KING'S BENCH FOR SASKATCHEWAN

Citation: 2026 SKKB 22

Date: **2026 01 27**
File No.: KBG-RG-01734-2023
Judicial Centre: Regina

BETWEEN:

DR. PETRUS BIERMAN

APPLICANT

- and -

THE JOINT MEDICAL PROFESSIONAL REVIEW COMMITTEE
and MINISTER OF HEALTH (SASKATCHEWAN)

RESPONDENTS

Counsel:

Richika J. Bodani and Anthony D. Thera	for the applicant
Christoph Meier	for the respondents

JUDGMENT
JANUARY 27, 2026

ROBERTSON J.

Contents

INTRODUCTION

[1] This decision addresses an appeal under s. 49.21 of *The Saskatchewan Medical Care Insurance Act*, RSS 1978, c S-29 [*Act*]. The appellant, Dr. Petrus Bierman [Dr. Bierman], appeals against the June 27, 2023 decision of the respondent, The Joint Medical Professional Review Committee [Committee]. The Committee ordered a reassessment and recovery of $254,015.52 from Dr. Bierman's billings from a 20 month period between November 4, 2019 to June 12, 2021 and payment of an additional amount of $25,000 for a total payment order of $279,015.52 [Decision].

[2] For the reasons which follow, the appeal is dismissed because Dr. Bierman has not satisfied the onus of showing any reviewable error in the record of proceeding, in particular the Decision. The Decision meets the test of being intelligible, transparent and justified in its conclusions. Its reasons satisfactorily explain its multiple findings of incorrect billings, improper billings for services that were not medically necessary, inadequate documentation and inappropriate patterns of practice. These reasons support the orders for repayment and for payment of $25,000 as an additional amount.

BACKGROUND

History of these proceedings

[3] The Court file supports the following chronology of events:

2021	
September 28	Letter from Committee to Dr. Bierman informing him of review of his billings for the period November 4, 2019 to June 12, 2021 and requesting documentation
December 3	Dr. Bierman letter in response
December 23	Dr. Bierman letter to Committee providing additional information
2022	
January 26	Letter from Committee to Dr. Bierman requesting additional records
February 9	Dr. Bierman provides further records
February 18	Committee review of records
September 26	Committee letter requesting interview, identifying nine areas of concern with Dr. Bierman's billing practices
2023	
March 16	Committee interview of Dr. Bierman
June 27	Committee Decision

July 29	Dr. Bierman files Notice of Appeal to Court
2024	
September 3	Fiat of Kuski Bassett J. regarding application for sealing order
September 17	Klatt J. grants consent sealing order
2025	
April 28	Clackson J. grants consent scheduling order with filing deadlines
2026	
January 5	Robertson J. hears appeal with decision reserved

LAW

Prior judgments of this Court

[4] This Court has, over the past thirty-five years, decided appeals under s. 49.21 of the *Act* in the following judgments.

1) *Rengarajan v The Joint Medical Professional Review Committee and Minister of Health (Saskatchewan)* (26 June 2025), Regina QBG-SA-00554-2021 (SKKB) [*Rengarajan*] (Crooks J.)

- appeal dismissed, costs of $2,000 awarded to Saskatchewan

2) *Tanyi-Remarck* v *The Joint Medical Professional Review Committee and Minister of Health (Saskatchewan)*, 2024 SKKB 195 [*Tanyi-Remarck*] (Currie J.)

- appeal dismissed; costs on Column 3 of Tariff awarded to

Saskatchewan

3) *Amu-Darko v The Joint Medical Professional Review Committee and Minister of Health*, 2023 SKKB 48 [*Amu-Darko*] (McMurtry J.)

- appeal dismissed; with costs awarded to Saskatchewan

4) *Patel v The Joint Medical Professional Review Committee and Minister of Health*, 2022 SKKB 245 [*Patel*] (Robertson J.)

- appeal dismissed; costs on Column 2 awarded to Saskatchewan

5) *Malhotra v The Joint Medical Professional Review Committee and Minister of Health*, 2022 SKQB 124 [*Malhotra*] (Crooks J.)

- appeal allowed in part and remitted back to Committee; no costs ordered

6) *Colistro v The Joint Medical Professional Review Committee and Minister of Health*, 2021 SKQB 62 [*Colistro*] (Bardai J.) (as he then was)

- appeal allowed in part and remitted back to Committee; no costs ordered

7) *Mitchell v The Joint Medical Professional Review Committee and Minister of Health*, 2020 SKQB 334 [*Mitchell*] (Tochor J.) (as he then was)

- appeal allowed in part and remitted back to Committee: costs on Column 2 awarded to Saskatchewan

8) *Michel v The Joint Medical Professional Review Committee and Minister of Health*, 2019 SKQB 209 [*Michel*] (Barrington -Foote J.) (as he then was)

- appeal allowed in part and referred back to Committee for reconsideration; costs on Column 1 awarded to appellant-

physician

9) *Belak v The Joint Medical Professional Review Committee and Minister of Health*, 2015 SKQB 388 [*Belak*] (Krogan J.)

- appeal dismissed; no order as to costs

10) *Oduntan v The Joint Medical Professional Review Committee*, 2011 SKQB 252 [*Oduntan*] (Dawson J.)

- appeal allowed in part, quashing one order for reduction; costs awarded to appellant-physician

11) *Offiah v The Joint Medical Professional Review Committee*, 2011 SKQB 227 [*Offiah*] (Dawson J.)

- appeal allowed in part, quashing one order for reduction; costs awarded to appellant-physician

12) *Demkiw-Bartel v The Joint Medical Professional Review Committee*, 2010 SKQB 325 [*Demkiw-Bartel*] (Foley J.)

- appeal dismissed; costs awarded to Saskatchewan

13) *New v Saskatchewan (Health)*, 2010 SKQB 111 [*New*] (Kovach J.)

- appeal dismissed

14) *Demkiw-Bartel v The Joint Medical Professional Review Committee*, 2009 SKQB 145 (Gabrielson J.)

- order allowing amendment of notice of appeal; costs in the cause

15) *Huerto v Saskatchewan*, 2008 SKCA 107 [*Huerto CA*]; affirming 2005 SKQB 373 (Allbright J.)

- civil action by physician seeking order to compel payments of account dismissed as premature

16) *Anstead v The Joint Medical Professional Review Committee*, 2006 SKQB 221 [*Anstead*] (Allbright J.)

- appeal dismissed with no award as to costs

17) *Wong v The Joint Medical Professional Review Committee*, 2005 SKQB 1 [*Wong #1*] (Ball J.)

- appeal allowed in part, quashing one order for repayment; costs awarded to appellant-physician on Column 2

18) *Wong v The Joint Medical Professional Review Committee*, 2005 SKQB 483 [*Wong #2*] (Ball J.)

- appeal allowed in part, referring matter back to Committee to reconsider and provide reasons for decision. Costs to be dealt with on final appeal

19) *Kassett v The Joint Medical Professional Review Committee*, 2004 SKQB 490 [*Kassett*] (Matheson J.)

- appeal allowed; costs awarded to appellant-physician

20) *Das v The Joint Medical Professional Review Committee*, 2002 SKQB 514 [*Das*] (Kovach J.)

- appeal allowed with referral back to Committee; leave to return on issue of costs if no agreement

21) *Price v The Joint Medical Professional Review Committee*, 2001 SKQB 274 [*Price*] (Kyle J.)

- appeal allowed with decision set aside; costs awarded to appellant-physician

22) *Hussain v The Joint Medical Professional Review Committee*, 2001 SKQB 229 [*Hussain*] (Dovell J.)

