Act; ("établissement de santé")

Note: On a day to be named by proclamation of the Lieutenant Governor, section 1 is amended by adding the following definition:

"independent health facility" means an independent health facility within the meaning of the *Independent Health Facilities Act*; ("établissement de santé autonome")

See: 2009, c. 26, ss. 11 (1), 27 (2).

"insured person" means a person who is entitled to insured services under this Act and the regulations; ("assuré")

"insured services" means services that are determined under section 11.2 to be insured services; ("services assurés")

"joint committee" means the Joint Committee on the Schedule of Benefits established under subsection 5 (1); ("comité mixte")

"Minister" means the Minister of Health and Long-Term Care; ("ministre")

"Ministry" means the Ministry of Health and Long-Term Care; ("ministère")

"past cost of insured services" means the total cost of the insured services made necessary as the result of an injury and provided to a patient up to and including the date of settlement or, where there is no settlement, the first day of trial; ("coût antérieur des services assurés")

"payment committee" means the Physician Services Payment Committee established under subsection 5.4 (1); ("comité de paiement")

"payment correction list" means the list of circumstances described in subsection 18 (2) for which payments are subject to correction; ("liste de rectification au titre des paiements")

"physician" means a legally qualified medical practitioner lawfully entitled to practise medicine in the place where medical services are rendered by the physician; ("médecin")

"Plan" means the Ontario Health Insurance Plan referred to in section 10; ("Régime")

"practitioner" means a person other than a physician who is lawfully entitled to render insured services in the place where they are rendered; ("praticien")

"prescribed" means prescribed by the regulations; ("prescrit")

"regulations" means the regulations made under this Act; ("règlements")

"resident" means a resident as defined in the regulations and the verb "reside" has a corresponding meaning; ("résident")

"Review Board" means the Physician Payment Review Board established under subsection 5.1 (1); ("Commission de révision")

"schedule of benefits" means the schedule of benefits as defined by the regulations. ("liste des prestations") R.S.O. 1990, c. H.6, s. 1; 1993, c. 2, s. 12; 1993, c. 32, s. 2 (1); 1994, c. 17, s. 68; 1996, c. 1, Sched. H, s. 1 (2); 1998, c. 18, Sched. G, s. 54 (1); 2006, c. 19, Sched. L, s. 11 (2, 4); 2007, c. 10, Sched. G, s. 1; 2009, c. 33, Sched. 18, ss. 11 (1), 17 (2).

ADMINISTRATION

Administration of Plan by Minister

2. (1) The Minister is responsible in respect of the administration and operation of the Plan and is the public authority for Ontario for the purposes of the *Canada Health Act*. R.S.O. 1990, c. H.6, s. 2 (1).

Duties of Minister

(2) The Minister may,

(a) enter into arrangements for the payment of remuneration to physicians and practitioners rendering insured services to insured persons on a basis other than fee for service;

(b) enter into agreements with persons, organizations and government agencies outside Ontario for the provision of insured services to insured persons.

(c), (d), (e) Repealed: 2009, c. 33, Sched. 18, s. 11 (2).

R.S.O. 1990, c. H.6, s. 2 (2); 2009, c. 33, Sched. 18, s. 11 (2).

Collection of personal information

(3) The Minister may collect, directly or indirectly,

(a) personal information that relates to the eligibility of a person to become or to continue to be an insured person; or

(b) the prescribed personal information, which may include a photograph and signature, that relates to the form or content of the health card. 1994, c. 17, s. 69.

Agreements concerning personal information

(4) The Minister may enter into agreements to collect, use or disclose the personal information referred to in clause (3) (a) and to collect and use the personal information referred to in clause (3) (b). 1994, c. 17, s. 69.

Agreements concerning payment information

(4.1) The Minister may enter into agreements to collect, use and disclose,

(a) personal information concerning insured services provided by physicians, practitioners or health facilities; and

(b) such other personal information as may be prescribed. 1996, c. 1, Sched. H, s. 2 (1).

Limitation

(5) An agreement shall provide that personal information collected or disclosed under the agreement will be used only,

(a) to verify the accuracy of information held or exchanged by a party to the agreement;

(b) to administer or enforce a law administered by a party to the agreement; or

(c) for such other purposes as may be prescribed. 1994, c. 17, s. 69; 1996, c. 1, Sched. H, s. 2 (2).

Confidentiality

(6) An agreement shall provide that personal information collected, used or disclosed under it is confidential and shall establish mechanisms for maintaining the confidentiality of the information. 1996, c. 1, Sched. H, s. 2 (3).

Physiotherapy clinics

(7) In the case of physiotherapy clinics that have been prescribed as health facilities for the purposes of the definition of "health facility" in section 1, the Minister may,

(a) approve a change to the name, ownership or location of the clinic; or

(b) approve another clinic to be the replacement for that clinic,

and such a clinic shall be deemed to be prescribed as a health facility, but, for greater certainty, the Minister may not approve a change that increases the number of clinics that are prescribed. 2007, c. 10, Sched. C, s. 1.

List

(8) The Minister shall keep and maintain a list of clinics approved under subsection (7) and ensure that the list is available to the public. 2007, c. 10, Sched. C, s. 1.

Ontario-Canada agreement

3. (1) The Government of Ontario, represented by the Minister of Finance, may enter into and amend from time to time an agreement with the Government of Canada under which Canada will contribute to the cost of that part of the Plan related to the provision of any insured services in or by hospitals and health facilities in accordance with such terms and conditions as the agreement provides. R.S.O. 1990, c. H.6, s. 3 (1); 2006, c. 19, Sched. L, s. 11 (5).

Idem

(2) The Government of Ontario, represented by the Minister, may enter into and amend from time to time an agreement with the Government of Canada under which Canada will contribute to the cost of that part of the Plan related to insured services other than insured services provided in or by a hospital or health facility, in accordance with such terms and conditions as the agreement provides. R.S.O. 1990, c. H.6, s. 3 (2).

General Manager

4. (1) A General Manager for the Plan shall be appointed by the Lieutenant Governor in Council. R.S.O. 1990, c. H.6, s. 4 (1).

Duties

(2) Subject to this Act and the regulations, it is the function of the General Manager and he or she has the power,

(a) to administer the Plan as the chief executive officer of the Plan;

(b) to carry out registrations in the Plan, including the determination of eligibility and the verification of eligibility;

(c) to make payments by the Plan for insured services, including the determination of eligibility and amounts;

(d) to establish and maintain branch offices for the administration of the Plan;

(e) to conduct actions and negotiate settlements on behalf of the Plan under the subrogation of the Plan under this Act to the rights of insured persons;

(f) to require any information required or permitted to be provided to the General Manager under this Act or the regulations to be provided in such form as he or she specifies;

(g) to perform such other function and discharge such other duties as are assigned to the General Manager by this Act and the regulations or by the Minister. R.S.O. 1990, c. H.6, s. 4 (2); 2006, c. 19, Sched. L, s. 3 (1).

Collection of personal information

4.1 (1) The Minister and the General Manager may directly or indirectly collect personal information, subject to such conditions as may be prescribed, for purposes related to the administration of this Act, the *Commitment to the Future of Medicare Act, 2004* or the *Independent Health Facilities Act* or for such other purposes as may be prescribed. 1996, c. 1, Sched. H, s. 3; 2006, c. 19, Sched. L, s. 3 (2).

Use of personal information

(2) The Minister and the General Manager may use personal information, subject to such conditions as may be prescribed, for purposes related to the administration of this Act, the *Commitment to the Future of Medicare Act, 2004* or the *Independent Health Facilities Act* or for such other purposes as may be prescribed. 1996, c. 1, Sched. H, s. 3; 2006, c. 19, Sched. L, s. 3 (3).

Disclosure

(3) The Minister and the General Manager shall disclose personal information if all prescribed conditions have been met and if the disclosure is necessary for purposes related to the administration of this Act, the *Commitment to the Future of Medicare Act, 2004* or the *Independent Health Facilities Act* or for such other purposes as may be prescribed. However, the Minister or the General Manager shall not disclose the information if, in his or her opinion, the disclosure is not necessary for those purposes. 1996, c. 1, Sched. H, s. 3; 2006, c. 19, Sched. L, s. 3 (4).

Obligation

(4) Before disclosing personal information obtained under the Act or under an agreement, the person who obtained it shall delete from it all names and identifying numbers, symbols or other particulars assigned to individuals unless,

(a) disclosure of the names or other identifying information is necessary for the purposes described in subsection (3), 2 (5) or 38 (4); or

(b) disclosure of the names or other identifying information is otherwise authorized under the *Freedom of Information and Protection of Privacy Act* or the *Personal Health Information Protection Act, 2004*. 1996, c. 1, Sched. H, s. 3; 2004, c. 3, Sched. A, s. 85 (1).

JOINT COMMITTEE

Joint Committee on the Schedule of Benefits

5. (1) The Minister shall establish a joint committee to perform the functions set out in subsection (3) and the committee shall be known in English as the Joint Committee on the Schedule of Benefits and in French as the Comité mixte de la liste des prestations. 2007, c. 10, Sched. G, s. 2 (1).

Members

(2) The joint committee shall consist of the prescribed number of members appointed by the Minister,

(a) one-half of whom shall be appointed from among physicians nominated for the purpose by the Ontario Medical Association; and

(b) one-half of whom shall be other physicians. 2007, c. 10, Sched. G, s. 2 (1).

Functions

(3) The joint committee will,

(a) provide an opinion on its interpretation of any of the provisions of the schedule of benefits,

(i) upon the written request of the General Manager, or

(ii) upon the written request of a physician if clause 18 (14) (c) applies, but shall provide such an opinion without considering any matters specific to the physician's claim;

(b) where in the opinion of the joint committee it is appropriate to do so, make recommendations to the General Manager and the Ontario Medical Association on amendments to the schedule of benefits based on its opinions under clause (a);

(c) publish, maintain and amend the payment correction list on the internet at a website that is accessible to physicians; and

(d) perform such other duties as may be prescribed. 2007, c. 10, Sched. G, s. 2 (1); 2009, c. 33, Sched. 18, s. 11 (3).

Limitation

(4) The joint committee has the power to act only in an advisory capacity under clause (3) (a) and shall not hold hearings. 2007, c. 10, Sched. G, s. 2 (1).

Response

(5) The joint committee shall respond to a request under clause (3) (a) within 30 business days of receiving the request, or within any other time that may be prescribed. 2007, c. 10, Sched. G, s. 2 (1).

If can't reach opinion

(6) If the joint committee is unable to come to an opinion in response to a request under clause (3) (a), it shall issue a report to that effect. 2007, c. 10, Sched. G, s. 2 (1).

(7) Repealed: 2009, c. 33, Sched. 18, s. 11 (4).

Payment correction list

(8) For greater clarity, a circumstance described in subsection 18 (2) may be listed or described on the payment correction list without specific reference to subsection 18 (2). 2007, c. 10, Sched. G, s. 2 (1).

(9) Repealed: 2009, c. 33, Sched. 18, s. 11 (5).

Remuneration and expenses

(10) Members of the joint committee may be paid such remuneration and receive such reimbursement for expenses as the Lieutenant Governor in Council may determine. 2007, c. 10, Sched. G, s. 2 (1).

Review Board established

5.1 (1) There is established a board to be known in English as the Physician Payment Review Board and in French as Commission de révision des paiements effectués aux médecins. 2007, c. 10, Sched. G, s. 2 (1).

Duties

(2) The Review Board shall perform such duties as are set out in this Act and Schedule 1. 2007, c. 10, Sched. G, s. 2 (1).

May only order authorized payments

(3) For greater certainty, the Review Board may only order payments that are authorized under this Act. 2007, c. 10, Sched. G, s. 2 (1).

Application of SPPA

(4) Subject to subsection 12 (5) of Schedule 1, the *Statutory Powers Procedure Act* applies to all proceedings of the Review Board. 2007, c. 10, Sched. G, s. 2 (1).

Composition

(5) The Review Board shall be composed of no fewer than 26 and no more than 40 members who shall be appointed by the Lieutenant Governor in Council on the recommendation of the Minister, as follows:

1. No fewer than 20 and no more than 30 members who are physicians, one-half of whom are to be selected by the Minister for the Minister's recommendation, and one-half of whom are to be selected by the Ontario Medical Association for the Minister's recommendation. If there are not sufficient nominees put forward by that Association to permit the minimum number of 20 physicians to be appointed, the Minister may recommend sufficient physicians to meet or exceed the minimum requirement.
2. No fewer than six and not more than 10 members who are not physicians and who are selected from the public. 2007, c. 10, Sched. G, s. 2 (1).

Same

(6) A physician shall not be appointed or reappointed as a member of the Review Board unless,

(a) he or she is actively engaged in rendering insured services to insured persons and submitting accounts for insured services to the Plan at the time of first appointment; and

(b) he or she has not been retired from rendering insured services to insured persons and submitting accounts for insured services to the Plan for more than three years in the case of a reappointment. 2007, c. 10, Sched. G, s. 2 (1).

Same

(7) Both the Ontario Medical Association and the Minister shall make best efforts to ensure that physicians recommended for appointment to the Review Board represent a broad range of physician practices. 2007, c. 10, Sched. G, s. 2 (1).

Same

(8) A person may not be appointed as a member of the Review Board if he or she is employed,

(a) under Part III of the *Public Service of Ontario Act, 2006*; or

(b) by any agency of the Crown. 2007, c. 10, Sched. G, s. 2 (4).

Chair and vice chairs

(9) The Review Board shall elect one of its members as its chair and at least one but not more than three of its members as a vice chair. 2007, c. 10, Sched. G, s. 2 (1).

Remuneration and expenses

(10) The members of the Review Board and persons appointed under subsection (11) shall be paid the remuneration and expenses the Lieutenant Governor in Council determines except that the remuneration for physician members shall not be less than $500 a day. 2007, c. 10, Sched. G, s. 2 (1).

Appointment of persons to assist

(11) The Review Board may appoint from time to time one or more persons having technical or special knowledge of any matter before it to inquire into and report to the Review Board and to assist the Review Board in any capacity in respect of any matter before it. 2007, c. 10, Sched. G, s. 2 (1).

Not to sit on Review Board or review panel

(12) A person appointed pursuant to subsection (11) shall not sit as a member of the Review Board or of any review panel appointed to conduct a hearing. 2007, c. 10, Sched. G, s. 2 (1).

Employees

(13) Such employees as the Review Board considers necessary to carry out its duties may be appointed under the Part III of the *Public Service of Ontario Act, 2006*. 2007, c. 10, Sched. G, s. 2 (4).

Annual meeting

(14) The Review Board shall meet annually to review its policies and procedures. 2007, c. 10, Sched. G, s. 2 (1).

Annual report

(15) The Review Board shall report annually to the Minister. 2007, c. 10, Sched. G, s. 2 (1).

Tabling of report

(16) The Minister shall submit the report to the Lieutenant Governor in Council and shall cause the report to be laid before the Assembly if it is in session or, if not, at the next session. 2007, c. 10, Sched. G, s. 2 (1).

Disclosure

5.2 (1) A nominee or other potential appointee to the joint committee or the Review Board shall notify the Minister if he or she has been found guilty of fraud under the *Criminal Code* (Canada) or if he or she has been found guilty of an offence under the laws of Canada or a province or territory that is relevant to his or her suitability to sit as a member, unless the finding of guilt is for an offence for which he or she has received a pardon. 2007, c. 10, Sched. G, s. 2 (1).

Same

(2) The requirement to disclose as set out in subsection (1) continues during the term of the person's appointment or any subsequent reappointment. 2007, c. 10, Sched. G, s. 2 (1).

Disqualification

5.3 (1) A person who has been found guilty of fraud under the *Criminal Code*

(Canada) or has been found guilty of an offence under the laws of Canada or a province or territory that in the Minister's opinion is relevant to the person's suitability to sit as a member of the joint committee or the Review Board may not be appointed or reappointed as a member of the joint committee or the Review Board, unless the finding of guilt is for an offence for which the person has received a pardon. 2007, c. 10, Sched. G, s. 2 (1).

Same

(2) A physician who has been the subject of a finding of professional misconduct, incompetence or incapacity whether in Ontario or in another jurisdiction may not be appointed or reappointed as a member of the joint committee or the Review Board. 2007, c. 10, Sched. G, s. 2 (1).

Time-limited disqualification

(3) A physician who has been required to reimburse the Plan as a result of a decision of the Medical Review Committee, the Review Board or the Appeal Board may not be appointed or re-appointed as a member of the joint committee or the Review Board until 10 years have passed since he or she was last required to reimburse the Plan. 2007, c. 10, Sched. G, s. 2 (1).

Continuing qualifications

(4) A person's membership in the joint committee or the Review Board is automatically terminated,

(a) in the case of a physician, if he or she ceases to be a member of the College of Physicians and Surgeons of Ontario;

(b) in the case of any member, if he or she ceases to be qualified under subsection (1), (2) or (3); and

(c) in the case of any member, if he or she fails to provide information required under subsection (6) within the time specified by the Minister. 2007, c. 10, Sched. G, s. 2 (1).

Waiver

(5) If the Minister believes that the circumstances justify it, the Minister may appoint a person who is otherwise disqualified under subsection (1), (2) or (3), or reappoint a person whose membership has been automatically terminated under subsection (4), unless the disqualification or termination is the result of a conviction for fraud under the *Criminal Code* (Canada) for which the person has not received a pardon. 2007, c. 10, Sched. G, s. 2 (1).

Information

(6) Any person being considered for appointment or reappointment to the joint committee or the Review Board and any member of the joint committee or the Review Board shall, if requested to do so by the Minister, provide the Minister within the time specified in the request with any information relevant to determining the person's eligibility to be appointed or reappointed or to remain a member, as a condition of being appointed or reappointed or continuing to be a member, as the case may be. 2007, c. 10, Sched. G, s. 2 (1).

Physician Services Payment Committee

5.4 (1) The Minister shall establish a committee to perform the functions set out in subsection (5) and the committee shall be known in English as the Physician Services Payment Committee and in French as the Comité de paiement des services de médecin. 2007, c. 10, Sched. G, s. 3.

Members

(2) The payment committee shall consist of the prescribed number of physicians,

appointed by the Minister,

(a) one-half of whom shall be appointed from among physicians nominated for the purpose by the Ontario Medical Association; and

(b) one-half of whom shall be other physicians. 2007, c. 10, Sched. G, s. 3.

Qualifications, disclosure, etc.

(3) Sections 5.2 and 5.3 apply with necessary modifications to the payment committee. 2007, c. 10, Sched. G, s. 3.

Chair

(4) The Minister shall appoint a chair for the payment committee, who shall not be a member of the committee, and shall not have a vote in any proceedings of the payment committee. 2007, c. 10, Sched. G, s. 3.

Functions

(5) The payment committee will have the responsibility for making recommendations to the Minister with respect to amendments to the schedule of benefits and other physician payment programs, and in particular shall,

(a) make timely and appropriate recommendations to amend the schedule of fees and other payment programs to reflect current medical practice and meet the needs of the health care system;

(b) conduct specialty specific or service specific reviews;

(c) on the request of the General Manager, provide its opinion on any proposed amendments to the schedule of benefits; and

(d) Repealed: 2009, c. 33, Sched. 18, s. 11 (6).

2007, c. 10, Sched. G, s. 3; 2009, c. 33, Sched. 18, s. 11 (6).

Performing role of joint committee

(6) The Lieutenant Governor in Council may make regulations assigning to the payment committee any or all of the role and functions of the joint committee, and where such a regulation has been made, every reference in this Act to anything that may be done by the joint committee with respect to its role or function shall be deemed to be a reference to the payment committee. 2007, c. 10, Sched. G, s. 3.

Remuneration and expenses

(7) Members of the payment committee may be paid such remuneration and receive such reimbursement for expenses as the Lieutenant Governor in Council may determine. 2007, c. 10, Sched. G, s. 3.

PRACTITIONER REVIEW COMMITTEES

Practitioner review committees

6. (1) The Minister shall appoint the following practitioner review committees:

1. A chiropody review committee composed of the prescribed number of members who are not physicians or practitioners and the prescribed number of members from among the persons nominated by the College of Chiropodists of Ontario.

2. Repealed: 2009, c. 33, Sched. 18, s. 11 (7).

3. A dentistry review committee composed of the prescribed number of members who are not physicians or practitioners and the prescribed number of members from among the persons nominated by The Royal College of Dental Surgeons of

Ontario.

4. An optometry review committee composed of the prescribed number of members who are not physicians or practitioners and the prescribed number of members from among the persons nominated by the College of Optometrists of Ontario.

5. An osteopathy review committee composed of the prescribed number of members who are not physicians or practitioners and the prescribed number of members from among the persons nominated by the Board of Directors of Osteopathy appointed under the *Drugless Practitioners Act*. 1993, c. 32, s. 2 (3); 1998, c. 18, Sched. G, s. 54 (2, 3); 2009, c. 33, Sched. 18, s. 11 (7).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (1) is amended by adding the following paragraph:

6. Such other practitioner review committees as may be prescribed, composed of such members or classes of members as may be prescribed.

See: 2009, c. 26, ss. 11 (2), 27 (2).

Same

(1.1) The number of members of a practitioner review committee who are not physicians or practitioners shall be not more than two-thirds the number of members who are nominated by a professional governing body. 1993, c. 32, s. 2 (3).

Committee of board or college

(2) Every practitioner review committee is a committee of the board or college that nominates persons appointed as members of the committee. R.S.O. 1990, c. H.6, s. 6 (2).

Quorum

(3) Three members of a practitioner review committee, one of whom shall be a member who is not a physician or practitioner, constitute a quorum of the committee. However, one member who is a practitioner constitutes a quorum for the purposes of a review requested under subsection 18.1 (4) or 39.1 (3). 1996, c. 1, Sched. H, s. 5 (1).

(3.1) Repealed: 2009, c. 33, Sched. 18, s. 11 (8).

Remuneration

(4) The members of a practitioner review committee shall be paid such remuneration for their services, on an hourly basis, a daily basis or otherwise, as the Lieutenant Governor in Council determines. R.S.O. 1990, c. H.6, s. 6 (4).

Administration expenses

(5) Every practitioner review committee shall be paid such amounts for the expenses of the committee and the engaging of assistance for the committee as may be approved by the Minister. R.S.O. 1990, c. H.6, s. 6 (5).

Ineligibility

(6) A person may not be a member of a practitioner review committee if he or she is employed,

(a) under Part III of the *Public Service of Ontario Act, 2006*; or

(b) by any agency of the Crown. 2006, c. 35, Sched. C, s. 53.

Duties

(7) Every practitioner review committee shall perform such duties as are assigned to it under the Act and shall make reports and recommendations respecting any matter referred to it by the Minister, the Appeal Board or the board or college of which it is a committee. 1996,

c. 1, Sched. H, s. 5 (2).

Powers

(8) Members of a practitioner review committee have the powers of an inspector appointed under subsection 40 (3). 1996, c. 1, Sched. H, s. 5 (2).

MEDICAL ELIGIBILITY COMMITTEE

Medical Eligibility Committee

7. (1) The Minister may appoint in writing such number of physicians as he or she considers appropriate from time to time not to exceed fifteen, to form a committee to be known in English as the Medical Eligibility Committee and in French as comité d'admissibilité médicale.

Term of office

(2) The Minister shall specify the term of office for each physician in his or her written appointment.

Quorum

(3) Any three members constitute a quorum and are sufficient for the exercise of all functions of the Medical Eligibility Committee.

Divisions of Committee

(4) The Medical Eligibility Committee may sit in several divisions simultaneously, if a quorum of the Committee is present in each division.

Decision of Committee

(5) The decision of the majority of the members of the Medical Eligibility Committee present and constituting a quorum is the decision of the Committee.

Qualifications of members

(6) No member of the Medical Eligibility Committee shall be employed in the service of Ontario or any agency of the Crown.

Committee chair

(7) The Minister shall from time to time designate one of the physicians to be the chair of the Committee who shall assign the members to sit on the various divisions of the Committee and prescribe the duties to be performed by each division.

Remuneration

(8) The members of the Medical Eligibility Committee shall be paid such remuneration for their services, on an hourly basis, a daily basis or otherwise, as the Lieutenant Governor in Council determines. R.S.O. 1990, c. H.6, s. 7 (1-8).

Duties

(9) The Medical Eligibility Committee shall perform such duties as are assigned to it under the Act or by the Minister. 1996, c. 1, Sched. H, s. 6.

REPORT TO ASSEMBLY

8. Repealed: 1998, c. 18, Sched. G, s. 54 (4).

Report to Assembly

9. The Minister shall make a report annually to the Lieutenant Governor in Council upon the affairs of the Plan and the Minister shall lay the report before the Assembly if it is in session or, if not, at the next session. R.S.O. 1990, c. H.6, s. 9.

ONTARIO HEALTH INSURANCE PLAN

Ontario Health Insurance Plan continued

10. The Ontario Health Insurance Plan is continued for the purpose of providing for insurance against the costs of insured services on a non-profit basis on uniform terms and conditions available to all residents of Ontario, in accordance with this Act, and providing other health benefits related thereto. R.S.O. 1990, c. H.6, s. 10.

Right to insurance

11. (1) Every person who is a resident of Ontario is entitled to become an insured person upon application therefor to the General Manager in accordance with this Act and the regulations. R.S.O. 1990, c. H.6, s. 11 (1).

Establishing entitlement

(2) It is the responsibility of every person to establish his or her entitlement to be, or to continue to be, an insured person. 1994, c. 17, s. 70.

Military families

(2.1) Where an application under subsection (1) is made with respect to a spouse or dependant of a member of the Canadian Forces, he or she is exempt from any waiting period that would otherwise apply. 2007, c. 16, Sched. B, s. 1.

Change in information

(3) It is the responsibility of every person who has been registered as an insured person to report to the General Manager, within 30 days of its occurrence, every change in the information that was reported to the General Manager for the purposes of establishing his or her entitlement to be or continue to be an insured person. 2007, c. 10, Sched. C, s. 2.

Health card

11.1 (1) A health card remains the property of the Minister at all times.

Taking possession of card

(2) A prescribed person may take possession of a health card that is surrendered to him or her voluntarily.

Return to General Manager

(3) On taking possession of a health card under subsection (2), the person shall return it to the General Manager as soon as possible.

Protection from liability

(4) No proceeding for taking possession of a health card shall be commenced against a person who does so in accordance with subsection (2). 1993, c. 32, s. 2 (4).

Insured services

11.2 (1) The following services are insured services for the purposes of the Act:

1. Prescribed services of hospitals and health facilities rendered under such conditions and limitations as may be prescribed.
2. Prescribed medically necessary services rendered by physicians under such conditions and limitations as may be prescribed.
3. Prescribed health care services rendered by prescribed practitioners under such conditions and limitations as may be prescribed. 1996, c. 1, Sched. H, s. 8.

Exceptions

(2) Despite subsection (1), services that a person is entitled to under the insurance plan established under the *Workplace Safety and Insurance Act, 1997* or under the *Homes for Special Care Act* or under any Act of the Parliament of Canada except the *Canada Health Act* are not insured services. 1996, c. 1, Sched. H, s. 8; 1997, c. 16, s. 7.

Restrictions

(3) Such services as may be prescribed are insured services only if they are provided in or by designated hospitals or health facilities.

Same

(4) Such services as may be prescribed are insured services only if they are provided to insured persons in prescribed age groups.

Same

(5) Such services as may be prescribed are not insured services when they are provided to insured persons in prescribed age groups. 1996, c. 1, Sched. H, s. 8.

Entitlement to insured services

12. (1) Every insured person is entitled to payment to himself or herself or on his or her behalf for, or to be otherwise provided with, insured services in the amounts and subject to such conditions and co-payments, if any, as are prescribed. R.S.O. 1990, c. H.6, s. 12.

(2), (3) Repealed: 2007, c. 10, Sched. G, s. 4.

Choice of physician or practitioner

13. This Act shall not be administered or construed to affect the right of an insured person to choose his or her own physician or practitioner, and does not impose any obligation upon any physician or practitioner to treat an insured person. R.S.O. 1990, c. H.6, s. 13.

Other insurance prohibited

14. (1) Every contract of insurance, other than insurance provided under section 268 of the *Insurance Act*, for the payment of or reimbursement or indemnification for all or any part of the cost of any insured services other than,

(a) any part of the cost of hospital, ambulance and long-term care home services that is not paid by the Plan;

(b) compensation for loss of time from usual or normal activities because of disability requiring insured services;

(c) any part of the cost that is not paid by the Plan for such other services as may be prescribed when they are performed by such classes of persons or in such classes of facilities as may be prescribed,

performed in Ontario for any person eligible to become an insured person under this Act, is void and of no effect in so far as it makes provision for insuring against the costs payable by the Plan and no person shall enter into or renew such a contract. R.S.O. 1990, c. H.6, s. 14 (1); 1996, c. 1, Sched. H, s. 10; 2007, c. 8, s. 209.

Resident not to benefit from prohibited insurance

(2) A resident shall not accept or receive any benefit under any contract of insurance prohibited under subsection (1) whereby the resident or his or her dependants may be provided with or reimbursed or indemnified for all or any part of the costs of, or costs directly related to the provision of any insured service. R.S.O. 1990, c. H.6, s. 14 (2).

Exceptions

(3) Subsections (1) and (2) do not apply to a contract of insurance entered into by a resident whose principal employment is in the United States of America and who is entitled to enter into the contract by virtue of his or her employment. R.S.O. 1990, c. H.6, s. 14 (3).

Idem

(4) Where payment is made to or on behalf of an insured person under a contract or agreement referred to in subsection (3) and such payment is less than would have been made

under this Act and the regulations for the same insured services, the General Manager may pay to or on behalf of the insured person the difference between the amount paid under the contract or agreement and the amount established by the regulations for the insured services for which payment was made under the contract or agreement. R.S.O. 1990, c. H.6, s. 14 (4).

Exception

(5) Subsections (1) and (2) do not apply during the period that a person who is a resident must wait to be registered as an insured person. 2000, c. 26, Sched. H, s. 1 (5); 2006, c. 19, Sched. L, s. 3 (5).

Billing – physicians

15. (1) A physician shall submit all of his or her accounts for the performance of insured services rendered to an insured person directly to the Plan in accordance with and subject to the requirements of this Act and the regulations, unless an agreement under subsection 2 (2) provides otherwise. 2004, c. 5, s. 36.

Requirements where Plan billed

(2) Where a physician submits his or her accounts directly to the Plan under this section,

(a) payment shall be made,

(i) directly to the physician, or

(ii) as the physician directs in accordance with section 16.1; and

(b) the payment by the Plan for the insured services rendered to an insured person constitutes payment in full of the account. 2004, c. 5, s. 36.

Where s. 2 (2) applies

(3) Where an account is submitted to the Plan in accordance with subsection 2 (2) with respect to insured services rendered to an insured person, the payment by the Plan constitutes payment in full of the account. 2004, c. 5, s. 36.

Billing – practitioners

15.1 (1) A designated practitioner shall submit all of his or her accounts for the performance of insured services directly to the Plan in accordance with and subject to the requirements of this Act and the regulations, unless an agreement under subsection 2 (2) provides otherwise. 2004, c. 5, s. 36.

Same – non-designated

(2) A non-designated practitioner shall submit directly to the Plan that part of his or her account for insured services rendered to an insured person that is payable by the Plan, unless an agreement under subsection 2 (2) provides otherwise. 2004, c. 5, s. 36.

Requirements where Plan billed

(3) Where a practitioner submits his or her accounts directly to the Plan under this section,

(a) payment shall be made,

(i) directly to the practitioner, or

(ii) as the practitioner directs in accordance with section 16.1;

(b) in the case of a designated practitioner, the payment by the Plan for the insured services performed constitutes payment in full of the account; and

(c) in the case of a non-designated practitioner, the payment by the Plan for that part

of his or her account for an insured service rendered to an insured person that is payable by the Plan constitutes payment in full of that part of the account. 2004, c. 5, s. 36.

Where s. 2 (2) applies

(4) Where an account is submitted to the Plan in accordance with subsection 2 (2) with respect to insured services rendered to an insured person, the payment by the Plan constitutes payment in full of the account. 2004, c. 5, s. 36.

Interpretation

(5) In this section,

"designated practitioner", "non-designated practitioner" and "practitioner" have the same meanings as in Part II of the *Commitment to the Future of Medicare Act, 2004*. 2004, c. 5, s. 36.

Transitional

15.2 (1) The following rules apply with respect to a physician or designated practitioner to whom subsection 11 (7) of the *Commitment to the Future of Medicare Act, 2004* applies:

1. Sections 15 and 15.1 do not apply to him or her.
2. Subsections 15 (5), 16 (5), 16.1 (2), 17 (2), 25 (2) to (9), and 27.2 (3) and (4), as applicable, as they existed immediately before their repeal by the *Commitment to the Future of Medicare Act, 2004* continue to apply to the physician or designated practitioner, as the case may be, as if they had not been repealed, except in respect of any prescribed accounts or classes of accounts, and subject to any prescribed circumstances or conditions.
3. Where, under subsection 27.2 (3), the physician or designated practitioner is required to temporarily submit his or her accounts directly to the Plan, the submission of the accounts is not a deemed election for the purposes of subsection 11 (6) of the *Commitment to the Future of Medicare Act, 2004*, but subsection 10 (3) of that Act applies to him or her during the time that he or she is temporarily required to submit accounts directly to the Plan.
4. All other applicable provisions of this Act apply to the physician or designated practitioner. 2004, c. 5, s. 36.