- appeal allowed with order for re-hearing; costs awarded to

appellant-physician

23) *Sothilingam v The Joint Medical Professional Review Committee*, 1998 CanLII 13988, 167 Sask R 76 (SKQB) [*Sothilingam*] (Zarzeczny J.)

- appeal allowed in part and remitted to Committee; costs awarded to appellant-physician

24) *Huerto v Saskatchewan (Minister of Health*), 1998 CanLII 13596, 170 Sask R 21 (SKQB) [*Huerto 1998*] (Baynton J.) (as he then was)

- appeal allowed and Committee order varied (judicial review application dismissed); leave to return on issue of costs if no agreement

25) *Blackwell v The Joint Medical Professional Review Committee*, 1998 CanLII 13404 (SKQB) [*Blackwell*] (Zarzeczny J.)

- appeal dismissed; award of costs if asked for

26) *Appavoo v The Joint Medical Professional Review Committee*, 1995 CanLII 5625, 127 Sask R 34 (SKQB) [*Appavoo*] (Osborn J.)

- appeal dismissed; costs awarded to Saskatchewan

27) *Misra v The Joint Medical Professional Review Committee*, 1994 CanLII 4966 (SKQB) [*Misra*] (Wedge J.)

- appeal dismissed; costs awarded to Saskatchewan

28) *Huerto v Saskatchewan Minister of Health*, 1994 CanLII 4901, 124 Sask R 21 (SKQB) [*Huerto 1994*] (Hunter J.) (as she then was)

- appeal dismissed

29) *Minhas v Saskatchewan (Minister of Health),* 1992 CanLII 8144, 102 Sask R 171 (SKQB) [*Minhas*] (Noble J.)

- appeal dismissed; no order as to costs

30) *Osiowy v Saskatchewan*, 1992 CanLII 7822, 101 Sask R 25 (SKQB) (Malone J.)

- appeal dismissed; no order as to costs

31) *Barber v Saskatchewan (Minister of Health*), 1991 CanLII 7644, 94 Sask R 37 (SKQB) [*Barber*] (Baynton J.)

- appeal dismissed; with costs

32) *Ramsahoi v Saskatchewan (Minister of Health)*, 1990 CanLII 7328, 85 Sask R 42 (SKQB) [*Ramsahoi*] (Wedge J.)

- substance of appeal dismissed, with referral back to Committee to reconsider the form of its order; costs awarded 75% to appellant-physician and 25% to Saskatchewan

[5] This list of decisions, while comprehensive, is not exhaustive, since the Court will have issued many unreported decisions. In *Ramsahoi* at paras 29 and 32, Wedge J. stated that decision was the first appeal since the 1998 amendments to the *Act* which changed the billing review process by creating the Committee. The Committee then introducing the interview of the subject physician as part of its inquiry process.

[6] In applying this case law as precedent, one must be mindful that the Committee's process and practice changed over the years in response to both legislative amendments and to direction provided in the Court's decisions, such as by enhanced and express requirements for physician documentation to support billings. See: *Patel* at para 99. The Court's decisions have also been guided by changes in law, such as the standard of review on appeal. See: *Canada (Minister of Citizenship and Immigration) v Vavilov*, 2019 SCC 65.

[7] Dr. Bierman, in oral argument, argued that the case law is inconsistent as a result of the absence of a right of appeal from this Court. I read the case law listed above, in part to see whether this charge was warranted. My conclusion is that the case

law is generally consistent. As will be illustrated in the following review of the law, the Court's decisions usually take note of previous decisions. While there are changes of approach, the cases show an evolution guided by precedent.

Purpose of the Act

[8] In *Huerto 1998*, Baynton J. stated that the purpose of the *Act* was to relieve Saskatchewan residents from having to make direct payment for medical care:

> [55] … The primary object of the Saskatchewan Medical Care Insurance Act is to relieve each of the residents of the province from having to bear, directly and individually, his or her costs of medical care. That purpose is achieved by means of a plan of insurance, with the government being constituted as an insurer and the residents as the beneficiaries. …

[9] It might be added that the *Act* also benefits physicians by relieving them of the responsibility to collect payment directly from their patients and guaranteeing payment for insured medical services through a single payor. This is a significant benefit for any private business.

Billing Review Process

[10] The purpose of the billing review process is to protect the integrity of public finances by ensuring that public funds are properly expended for their intended purpose.

[11] The *Act* and *The Saskatchewan Medical Care Insurance Payment Regulations, 1994*, RRS c S-29 Reg 19 [*Regulations*] provide for payment to physicians for medically necessary services provided to members of the public. Payment is limited to a prescribed fee for insured services.

[12] To obtain payment from the Minister of Health [Ministry], the billing physician must meet the billing requirements in the Physician Payment Schedule. The

Regulations at s 5 list documentation or content requirements for payment of bills presented by physicians for insured medical services they provided.

[13] In *Huerto CA*, Richards J.A. (as he then was) for the Court of Appeal made the unsurprising observation that the Government is not required to pay for medical services just because the service was provided and billed:

> [35] Thus, overall, it is apparent that the Payment Schedule allows the Government, in at least some circumstances, to request more information about he services underpinning an account and, in appropriate situations, to deny payment of an account. The Schedule does not oblige the Government to compensate a physician merely because a service has been provided and an account submitted.

[14] In *Patel* at paras 9 - 16, I described the statutory scheme:

> **Statutory scheme**
>
> [9] Under our public health system, patients do not pay directly for medical care and treatment. Most physicians (medical doctors) are in private practice and bill the government for payment of their services to patients. Section 18 of the *Act* authorizes the Minister to make payment for the provision of insured services. "Insured services" is defined in s. 14 of the *Act* as "medically required services provided in Saskatchewan by a physician". The amount paid for insured services is determined by the Physician Payment Schedules, pursuant to ss. 5(1)(f) and 6(1)(d) of *The Saskatchewan Medical Care Insurance Payment Regulations, 1994*, RRS c S-29 Reg 19.
>
> [10] In *Colistro v Joint Medical Professional Review Committee*, 2021 SKQB 62 at para 11 [*Colistro*], Bardai J. described the criteria for payment:
>
> > [11] In practical terms, in order to be paid for a service:
> >
> > (a) the treatment for which payment is sought must be medically required by the patient;

> (b) the physician providing the service must have the qualifications to perform the service and provide the treatment;
>
> (c) the treatment must be performed and/or supervised by the physician as required by the Schedule;
>
> (d) the appropriate code in the Schedule must be identified; and
>
> (e) the assessment criteria contained in the Schedule must be satisfied.

[11] Payment of physician billing generally operates under an honour system.

[12] The review process under the *Act* is designed to provide some control over public payment for medical services while affording procedural safeguards and fairness to the subject of the billing review.

[13] The Minister does random audits of billing patterns. If a statistical deviation is found, it is referred to the Director of Professional Review [Director] appointed under s. 49.1 of the *Act*. In this case, an audit identified concerns with Dr. Patel's billing patterns. Dr. Patel had the highest billings amongst his group of family physicians (Final Order at page 4; Record at S652).

[14] The Director may make a referral to the Committee if it appears that monies have been paid "by reason of any departure from a pattern of medical practice acceptable to the committee" (s. 49.2(2) of the *Act*). The Director, David Guerrero, made a referral to the Committee in this case. To ensure objectivity in the initial review, the referral did not identify Dr. Patel as the subject.

[15] The Committee is composed of physicians appointed by the Minister, the College and the Saskatchewan Medical Association, pursuant to s. 4(1) of *The Medical Care Insurance Peer Review Regulations*, RRS c S-29 Reg 18 [*Regulations*]. Section 5 of those *Regulations* authorize the Committee to also appoint "temporary members". These temporary members may have additional experience in the subject physician's

> specialized area of practice. The Committee therefore has institutional expertise and operates as a form of peer review.
>
> [16] The Committee has both an investigative and adjudicative function. …

[15] The Ministry authorizes payment of billed services. In doing so, the Ministry reviews and audits billings to identify concerns or improper billings. The Director of Professional Review may, pursuant to s. 49.2(2) of the *Act*, refer such identified billings to the Committee for investigation and adjudication. When doing so, the Director may provide a statistical analysis of the subject physician's billings over a set period of time. That statistical analysis compares the billings of the subject physician with billings of other Saskatchewan physicians in similar practice.

Role of the Committee

[16] The Committee is a statutory body established under ss. 49 and 49.2 of the *Act*. Sections 49.5 and 49.6 authorize the Committee to gather information and hear evidence:

> **Powers of committee**
>
> **49.5** The members of each committee, in addition to any powers granted to them by this Act, have all of the powers conferred on a commission by sections 11, 15 and 25 of *The Public Inquiries Act, 2013.*
>
> **Required information**
>
> **49.6** The committee or a person authorized by the committee may request any information that it considers relevant to its investigation from the physician whose insured services are under investigation and the physician shall provide the committee or the person authorized by the committee, as the case may be, with the information.

[17] The Committee exercises both investigative and adjudicative authority in fulfilling its supervisory jurisdiction: *Patel* at para 16; and *Huerto 1998* at paras 45 and

50.

[18] Section 49.2(5) authorizes the Committee to make orders for re-payment of billings:

> **49.2**(5) Where a matter has been referred to the committee pursuant to subsection (2), the committee may order that:
>
> (a) in the case of insured services for which payment has not been made by the minister, payment should not be made, or should be made at a reduced level, for all or any part of the services;
>
> (b) in the case of insured services for which payment has been made by the minister, all or part of the amount paid by the minister should be recovered from the physician.

[19] In *Huerto 1998* at paras 5 and 54, Baynton J. described the legislative objective of a review hearing under s. 49.2 of the *Act*:

> 5 The legislative objective of the professional review provided for in *The Saskatchewan Medical Care Insurance Act* is to impose some controls and limits on the liability of the public purse to pay billings by care providers (in this case medical doctors) for services to their patients (in this case cardiac patients). Even though the ultimate goal of the provision of medical services is to provide quality patient care, the depth of the public purse is not unlimited. Unless such care is provided in a cost effective manner the demands on the public purse will become unacceptable. Accordingly the economics of providing quality patient care is the primary issue to be determined by a professional review.
>
> …
>
> 54 … The whole object of a review hearing pursuant to s. 49.2 is to determine if the billing aspect of the pattern of medical practice is acceptable to the Committee. Section 49.2 is not concerned with the professional competence of a physician but with the billings of a physician respecting insured services. …

[20] These passages were quoted with approval in: *Mitchell* at para 34; *Oduntan* at para 25; *Offiah* at paras 38-39; *New* at paras 23-24; *Anstead* at para 6; *Das* at para 5; *Hussain* at para 6; and *Kassett* at para 6.

[21] In *Colistro* at para 66, Bardai J. referred to *Huerto 1998* in describing the role of the Committee:

> [66] It needs to be noted that the role of the JMPRC is not to assess competence. The questions that the JMPRC must answer are: is the procedure medically required; does the physician have the qualifications to do the procedure; did the physician do the work and provide the treatment; what is the applicable provision and code in the Schedule; and have the assessment criteria in the Schedule been met? It is not the JMPRC's function to determine competence. In *Huerto v Saskatchewan (Minister of Health)* (1998), 170 Sask R 21 (QB) at para 54, the Court held:
>
> > [54] ... The whole object of a review hearing pursuant to s. 49.2 is to determine if the billing aspect of the pattern of medical practice is acceptable to the Committee. Section 49.2 is not concerned with the professional competence of a physician but with the billings of a physician respecting insured services. ...

[22] This passage was quoted with approval in *Malhotra* at para 28.

Committee procedure

[23] Section 49(5) of the *Act* allows the Committee, subject to express requirements of the *Act* and any *Regulations*, to determine its own rules and procedure.

[24] In *Knight v Indian Head School Division No. 19*, 1990 CanLII 138, [1990] 1 SCR 653 at p 685 (SCC), L'Heureux-Dubé J. for the Supreme Court of Canada held that an administrative tribunal is, subject to requirements of its enabling statute and natural justice, "master of its own procedure":

> It must not be forgotten that every administrative body is the master of its own procedure and need not assume the trappings of

> a court. The object is not to import into administrative proceedings the rigidity of all the requirements of natural justice that must be observed by a court, but rather to allow administrative bodies to work out a system that is flexible, adapted to their needs and fair. …

[25] In *Huerto 1998*, Baynton J. wrote:

> [44] The legislation also provides that it is the Committee that decides on the procedure it will follow and it may consider whatever it considers relevant. The only significant statutory requirement imposed on the conduct and operations of the Committee is that it must observe the rules of natural justice. …
>
> . . .
>
> [70] My decision should not be interpreted to suggest that review proceedings are invalid unless they take on the appearance of a formal trial or court hearing. That is obviously not what is intended by the legislation nor is it the most effective procedure by which to determine if repayment orders should be made. The costs in most cases would be prohibitive. …

[26] In *Colistro* at para 13, Bardai J. wrote:

> [13] … The JMPRC's role is to determine whether a physician should be required to repay the Minister of Health because of overbilling, erroneous billing or because the services provided were unnecessary or excessive. For the purpose of carrying out its duties, the JMPRC may determine its own rules of practice and procedure and the manner in which it will conduct its affairs. …

[27] From my review of the appeal record and this Court's reported decisions of appeals, it appears that the Committee follows the process described below.

[28] The Committee is composed of physicians to provide peer review of billing practices. The Committee members are usually selected from the same practice area of the subject physician.

[29] The Decision at page 4 (Record, p. X557) states “The Committee’s review proceeds in stages and may be terminated at any stage, if the Committee is satisfied that the initial concerns are not supported.”

[30] The Committee initially reviews the statistical profile provided by the Ministry to determine whether further investigation is warranted. If so, the Committee requests records from the subject physician which are also reviewed. If the Committee finds concerns with the billing practices of the subject physician, the Committee informs the subject physician by written notice. The subject physician is asked to attend for an interview to discuss those concerns.

[31] The subject physician may be accompanied by their lawyer at the interview. The subject physician is given the opportunity to make an opening and closing statement. In between the opening and closing statements, Committee members question the subject physician about his or her billing practices and records.

[32] After the interview, the Committee meets *in camera* to decide whether to make an order requiring re-payment of billings and whether to order payment of an additional amount up to $50,000. The Committee’s decision is issued in writing with reasons.

[33] The Committee used to provide a draft decision to the subject physician before issuing its final order. It discontinued that practice as of September 26, 2022. (Decision, p. 6; Record, p. X559)

Right of appeal

[34] Section 49.21 of the *Act* authorizes an appeal from an order of the Committee to this Court:

Appeal to judge

49.21(1) Subject to subsection (2), a physician who is aggrieved by an order of the committee made pursuant to section 49.2 may appeal to a judge of the Court of King's Bench by serving the director with a notice of appeal and filing the notice of appeal with the local registrar of the court within 30 days after the day on which the order is served on the physician.

(2) The judge hearing the appeal shall consider only the record of the proceedings of the committee with respect to the order appealed from and the evidence presented at those proceedings and may make an order:

(a) affirming or varying the order appealed from;

(b) refering the matter back to the committee with directions to reconsider it; or

(c) quashing the order appealed from and substituting any order that the judge considers the committee ought to have made.