Same

(2) Where a designated practitioner to whom section 11 of the *Commitment to the Future of Medicare Act, 2004* applies submits his or her accounts for the rendering of insured services to insured persons directly to the Plan, subsections 25 (2) to (9) of this Act, as they existed before their repeal, apply to him or her with respect to accounts submitted before he or she commenced submitting his or her accounts directly to the Plan. 2004, c. 5, s. 36; 2007, c. 10, Sched. G, s. 5 (1).

Same

(2.1) Despite paragraph 2 of subsection (1), subsections 25 (3), (4), (5), (6) and (8), as they existed immediately before their repeal by the *Commitment to the Future of Medicare Act, 2004* cease to apply to physicians on the day that this subsection comes into force. 2007, c. 10, Sched. G, s. 5 (2).

Interpretation

(3) In this section,

"physician" and "designated practitioner" mean a physician or designated practitioner within the meaning of Part II of the *Commitment to the Future of Medicare Act, 2004*. 2004, c. 5, s. 36.

Billing numbers

16. (1) An account or claim submitted in the name of a physician or practitioner in conjunction with the billing number issued to the physician or practitioner, and any payment made pursuant to the account or claim is deemed to have been,

(a) submitted personally by the physician or practitioner;

(b) paid to the physician or practitioner personally;

(c) received by the physician or practitioner personally; and

(d) made by and submitted with the consent and knowledge of the physician or practitioner. 2004, c. 5, s. 36.

Health facilities

(2) Subsection (1) applies with necessary modifications to health facilities. 2004, c. 5, s. 36.

Applies despite direction

(3) This section applies despite a direction given pursuant to section 16.1. 2004, c. 5, s. 36.

Exception

(4) This section does not apply to an account, claim or payment in the circumstances and on the conditions prescribed in the regulations. 2004, c. 5, s. 36.

Definition

(5) In this section,

"billing number" means the unique identifying number issued by the General Manager to a physician, practitioner or health facility for the purpose of identifying the accounts or claims for insured services rendered by that physician, practitioner or health facility. 2004, c. 5, s. 36.

Direction to make payments to entity

16.1 (1) A physician or a practitioner may direct that payments for services performed by the physician or practitioner and to which the physician or practitioner is lawfully entitled may be directed to such person or entity as may be prescribed and in such circumstances and on such conditions as may be prescribed, including such requirements and other matters with respect to directions as may be prescribed. 2000, c. 42, Sched., s. 19.

(2) Repealed: 2004, c. 5, s. 37.

Person or entity not entitled

(3) The entitlement to payment for services performed by a physician or a practitioner is that of the physician or practitioner and not that of the person or entity to which the physician or practitioner has directed that such a payment be made. 2000, c. 42, Sched., s. 19.

Repayment to Plan

(4) Where payment is made by the Plan to a person or entity pursuant to subsection (1), any money owing to the Plan by the physician or the practitioner may be recovered from the physician or practitioner personally. 2000, c. 42, Sched., s. 19.

Interpretation

(5) A reference in this Act or the regulations to a payment to a physician or a

practitioner where the reference relates to a payment for services performed by the physician or practitioner shall be deemed to include a payment made to a person or entity pursuant to a direction made under this section. 2000, c. 42, Sched., s. 19.

Keeping and inspection of records

(6) Section 37.1 applies with necessary modifications to a person or entity to whom payment is made pursuant to a direction by a physician or practitioner and,

(a) in the case of a direction by a practitioner, subsections 40 (3) and (4) and sections 40.1 and 40.2 apply with necessary modifications to an inspection of the records required to be kept; and

(b) in the case of a direction by a physician, subsections 37 (5) to (7) apply with necessary modifications in respect of the records required to be kept. 2007, c. 10, Sched. G, s. 6.

Accounts for insured services

17. (1) Physicians, practitioners and health facilities shall prepare accounts for their insured services in such form as the General Manager may require. The accounts must meet the prescribed requirements. 1996, c. 1, Sched. H, s. 11.

(2) Repealed: 2004, c. 5, s. 38.

Time for submitting

(3) The physician, practitioner, health facility or, in the case of a patient who is billed directly, the patient must submit an account for an insured service to the General Manager within such time after the service is performed as may be prescribed. When submitted, the account must be in the required form and meet the prescribed requirements. 1996, c. 1, Sched. H, s. 11; 2000, c. 26, Sched. H, s. 1 (6).

Fees payable for insured services

17.1 (1) A physician or practitioner who submits an account to the General Manager in accordance with this Act for insured services provided by the physician or practitioner is entitled to be paid the fee determined under this section. 2007, c. 10, Sched. G, s. 7.

Same

(2) An insured person who submits an account to the General Manager in accordance with this Act for insured services provided by a physician or practitioner to the insured person is entitled to be paid the fee determined under this section. 2007, c. 10, Sched. G, s. 7.

Amount

(3) The basic fee payable for an insured service is the amount set out in the regulations. The amount may differ for different classes of physician or practitioner. 1996, c. 1, Sched. H, s. 12.

Same

(4) The regulations may provide that the basic fee for an insured service is nil. 1996, c. 1, Sched. H, s. 12.

Adjustment of amount

(5) The basic fee payable for an insured service performed by a physician or practitioner may be increased or decreased as provided in the regulations based upon one or more of the following factors:

1. The professional specialization of the physician or practitioner.
2. The relevant professional experience of the physician or practitioner.
3. The frequency with which the physician or practitioner provides the insured

service.

4. The geographic area in which the insured service is provided.

5. The setting in which the insured service is provided.

6. The period of time when the insured service is provided.

7. Such other factors as may be prescribed. 1996, c. 1, Sched. H, s. 12.

Threshold amount

(6) If the total amount payable for one or more prescribed insured services provided by a physician or practitioner during a prescribed period equals or exceeds a prescribed amount, the fee payable for an insured service may be increased or decreased in accordance with the regulations. The fee payable may be reduced to nil. 1996, c. 1, Sched. H, s. 12.

Same

(7) A change made under subsection (6) in the fee payable for an insured service is imposed in addition to any change made under subsection (5) in the basic fee payable. 1996, c. 1, Sched. H, s. 12.

(8) Repealed: 2007, c. 10, Sched. G, s. 7.

Fees payable, health facilities

17.2 (1) Subject to section 28, a health facility that submits an account to the General Manager in accordance with the Act for insured services performed by the facility is entitled to be paid the fee determined under this section.

Same

(2) Subsections 17.1 (3) and (4) apply, with necessary modifications, with respect to the basic fee payable for an insured service.

Adjustment of amount

(3) The basic fee payable for an insured service performed by a health facility may be increased or decreased as provided in the regulations based upon such factors as may be prescribed.

Threshold amount

(4) Subsections 17.1 (6) and (7) apply, with necessary modifications, with respect to the fee payable to a health facility. 1996, c. 1, Sched. H, s. 12.

Payment of accounts

18. (1) The General Manager shall determine all issues relating to accounts for insured services in accordance with this Act and shall make the payments from the Plan that are authorized under this Act. 2007, c. 10, Sched. G, s. 8 (1).

Same

(2) The General Manager may refuse to pay for a service provided by a physician, practitioner or health facility or may pay a reduced amount in the following circumstances:

1. If the General Manager is of the opinion that all or part of the insured service was not in fact rendered.

2. If the General Manager is of the opinion that the nature of the service is misrepresented, whether deliberately or inadvertently.

3. For a service provided by a physician, if the General Manager is of the opinion, after consulting with a physician, that all or part of the service was not medically necessary.

4. For a service provided by a practitioner, if the General Manager is of the opinion, after consulting with a practitioner who is qualified to provide the same service, that all or part of the service was not therapeutically necessary.

5. For a service provided by a health facility, if the General Manager is of the opinion, after consulting with a physician or practitioner, that all or part of the service was not medically or therapeutically necessary.

6. If the General Manager is of the opinion that all or part of the service was not provided in accordance with accepted professional standards and practice.

7. In such other circumstances as may be prescribed. 1996, c. 1, Sched. H, s. 13.

Refusal to pay

(3) The General Manager shall refuse to pay for an insured service if the account for the service is not prepared in the required form, does not meet the prescribed requirements or is not submitted to him or her within the prescribed time. However, the General Manager may pay for the service if there are extenuating circumstances. 2007, c. 10, Sched. G, s. 8 (2).

Refusal to pay

(4) Despite subsection (2), the General Manager may refuse to pay a physician for a service or pay a reduced amount for the service only if a circumstance described in subsection (2) that is also set out or described in the payment correction list exists in respect of the claim or claims, or if permitted to do so by an order of the Review Board. 2007, c. 10, Sched. G, s. 8 (2).

Referral to Review Board for expedited hearing

(5) Where the General Manager is of the opinion that for a claim or claims submitted for insured services rendered by a physician, a circumstance described in subsection (2) that is not also set out or described in the payment correction list exists in respect of the claim or claims, and is of the opinion that the physician knew or ought to have known that the claim or claims were false, the General Manager may give a notice to the Review Board requesting it to hold an expedited hearing. 2007, c. 10, Sched. G, s. 8 (2).

Expedited hearing, notice

(6) The General Manager may request an expedited hearing without notice to the physician, but shall promptly afterwards give notice to the physician. 2007, c. 10, Sched. G, s. 8 (2).

Reimbursement, practitioner or health facility

(7) The General Manager may require a practitioner or health facility to reimburse the Plan for an amount paid for a service if, after the payment is made, the General Manager is of the opinion that a circumstance described in subsection (2) exists. 2007, c. 10, Sched. G, s. 8 (2).

Exception, practitioner

(8) Despite subsection (7), the General Manager shall not require a practitioner to reimburse the Plan if the sole reason for requiring the reimbursement is that a circumstance described in paragraph 4 or 6 of subsection (2) exists. 2007, c. 10, Sched. G, s. 8 (2).

Notice, practitioner and health facilities

(9) The General Manager shall give notice to a practitioner or health facility of a decision to refuse to pay for a service, to pay a reduced amount or to require that the Plan be reimbursed. 2007, c. 10, Sched. G, s. 8 (2).

Notice, physician, refusal to pay or reduced payment

(10) The General Manager shall give notice to a physician of a decision to refuse to pay for a service or to pay a reduced amount because a circumstance described in subsection (2) that is set out or described in the payment correction list exists in respect of the claim or claims. 2007, c. 10, Sched. G, s. 8 (2).

Notice, physician, re payment correction list after payment

(11) Despite subsections (14) to (18), if the General Manager is of the opinion that an amount paid to a physician for a service should not have been paid or should have been paid at a reduced amount because a circumstance described in subsection (2) that is set out or described in the payment correction list exists in respect of the claim or claims, the General Manager may give notice to the physician of the circumstance and of the amount the General Manager believes is owing. 2007, c. 10, Sched. G, s. 8 (2).

Limitation on when notice may be given

(12) No notice may be given under subsection (11) more than 19 months after the service to which the claim or claims relates was rendered. 2007, c. 10, Sched. G, s. 8 (2).

Request for hearing by physician

(13) If the physician disagrees with the decision or opinion of the General Manager as set out in a notice given under subsection (10) or (11), the physician may, within 20 business days of receiving the notice, give a notice to the Review Board requesting it to hold a hearing and at the same time give notice of the request to the General Manager and, in the case of a matter to which subsection (11) applies,

(a) if the physician gives the notice within the 20 business days, the General Manager shall not take any steps to recover any amount alleged to be owed by the physician to the Plan pending the Review Board's order; or

(b) if there is no notice given within the 20 business days, the General Manager may direct the physician to reimburse the Plan. 2007, c. 10, Sched. G, s. 8 (2).

Notice of initial opinion

(14) Where the General Manager is of the initial opinion that a circumstance described in subsection (2) exists in respect of one or more claims paid for services provided by a physician, the General Manager may give the physician a notice that,

(a) sets out a brief statement of the facts giving rise to the General Manager's initial opinion as well as the General Manager's interpretation of any of the provisions of the schedule of benefits relevant to the matter;

(b) advises that the General Manager is reviewing the physician's claims and that the physician may, not later than 20 business days after receiving the notice, provide the General Manager in writing with any information that he or she believes is relevant to determining whether a circumstance described in subsection (2) exists in respect of the claim or claims paid as submitted by the physician or an insured person for services provided by the physician; and

(c) advises that the physician may seek an opinion of the joint committee in accordance with clause 5 (3) (a) unless the joint committee has already provided an opinion on the interpretation of those provisions. 2007, c. 10, Sched. G, s. 8 (2).

Notice

(15) If, after reviewing records and other information in his or her possession and any opinions received from the joint committee, the General Manager is of the opinion that a circumstance described in subsection (2) exists in respect of one or more claims paid for services provided by the physician, the General Manager may give a notice to the physician

that,

(a) provides the physician with the General Manager's reasons for his or her opinion; and

(b) notifies the physician that, unless the physician submits future claims for those services in accordance with the General Manager's opinion, future claims may be referred to the Review Board and payments for those services may be subject to reimbursement in whole or in part after the date notice is given. 2007, c. 10, Sched. G, s. 8 (2).

Disagreement with notice

(16) The physician may, within 20 business days of receiving the notice under subsection (15), give a notice to the Review Board requesting it to hold a hearing with respect to the interpretation of any of the provisions of the schedule of benefits relevant to the matter. 2007, c. 10, Sched. G, s. 8 (2).

Where continuing inappropriate claims

(17) If the General Manager has given a notice under subsection (15) and the physician has not requested a hearing by the Review Board within the time provided in subsection (16) and if, upon reviewing the claims for services rendered by the physician and any other information in the General Manager's possession, the General Manager is of the opinion that a circumstance described in subsection (2) continues to exist, the General Manager may give a notice to the Review Board requesting it to hold a hearing, and shall promptly give the physician notice of the request. 2007, c. 10, Sched. G, s. 8 (2).

Immediate referral for false claims by physician

(18) Despite subsection (17), the General Manager may give a notice to the Review Board requesting it to hold a hearing without giving a notice to the physician under subsection (15), but shall promptly afterwards give notice to the physician of the request for a hearing, if the General Manager is of the opinion that a circumstance described in subsection (2) exists in respect of one or more claims paid for services provided by the physician, and that the physician knew or ought to have known that the claims submitted to the Plan were false. 2007, c. 10, Sched. G, s. 8 (2).

Settlement with physician

(19) Nothing in this section prevents the General Manager and physician from settling, at any time and despite any other provision of this Act, any disagreement between the General Manager and the physician with respect to accounts. 2007, c. 10, Sched. G, s. 8 (2).

Payment unless alternative

(20) If as a result of a settlement with the General Manager or an order of the Review Board money is owed to the Plan, or where the General Manager is proceeding under clause (13) (b), the money shall be paid to the Plan through any method permitted under this Act unless the settlement or Review Board order provides an alternative method of payment. 2007, c. 10, Sched. G, s. 8 (2).

18.0.1-18.0.4 Repealed: R.S.O. 1990, c. H.6, s. 18.0.5 (1). (See: 2007, c. 10, Sched. G, s. 10.)

18.0.5 Repealed: R.S.O. 1990, c. H.6, s. 18.0.5 (2). (See: 2007, c. 10, Sched. G, s. 10.)

Settlement

18.0.6 (1) Where, during the time that any of sections 18.0.1, 18.0.2, 18.0.3 and 18.0.4 and paragraph 3 of subsection 20 (1) are in force, the General Manager and a physician come to an agreement regarding a matter to which one of those sections applies,

the General Manager shall be deemed to have had the authority to enter into the agreement, and no action shall, either during the time they are in force or after, be commenced against any of the following as a result of entering into the agreement:

1. The General Manager.
2. The Minister, the Crown in right of Ontario or an employee or agent of the Crown.
3. The Medical Review Committee, any of its members, inspectors or employees or agents, if any.
4. The Appeal Board or any of its members, employees or agents. 2007, c. 10, Sched. G, s. 11 (1).

Where no settlement

(2) If, immediately before section 18.0.1 came into force, a matter was referred to the Medical Review Committee under section 39.1 as it existed at that time, and where at the time this section comes into force there has been no agreement referred to in subsection (1) concerning the matter, the matter shall be deemed to have been withdrawn. 2007, c. 10, Sched. G, s. 11 (2).

Same

(3) If, during the time that section 18.0.1 was in force, a physician had requested a review by the Transitional Physician Audit Panel under subsection 18.0.1 (3), as it read before section 9 of Schedule G to the *Health System Improvements Act, 2007* came into force, and where at the time this subsection comes into force there has been no agreement between the physician and the General Manager with respect to the matter, the decision of the General Manager referred to in subsection 18.0.1 (3) is deemed to be withdrawn and the General Manager is authorized to reimburse any amounts recovered plus interest, if applicable. 2007, c. 10, Sched. G, s. 11 (3).