(3) The taking of an appeal under this section stays the operation of the order appealed against pending the disposition of the appeal or other order of the judge.

(4) There is no appeal from the decision of a judge pursuant to this section.

Appeal on the record

[35] Section 49.21(2) provides that the appeal is on the record of the proceedings of the Committee. The practice is for the Ministry to provide the record in a binder, including a transcript of the interview.

[36] This Court has repeatedly stated that the appeal is not a re-hearing of the billing review. The Court will not substitute its assessment of facts for that of the Committee which heard the evidence, unless there was a palpable and overriding error that affected the Committee's assessment of facts. See: *Colistro* at para 21; *Michel* at para 14; *Oduntan* at para 76; *Offiah* at para 75; *Misra*; *Appavoo* at para 33; *Barber* at

para 14; and *Ramsahoi* at para 47.

Standard of review

[37] In *Colistro* at paras 5 and 21, Bardai J. summarized the standard of review on an appeal under s. 49.21 of the *Act*:

> [5] In short, the standard of review will depend on the nature of the issue raised. Questions of statutory interpretation and other questions of law are subject to the standard of correctness. Questions of fact are subject to the standard of palpable and overriding error. Finally, absent an extricable error of law, questions of mixed fact and law are also subject to the palpable and overriding error standard.
>
> . . .
>
> [21] The interpretation of the *Act,* the *Regulations* and the Schedule enacted pursuant to the *Regulations* are questions of law and are subject to review on a correctness standard. See: *Abrametz*, at paras 71-85 [2020 SKCA 81]. That said, the application of the statutory criteria to the evidence to determine whether Dr. Colistro was billing appropriately are questions of mixed fact and law, reviewable on the deferential standard of palpable and overriding error, absent an extricable question of law. …

[38] Currie J. quoted these passages with approval in *Tanyi-Remarck* at paras 9-10.

Scope of appeal

[39] In *Barber* at para 9, Baynton J. summarized the grounds on which the Court would interfere with a decision of the Committee:

> [9] The nature and scope of an appeal under the *Act* was the subject of a recent decision of this court. In *Ramsahoi v. Saskatchewan (Min. of Health) et al.* (1990), 85 Sask.R. 42, Wedge, J., extensively reviewed the provisions of the legislation and her conclusions need not be restated here. It is sufficient for

> the purposes of this appeal to note that at p. 53, in dismissing the appeal, she outlined the grounds upon which the
>
> 1. It exceeded or failed to exercise its jurisdiction;
>
> 2. It failed to observe the rules of natural justice;
>
> 3. It made an error in law;
>
> 4. Its findings were not reasonably supported by the evidence and the material which it was entitled in law to consider.

[40] This summary was quoted with approval in subsequent decisions of the Court. See: *Michel* at para 10; *Mitchell* at para 10; *Belak* at para 55; *Oduntan* at para 21; *Offiah* at para 10; *Wong* #2 at para 2; *Hussain* at para 9; *Sothilingam* at para 3; *Huerto 1998* at para 32; *Blackwell* at para 12; *Appavoo* at para 12; *Huerto 1994* at para 3; and *Minhas* at para 7. In *Minhas* at para 10, Noble J. added that "we must examine the reasons given by the Review Committee carefully to see whether or not their ultimate decision is based on reasonable findings of fact."

Jurisdictional error

[41] The Committee is a creature of statute. As such, its jurisdiction is established by and confined to the authority provided by the *Act*. The standard of review on a question of jurisdiction is correctness. In *Michel* at para 13 and *Mitchell* at para 16, the Court observed that true questions of jurisdiction are narrow.

[42] In *Kassett* at paras 29-31, the Court allowed the physician's appeal where the Committee went beyond its jurisdiction in ordering repayment for services which had been provided. The Court held that this order was not for repayment of over-billing, but a penalty, which was beyond the Committee's jurisdiction. (There was no provision to order payment of an "additional amount" order at that time.):

> [28] The Committee must have accepted Dr. Kassett's explanation for inadequate documentation because in the paragraph of its report immediately preceding its final order,

> entitled "The Committee made the following comments", it was stated:
>
> > The Committee never doubted that Dr. #7243 (Dr. Kassett) provided the service.
>
> [29] If there were no, or insufficient, documents to permit a conclusion that medical services for which payment had been made by the Minister of Health to a medical practitioner, were actually performed, the Committee would certainly be entitled to reassess the medical practitioner. But in this instance it was clearly stated that the medical services, for which Dr. Kassett received payment, were performed. Thus, he was entitled to be paid.
>
> [30] By reducing certain payments to Dr. Kassett to 95%, "due to inadequate documentation", the Committee was penalizing Dr. Kassett. As was clearly stated in *Huerto v. Saskatchewan, supra*, the function of the Committee is to determine whether a medical practitioner should be required to make a repayment to the Minister of Health because of overbilling, misbilling, or because the services, for which payment was made, were not provided or were unnecessary or excessive. And as was clearly stated in *Datta v. Sask., supra* [1986 CanLII 3245, 52 Sask R 18 (SKCA)], the object is "not to penalize or discipline".
>
> [31] In this instance, the reassessment because of inadequate documentation can only be viewed as a penalty and must therefore be quashed. The assessment "due to misbilling" is confirmed.

Rules of natural justice

[43] Section 49.2(10) of the *Act* requires that the Committee observe the rules of natural justice. The rules of natural justice have been described as "fair play in action". In *Offiah* at paras 13 - 17 Dawson J. wrote:

> [13] The appellant submits the Committee did not provide him with adequate particulars of their specific concerns in advance of the hearing. The appellant submits that this deprived him of the opportunity to be fully prepared to respond to those concerns at the hearing and as a result the reassessment should be set aside.

> [14] Section 49.2(10) of the *Act* provides as follows:
>
> > 49.2 (10) In making an order pursuant to this section, the committee shall observe the rules of natural justice.
>
> [15] It is clear that the rules of natural justice impose a duty on the Committee to act fairly and to provide procedural fairness. …
>
> . . .
>
> [17] The rules of natural justice entitle the appellant to a fair hearing, which means that he was entitled to know the case against him and be given a meaningful opportunity to respond.

[44] The Court relied on breaches of natural justice in allowing appeals in:

- *Hussain* at paras 36-44, for failing to inform the subject physician of the Committee's concerns prior to the interview;
- *Price* at paras 14 and 19-20, for basing its decision on documentation shortfall, when it was his practice profile that gave rise to the interview hearing;
- *Das* at paras 51 and 55, by denying the subject physician's request to provide his own statistical evidence in response to the statistical profile considered by the Committee;
- *Wong* #2 at para 27, where the Committee based its decision on evidence without giving the subject physician a fair opportunity to respond to that evidence.

[45] In *Hussain* at paras 36-37, Dovell J. wrote:

> [36] Lord Denning stated in *Selvarajan v. Race Relations Board*, [1976] 1 All E.R. 12 (C.A.) at p. 19:
>
> > . . .The fundamental rule is that, if a person may be subjected to pains or penalties, or be exposed to

> prosecution or proceedings, or deprived of remedies or redress, or in some such way adversely affected by the investigation and report, then he should be told of the case made against him and be afforded a fair opportunity of answering it. . .