Transitional

18.0.7 (1) Where, by virtue of subsection 18.0.2 (11) as it existed during the time it was in force, payments to a physician continued to be suspended, the suspension shall remain in effect until the physician has complied with subsections 37 (1) and (3) to the satisfaction of the General Manager. 2007, c. 10, Sched. G, s. 12.

Same

(2) Where, during the time that section 18.0.1 was in force, the Transitional Physician Audit Panel commenced a review, it has the authority to complete the review and issue a direction in accordance with that section. 2007, c. 10, Sched. G, s. 12.

Review by committee

18.1 (1), (2) Repealed: 2007, c. 10, Sched. G, s. 13 (1).

Review by committee, practitioner

(3) A practitioner may request that a decision of the General Manager under subsection 18 (2) or (5) be reviewed by the applicable practitioner review committee. 1996, c. 1, Sched. H, s. 13.

Same

(4) The practitioner may request that the review be performed by a single member of the practitioner review committee,

(a) if the amount of money in dispute is less than such amount as may be prescribed; or

(b) if the General Manager consents to a review by a single committee member. 1996,

c. 1, Sched. H, s. 13.

Time for request

(5) A request for a review must be made within 60 days after the practitioner receives notice of the decision of the General Manager and must be accompanied by the prescribed application fee for the type of review requested. 1996, c. 1, Sched. H, s. 13; 2007, c. 10, Sched. G, s. 13 (2).

Expedited review

(6) The following rules apply with respect to a review by a single committee member:

1. The review must begin promptly after the request is made and must be conducted expeditiously.
2. The committee member may give any direction that the applicable committee is authorized under subsection (10) to give. If the review results from a request made under clause (4) (a), the direction may provide for payment or reimbursement of an amount greater than the prescribed amount referred to in that clause.
3. In such circumstances as the committee member considers appropriate, he or she may recommend that the General Manager consider requesting a review under section 39.1 and may give the General Manager such information as the committee member considers appropriate.
4. Following the review, the committee member shall promptly give notice to the practitioner of his or her direction under paragraph 2. The committee member is not required to give written reasons for the direction. 1996, c. 1, Sched. H, s. 13; 2002, c. 18, Sched. I, s. 8 (1, 2); 2007, c. 10, Sched. G, s. 13 (3, 4).

Same, reconsideration

(7) A person aggrieved by the direction given by the single committee member may request the applicable practitioner review committee to reconsider the matter. 2007, c. 10, Sched. G, s. 13 (5).

Request for reconsideration

(8) A request for reconsideration must be made within 30 days after the practitioner receives notice of the single committee member's direction, and must be accompanied by the prescribed application fee. 2002, c. 18, Sched. I, s. 8 (4); 2007, c. 10, Sched. G, s. 13 (6).

Procedural directions

(9) During a review or reconsideration, the applicable committee or a single committee member, as the case may be, may require the practitioner to take such steps by such time as the committee or member may determine. 1996, c. 1, Sched. H, s. 13; 2007, c. 10, Sched. G, s. 13 (7).

Direction by committee

(10) Following the review or following its reconsideration of a review by a single committee member, the practitioner review committee may give a direction,

(a) that the decision of the General Manager be confirmed;

(b) that the General Manager make a payment in accordance with the submitted account;

(c) that the General Manager pay a reduced amount, as calculated by the General Manager in accordance with the direction; or

(d) that the practitioner reimburse the Plan in the amount calculated by the General Manager in accordance with the direction. 2002, c. 18, Sched. I, s. 8 (5); 2007,

c. 10, Sched. G, s. 13 (8, 9).

Recommendation of further review

(11) Following the review or following its reconsideration of a review by a single committee member, the practitioner review committee may recommend in such circumstances as it considers appropriate that the General Manager consider requesting a review under section 39.1 and may give the General Manager such information as it considers appropriate. 1996, c. 1, Sched. H, s. 13; 2007, c. 10, Sched. G, s. 13 (10).

Notice

(12) The applicable committee shall serve the persons affected by a direction given under subsection (10) with a notice stating that the practitioner may appeal it to the Appeal Board. 1996, c. 1, Sched. H, s. 13; 2007, c. 10, Sched. G, s. 13 (11).

Reasons for direction

(13) Upon request, the applicable committee shall give the persons affected by its direction written reasons for it. 1996, c. 1, Sched. H, s. 13.

Interest

(14) If, as a result of a direction, an amount is payable by or to a practitioner, interest is also payable on the amount. Interest is calculated in the prescribed manner and is payable from the date determined in the prescribed manner. 1996, c. 1, Sched. H, s. 13; 2007, c. 10, Sched. G, s. 13 (12).

Additional payment

(15) The practitioner shall pay an additional amount for the cost of the review and for the cost of any reconsideration of a review,

(a) if a decision of the General Manager refusing to pay an account for services provided by the practitioner is confirmed;

(b) if, as a result of a direction, the practitioner is required to reimburse the Plan; or

(c) if the General Manager is required to pay him or her less than the amount of the account submitted for the insured services. 1996, c. 1, Sched. H, s. 13; 2007, c. 10, Sched. G, s. 13 (13).

Same

(16) The additional amount under subsection (15) shall be determined in the prescribed manner. 1996, c. 1, Sched. H, s. 13.

Refund of fee

(17) The General Manager shall refund any portion of the application fee paid by the practitioner that remains after the additional amount, if any, under subsection (15) is paid. 1996, c. 1, Sched. H, s. 13; 2007, c. 10, Sched. G, s. 13 (14).

Publication of details

(18) The General Manager may make public the following information relating to the matter under review:

1. The name and specialty, if any, of the practitioner.

2. The municipality or geographic area in which the practitioner practised his or her profession when the services giving rise to the direction of the applicable committee were provided.

3. The municipality or geographic area in which the practitioner practises his or her profession when the information is made public.

4. A description of the situation under review. The description must not identify, or enable a person to identify, a patient.

5. The amount, if any, that the practitioner is required to pay to the Plan.

6. Such other information as may be prescribed. 1996, c. 1, Sched. H, s. 13; 2002, c. 18, Sched. I, s. 8 (6); 2007, c. 10, Sched. G, s. 13 (15).

No appeal

(19) The decision of the General Manager to make information public under subsection (18) is final and shall not be appealed to the Appeal Board or the Divisional Court. 1996, c. 1, Sched. H, s. 13.

Restriction

(20) The General Manager shall not make the information public until any appeal of a related direction given under subsection (10) is finally determined. 1996, c. 1, Sched. H, s. 13.

Same

(21) The General Manager shall not make the information public if the matter is reviewed by a single committee member and no reconsideration of the review is requested under subsection (7). 1996, c. 1, Sched. H, s. 13.

Review of referrals

18.2 (1) If the General Manager is of the opinion that a service performed by a physician, practitioner, health facility or independent health facility is not medically necessary, and that service was requested by another physician, the General Manager may give a notice to the Review Board requesting it to hold a hearing to review the provision of the service that was requested. 2007, c. 10, Sched. G, s. 14.

Where finding that not necessary

(2) If the Review Board finds that the requested service was not medically necessary, the physician who requested the provision of the service shall pay to the Plan the amount paid by the Plan to the physician, practitioner, health facility or independent health facility who performed the service, and the General Manager may require the amount owing be paid through any method permitted under this Act. 2007, c. 10, Sched. G, s. 14.

Note: On a day to be named by proclamation of the Lieutenant Governor, the Act is amended by adding the following section:

Practitioners and health facilities

18.2.1 If the General Manager is of the opinion that a service performed by a physician, practitioner, health facility, hospital or independent health facility is not medically necessary, or is rendered in other prescribed circumstances, and that service was requested by a practitioner or health facility,

(a) the practitioner or health facility who requested the provision of the service is liable to pay to the Plan the amount paid by the Plan to the physician, practitioner, health facility, hospital or independent health facility that performed the service; and

(b) the General Manager may make a direction requiring the amount owing to be paid to the Plan, and recover the amount through any method permitted under this Act. 2009, c. 26, s. 11 (3).

See: 2009, c. 26, ss. 11 (3), 27 (2).

Physician payment review process

18.3 (1) Where under this Act a physician or the General Manager gives notice to the Review Board requesting it to hold a hearing, the matter shall be dealt with by the Review Board in accordance with this Act and Schedule 1. 2007, c. 10, Sched. G, s. 14.

Same

(2) A review panel of the Review Board may determine all issues relating to payments for insured services and may make orders for payments from the Plan that are authorized under this Act. 2007, c. 10, Sched. G, s. 14.

When services not medically necessary

19. (1) Where there is a dispute regarding a decision by the General Manager that an insured person is not entitled to an insured service in a hospital or health facility because such service is not medically necessary, the General Manager, upon receiving notice of such dispute, shall refer the matter to the Medical Eligibility Committee.

Medical Eligibility Committee to consider

(2) The Medical Eligibility Committee shall consider the facts relevant to the disputed decision, including any medical records and reports about the insured person and, when considered necessary by the Committee, interviewing the insured person and discussing the matter with the person and his or her physician.

Recommendations

(3) After giving consideration to the matter, the Medical Eligibility Committee shall recommend to the General Manager either that he or she pay or refuse to pay, according to the findings of the Committee, the sum or sums claimed by the insured person to be payable to the person or on his or her behalf, as the case may be, and that the General Manager approve or refuse to approve, in accordance with the recommendations of the Committee, the provision of the insured service or services that are in dispute and, subject to sections 20 to 24, the General Manager shall carry out the recommendations of the Committee. R.S.O. 1990, c. H.6, s. 19.

19.1 Repealed: 2004, c. 5, s. 39.

Refusal of claims, entitlement

19.2 (1) The General Manager may refuse a claim for payment for insured services if, in the opinion of the General Manager, the person who received the services was not an insured person at the time the services were rendered.

Direction by Appeal Board to pay

(2) The Appeal Board may direct the General Manager to pay any claims he or she refused to pay under subsection (1) if, after a hearing, the Appeal Board determines that the person to whom the insured services were rendered was an insured person at the time the services were rendered. 1994, c. 17, s. 71.

Appeal to Appeal Board

20. (1) The following persons may appeal the following matters to the Appeal Board:

1. A person who has applied to become or continue to be an insured person may appeal a decision of the General Manager refusing the application.
2. An insured person who has made a claim for payment for insured services may appeal a decision of the General Manager refusing the claim or reducing the amount so claimed to an amount less than the amount payable by the Plan.
3. Repealed: 2007, c. 10, Sched. G, s. 15.

4. The affected practitioner may appeal a direction of a practitioner review committee under subsection 18.1 (10) but not a direction of a single committee member under paragraph 2 of subsection 18.1 (6). 1996, c. 1, Sched. H, s. 15; 2002, c. 18, Sched. I, s. 8 (10, 11); 2007, c. 10, Sched. G, s. 15.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (1) is amended by adding the following paragraph:

5. A practitioner or health facility required by the General Manager to make a payment under section 18.2.1 may appeal the direction.

See: 2009, c. 26, ss. 11 (4), 27 (2).

Notice of appeal

(2) The appellant shall file a notice of appeal within 15 days after receiving notice of the decision of the General Manager or the direction of the applicable committee. 1996, c. 1, Sched. H, s. 15.

Powers of Appeal Board

21. (1) If a person requires a hearing, the Appeal Board shall appoint a time for and hold the hearing and may, by order, direct the General Manager to take such action as the Appeal Board considers the General Manager should take in accordance with this Act and the regulations. 2002, c. 18, Sched. I, s. 8 (12).

Same

(1.0.1) For the purposes of making an order under subsection (1), the Appeal Board may amend a direction of the General Manager or a practitioner review committee and shall do so in accordance with this Act and the regulations. 2002, c. 18, Sched. I, s. 8 (12); 2007, c. 10, Sched. G, s. 16 (1).

Security for payment

(1.1) The Appeal Board may make an order at any time directing a practitioner to provide security for payment of all or part of an amount determined by the General Manager or a practitioner review committee to be owing to the Plan and may impose such conditions as the Appeal Board considers appropriate. 1996, c. 1, Sched. H, s. 16; 2007, c. 10, Sched. G, s. 16 (2).

Same

(1.2) The Appeal Board shall make an order for security for payment in such circumstances as may be prescribed. The security must meet such requirements as may be prescribed. 1996, c. 1, Sched. H, s. 16.

Extension of time for hearing

(2) The Appeal Board may extend the time for the giving of notice by a person requiring a hearing under this section, either before or after expiration of such time, where it is satisfied that there are apparent grounds for granting relief to the claimant pursuant to a hearing and that there are reasonable grounds for applying for the extension, and the Appeal Board may give such directions as it considers proper consequent upon the extension. R.S.O. 1990, c. H.6, s. 21 (2).

Parties

22. (1) The General Manager is a party to all proceedings before the Appeal Board. 1996, c. 1, Sched. H, s. 17.

(2) Repealed: 2007, c. 10, Sched. G, s. 17.

Same

(3) The practitioner review committee and the practitioner are parties to an appeal from a direction of the committee. 1996, c. 1, Sched. H, s. 17.

Same

(4) The Appeal Board may add such other parties to a proceeding as it considers appropriate. 1996, c. 1, Sched. H, s. 17.

Evidence

Examination of documentary evidence

23. (1) A person who is a party to proceedings before the Appeal Board shall be afforded an opportunity to examine before the hearing any written or documentary evidence that will be produced or any report the contents of which will be given in evidence at the hearing. R.S.O. 1990, c. H.6, s. 23 (1).

Board members not to have investigated prior to hearing

(2) Members of the Appeal Board holding a hearing shall not have taken part, before the hearing, in any investigation or consideration of the subject-matter of the hearing and shall not communicate directly or indirectly in relation to the subject-matter of the hearing with any person or with any party or representative of the party except upon notice to and with opportunity for all parties to participate, but the Appeal Board may seek legal advice from an adviser independent from the parties and in such case the nature of the advice should be made known to the parties in order that they may make submissions as to the law. R.S.O. 1990, c. H.6, s. 23 (2).

Recording evidence

(3) The oral evidence taken before the Appeal Board at a hearing shall be recorded and, if so required, copies of a transcript thereof shall be furnished upon the same terms as in the Superior Court of Justice. R.S.O. 1990, c. H.6, s. 23 (3); 2006, c. 19, Sched. C, s. 1 (1).

Findings of fact

(4) The findings of fact of the Appeal Board pursuant to a hearing shall be based exclusively on evidence admissible or matters that may be noticed under section 15 or 16 of the *Statutory Powers Procedure Act*. R.S.O. 1990, c. H.6, s. 23 (4).

(5) Repealed: 1998, c. 18, Sched. G, s. 54 (5).

Release of documents, etc.

(6) Documents and things put in evidence at the hearing shall, upon the request of the person who produced them, be released to the person by the Appeal Board within a reasonable time after the matter in issue has been finally determined. R.S.O. 1990, c. H.6, s. 23 (6).

Appeal to Divisional Court

24. (1) Any party to the proceedings before the Appeal Board under this Act may appeal from its decision or order to the Divisional Court in accordance with the rules of court. R.S.O. 1990, c. H.6, s. 24 (1); 1998, c. 18, Sched. G, s. 54 (6).

Record to be filed in court

(2) Where any party appeals from a decision or order of the Appeal Board, the Appeal Board shall forthwith file in the Divisional Court the record of the proceedings before it in which the decision was made, which, together with the transcript of evidence if it is not part of the Appeal Board's record, shall constitute the record in the appeal.

Minister to be heard

(3) The Minister is entitled to be heard by counsel or otherwise upon the argument of an appeal under this section.

Powers of court on appeal

(4) An appeal under this section may be made on questions of law or fact or both and the court may affirm or may rescind the decision of the Appeal Board and may exercise all powers of the Appeal Board to direct the General Manager to take any action which the Appeal Board may direct the General Manager to take and as the court considers proper and for such purposes the court may substitute its opinion for that of the General Manager or of the Appeal Board, or the court may refer the matter back to the Appeal Board for rehearing, in whole or in part, in accordance with such directions as the court considers proper. R.S.O. 1990, c. H.6, s. 24 (2-4).

Security for payment

(5) Subsections 21 (1.1) and (1.2) apply, with necessary modifications, with respect to the court. 1996, c. 1, Sched. H, s. 18.

Furnishing reasons to professional governing body

25. (1) Where a decision of the General Manager to refuse or reduce a payment or to require and recover reimbursement of any overpayment of any amount paid by the Plan on any of the grounds referred to in paragraphs 1 to 7 of subsection 18 (2) has become final, the General Manager shall furnish the Minister and the governing body of the profession of which the practitioner rendering the services is a member with a copy of the decision and the reasons therefor, and in all other cases the General Manager may furnish such governing body with a copy of the decision and the reasons therefor. R.S.O. 1990, c. H.6, s. 25 (1); 2002, c. 18, Sched. I, s. 8 (13); 2007, c. 10, Sched. G, s. 18.