[37] Dr. Hussain was not afforded a fair opportunity to answer the real concerns of the JMPRC. The Committee had a duty once it had been provided with the documentation and realized it had other concerns regarding Dr. Hussain's billing practice to bring those additional concerns to his attention prior to the hearing taking place. To wait in the weeds with undisclosed concerns until the time of the hearing and to firstly bring those concerns to a physician's attention during that hearing was not fair to the physician. The physician may have made a conscious decision, as was the case in all likelihood here, that he could attend the hearing himself and explain his high numbers. If for no other reason than giving a physician the opportunity of assessing his or her case to determine whether or not to bring an advisor with him or her, it is fundamental that all of the concerns of the JMPRC are to be provided to a physician prior to the hearing commencing. In the event the JMPRC has additional concerns as the hearing progresses, those concerns are to be clearly outlined to the physician and he or she given an ample opportunity to answer those additional concerns. It may very well be that an adjournment would be necessary in that regard.

[46] In *Price*, Kyle J. wrote:

> [19] In any investigation, new concerns not related to the original area of interest may well arise. In such cases it is reasonable to advise the party under investigation of the new focus, giving time to take advice and to respond. Where, as here, those concerns are treated in passing without any suggestion of intended action they ought not to form the basis of sanctions.
>
> [20] I conclude that there was a denial of natural justice. As the principal concerns of the Committee have been met and have resulted in no action, the decision of the Committee and the consequent assessment must be set aside.

[47] In *Das*, Kovach J. wrote:

> [51] By failing or neglecting to either provide or consider the need for the statistical evidence requested by Dr. Das, the Committee has failed to properly observe the rules of natural justice. The Committee should have allowed Dr. Das to present, for their consideration, any statistical analysis that may have been available to him, to support his position. The question the Committee should have considered was not whether the analysis would materially alter its decision but whether it could have altered it at all.

[48] In *Wong #2* at para 27, Ball J. wrote:

> [26] The Act gives the Committee a considerable amount of latitude in terms of the information it may choose to act upon. Subsection 49.2(8) of the Act authorizes the Committee to take into account anything that it considers relevant, including a statistical or other comparison between insured services provided by the physician being considered and insured services provided by other physicians or groups of physicians. The legislation also specifically states that the Committee "... is not required to examine the provision of any individual insured service that has been provided by the physician."
>
> [27] Although the Committee may have a discretion with respect to the evidence it chooses to rely on, once it decides to base its decision on certain evidence it is required to give the appellant a fair opportunity to respond to it. It is clear in this case that the appellant was never informed of the facts on which the Committee intended to rely to support its reassessment of fees for "over servicing." This meant that he was given no opportunity to point out to the Committee that there was no discernable connection between the facts on which it relied and the order it eventually made.

Error in law

[49] The standard of review on a pure question of law is correctness. The standard of review on a mixed question of fact and law is palpable and overriding error.

[50] Failure to provide adequate reasons sufficient to allow for appellate review is an error in law. The Court allowed appeals on this basis in*: Colistro* at paras 48 – 50; *Mitchell* at para 70; and *Michel* at paras 62 and 66.

Findings not reasonably supported by the evidence

[51] Section 49.2(8) of the *Act* allows the Committee to consider "anything" it considers relevant:

> **Joint medical profession review committee**
>
> 49.2 …
>
> (8) In determining whether an order should be made pursuant to subsection (5) or (7), the committee may take into account anything that it considers relevant, including a statistical or other comparison between the provision of insured services by the physician whose insured services are being considered and the provision of insured services by other physicians or groups of physicians, but it is not required to examine the provision of any individual insured service that has been provided by the physician.

[52] The Court allowed physician appeals where the Committee's findings were not reasonably supported by the evidence in: *Huerto 1998* at paras 52 and 70; *Sothilingam* at paras 31 and 35; and *Wong #1* at paras 39-41.

Onus of proof

On appeal to the Court

[53] Section 49.21 of the *Act* confers a right of appeal to this Court against the Committee decision to the subject physician only. On an appeal to this Court, the appellant has the onus of proof. See: *Patel* at para 38; *Colistro* at para 3; and *New* at para 28.

On billing review by Committee

[54] The Decision at p. 12 (Record, p. X565) discusses "Physician Billing Obligations":

> **Physician Billing Obligations:**
>
> The onus is on the physician to demonstrate that they have appropriately met the Physician Payment Schedule requirements in order to bill and receive payment for medically required services through the publicly funded system. Physician are also expected to be aware of their billing obligations as stated under each Physican Payment Schedule service code effective for the specific date of service. Physicians are notified of any changes to the Payment Schedule via a Physician's Newsletter which is issued on April 1 and October 1 of each year.

[55] A physician who presents a bill for payment must demonstrate their entitlement to payment. This onus continues in a billing review before the Committee, both in responding to requests for records and in answering questions at the interview.

[56] On a billing review by the Committee, a presumption may arise, including from the statistical analysis provided by the Director to the Committee, that a billing or pattern of billing does not meet the requirements for payment or appears to depart from acceptable practice. When that occurs, the subject physician has the onus of demonstrating that he met the billing requirements. This onus of proof on the subject physician does not constitute a reverse onus. See: *Rengarajan* at para 38; *Tanyi-Remarck* at para 47; *Amu-Darko* at para 26; *Patel* at paras 55-60; *Malhotra* at para 91; *New* at para 28; and *Huerto 1998* at paras 48-50.

Departure from the norm may justify finding

[57] The Committee may find a departure from acceptable billing practice from the statistical analysis provided by the Director. See: *Sothilingam* at para 29; and *Huerto 1994* at para 94.

[58] In *Huerto 1994* at para 32, Hunter J. wrote:

> [32] The Act provides that the Committee may take into account statistical or other comparisons between the services of the physician with respect to whom they are conducting a review and the services of other physicians or groups of physicians. As well, the Director refers matters to the Committee on the basis of money paid or about to be paid to a physician for insured services which he believes may represent a departure from a pattern of medical practice which is acceptable. In other words, the tenor of those sections of the Act is to govern the payment to physicians for insured services. This necessarily emphasizes the economic considerations. Furthermore, Huerto provided the Committee with a lengthy and detailed economic analysis in an attempt to show the Committee that his method of frequency of patient contacts and testing was more economical than cardiologists who had hospital privileges. There is no question but that it is acceptable for the Committee to examine billing patterns and to review how the pattern of one physician differs from another physician or group of physicians. The Committee had a hearing to give Huerto the opportunity to explain the deviations it observed in his billing pattern as compared to a group of physicians. Again, the legislation puts the emphasis on the payment for insured services and the Committee did not abuse the discretion vested in it by the legislation in conducting the review and hearing with respect to this matter and did not exceed its jurisdiction.

[59] In *Sothilingam* at para 29, Zarzeczny J. wrote:

> [29] In a larger sense it may well be that the evidence the JMPRC had with respect to the patient group having 10 or more attendances might well permit some appropriate conclusions to be drawn with respect to patients in the under 10 attendance group. Nevertheless the extent of the inquiry actually undertaken by the JMPRC with respect to the former group itself recognizes the importance of a detailed analysis to support conclusions which might otherwise generally be reached based upon overall statistical evaluations. It is very clear that the appellant billed a far greater amount than the group mean, and that he saw an extraordinary number of patients compared to the mean. Either one or both of these circumstances tend to invite a conclusion which might support

the decision of the JMPRC.

Deference to Committee

[60] The Court will give deference to the Committee on findings of fact, including appropriate medical practice, on the basis of the standard of review and the Committee's acknowledged experience and expertise. See: *Rengarajan* at para 135; *Patel* at paras 64 and 84; *Malhotra* at para 34; *Mitchell* at para 86; *Belak* at paras 59 and 140; *New* at para 36; *Anstead* at para 50; *Wong* #1 at para 33; *Huerto 1998* at paras 62-63; and *Ramsahoi* at paras 46-47.