(2) Repealed: 2004, c. 5, s. 40 (1).

(3) Repealed: 2004, c. 5, s. 40 (2).

(4)-(7) Repealed: 2004, c. 5, s. 40 (3).

(8), (9) Repealed: 2004, c. 5, s. 40 (4).

Service of notice

26. (1) Except where otherwise provided, any notice required by or provided for in this Act may be served,

(a) by personal service;

(b) by courier;

(c) by registered mail; or

(d) by any other prescribed method. 2007, c. 10, Sched. G, s. 19.

When effective

(2) Service of a notice is effective,

(a) in the case of a notice under clauses (1) (a) to (c), on the day of delivery; and

(b) in the case of a notice under clause (1) (d), as provided for in the regulations. 2007, c. 10, Sched. G, s. 19.

Service by lettermail

(3) Where an attempt has been made to effect service by a method set out in subsection (1), and for any reason service could not be effected, service may be made by lettermail. 2007, c. 10, Sched. G, s. 19.

Same

(4) Service by lettermail shall be deemed to be effective 14 business days after the day of mailing, unless the person or entity on whom service is to be made establishes that the

notice was not received until a later date for reasons that he, she or it could not control, in which case service is effective on the day that the notice is actually received. 2007, c. 10, Sched. G, s. 19.

26.1 Repealed: 1996, c. 1, Sched. H, s. 19.

Proposed revision of O.M.A. schedule of fees

27. At least six months before any proposed revision of the schedule of fees of the Ontario Medical Association, the Ontario Medical Association shall notify the Minister of the proposed revision and the Minister shall arrange and implement discussions with representatives of the said Association respecting the details and extent of any proposed changes in the schedule of fees. R.S.O. 1990, c. H.6, s. 27.

Contributions to the Plan

27.1 (1) Every physician, practitioner and health facility who provides insured services shall make such contribution to the Plan as may be prescribed relating to the amount of fees payable to him, her or it under the Plan during such prior period as may be prescribed.

Amount

(2) The amount of the basic contribution from each physician, practitioner or health facility shall be determined in accordance with the regulations.

Adjustment

(3) The basic contribution from a physician, practitioner or health facility may be increased or decreased as provided in the regulations based upon such factors as may be prescribed.

Exemption

(4) Such classes of physicians, practitioners or health facilities as may be prescribed are exempt from making a contribution to the Plan. 1996, c. 1, Sched. H, s. 20.

Payments, etc., to the Plan

27.2 (1) The General Manager may obtain or recover money that a physician, practitioner or health facility owes to the Plan by set off against any money payable to him, her or it under the Plan. 1996, c. 1, Sched. H, s. 21.

Same

(2) The General Manager may obtain or recover money from a practitioner by set-off despite a review by the Medical Eligibility Committee or a practitioner review committee or an appeal to the Appeal Board from the practitioner review committee or a subsequent appeal to the Divisional Court from a decision of the Appeal Board concerning whether the money is owed to the Plan. 2007, c. 10, Sched. G, s. 20.

(3), (4) Repealed: 2004, c. 5, s. 41.

Payment by contribution to annual expenditures

28. Any amounts payable to or on behalf of an insured person under the Plan in respect of insured services provided by or in a hospital or health facility may be paid in the form of the payment by the Province of all or any part of the annual expenditures of such hospital or health facility, where such payment by the Province is authorized under any Act. R.S.O. 1990, c. H.6, s. 28.

Disclosure authorized

29. (1) Every insured person shall be deemed to have authorized his or her physician or practitioner, a hospital or health facility which provided a service to the insured person and any other prescribed person or organization to give the General Manager particulars of services provided to the insured person,

(a) for the purpose of obtaining payment under the Plan for the services;

(b) for the purpose of enabling the General Manager to monitor and control the delivery of insured services;

(c) for the purpose of enabling the General Manager to monitor and control payments made under the Plan or otherwise for insured services; and

(d) for such other purposes as may be prescribed. 1996, c. 1, Sched. H, s. 22.

Immunity

(2) No action lies against a person or organization for giving information to the General Manager under the Act. 1996, c. 1, Sched. H, s. 22.

Exception

(3) This section does not apply where the *Personal Health Information Protection Act, 2004* applies. 2004, c. 3, Sched. A, s. 85 (2).

29.1-29.8 Repealed: 2007, c. 10, Sched. G, s. 21.

SUBROGATION

Subrogation

30. (1) Where, as the result of the negligence or other wrongful act or omission of another, an insured person suffers personal injuries for which he or she receives insured services under this Act, the Plan is subrogated to any right of the insured person to recover the cost incurred for past insured services and the cost that will probably be incurred for future insured services, and the General Manager may bring action in the name of the Plan or in the name of that person for the recovery of such costs.

Payment by Plan recoverable by insured

(2) For the purposes of subsection (1), the payment by the Plan for insured services shall not be construed to affect the right of the insured person to recover the amounts so paid in the same manner as if such amounts are paid or to be paid by the insured person.

Cost of hospital services

(3) For the purposes of this section, the cost of insured services rendered to an insured person in or by a hospital or health facility shall be at the rate charged by the hospital or health facility to a person who is not an insured person. R.S.O. 1990, c. H.6, s. 30 (1-3).

Exception

(4) Despite subsection (1), the Plan is not subrogated to the rights of an insured person in respect of personal injuries arising directly or indirectly from the use or operation, after the 21st day of June, 1990 and before the day section 267.1 of the *Insurance Act* comes into force, of an automobile in Canada, the United States of America or any other jurisdiction designated in the *Statutory Accident Benefits Schedule* under the *Insurance Act*. 1993, c. 10, s. 53.

Exception

(5) Despite subsection (1), the Plan is not subrogated to the rights of the insured person, as against a person who is insured under a motor vehicle liability policy issued in Ontario, in respect of personal injuries arising directly or indirectly from the use or operation, after section 29 of the *Automobile Insurance Rate Stability Act, 1996* comes into force, of an automobile in Ontario or in any other jurisdiction designated in the *Statutory Accident Benefits Schedule* under the *Insurance Act*.

Definition

(6) In subsection (5),

"motor vehicle liability policy" has the same meaning as in the *Insurance Act*. 1996, c. 21, s. 51.

Subrogated claim included in action

31. (1) Any person who commences an action to recover for loss or damages arising out of the negligence or other wrongful act of a third party, to which the injury or disability in respect of which insured services have been provided is related shall, unless otherwise advised in writing by the General Manager, include a claim on behalf of the Plan for the cost of the insured services. R.S.O. 1990, c. H.6, s. 31 (1).

Recovery paid to Ontario

(2) Where a person recovers a sum in respect of the cost of insured services, the person shall forthwith pay the sum recovered to the Minister of Finance. R.S.O. 1990, c. H.6, s. 31 (2); 2006, c. 19, Sched. L, s. 11 (5).

Motor Vehicle Accident Claims Fund

32. The Plan is not an insurer within the meaning of the *Insurance Act*, as referred to in section 22 of the *Motor Vehicle Accident Claims Act*, and may be awarded payment from the Motor Vehicle Accident Claims Fund. R.S.O. 1990, c. H.6, s. 32.

Judge to divide award

33. The judge at trial shall, if the evidence permits, apportion the elements of the injured person's loss and damages so as to clearly designate the amount of the Plan's recovery for the past cost of insured services and separate it from the amount of the Plan's recovery of future cost of insured services, if any. R.S.O. 1990, c. H.6, s. 33.

Release not to bind Plan

34. No release or settlement of a claim for damages for personal injuries in a case where the injured person has received insured services under this Act shall be binding on the Plan unless the General Manager has approved the release or settlement. R.S.O. 1990, c. H.6, s. 34.

Insurer to pay Ontario

35. A liability insurer shall notify the General Manager of negotiations for settlement of any claim for damages including insured services and may pay to the Minister of Finance any amount referable to a claim for recovery of the cost of insured services and such payment discharges the obligation of the liability insurer to pay that amount to the insured person. R.S.O. 1990, c. H.6, s. 35; 2006, c. 19, Sched. L, s. 11 (5).

Future insured services

36. Where a judgment or settlement includes future cost of insured services, the Plan shall provide the future insured services included in the judgment or settlement. R.S.O. 1990, c. H.6, s. 36.

DIRECT RECOVERY

Direct cause of action

36.0.1(1)If the Plan has paid for insured services as a result of the negligence or other wrongful act or omission of a person, the Plan has a right, independent of its subrogated right under subsections 30 (1) and 46 (5), to recover, directly against that person, the costs for insured services that have been incurred in the past and that will probably be incurred in the future as a result of the negligence or the wrongful act or omission.

Action

(2)The General Manager may bring an action in the name of the Plan or the Minister may bring an action in his or her own name for recovery of the costs referred to in subsection

(1).

Exception

(3)The Plan shall not recover costs under this section,

(a) against a physician if the negligence or wrongful act or omission of the physician occurred while the physician was acting within the scope of his or her practice and in such circumstances as may be prescribed;

(b) against a hospital under the *Public Hospitals Act* or a laboratory under the *Laboratory and Specimen Collection Centre Licensing Act* if the negligence or wrongful act or omission upon which the action is based occurred in the course of providing services that the hospital is approved to provide, or that the laboratory is licensed to provide, as the case may be, and in such circumstances as may be prescribed; or

(c) against such other persons or entities as may be prescribed in such circumstances as may be prescribed.

Preservation of rights of insured persons

(4)An action under this section shall not prevent an insured person from recovering the cost or damages to which the person would otherwise be entitled.

Cost of hospital services

(5)For the purposes of this section, the cost of insured services rendered in or by a hospital or health facility shall be at the rate charged by the hospital or health facility to persons who are not insured.

Disclosure of information

(6)To the extent that any information relating to insured services is produced in a proceeding under this section, the information shall be produced in a manner that protects the identity of the insured person and of the provider of insured services. 1999, c. 10, s. 1.

THIRD PARTY SERVICES

Third party service

36.1 (1) For the purposes of this section and sections 36.2 to 36.4, a third party service is a service that,

(a) is provided by a service provider in connection or partly in connection with,

(i) a request or requirement, made by a person or entity, that information or documentation relating to an insured person be provided, or

(ii) a request or requirement, made by a person or entity, that an insured person obtain a service from a service provider;

(b) is not an insured service or is deemed, by a regulation made under clause 45 (1) (i), not to be an insured service; and

(c) is prescribed as a third party service or is prescribed as a third party service in circumstances specified in the regulation.

Third party

(2) For the purposes of this section and sections 36.2 to 36.4, a third party is a person or entity who makes a request or requirement referred to in clause (1) (a).

Service provider

(3) For the purposes of this section and sections 36.2 to 36.4, a service provider is a physician, practitioner, hospital or health facility, or an independent health facility as defined

in the *Independent Health Facilities Act*.

Regulations re third parties

(4) Despite subsection (2), a regulation may be made, in relation to a specified third party service or in relation to a third party service provided in specified circumstances,

(a) prescribing another person or entity as a third party instead of or in addition to the person or entity who makes the request or requirement referred to in clause (1) (a);

(b) if more than one person or entity make the request or requirement referred to in clause (1) (a), prescribing one or more of them as third parties and providing that the others are not third parties; or

(c) providing that there is no third party.

Deemed requirement or request

(5) For the purpose of subsection (1), a person or entity shall be deemed to have required or requested that information or a document relating to the insured person be provided, or that the insured person obtain a service from a service provider, if providing the information or document or obtaining the service is related to the person or entity doing or not doing anything in relation to the insured person or related to the insured person receiving or not receiving anything from the third party. 1993, c. 32, s. 2 (7).

Third party liable

36.2 (1) If a service provider who provides a third party service to an insured person renders an account for payment to the third party, the third party is liable for payment of the account, subject to subsection 36.3 (3).

Same

(2) If an insured person pays all or part of an account rendered to him or her by a service provider for a third party service provided to the insured person, the third party is liable to reimburse the insured person for the amount paid, subject to subsection 36.3 (4).

Insured person's liability to pay

(3) Nothing in this section affects any liability of an insured person to pay a service provider's account for a third party service.

Right to render account at time of service

(4) Nothing in sections 36.1 to 36.4 affects any right of a service provider to render an account for a third party service at the time the service is rendered.

No double recovery

(5) The total amount that the service provider recovers in respect of a third party service shall not exceed the amount of the account rendered. 1993, c. 32, s. 2 (7).

Amounts owing by third parties

Application of section

36.3 (1) This section applies to,

(a) an amount owing by a third party to a service provider under subsection 36.2 (1);

(b) an amount owing by a third party to an insured person under subsection 36.2 (2); and

(c) an amount owing by an insured person to a service provider for a third party service provided to the insured person by the service provider.

Proceeding to recover payment

(2) An amount referred to in subsection (1) may be recovered in a court proceeding or,

if a body is designated or established under clause 45 (1.1) (f), in a proceeding before the body.

Court, body may reduce amount payable

(3) In a proceeding to recover an amount referred to in clause (1) (a) or (c), the court or body, in addition to any other order it may make, may order the third party or the insured person, as the case may be, to pay the service provider an amount that is less than the amount charged by the service provider for the third party service if the court or body finds that the amount charged by the service provider for the third party service is excessive.

Same

(4) In a proceeding to recover an amount referred to in clause (1) (b), the court or body, in addition to any other order it may make, may order the third party to pay the insured person an amount that is less than the amount paid by the insured person to the service provider for the third party service if the court or body finds that the amount charged by the service provider for the third party service is excessive.

Determining whether excessive

(5) In determining whether an amount charged by a service provider other than a physician for a third party service is excessive, the court or body shall consider any applicable guidelines respecting third party services and any applicable schedule of fees, and may consider any other relevant factors.

Same

(6) In determining whether an amount charged by a physician for a third party service is excessive, the court or body shall consider the Ontario Medical Association's guidelines respecting third party services and its schedule of fees, and may consider any other relevant factors.

Same

(7) The Lieutenant Governor in Council may, in a regulation, provide that the court or body shall consider other matters in addition to or instead of the guidelines and schedules of fees referred to in subsections (5) and (6).

Adding service provider as party

(8) No order shall be made under subsection (4) unless the service provider has been added as a party to the proceeding.

Same

(9) The service provider may be added as a party to the proceeding referred to in subsection (4) on such terms as the court or body considers just. 1993, c. 32, s. 2 (7).

Service provider to reimburse insured person

36.4 If, under subsection 36.3 (4), the court or body orders the third party to pay the insured person an amount that is less than the amount paid by the insured person to the service provider for the third party service, the service provider is liable to repay the difference to the insured person. 1993, c. 32, s. 2 (7).

GENERAL

General information requirement

37. (1) Every physician and practitioner shall give the General Manager such information, including personal information, as may be prescribed,

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (1) is amended by striking out "physician and practitioner" in the portion before clause (a) and substituting "physician, practitioner, health facility, hospital and independent

health facility". See: 2009, c. 26, ss. 11 (5), 27 (2).

(a) for purposes related to the administration of this Act, the *Commitment to the Future of Medicare Act, 2004* or the *Independent Health Facilities Act*; or

(b) for such other purposes as may be prescribed. 2007, c. 10, Sched. G, s. 22 (1).

Same

(2) Such persons or organizations as may be prescribed shall give the General Manager such information, including personal information, as may be prescribed and such information as he or she may require for the purpose of administering the Act. 1996, c. 1, Sched. H, s. 30.

Time

(3) The information shall be provided in such form and within such time as the General Manager may require. 1996, c. 1, Sched. H, s. 30.

Application

(4) This section applies despite anything in the *Regulated Health Professions Act, 1991*, an Act listed in Schedule 1 to the *Regulated Health Professions Act, 1991*, the *Drugless Practitioners Act* or any regulations made under those Acts. 1996, c. 1, Sched. H, s. 30.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (4) is amended by the Statutes of Ontario, 2007, chapter 10, Schedule P, section 16 by striking out "the *Drugless Practitioners Act*". See: 2007, c. 10, Sched. P, ss. 16, 21 (2).

Rules re providing records and information

(5) Where the General Manager requires a physician to provide records or any other information under subsection (1), the following rules apply:

1. The physician shall submit copies of the requested records or other information and, where required by the General Manager, shall include a signed certificate of authenticity and a signed copy of an audit trail for electronic records.

2. If the General Manager is not satisfied with the copies of the requested records or other information, the General Manager may require the physician to produce the original documents to the General Manager, and the documents shall be returned to the physician in a timely manner after copies have been made.