[61] In *Huerto 1998*, Baynton J. wrote:

> [62] The Court is usually placed in the unenviable position of having to consider the validity or credibility of this conflicting opinion evidence. Certainly a medically qualified committee is in a much better position than a court to assess such issues. In fact the legislation implies, as affirmed by the case law, that a committee is entitled to use its expertise in assessing the evidence. The Court has no such advantage. If the decision of a committee is reasonably supported by one version of the evidence, the Court in my respectful view should give deference to the committee and should not substitute its own view of the evidence. The Court should intervene only if the evidence as a whole clearly demonstrates that the decision of the committee is in error because it is not reasonably supported by that evidence.
>
> [63] The determination by the Court of whether the decision is "reasonably" supported by the evidence will depend in part on the nature of the evidence presented. The Court, for example, will be more inclined to rely on its own view of the evidence if the evidence is comprised primarily of statistical analyses rather than medical opinions. As well, less deference will be given to a committee in cases, such as the one before me, where considerable evidence has been presented on behalf of the medical professional under review. In such a case the judicial role of a committee becomes more prominent than its investigative role and its own expertise becomes less crucial to its ultimate decision.

[62] In *Anstead* at paras 49 - 50, Allbright J. wrote:

> [49] While the appellant has suggested that the committee in essence relied to a significant degree upon information that was not provided by way of disclosure to him, it is with respect that I observe that the committee's articulated reasons do not support this contention. The committee quite clearly defines the various areas which underlie their analysis and resulting rationale.
>
> [50] In considering this issue, it is necessary to also observe that the committee possesses a degree of unique expertise through training and background and a review of their reasons must be accorded a degree of deference which reflects that background and unique committee composition.

[63] In *New* at para 36, Kovach J. wrote:

> [36] Determinations of patient over-servicing require an assessment to be made by professional members of the Committee. As indicated in the above quotation, the conclusions of a professional committee warrant deference where peers determine conduct, in the level of treatment, to be an unacceptable departure from the norm.

[64] In *Belak* at paras 59 and 140, Krogan J. wrote:

> [59] Deference is required given the special expertise of the Committee. The question is whether the Committee's decision falls within the range of acceptable and rational solutions. This Court must assess reasonableness as it relates to the process of the Committee's articulation of reasons and as it relates to the outcome. In terms of the outcome, a review of reasonableness is concerned with whether the decision falls within a range of possible, acceptable outcomes defensible in fact and law.
>
> . . .
>
> [140] The Committee arrived at a conclusion, based on a thorough review of the records, and information provided by Dr. Belak, as to what visits were medically necessary. The Committee members were uniquely situated to make that determination given the medical training and experience they brought to the analysis. They were better able than that of the court to engage in an assessment of

> medical necessity. Deference ought to be paid to such conclusions. As noted in *Ramsahoi* at para 46, the court stated:
>
> > 46 ...Although a judge on appeal is given the power, in s. 49.21(1), to substitute an order it considers that the Committee ought to have made for the order it did make, it must be acknowledged that the *Act* gives a committee of physicians the responsibility of insuring that no other member of its profession is over-billing the Minister of Health. In so doing, these physicians use their medical background and experience in making their assessments of patterns of medical practice.

[65] In *Rengarajan* at para 135, Crooks J. wrote:

> [135] Given their collective expertise, the Committee is in a far better position than this Court to determine what medical information is appropriate or necessary for the management of chronic disease. …

What constitutes sufficient notice?

[66] The Court commented on what constitutes sufficient notice in dismissing appeals based on breach of natural justice in: *Tanyi-Remarck* at paras 34-37; *Malhotra* at para 140; and *Offiah* at para 29.

[67] In *Offiah* at paras 16, 17, 25 and 29, Dawson J. wrote:

> [16] In *Huerto v. Saskatchewan (Minister of Health) et al* (1995), 132 Sask. R. 59 (Q.B.), [1995] 5 W.W.R. 199 ("*Huerto 1995"*), Laing J. (as he then was) said the following about this issue at para. 29:
>
> > [29] The Committee is not a party to an action, but is a statutory delegate, with a statutory mandate. The mandate includes the right to review the pattern of billing of physicians. In the exercise of its mandate it is entitled to ask questions of the physician in question. Once the physician knows the factual information available to the Committee, and the areas of practice that will be the subject of questioning, the requirements of procedural fairness are satisfied. If a physician does not know the answer to a

> question, the physician is at liberty to say so and provide an undertaking to supply the answer....
>
> [17] The rules of natural justice entitle the appellant to a fair hearing, which means that he was entitled to know the case against him and be given a meaningful opportunity to respond.
>
> . . .
>
> [25] The appellant submits that prior to the hearing, he should have been provided with a list of issues relating to particular patients, but it is clear that such an expectation was rejected in *Huerto 1995, supra* and in *Grabowski v. Joint Chiropractic Professional Review Committee*, 1999 SKQB 9 183 Sask.R. 47,…
>
> . . .
>
> [29] The Committee here provided notice of the factual information available to the Committee, the areas of practice that would be subject to questioning and the files relating to those issues. The jurisprudence to date confirms that with such notice, procedural fairness has been met.

[68] In *Malhotra* at para 140, Crooks J. wrote:

> [140] Natural justice does not require an opportunity to be heard after a decision is made, but rather that the physician have an opportunity to make submissions and put forward their case before a decision is taken. While there is a fair opportunity to respond and provide documents, that does not suggest an endless opportunity to do so. The physician cannot keep returning with more and more documentation until they get the decision they want after the evidentiary portion of the assessment is concluded.

Committee determines what is "acceptable"

[69] Section 49.2(1) of the *Act*, which provides for referrals by the Director of Professional Review to the Committee, uses the words "by reason of any departure from a pattern of medical practice acceptable to the committee". The Court has interpreted these words as establishing the standard for acceptable billings, including whether the service was medically required, as "acceptable to the committee". See: *Colistro* at paras

25-28; *Oduntan* at para 63; *Offiah* at para 64; and *Huerto 1998* at para 54.

[70] In *Offiah* at para 64, Dawson J. wrote:

> [64] In the cases referred to above, the court clearly articulated that the role and mandate of the Committee is to determine if the billing aspect of the pattern of medical practice of a medical practitioner is acceptable to the Committee. In reference to the lack of documentation, this Court has concluded that the issue must be analysed with reference to the specific payment schedule. The payment schedule sets out the medical services the medical practitioner must perform in order to be paid for a particular service. Each payment schedule contains a list of medical services to be performed and in some instances, for some services, that includes a record. In respect of documentation, or lack of documentation, the "billing aspect" of the pattern of a medical practice is defined by the payment schedule. The jurisprudence is clear that the Committee is entitled to examine whether the physician performed all of the constituent elements set out in the payment schedule, which in some cases includes a record requirement.

[71] In *Colistro* at paras 25-29, Bardai J. wrote:

> [25] Section 49.2(2) of the *Act* pursuant to which the JMPRC derives its authority states that:
>
> > **49.2**(2) Where, in respect of insured services provided by a physician, it appears to the director that a physician has received or may receive from the minister or that a physician has caused or may cause the minister to pay to any person, or both, either directly or indirectly, any amount of money **by reason of any departure from a pattern of medical practice acceptable to the committee**, he may refer the matter to the committee. [Emphasis added]
>
> [26] The reference to a "departure from a pattern of medical practice acceptable to the committee" indicates a more objective test than the one proposed by Dr. Colistro and that, if there is a subjective component, and I agree that there is, it is the JMPRC's opinion, belief and understanding that counts.

> [27] In this context, "medically required" means a treatment, service, test or supply which is generally accepted by the JMPRC (which is comprised of multiple physicians representing a number of disciplines) as essential, effective and appropriate in the diagnosis, care or treatment of a specific medical condition, sickness or injury. It reflects the level of care and standard of practice the JMPRC expects a physician to provide based on the healthcare needs of a given patient. Language similar, albeit not identical, to this language can be found in employee health benefit policies within the context of defining medically necessary care. See, for example: *International Union of Operating Engineers Local 115 v SMS Equipment Inc.*, 2019 CanLII 1726 (BCLA) at para 31; *Kingston (City) v Kingston Professional Firefighters' Association*, 2015 CanLII 56247 (Ont LA) at para 17, and *Teamsters (Chemical, Energy and Allied Workers, Local Union No. 1979) v McKesson Canada Corporation*, 2011 CanLII 99377 (Ont LA).
>
> [28] Simply put, Dr. Colistro does not get to define "medically required" within the context of this specific legislation. It is not his opinion of what is required that counts.
>
> [29] It is evident from the comments of the JMPRC that they correctly interpreted the legislation when they found, for example, in their letter of August 21, 2017, that Dr. Colistro's "billing pattern is not within accepted medical practices or standard of care and is not medically required." Clearly, the JMPRC adopted a test based on their assessment of what is accepted medical practice.

Consequences of inadequate documentation

[72] The Decision at pp. 32 – 33 (Record, pp. X585 – X586) commented on the obligation of physicians to keep proper records of billed services:

> **Committee Commentary:**
>
> Record keeping/documentation is considered part of a physician's "pattern of medical practice". In a system which depends on the expenditure of public funds, there is an obligation to look behind the face of the accounts presented for payment and examine the basis for payment. The Physician Payment Schedule does not oblige the Government to compensate a physician merely because "a" service has been

> provided and an account submitted. The Committee does not interpret the documentation requirements associated with a particular service to mean that simply performing "a" service without the appropriate and required documentation entitles a physician to be paid – or that "any" documentation present in the medical record implying "a" service was performed, should entitle a physician to be paid.
>
> One of the purposes of the medical record in the context of this Committee's mandate is to determine whether an insured service was provided, whether it was medically required, whether it was actually provided, and whether it has fulfilled the billing requirements as outlined in the Physician Payment Schedule. Completing the record according to each service code requirement is part of the work for which physicians are paid. When a pattern of practice has been established that involves a failure to document accordingly, it may result in a deduction in that portion of the billing.

[73] The Court has upheld Committee findings of improper billings based on the subject physician's inadequate documentation of the insured service in: *Patel* at para 101; and *Malhotra* at para 167. The ordered repayment may be for failure to document or for failure to provide the service, based on an adverse inference drawn from the lack of documentation, or both. Ordering repayment for both failures or omissions is not improper doubling for the same omission, provided the evidence supports the separate findings.

[74] In *Malhotra* at para 166, Crooks J. wrote:

> [166] In this case, the JMPRC focussed on Dr. Malhotra's obligations to be accountable and forthright in the recovery of the limited resources available for healthcare in the province. In my view, the extent of the billing issues, including billing for services where she was found not to be present, warranted a fine at the high end and it was within the JMPRC's discretion to make this order. The JMPRC did not err in principle, misapprehend or fail to consider material evidence, fail to act judicially, or reach a decision so clearly wrong that it would result in an injustice.

[75] In *Patel* at paras 100 - 101, I wrote:

> [100] The Final Order repeatedly refers to the inadequacy of Dr. Patel's medical records, noting both omissions and illegible handwriting. The Final Order at page 21 (Record at S669) concludes that "15% to be the total value of the documentation component in each visit service code."
>
> [101] In other words, since the Minister pays doctors to complete these medical records as part of the service provided to the patient, failure to do so may result in a deduction of that part of the billing. Given that the Committee members are physicians and tasked with review of physician billings, I accept that they were in the best position to make this estimate. I find no palpable and overriding error in this finding of fact.

Mathematical formula not required

[76] The Committee is not required to provide a mathematical formula supporting its orders for recovery of billings. See: *Patel* at para 69; *Offiah* at para 77; *Demkiw-Bartel* at para 19; *Anstead* at para 50; and *Minhas* at paras 20-22.

Extrapolation or estimate allowed

[77] The Court has accepted the Committee's use of extrapolation and estimates in determining a percentage recovery for billing categories. See: *Tanyi-Remarck* at paras 81-82; *Patel* at para 68; *Mitchell* at para 86; and *Minhas* at paras 20 and 22.

Additional Amount

[78] Section 49.2(7) of the *Act* authorizes the Committee to order payment of an "additional amount":

> **Joint medical profession review committee**
>
> 49.2(1) …
>
> . . .
>
> (7) Where the committee makes an order pursuant to subsection (5), it may make a further order requiring the physician to pay to the minister an additional amount not exceeding $50,000.

[79] The only condition for such an order is an order under s. 49.2(5), which authorizes an order to reduce payment to the subject physician or for the subject physician to make repayment of billed services which had been paid.

[80] This Court has upheld orders for payment of additional amounts in: *Rengarajan* at para 157 ($15,000); *Tanyi-Remarck* at paras 115 and 118 ($50,000); *Amu-Darko* at para 88 ($15,000); *Patel* at para 109 ($50,000); *Malhotra* at para 166 ($50,000); and *Belak* at para 44 ($50,000); The Court in *Amu-Darko* at para 88, *Malhotra* at para 158 and *Belak* at para 143 stated that the purpose of orders for payment of an additional amount is to encourage compliance with the *Act* and the Payment Schedule. In *Rengarajan* at para 157, Crooks J. added that "the extent of the billing issues warranted a fine of some sort."

[81] The Court has, in some but not all cases, described this "additional amount" as a "fine". See: *Rengarajan* at para 157; *Tanyi-Remarck* at paras 112-115; *Amu-Darko* at paras 87-88; *Malhotra* at para 158; and *Belak* at paras 123 and 143. Physicians subject to orders to pay an additional amount have on appeal questioned its characterization as a "fine", pointing to other decisions of this Court which held that it is not the function of the Committee to discipline, penalize or sanction subject physicians. See: *Patel* at para 30; *Kassett* at para 30; *Price* at para 19; and *Barber* at para 16. Those decisions follow from that of the Court of Appeal in *Saskatchewan Medical Care Insurance Commission; Barsoum v Saskatchewan Medical Care Insurance Commission; Marian v Joint Professional Review Committee and*

Saskatchewan Medical Care Insurance Commission, 1986 CanLII 3245 at para 31, 33 DLR (4th) 507 (SKCA), where Bayda C.J.S., referring to the predecessor Commission, wrote:

> [31] Did the Commission fail to comply with the doctrine of procedural fairness? Before answering this question, it is useful to briefly explore the nature of the proceedings envisaged by s. 49(2) of the *Act.* The object of the proceedings is to determine if a particular physician owes a statutory debt (which to exist, I note parenthetically, does not necessarily need the same components or preconditions as a debt under common law). **The object is not to penalize or to discipline.** The proceedings are designed to recover summarily something from the physician that it is said does not belong to him, something that he had no right to acquire in the first place. They are not designed to punish for a public wrong against society by imposing a fine or by imprisoning. They are not designed to punish for a professional breach of trust by the imposition of sanctions, by suspending the physician from his practice or by striking his name from the register. The intent of the statutory provision has nothing to do with the deprivation of a person's liberty or the security of his person or with the deprivation of his livelihood. It has to do, however, with the determination of a simple question (of mostly fact and some law - private law): to whom does an item of personal property (a sum of money) belong?
>
> [emphasis added]

[82] This passage was quoted in *Patel* at para 105; *Belak* at para 118; *Oduntan* at para 28; *Offiah* at para 15; *Anstead* at para 42; and *Kassett* at para 30.