3. Where a physician fails to produce the copies or originals of records or other information required under this section, the General Manager may, on notice to the physician, apply to a provincial judge or justice of the peace for an order compelling production of the required records or other information and the provincial judge or justice of the peace may issue the order where he or she is satisfied that there are reasonable grounds for believing that the physician failed to produce the records or other information. 2007, c. 10, Sched. G, s. 22 (2).

Electronic records

(6) Where records required to be kept by physicians for the purposes of this Act are in electronic form, they shall have the characteristics of electronic records set out in the regulations under the *Medicine Act, 1991*. 2007, c. 10, Sched. G, s. 22 (2).

Certificate of authenticity

(7) A certificate of authenticity required under this section shall be in the form supplied by the General Manager unless otherwise prescribed. 2007, c. 10, Sched. G, s. 22 (2).

Record-keeping

37.1 (1) For the purposes of this Act, every physician, practitioner and health facility shall maintain such records as may be necessary to establish whether he, she or it has provided an insured service to a person. 1996, c. 1, Sched. H, s. 31.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (1) is amended by the Statutes of Ontario, 2007, chapter 10, Schedule G, subsection 23 (1) by striking out "physician". See: 2007, c. 10, Sched. G, ss. 23 (1), 36 (2).

Same

(2) For the purposes of this Act, every physician, practitioner and health facility shall maintain such records as may be necessary to demonstrate that a service for which he, she or it prepares or submits an account is the service that he, she or it provided. 1996, c. 1, Sched. H, s. 31.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (2) is amended by the Statutes of Ontario, 2007, chapter 10, Schedule G, subsection 23 (2) by striking out "physician". See: 2007, c. 10, Sched. G, ss. 23 (2), 36 (2).

Same

(3) For the purposes of this Act, every physician and health facility shall maintain such records as may be necessary to establish whether a service he, she or it has provided is medically necessary. 1996, c. 1, Sched. H, s. 31.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (3) is repealed by the Statutes of Ontario, 2007, chapter 10, Schedule G, subsection 23 (3) and the following substituted:

Same

(3) For the purposes of this Act, every health facility shall maintain such records as may be necessary to establish whether a service it has provided is medically necessary. 2007, c. 10, Sched. G, s. 23 (3).

See: 2007, c. 10, Sched. G, ss. 23 (3), 36 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, section 37.1 is amended by adding the following subsection:

Practitioners and health facilities

(3.1) For the purposes of this Act, every practitioner and health facility shall maintain such records as may be necessary to establish whether a service the practitioner or health facility requests is medically necessary or is rendered in the prescribed circumstances mentioned in section 18.2.1. 2009, c. 26, s. 11 (6).

See: 2009, c. 26, ss. 11 (6), 27 (2).

Same

(4) For the purposes of this Act, every practitioner and health facility shall maintain such records as may be necessary to establish whether a service he, she or it has provided is therapeutically necessary. 1996, c. 1, Sched. H, s. 31.

Note: On a day to be named by proclamation of the Lieutenant Governor, section 37.1 is amended by the Statutes of Ontario, 2007, chapter 10, Schedule G, subsection 23 (4) by adding the following subsection:

Same

(4.1) For the purposes of this Act, every physician shall maintain records that,

(a) comply with any requirements respecting records set out in the regulations made under the *Medicine Act, 1991*; and

(b) comply with any additional requirements that may be provided for in the schedule of benefits. 2007, c. 10, Sched. G, s. 23 (4).

See: 2007, c. 10, Sched. G, ss. 23 (4), 36 (2).

Same

(5) The records described in subsections (1), (2), (3) and (4) must be prepared promptly when the service is provided. 1996, c. 1, Sched. H, s. 31.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (5) is repealed and the following substituted:

Prompt preparation

(5) The records described in subsections (1), (2), (3), (3.1) and (4) must be prepared promptly after the service is requested or provided as the case may be. 2009, c. 26, s. 11 (7).

See: 2009, c. 26, ss. 11 (7), 27 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (5) is repealed by the Statutes of Ontario, 2007, chapter 10, Schedule G, subsection 23 (5) and the following substituted:

Prompt preparation

(5) The records described in subsections (1), (2), (3), (4) and (4.1) must be prepared promptly after the service is provided. 2007, c. 10, Sched. G, s. 23 (5).

See: 2007, c. 10, Sched. G, ss. 23 (5), 36 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (5) is repealed and the following substituted:

Prompt preparation

(5) The records described in subsections (1), (2), (3), (3.1), (4) and (4.1) must be prepared promptly after the service is requested or provided as the case may be. 2009, c. 26, s. 11 (8).

See: 2009, c. 26, ss. 11 (8), 27 (2).

Obligation

(6) If there is a question about whether an insured service was provided, the physician, practitioner or health facility shall provide the following persons with all relevant information within his, her or its control:

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (6) is amended by the Statutes of Ontario, 2007, chapter 10, Schedule G, subsection 23 (6) by striking out "physician" in the portion before paragraph 1. See: 2007, c. 10, Sched. G, ss. 23 (6), 36 (2).

1. The General Manager.

2. An inspector who requests the information.

3. Repealed: 2007, c. 10, Sched. G, s. 23 (7).

4. In the case of a practitioner or health facility, a member of the applicable practitioner review committee who requests the information. 1996, c. 1, Sched. H, s. 31; 2007, c. 10, Sched. G, s. 23 (7).

Note: On a day to be named by proclamation of the Lieutenant Governor, section 37.1 is amended by adding the following subsection:

Same

(6.1) If there is a question about whether a service requested by a practitioner or health facility is medically necessary or is rendered in the prescribed circumstances mentioned in section 18.2.1,

(a) the practitioner or health facility shall provide the General Manager with all relevant information within his, her or its control; and

(b) in the case of a service rendered by another practitioner or health facility, or by a physician, hospital or independent health facility, the practitioner, health facility, physician, hospital or independent health facility shall provide the General Manager with all relevant information within his, her or its control. 2009, c. 26, s. 11 (9).

See: 2009, c. 26, ss. 11 (9), 27 (2).

Presumption

(7) In the absence of a record described in subsection (1), (3) or (4), it is presumed that an insured service was provided and that the basic fee payable is nil. 1996, c. 1, Sched. H, s. 31; 2002, c. 18, Sched. I, s. 8 (18).

Note: On a day to be named by proclamation of the Lieutenant Governor, section 37.1 is amended by adding the following subsection:

Same

(7.1) In the absence of a record described in subsection (3.1), it is presumed that the service requested was not medically necessary or was rendered in the prescribed circumstances mentioned in section 18.2.1. 2009, c. 26, s. 11 (10).

See: 2009, c. 26, ss. 11 (10), 27 (2).

Different service provided

(8) In the absence of a record described in subsection (2), the insured service that was provided is presumed to be the insured service, if any, that the General Manager considers to be described in the records as having been provided and not the insured service for which the account was prepared or submitted. 2002, c. 18, Sched. I, s. 8 (19).

Information confidential

38. (1) The persons listed in subsection (1.1) shall preserve secrecy with respect to all matters that come to their knowledge in the course of their employment or duties pertaining to insured persons and any insured services rendered and the payments made for those services, and shall not communicate any such matters to any other person except as otherwise provided in this Act, the *Personal Health Information Protection Act, 2004* and the *Freedom of Information and Protection of Privacy Act*. 2007, c. 10, Sched. G, s. 24 (1).

Persons referred to in subs. (1)

(1.1) The following are listed for the purposes of subsection (1):

1. The members of the Review Board, the Appeal Board, a practitioner review committee and the Medical Eligibility Committee.
2. The employees, agents and inspectors, if any, of the Review Board, the Appeal Board, a practitioner review committee and the Medical Eligibility Committee.
3. The General Manager and persons engaged in the administration of this Act. 2007, c. 10, Sched. G, s. 24 (1).

(2), (3) Repealed: 2007, c. 10, Sched. G, s. 24 (2).

Exception for professional discipline

(4) If, in the course of the administration of this Act and the regulations, the General Manager or a practitioner review committee obtains reasonable grounds to believe that a physician or practitioner is incompetent, incapable or has committed professional misconduct, the General Manager or the practitioner review committee, as the case may be, shall give the following information to the statutory body governing the profession of the physician or practitioner:

1. Information pertaining to the date or dates on which insured services were provided and for whom, the name and address of the hospital and health facility or person who provided the services, the amounts paid or payable by the Plan for such services and the hospital, health facility or person to whom the money was paid or is payable.
2. Information pertaining to the nature of the insured services provided by the physician or practitioner.
3. Information concerning any diagnosis given by the physician or practitioner.
4. Such other personal information as may be prescribed. 2002, c. 18, Sched. I, s. 8 (20); 2007, c. 10, Sched. G, s. 24 (3, 4).

Filing with court

38.1 A copy of any of the following may be filed with the Superior Court of Justice after the time in which an appeal may be made has passed, and once filed shall be entered in the same way as a judgment or order of the Superior Court of Justice and is enforceable as an order of that court:

1. A decision of the Appeal Board made under this Act.
2. An order of the Review Board made under this Act.
3. An agreement to reimburse the Plan signed by a physician.
4. A direction to pay the Plan given by the General Manager under clause 18 (13) (b). 2007, c. 10, Sched. G, s. 25.

Note: On a day to be named by proclamation of the Lieutenant Governor, paragraph 4 is repealed and the following substituted:

4. A direction to pay the Plan given by the General Manager under clause 18 (13) (b) or 18.2.1 (b).

See: 2009, c. 26, ss. 11 (11), 27 (2).

Protection from liability

39. (1) No action or other proceeding shall be instituted against any of the persons listed in subsection (2) for any act done in good faith in the performance or intended performance of the person's duty or for any alleged neglect or default in the performance in

good faith of the person's duty. 2007, c. 10, Sched. G, s. 26 (1).

Persons referred to in subs. (1)

(2) The following are listed for the purposes of subsection (1):

1. The members of the Review Board, a practitioner review committee, the joint committee and the Medical Eligibility Committee.
2. The employees, agents or inspectors, if any, of the Review Board, a practitioner review committee, the joint committee and the Medical Eligibility Committee.

2.1 Members, employees and agents, if any, of the payment committee.

3. The General Manager and persons engaged in the administration of this Act. 2007, c. 10, Sched. G, s. 26.

General review re insured services

39.1 (1) Repealed: 2007, c. 10, Sched. G, s. 27 (1).

Same

(2) The General Manager may request a practitioner review committee to review the provision of insured services by a practitioner. The request may specify the types of insured services to be reviewed and the period during which the services were provided. 1996, c. 1, Sched. H, s. 33.

Expedited review

(3) The General Manager may request that the review be performed by a single member of the applicable committee. 1996, c. 1, Sched. H, s. 33.

Same

(4) Subsections 18.1 (6) to (9) apply with respect to a review by a single committee member. 1996, c. 1, Sched. H, s. 33.

Directions

(5) Following a review or following a reconsideration of a review by a single committee member, the practitioner review committee may direct the General Manager,

(a) to increase the amount paid to the practitioner for an insured service; or

(b) to require the practitioner to repay all or part of any payment made under the Plan. 2007, c. 10, Sched. G, s. 27 (2).

Same

(6) A direction under clause (5) (b) may be made only in the following circumstances:

1. If the applicable committee has reasonable grounds to believe that all or part of the insured services were not rendered.
2. If the applicable committee has reasonable grounds to believe that all or part of the services,
   i. Repealed: 2007, c. 10, Sched. G, s. 27 (3).
   ii. were not therapeutically necessary, if they were provided by a practitioner.
3. If the applicable committee has reasonable grounds to believe that the nature of the services is misrepresented, whether deliberately or inadvertently.
4. If the applicable committee has reasonable grounds to believe that all or part of the services were not provided in accordance with accepted professional standards and practice.

5. In such other circumstances as may be prescribed. 1996, c. 1, Sched. H, s. 33; 2007, c. 10, Sched. G, s. 27 (3).

Same

(7) Subsections 18.1 (14) to (16) and (18) to (20) apply following a review. 1996, c. 1, Sched. H, s. 33; 2002, c. 18, Sched. I, s. 8 (21).

Notice

(8) The applicable committee shall serve the persons affected by a direction given under subsection (5) with a notice stating that the practitioner may appeal it to the Appeal Board. 1996, c. 1, Sched. H, s. 33; 2007, c. 10, Sched. G, s. 27 (4).

Reasons for decision

(9) Upon request, the applicable committee shall give the persons affected by its direction written reasons for it. 1996, c. 1, Sched. H, s. 33.

Appeal

(10) Section 20 applies, with necessary modifications, with respect to an appeal to the Appeal Board. 1996, c. 1, Sched. H, s. 33.

Inspectors, Medical Review Committee

40. (1), (2) Repealed: 2007, c. 10, Sched. G, s. 28.

Inspectors, practitioner review committees

(3) The Minister may appoint inspectors from among the persons nominated by a body referred to in section 6 that nominates persons for appointment to a practitioner review committee. These inspectors shall act only under the direction of the applicable practitioner review committee. 1996, c. 1, Sched. H, s. 34.

Powers

(4) The powers and duties of inspectors appointed under subsection (3) relate only to the provision of insured services by practitioners engaged in the practice of the applicable health discipline. 1996, c. 1, Sched. H, s. 34.

Powers of inspectors

40.1 (1) An inspector has the following powers:

1. To interview a practitioner and members of his or her staff on matters that relate to the provision of insured services.
2. To interview persons employed in a hospital, health facility or such other type of health care facility as may be prescribed in which insured services are provided, or the operator of one, on matters that relate to the provision of insured services.
3. To question a person on matters that may be relevant to an inspection, review or reconsideration of a review, subject to the person's right to have counsel or some other representative present during the examination.
4. To enter and inspect premises where insured services are provided and to inspect the operations carried out on the premises.
5. To inspect and receive information from health records or from notes, charts and other material relating to patient care, regardless of the form or medium in which such records or material are kept, and to reproduce and retain copies of them.
6. To inspect, at any reasonable time, all books of account, documents, correspondence and records, including payroll and employment records, regardless of the form or medium in which the records are kept, and to reproduce and retain copies of them.

7. To remove material described in paragraph 5 or 6 for the purpose of copying it. The inspector must show the certificate of his or her appointment by the Minister and must give a receipt for the material. The material must be promptly returned to the person apparently in charge of the premises from which the material is removed.

8. To enter premises where material required for the purposes of the Act, and material referred to in paragraphs 5 and 6, is stored for the purpose of inspecting it. 1996, c. 1, Sched. H, s. 34; 2007, c. 10, Sched. G, s. 29 (1).

Same

(2) Section 33 of the *Public Inquiries Act*, *2009* applies to the activities of an inspector only in relation to those persons described in paragraphs 1 and 2 of subsection (1). 2009, c. 33, Sched. 6, s. 61.

Notice

(3) The inspector shall give five days written notice to the practitioner or administrator of the hospital, health facility or other health care facility that the inspector wishes to conduct an interview described in paragraph 1 or 2 of subsection (1). 1996, c. 1, Sched. H, s. 34; 2007, c. 10, Sched. G, s. 29 (2).

Same

(4) The notice must, where practicable, state the subject-matter of the interview and the identity or the position, if known, of the person or persons to be interviewed. 1996, c. 1, Sched. H, s. 34.

Same

(5) The notice must state that the person to be interviewed is entitled to be represented by legal counsel. 1996, c. 1, Sched. H, s. 34.

Private residence

(6) An inspector shall not enter a private residence without the consent of an occupier except under the authority of a warrant under subsection (7). 1996, c. 1, Sched. H, s. 34.

Warrant

(7) A provincial judge or justice of the peace may issue a warrant in the prescribed form authorizing an inspector to enter a private residence for the purpose of conducting an inspection if the judge or justice of the peace is satisfied upon application by an inspector, on information upon oath, that there are reasonable grounds for doing so. 1996, c. 1, Sched. H, s. 34.

Legible records

(8) If a book, document, item of correspondence or record is kept in a form or medium that is not legible, the inspector may require the person apparently in charge of it to provide him or her with a legible physical copy for examination. 1996, c. 1, Sched. H, s. 34.

Cost

(9) The cost of providing the inspector with a legible copy under subsection (8) shall be borne by the practitioner or health facility, as the case may be. 1996, c. 1, Sched. H, s. 34; 2007, c. 10, Sched. G, s. 29 (3).

Obstruction

40.2 (1) No person shall obstruct an inspector or withhold or conceal from an inspector any book, document, correspondence, record or thing relevant to an inspection. 1996, c. 1, Sched. H, s. 34.

(2) Repealed: 2007, c. 10, Sched. G, s. 30 (1).

Same

(3) Every practitioner who provides insured services shall co-operate fully with an inspector who is carrying out an inspection under the Act or with a member of a practitioner review committee who is exercising powers or performing duties under the Act. 1996, c. 1, Sched. H, s. 34.

Same

(4) The operator and administrator of every hospital, health facility and other health care facility in which insured services are provided shall co-operate fully with an inspector who is carrying out an inspection under the Act and shall ensure that employees also co-operate fully. 1996, c. 1, Sched. H, s. 34.

Same

(5) Every person who receives insured services shall co-operate fully with an inspector who is carrying out an inspection under the Act. 1996, c. 1, Sched. H, s. 34.

Suspension of payments

(6) The General Manager may suspend payments under the Plan to a practitioner during any period when he or she fails to comply with subsection (3) without just cause, whether or not the practitioner is convicted of an offence. 2007, c. 10, Sched. G, s. 30 (2).

Same

(7) The General Manager may suspend payments under the Plan to a hospital or health facility during any period when its operator or administrator or its employees fail to comply with subsection (4) without just cause, whether or not the person is convicted of an offence. 1996, c. 1, Sched. H, s. 34.

Suspension of payments

40.3 (1) The General Manager may give a notice to the Review Board requesting it to hold a hearing and issue an order suspending payments or a portion of payments to a physician from the Plan, during any period when he or she fails to comply with section 37 without just cause. 2007, c. 10, Sched. G, s. 31.

Expedited review

(2) The Review Board shall commence a hearing within 30 days of receiving notice under subsection (1). 2007, c. 10, Sched. G, s. 31.

Where does not submit directly to the Plan

(3) In the case of a physician who, by virtue of section 11 of the *Commitment to the Future of Medicare Act, 2004*, does not submit accounts directly to the Plan, or is a physician to whom section 18.0.7 applies, the Review Board may make a further order requiring him or her to temporarily submit accounts directly to the Plan for the purpose of suspending payments under the order made under subsection (1). 2007, c. 10, Sched. G, s. 31.

Not deemed election

(4) Where a physician is required to temporarily submit his or her accounts directly to the Plan under an order of the Review Board, the submission of the accounts is not a deemed election for the purposes of subsection 11 (6) of the *Commitment to the Future of Medicare Act, 2004*, but subsection 10 (3) of that Act applies to him or her during the time that he or she is temporarily required to submit accounts directly to the Plan. 2007, c. 10, Sched. G, s. 31.

41., 42. Repealed: 2000, c. 26, Sched. H, s. 1 (7).

Offence, benefits by fraud

43. (1) No person shall knowingly obtain or attempt to obtain payment for or receive

or attempt to receive the benefit of any insured service that the person is not entitled to obtain or receive under this Act and the regulations.

Idem

(2) No person shall knowingly aid or abet another person to obtain or attempt to obtain payment for or receive or attempt to receive the benefit of any insured service that such other person is not entitled to obtain or receive under this Act and the regulations.

False information

(3) No person shall knowingly give false information in an application, return or statement made to the Plan or to the General Manager in respect of any matter under this Act or the regulations. R.S.O. 1990, c. H.6, s. 43.

Mandatory reporting

43.1 (1) A prescribed person who, in the course of his or her professional or official duties, has knowledge that an event referred to in subsection (2) has occurred shall promptly report the matter to the General Manager.

Events

(2) Subsection (1) applies to the following events:

1. An ineligible person receives or attempts to receive an insured service as if he or she were an insured person.
2. An ineligible person obtains or attempts to obtain reimbursement by the Plan for money paid for an insured service as if he or she were an insured person.
3. An ineligible person, in an application, return or statement made to the Plan or the General Manager, gives false information about his or her residency.

Definition, "ineligible person"

(3) In subsection (2),

"ineligible person" means a person who is neither an insured person nor entitled to become one.

Defence

(4) It is a defence to a proceeding for failure to make a report required by subsection (1) that the prescribed person delayed making the report because he or she believed, on reasonable grounds, that making the report might be a direct and immediate cause of serious bodily harm to a person, and made the report as soon as he or she was of the opinion that the danger no longer existed.

Voluntary reporting

(5) A prescribed person may report to the General Manager any matter relating to the administration or enforcement of this Act or the regulations.

Subss. (1) and (5) prevail

(6) Subsections (1) and (5) apply even if the information reported is confidential or privileged and despite any Act, regulation or other law prohibiting disclosure of the information.

Protection from liability

(7) No proceeding for making a report under subsection (1) or (5) or for providing information in connection with the report shall be commenced against a person unless he or she acts maliciously and the information on which the report is based is not true.

Exception: solicitor-client privilege

(8) Nothing in this section abrogates any privilege that may exist between a solicitor

and his or her client. 1993, c. 32, s. 2 (8).

General penalty, individual

44. (1) Every individual who contravenes any provision of this Act or the regulations for which no penalty is specifically provided is guilty of an offence and is liable,

(a) for a first offence, to a fine of not more than $25,000 or to imprisonment for a term of not more than 12 months, or to both;

(b) for a subsequent offence, to a fine of not more than $50,000 or to imprisonment for a term of not more than 12 months, or to both. 2002, c. 18, Sched. I, s. 8 (22).

No imprisonment for record-keeping offences

(1.1) Despite subsection (1), no person may be sentenced to a term of imprisonment for failing to keep or maintain records under section 37.1. 2007, c. 10, Sched. G, s. 32.

Same, corporation

(2) Every corporation that contravenes any provision of this Act or the regulations for which no penalty is specifically provided is guilty of an offence and is liable to a fine of not more than $50,000 for a first offence and to a fine of not more than $200,000 for a subsequent offence. 2002, c. 18, Sched. I, s. 8 (22).

Compensation or restitution

(3) The court that convicts a person of an offence under this section may, in addition to any other penalty, order that the person pay compensation or make restitution to any person who suffered a loss as a result of the offence. 2002, c. 18, Sched. I, s. 8 (22).

No limitation

(4) Section 76 of the *Provincial Offences Act* does not apply to a prosecution under this section. 2002, c. 18, Sched. I, s. 8 (22).

Regulations

45. (1) The Lieutenant Governor in Council may make regulations,

(a) respecting the form of the health card, and governing the issuance, possession, submission, surrender and destruction of the health card, including measures to protect its security;

(a.1) providing for the registration of persons as insured persons and prescribing waiting periods for registration;

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (1) is amended by adding the following clause:

(a.2) governing the issuance and use of general requisition numbers, including, without being limited to,

(i) requiring their use, and governing the circumstances in which they are to be used,

(ii) respecting applying for them, and the information that must be supplied in an application, and

(iii) specifying that a general requisition number may be the same as the billing number defined in subsection 16 (5);

See: 2009, c. 26, ss. 11 (12), 27 (2).

(b) defining “resident”, “dependant”, “spouse” and “member of the Canadian Forces” for the purposes of this Act or any provision of this Act;

Note: On a day to be named by proclamation of the Lieutenant Governor, clause (b) is repealed and the following substituted:

(b) defining "resident", "dependant", "spouse", "member of the Canadian Forces" and "requested by a practitioner or health facility" for the purposes of this Act or any provision of this Act;

See: 2009, c. 26, ss. 11 (13), 27 (2).

(b.1) prescribing the personal information that may be collected, used or disclosed under clause 2 (3) (b);

(c) providing for the continuation and termination of insurance coverage in respect of insured persons who cease to be eligible;

(c.1) prescribing numbers of members for the purposes of paragraphs 1, 3, 4 and 5 of subsection 6 (1);

(c.2) enabling the General Manager to set requirements, including requirements to provide documentation, relating to registration or renewal of registration as an insured person, or to verify a person's continuing eligibility to remain registered as an insured person, and making the meeting of any such requirements a condition of being or continuing to be an insured person;

(d) designating disciplines for the purpose of section 16;

(e) governing insured services, including specifying those services that are not insured services;

(f) governing fees payable for insured services;

(g) governing payments for insured services;

(h)-(j) Repealed: 1996, c. 1, Sched. H, s. 35 (1).

(k) providing for the making of claims for payment of the cost of insured services and prescribing the information that shall be furnished in connection therewith;

(l) prescribing the co-payments that shall be made by or on behalf of an insured person to qualify the person to receive those insured services specified in the regulations as requiring co-payments;

(m) providing for the times when and manner in which physicians shall submit accounts directly to the Plan under section 15;

(n) providing for the times when and manner in which practitioners shall submit accounts directly to the Plan under section 16;

(o) exempting any class of accounts from the application of section 15 or any provision thereof;

(p) exempting any class of accounts from the application of section 16 or any provision thereof;

(q) Repealed: 1996, c. 1, Sched. H, s. 35 (2).

(r) prescribing facilities that are health facilities for the purposes of this Act in addition to those referred to in the definition of "health facility" in section 1;

(r.1) governing service for the purposes of section 26, including prescribing anything that may be prescribed under that section and providing for situations in which service shall be deemed to have been made;

(r.2) Repealed: 2007, c. 10, Sched. G, s. 33 (2).

(s) prescribing procedures for the enforcement of and recovery under rights to which the Plan is subrogated and without restricting the generality of the foregoing,

(i) requiring the insured person and his or her solicitor to act on behalf of the Plan in any action,

(ii) requiring such notices as are prescribed,

(iii) providing for the terms and conditions under which an action to enforce such rights may be begun, conducted and settled,

(iv) prescribing the portion of the costs of an insured person incurred in an action for the recovery of such rights that shall be borne by the Plan;

(t) assigning additional duties to the General Manager, the joint committee or payment committee, practitioner review committees, the Medical Eligibility Committee and the Appeal Board;

(u) prescribing forms for the purposes of this Act and providing for their use;

(v) designating classes for the purpose of subsection 11 (3);

(w) prescribing persons for the purpose of subsection 11.1 (2);

(x) prescribing, for the purpose of clause 19.1 (3) (d), what constitutes an application for a provider number or its equivalent;

(x.1) governing the costs that may be recovered under section 36.0.1, including the determination of those costs, and the evidence that is admissible to prove those costs in an action under that section;

(y) prescribing persons for the purpose of subsections 43.1 (1) and (5);

(z) prescribing the co-payments for accommodation referred to in subsection 46 (2);

(z.1) prescribing anything that must or may be prescribed or that must or may be done in accordance with the regulations or as provided in the regulations. R.S.O. 1990, c. H.6, s. 45 (1); 1993, c. 32, s. 2 (9); 1994, c. 17, s. 72 (1, 2); 1996, c. 1, Sched. H, s. 35 (1, 2, 4); 1999, c. 10, s. 2; 2004, c. 5, s. 43 (1, 2); 2006, c. 19, Sched. L, s. 3 (7); 2007, c. 10, Sched. C, s. 3; 2007, c. 10, Sched. G, s. 33 (1-4); 2007, c. 16, Sched. B, s. 2; 2009, c. 33, Sched. 18, s. 11 (9).

Regulations

(1.1) The Lieutenant Governor in Council may make regulations,

(a) prescribing, for the purpose of clause 19.1 (3) (g), classes of physicians that are eligible for the purpose of section 19.1;

(b) prescribing the classes of physicians that are not eligible under subsection 19.1 (4);

(c) prescribing, for the purpose of clause 19.1 (7) (b), the purposes for which the Minister may exempt a physician or a class of physicians from the application of subsection 19.1 (1);

(d) prescribing services that meet the requirements of clauses 36.1 (1) (a) and (b) as third party services, or prescribing them as third party services in specified circumstances, and specifying the circumstances;

(e) in relation to a specified third party service or in relation to a third party service provided in specified circumstances,

(i) prescribing another person or entity as a third party instead of or in addition to the person or entity who makes the request or requirement referred to in clause 36.1 (1) (a),

(ii) if more than one person or entity make the request or requirement referred to in clause 36.1 (1) (a), prescribing one or more of them as third parties and providing that the others are not third parties, or

(iii) providing that there is no third party;

(f) designating or establishing a body that shall have power to decide disputes about payment for third party services, including power to summon witnesses and require the production of documents and power to award costs and interest;

(g) governing the composition of the body referred to in clause (f), the qualifications, appointment, functions and remuneration of its members and their immunity from liability;

(h) prescribing the parties to a proceeding before the body referred to in clause (f) and the rules governing practice, procedure and evidence in a proceeding before the body, including prescribing whether or not the body is required to hold a hearing;

(i) prescribing the duties and powers of the body referred to in clause (f) in relation to making decisions and orders;

(j) providing that a court or body acting under subsection 36.3 (4) shall consider other matters in addition to or instead of the guidelines and schedules of fees referred to in subsections 36.3 (5) and (6), and specifying those other matters. 1993, c. 32, s. 2 (10); 1996, c. 1, Sched. H, s. 35 (5, 6).

Classes

(1.2) A regulation may create different classes of persons, facilities, accounts, fees payable or payments and may establish different entitlements for or relating to each class or impose different requirements, conditions or restrictions on or relating to each class. 1996, c. 1, Sched. H, s. 35 (7).

Note: On a day to be named by proclamation of the Lieutenant Governor, section 45 is amended by the Statutes of Ontario, 2007, chapter 10, Schedule G, subsection 33 (5) by adding the following subsection:

Consultation

(1.3) The Lieutenant Governor in Council shall not make a regulation providing for additional requirements that physicians must comply with in maintaining records under clause 37.1 (4.1) (b) unless the Minister has first consulted either or both of the following:

1. The payment committee.

2. The Medical Services Payment Committee established by agreement between the Ontario Medical Association and the Crown in right of Ontario. 2007, c. 10, Sched. G, s. 33 (5).

See: 2007, c. 10, Sched. G, ss. 33 (5), 36 (2).

Adoption of schedules of fees

(2) A regulation may adopt by reference in whole or in part, with such changes as the Lieutenant Governor in Council considers necessary, the fees in any schedule of fees as prescribed amounts payable in whole or in part, by the Plan. R.S.O. 1990, c. H.6, s. 45 (2).

Ministerial order

(2.1) Upon the advice of the General Manager, and where the Minister considers it to be in the public interest to do so, the Minister may make an order amending a schedule of fees or benefits that has been adopted in a regulation in any manner the Minister considers appropriate for the purposes of the regulation. 2004, c. 5, s. 43 (3).

Duration

(2.2) An order made under subsection (2.1) remains in force until the earliest of the following events occurs:

1. The order is cancelled by an order made under subsection (2.3).
2. A regulation is made adopting a schedule of fees or benefits or an amendment to the schedule of fees or benefits in which essentially the same subject-matter is addressed.
3. Twelve months have elapsed from the making of the order. 2004, c. 5, s. 43 (3).

Cancellation

(2.3) Upon the advice of the General Manager, and where the Minister considers it to be in the public interest to do so, the Minister may make an order cancelling an order under subsection (2.1). 2004, c. 5, s. 43 (3).

Not a regulation

(2.4) An order made under subsection (2.1) or (2.3) is not a regulation for the purposes of Part III (Regulations) of the *Legislation Act, 2006*, but has the same effect as if the schedule of fees or benefits as amended by the order had been adopted by regulation. 2004, c. 5, s. 43 (3); 2006, c. 21, Sched. F, s. 136 (1).

Publication

(2.5) The Minister shall publish an order made under subsection (2.1) or (2.3) in *The Ontario Gazette*, and in any other manner the Minister considers appropriate, and the order is effective from the publication date of the issue of the *Gazette* in which publication is made, unless paragraph 2 or 3 of subsection (2.2) applies first. 2004, c. 5, s. 43 (3).

Variation

(2.6) An amendment made by an order under subsection (2.1) may be varied at any time by regulation. 2004, c. 5, s. 43 (3).

Restriction

(2.7) An order under subsection (2.1) may not be made more than once with respect to essentially the same subject-matter. 2004, c. 5, s. 43 (3).

When regulation may be effective

(3) A regulation is, if it so provides, effective with reference to a period before it is filed. R.S.O. 1990, c. H.6, s. 45 (3).

Exemptions

(3.1) A regulation may exempt a class of persons or facilities from the application of a specified provision of the Act or regulations. 1996, c. 1, Sched. H, s. 35 (8).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (3.1) is repealed and the following substituted:

Exemptions

(3.1) The Lieutenant Governor in Council may make regulations exempting any person, facility or entity or class of persons, facilities or entities from the application of any provision

of this Act, and may make such an exemption subject to any condition that may be provided for in the regulations. 2009, c. 26, s. 11 (14).

See: 2009, c. 26, ss. 11 (14), 27 (2).

Insured services

(3.2) Without limiting the generality of clause (1) (e), a regulation made under it may provide the following:

1. Which services rendered in or by hospitals and health facilities are insured services.
2. Which constituent elements form part of an insured service rendered by physicians or practitioners.
3. Which constituent elements shall be deemed not to form part of an insured service rendered by a physician or practitioner. 1996, c. 1, Sched. H, s. 35 (8).

Restriction

(3.3) A regulation made under clause (1) (e) or (g) shall not include a provision that would disqualify the Province of Ontario, under the *Canada Health Act*, for contribution by the Government of Canada because the Plan would no longer satisfy the criteria under that Act. 1996, c. 1, Sched. H, s. 35 (8).

Services designated without prescribing amounts payable

(4) The Lieutenant Governor in Council may make regulations under clause (1) (e) prescribing services that are insured services without prescribing any amounts payable by the Plan for those services. R.S.O. 1990, c. H.6, s. 45 (4).

Fees related to independent health facilities

(5) A regulation may prescribe an amount payable by the Plan for an insured service rendered in a hospital that has been approved under the Public Hospitals Act without prescribing an amount payable if the service is rendered in a health facility operated by a person to whom subsection 7 (7) of the *Independent Health Facilities Act* applies. R.S.O. 1990, c. H.6, s. 45 (5).

Circumstances

(6) A regulation made under clause (1) (l) may specify the circumstances in which it applies and may establish different entitlements or impose different requirements, conditions or restrictions in the specified circumstances. 1996, c. 1, Sched. H, s. 35 (9).

(7) Repealed: 1996, c. 1, Sched. H, s. 35 (9).

(8) Repealed: 1996, c. 1, Sched. H, s. 35 (10).

No appeal

45.1 (1) Every decision by a body designated or established under clause 45 (1.1) (f) respecting a dispute about payment for third party services shall be final and binding and shall not be subject to appeal. 1993, c. 32, s. 2 (11).

Enforcement of decision

(2) The body designated or established under clause 45 (1.1) (f) or a party to a proceeding before the body may file a copy of the decision or order of the body, excluding the reasons, in the Superior Court of Justice or, if the amount ordered to be paid does not exceed the monetary jurisdiction of the Small Claims Court, in the Small Claims Court and, when so filed, the decision or order may be enforced as an order of the court in which it is filed. 1993, c. 32, s. 2 (11); 2006, c. 19, Sched. C, s. 1 (1).

MENTAL ILLNESS

Mental illness

Definition

46. (1) In this section,

"hospital" means a psychiatric facility under the *Mental Health Act*. R.S.O. 1990, c. H.6, s. 46 (1); 2009, c. 33, Sched. 18, s. 11 (10).

Insured person entitled

(2) An insured person who is entitled to insured services under this Act and the regulations and who is admitted to a hospital under this section is entitled to such services as are required for the person's maintenance, care, diagnosis and treatment in accordance with this Act and the regulations without being required to pay or have paid on his or her behalf any premium or other charge other than a co-payment for accommodation prescribed in the regulations. 1994, c. 17, s. 73.

Exceptions

(3) Despite subsection (2), an insured person in respect of whom, but for this Act, the Government of Canada would have assumed the cost of the maintenance, care, diagnosis and treatment provided under this section is not entitled to receive insured services in a hospital as an insured person.

Accounts

(4) The General Manager shall keep the accounts, if any, of insured persons who receive hospital services under this section separate from the accounts of patients who receive insured services under the Plan.

Subrogation

(5) Where, as the result of negligence or other wrongful act or omission of another, an insured person suffers personal injuries for which he or she receives services under this section, the Plan is subrogated to any right of the insured person to recover the cost incurred for such services, past or future, and the provisions of this Act and the regulations applying to subrogation of the Plan for the cost of insured services apply with necessary modifications to subrogation of the Plan for the cost of services under this section. R.S.O. 1990, c. H.6, s. 46 (3-5).

SCHEDULE 1
PHYSICIAN PAYMENT REVIEW PROCESS

Purpose

1. The purpose of this Schedule is to establish procedures for the Physician Payment Review Board to hold hearings on payment matters that cannot be resolved between the General Manager and a physician through the provision of education and other assistance, and to provide for an appeal process from its decisions. 2007, c. 10, Sched. G, s. 34.

Definitions

2. In this Schedule,

"peer" means a physician who is a member of the same specialty group as the physician who is a party to a hearing by the Review Board; ("pair")

"public member" means a member of the Review Board who is not a physician; ("représentant du public")

"review panel" means a panel selected under subsection 3 (1); ("comité de révision")

"specialty group" means one of the specialty groups set out in the Index to the Consultations and Visits section of the schedule of benefits; ("domaine de spécialité")

"the Act" means the *Health Insurance Act*. ("la Loi") 2007, c. 10, Sched. G, s. 34.

Request for a hearing, general

3. (1) When the Review Board receives a notice that requests a hearing under section 18, 18.2 or 40.3 of the Act and proof of service of the notice, the chair of the Review Board or, in his or her absence, a vice chair shall select a panel in accordance with section 6 to hear and determine the matter before it. 2007, c. 10, Sched. G, s. 34.

Timing of hearing

(2) A panel selected under subsection (1) shall conduct the hearing in a timely manner within the prescribed time, if any, and shall make an order with written reasons within 30 business days of the close of submissions or, if another time has been prescribed, within that time. 2007, c. 10, Sched. G, s. 34.

Parties

(3) The parties to a hearing under subsection (1) are the General Manager and the physician or physicians named in the notice that requests a hearing. 2007, c. 10, Sched. G, s. 34.

Order of Review Board

(4) An order of a review panel is for all purposes an order of the Review Board. 2007, c. 10, Sched. G, s. 34.

Expedited hearings

4. (1) When the Review Board has received a request for an expedited hearing under subsection 18 (5) of the Act, the chair of the Review Board or, in his or her absence, a vice chair shall promptly select a panel to deal with the request, and the panel shall hear the matter and make an order as expeditiously as possible or, if a time has been prescribed, within that time. 2007, c. 10, Sched. G, s. 34.

Same

(2) The Review Board may make rules respecting the holding of expedited hearings. 2007, c. 10, Sched. G, s. 34.

Period of review

5. (1) In the case of a hearing under subsection 18 (16), (17) or (18) of the Act, unless the panel orders otherwise in accordance with paragraph 5 of subsection 11 (1) of this Schedule, the physician under review shall only be required to reimburse the Plan for services provided in a period that is no more than 12 months in duration. 2007, c. 10, Sched. G, s. 34.

Restriction

(2) Despite subsection (1) and unless the panel orders otherwise in accordance with paragraph 5 of subsection 11 (1) of this Schedule, the period of review for reimbursement purposes cannot be for a period that begins prior to the later of,

(a) the date of notice, if any, given under subsection 18 (15) of the Act that services may be subject to reimbursement; and

(b) 18 months prior to the date of a request for a hearing under subsection 18 (17) or (18) of the Act. 2007, c. 10, Sched. G, s. 34.

Relevant evidence regardless of date

(3) Nothing in this section precludes a party to a hearing from submitting, nor prevents the Review Board from admitting as evidence, any document, record or other information that is relevant to the hearing regardless of the date of the document, record or other information. 2007, c. 10, Sched. G, s. 34.

Panels

6. (1) A review panel shall consist of four members of the Review Board selected as follows:

1. The chair of the Review Board or, in his or her absence, a vice chair shall select the members of the panel that will conduct the hearing and determine the matter before it. The chair or the vice chair may be a member of a panel.
2. Three of the members must be physician members.
3. One member must be a public member.
4. Subject to paragraph 5, one of the three members appointed under paragraph 2 must be a peer of the physician who is the subject of the hearing, as determined by the chair or the vice chair, as the case may be.
5. If the chair or vice chair determines that no peer is available, or if the physician who is the subject of the hearing raises a concern about the peer member of the Review Board, including whether the peer is also a member of the same specialty as defined by the Royal College of Physicians and Surgeons of Canada as the physician who is the subject of hearing, the chair or vice chair may, in his or her sole discretion, appoint a physician advisor under subsection 5.1 (11) of the Act to provide advice to the panel.
6. The chair or vice chair of the Review Board, as the case may be, shall designate one of the members of the review panel as the chair of the panel. The chair of a review panel shall not be the peer of the physician who is the subject of the hearing. 2007, c. 10, Sched. G, s. 34.

Death, termination of membership

(2) If a member of a review panel which has begun a hearing with respect to a particular matter dies, has their appointment to the Review Board terminated or becomes unable or unwilling to continue as a member before the matter is concluded, the remaining members of the panel may deal with the matter, unless the member is a peer member, in which case the chair of the panel shall determine how to deal with the matter. 2007, c. 10, Sched. G, s. 34.

Expiry of term

(3) If the appointment of a member of a review panel expires before the hearing with respect to a particular matter has been completed, the member shall continue to be a member of the Review Board for the purposes of dealing with that matter. 2007, c. 10, Sched. G, s. 34.

Hearing by review panel

7. (1) A review panel shall hear and determine the matter before it. 2007, c. 10, Sched. G, s. 34.

Members holding hearing not to have taken part in investigation, etc.

(2) Members of the review panel shall not have taken part before the hearing in any consideration of the matter that is the subject of the hearing and shall not communicate directly or indirectly in relation to the matter with any person or with any party or representative of a party except upon notice to and opportunity for the parties to participate. 2007, c. 10, Sched. G, s. 34.

Legal advice

(3) The review panel may seek legal advice from a person who is not counsel in the hearing and, in such case, the nature of the advice shall be made known to the parties in order

that they may make submissions as to the law. 2007, c. 10, Sched. G, s. 34.

Conflict of interest

(4) A member of a review panel who has a conflict of interest shall, immediately upon discovery of the conflict, report the nature and extent of the conflict to the chair of the Review Board who shall determine what course of action to take in consequence. 2007, c. 10, Sched. G, s. 34.

If chair has conflict

(5) If the chair of the Review Board has a conflict of interest, he or she shall not assign himself or herself to a panel, and if he or she becomes aware of a conflict after already being assigned to a panel, he or she shall report the nature and extent of the conflict to a vice-chair who shall determine what course of action to take in consequence. 2007, c. 10, Sched. G, s. 34.

Majority determination

(6) The final determination of a matter before a review panel shall be by majority vote and, if there is a tie, the chair of the review panel's vote shall decide the matter. 2007, c. 10, Sched. G, s. 34.

Only members at hearing to participate in decision

(7) No member of the review panel shall participate in a decision of the review panel following a hearing unless he or she was present throughout the hearing and heard the evidence and argument of the parties. 2007, c. 10, Sched. G, s. 34.

Findings of fact

8. The findings of fact of a review panel pursuant to a hearing shall be based exclusively on evidence admissible or matters that may be noticed under sections 15 and 16 of the *Statutory Powers Procedure Act*. 2007, c. 10, Sched. G, s. 34.

Recording of evidence

9. The oral evidence taken before the review panel at a hearing shall be recorded and, if so required, copies of a transcript of the evidence shall be furnished upon the same terms as in the Superior Court of Justice. 2007, c. 10, Sched. G, s. 34.

Release of documentary evidence

10. Documents and things put in evidence at a hearing shall, upon the request of the person who produced them, be released to the person by the Review Board within a reasonable time after the matter in issue has been finally determined. 2007, c. 10, Sched. G, s. 34.

Orders

11. (1) The review panel may, as an order of the Review Board, make any order that it considers appropriate, including, without being limited to, any one or more of the following:

1. An order determining the proper amount, if any, to be paid to the physician in accordance with the Act and the regulations for the service provided, and requiring that,
   i. the General Manager pay the account in the amount set out in the order, or
   ii. the physician reimburse the Plan for any amount paid by the Plan for the service that is in excess of the amount set out in the order.
2. An order that, in the future, the physician submit claims for insured services to the Plan or to insured persons in accordance with the order of the Review Board.
3. Where the physician has breached a previous order of the Review Board, an order

that the General Manager refuse to pay, or pay a reduced amount as determined by the review panel, with respect to identical future claims submitted during a time period determined by the review panel.

4. An order that costs be awarded to either party in accordance with section 17.1 of the *Statutory Powers Procedure Act*.

5. An order that, despite subsections 5 (1) and (2), the period of review for reimbursement be for a period of more than 12 months, or that the period of review for reimbursement be for a period commencing prior to the date provided for in subsection 5 (2), or both, where the review panel determines that the physician knew or ought to have known that claims submitted to the Plan or to an insured person were false.

6. An order that the physician's entitlement to submit claims for insured services to the Plan or to receive payments from an insured person cease or be suspended for a period of time provided for in the order if one or more of the circumstances set out in subsection (5) exists. 2007, c. 10, Sched. G, s. 34.

Additional orders

(2) The General Manager may enter in evidence before the review panel a random sample of claims submitted by the physician to the Plan in respect of a fee code during the period of review and, in addition to any other order it may make, the review panel may order that the General Manager calculate the amount to be reimbursed for that fee code for that period, or a portion of that period, by assuming the results observed in the random sample are representative of all the claims during the period in question, where the review panel determines that,

(a) the physician is liable to reimburse the Plan;

(b) there has been a previous finding or order by a review panel that the physician reimburse the Plan and the physician has continued to make billing errors despite documented efforts to educate the physician regarding billing requirements; and

(c) the sample was random and had a reasonable confidence interval. 2007, c. 10, Sched. G, s. 34.

Limit on statistical inference

(3) For greater certainty, a review panel may not order that the General Manager may apply statistical methods to amounts to be reimbursed to the Plan unless subsection (2) applies. 2007, c. 10, Sched. G, s. 34.

Limitation on costs

(4) Despite paragraph 4 of subsection (1), costs shall not be awarded against a physician unless there has been a finding by the Review Board that one or more of the following apply:

1. The physician unreasonably failed to provide information or produce records.

2. The physician unreasonably failed to co-operate with the Ministry.

3. The physician unreasonably failed to co-operate in the proceeding before the review panel.

4. The physician was responsible for long or frequent delays in the proceeding before the review panel.

5. The physician failed to comply with a previous order of the Review Board. 2007, c. 10, Sched. G, s. 34.

Suspension

(5) An order under paragraph 6 of subsection (1) shall not be made unless the review panel finds that the physician knew or ought to have known that the claims submitted to the Plan or to insured persons were false. 2007, c. 10, Sched. G, s. 34.

Effect of suspension, etc.

(6) If a physician is the subject of an order under paragraph 6 of subsection (1), all insured services rendered by him or her during the period the order is in effect are deemed to be insured services payable at nil. 2007, c. 10, Sched. G, s. 34.

Interest payable by physician

(7) If a physician is ordered to reimburse the Plan, interest will accrue on the amount found to be improperly paid to the physician from the date that the General Manager's notice to the physician under the Act was effective. 2007, c. 10, Sched. G, s. 34.

Interest payable by General Manager

(8) Interest is payable by the General Manager to a physician in the circumstances set out in paragraphs 1 and 2, and in accordance with paragraph 3:

1. If the General Manager has sent notice of the General Manager's opinion to the physician pursuant to subsection 18 (15) of the Act, and the physician has submitted claims in accordance with the opinion but requested a hearing concerning the General Manager's opinion by the Review Board under subsection 18 (16) of the Act.
2. If the Review Board has concluded that the General Manager's opinion was incorrect in the circumstances and directed the General Manager to pay those claims as they would have been submitted if it were not for the opinion.
3. Interest accrues from the date the claims were submitted in accordance with the General Manager's opinion. 2007, c. 10, Sched. G, s. 34.

Report to College

(9) Where the Review Board is of the opinion, based on a hearing, that the physician may have committed an act of professional misconduct or may be incompetent or incapacitated, it shall file a report with the Registrar of the College of Physicians and Surgeons of Ontario. 2007, c. 10, Sched. G, s. 34.

Appeal

12. (1) A party to a hearing before the Review Board may appeal from its order to the Divisional Court in accordance with the rules of the court, but,

(a) personal health information contained in any document or evidence filed or adduced with regard to the appeal, or in any order or decision of the court shall not be made accessible to the public; and

(b) the Divisional Court may edit any documents it releases to the public to remove any personal health information. 2007, c. 10, Sched. G, s. 34.

Notice of appeal

(2) The appellant shall file a notice of appeal within 15 business days after receiving notice of the order of the Review Board. 2007, c. 10, Sched. G, s. 34.

Record to be filed in court

(3) Where any party appeals from an order of the Review Board, the Review Board shall forthwith file in the Divisional Court the record of the hearing in which the order was made, which, together with the transcript of evidence if it is not part of the Review Board's

record, shall constitute the record in the appeal. 2007, c. 10, Sched. G, s. 34.

Powers of court on appeal

(4) An appeal under this section may be made on questions of law or fact or both and the court may affirm or may rescind the order of the Review Board and may exercise all powers of the Review Board to direct the General Manager to take any action which the Review Board may direct the General Manager to take and as the court considers proper, and, for such purposes, the court may substitute its opinion for that of the Review Board. 2007, c. 10, Sched. G, s. 34.

Lift of stay

(5) Despite the *Statutory Powers Procedure Act* or any other Act, within 30 days of the physician filing an appeal to the Divisional Court under this section, the General Manager may bring a motion to the Divisional Court requesting it to lift the stay of an order made under paragraph 6 of subsection 11 (1) and the Divisional Court may order that the stay be lifted. 2007, c. 10, Sched. G, s. 34.

Français

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