[83] I agree with the views expressed by my colleagues as to the purpose of the additional amount and the discretionary authority of the Committee to order payment of the additional amount for those reasons. However, I am not comfortable with characterizing the additional amount as a fine. It seems to me more appropriate to view it as a form of costs to defray the financial cost of the Committee's inquiry where there is a finding of improper billing or over-billing. However, nothing really turns on how the additional amount is characterized in this appeal.

Summary

[84] The following principles emerge from this review of the law.

Scope of appeal and standard of review on appeal

[85] The scope of appeal against a Committee decision is limited. The standard of appeal is exacting. The Court will give deference to the Committee in its findings of fact and its determination of whether a service is medically required and what constitutes an acceptable pattern of practice. The appellant has the onus of proof. All of this means that, to succeed on appeal, the appellant must be able to clearly demonstrate a serious error in the manner in which the Committee conducted its inquiry which deprived the appellant of procedural fairness or serious error in its reasons for decision which amounted to an error of jurisdiction or error of law.

Jurisdiction

[86] The Committee has an investigative and adjudicative role, with discretion over how it conducts that inquiry. The focus is to gather information from the physician about their pattern of medical practice as it relates to billing. The Committee is the judge of what medical services are medically required and what is an acceptable pattern of practice. The interview is intended as an opportunity both for the Committee to inquire and the subject physician to respond. The Committee may discontinue an inquiry at any stage, if it is satisfied that the concerns which prompted the referral have been answered satisfactorily.

[87] The standard of review for jurisdictional error is correctness.

Natural Justice

[88] The process is not adversarial, so comparisons with adversarial proceedings are not apt.

[89] The rules of natural justice impose a duty on the Committee to act fairly and to provide procedural fairness. The rules of natural justice entitle the subject physicians to a fair hearing, which means they are entitled to know the case against them and be given a meaningful opportunity to respond.

[90] The right to know the case to meet is usually satisfied through: the Committee's letter informing the subject physician of the review and requesting documentation; the statistical analysis that is usually provided with that letter; any letters requesting additional information; the letter requesting an interview, which identify areas of concern; and the interview. It is sufficient to identify the general nature of the Committee's concerns with physician billings.

[91] The right to respond is provided through the ability of the subject physician to respond both in writing and in person at the interview. The subject physician may be accompanied and assisted by their lawyer at the interview, where they have the opportunity to make an opening and closing statement. If a new area of concern comes up at the interview, the Committee may be obliged to provide a further right to respond, if it intends to rely upon that new area of concern.

[92] The standard of review for breach of natural justice is correctness.

Error in law

[93] The standard of review for error of law is correctness.

Findings not supported by evidence

[94] The Committee is not required to identify or detail every default. The focus is on the pattern of billing.

[95] The Committee is entitled to estimate and extrapolate from a representative sample of billing records to determine a percentage for recovery of

billings. The Committee is not required to provide a mathematical formula to support the percentage of recovery of billings after reassessment, however, the basis of the order must not be a mystery. There must be a rationale which the Court can understand, in the sense that the decision is intelligible, transparent and justified by the reasons.

[96] The standard of review for findings not supported by evidence is palpable and overriding error. Generally, there must be no evidence to support the finding before the Court will interfere.

ISSUES

Grounds of Appeal

[97] As sometimes occurs, the grounds of appeal became more focused between the filing of the Notice of Appeal and the hearing of the appeal. To illustrate, I will reproduce below the grounds stated in the Notice of Appeal and in Dr. Bierman's Brief of Law, as well as stating the grounds put forward in oral argument on this appeal.

Notice of Appeal

[98] The Notice of Appeal stated the grounds of appeal as follows:

> AND TAKE FURTHER NOTICE that the Appellant appeals the JMPRC's Order on the following grounds:
>
> 2. That the JMPRC failed to observe the principles of natural justice in the following respects:
>
> (a) The JMPRC failed to consider the totality of the Appellant's submissions with respect to the issues under review, or alternatively, failed to produce adequate reasons for rejecting those submissions; and
>
> (b) The JMPRC failed to consider relevant evidence in reaching the conclusions in its Order, or alternatively, failed to provide adequate reasons for

rejecting or electing not to consider this evidence.

3. That the JMPRC has exceeded its jurisdiction in the following respects:

(a) The inquiry and Order with respect to the quality and content of documentation is beyond the JMPRC"s jurisdiction;

(b) The JMPRC imposed a reassessment of documentation and medical necessity that was punitive in nature; and

(c) The JMPRC imposed a $25,000 additional amount in addition to its reassessment that exceeded the JMPRC's jurisdiction and was punitive in nature.

4. The JMPRC failed to consider relevant evidence, and in addition, or in the alternative, the evidence did not reasonably support the Order in the following respects:

(a) The samples of medical records reviewed by the JMPRC in coming to its Order were not a representative sample of the overall quality of the Appellant's documentation or medical care and did not justify the conclusions drawn, nor the extent of those conclusions;

(b) The samples of medical records reviewed by the JMPRC in coming to its Order were not a representative sample of the Appellant's pattern of practice and do not justify the conclusions drawn, or the extent of those conclusions;

(c) The JMPRC failed to provide sufficient reasons or explanations regarding its consideration of the Appellant's documentation;

(d) The JMPRC failed to provide sufficient reasons or explanations regarding its consideration of the Appellant's pattern of practice as its relates to medical necessity;

(e) The JMPRC failed to provide sufficient reasons or explanations regarding its consideration of the Appellant's pattern of practice as its relates to the application of the Physician Payment Schedule;

(f) The JMPRC's conclusions are based on a series of extrapolations calculated using statistical outliers that are not representative of the Appellant's services, failing to consider evidence relating to the practical and statistical realities of the Appellant's medical practice;

(g) The JMPRC applied an unreasonable and unduly restrictive interpretation of the documentary requirements set out in the Physician Payment Schedule.

(h) The JMPRC applied an unduly and unreasonable restrictive interpretation of the concept of "medical necessity" as it applies to the considerations of documentation and the frequency of patient visits;

(i) The JMPRC failed to consider significant circumstantial changes that occurred during the period being reviewed, which had significant impacts on the Appellant's documentation, overall pattern of practice, and application of the Physician Payment Schedule; and

(j) The evidence before the JMPRC does not support the extrapolations and percentages by the JMPRC in its Order.

5. The JMPRC erred in applying an additional amount of $25,000 in addition to the Order.

6. The JMPRC erred in ordering the reassessment of the Appellant's Partial Assessment Services.

7. The JMPRC erred in ordering the reassessment of the Appellant's Complete Assessment Services.

8. The JMPRC erred in ordering the reassessment of the Appellant's Prescription Renewal Services.

9. The JMPRC erred in ordering the reassessment of the Appellant's Chronic Disease Management Services.

10. The JMPRC applied an arbitrary and unsupported standard with respect to the adequacy and quality of the Appellant's documentation.

> 11. The JMPRC erred in its application of statistics in establishing a percentage that was then extrapolated to form the reassessment applied to the Appellant's billings.
>
> 12. Such further and other grounds as counsel may advise and this Honourable Court may allow.

Dr. Bierman's Brief of Law

[99] Dr. Bierman's Brief of Law at paragraph 52 stated six grounds:

> 52. The Notice of Appeal filed in this matter raises several concerns with the JMPRC, their process, as well as the conclusions set out in its Final Order. These concerns will largely be broken down into four [sic] categories:
>
> 1) the JMPRC erred by exceeding its jurisdiction with respect to interpretations of the Physician Payment Schedule and assessment of Dr. Bierman's billings;
>
> 2) The Committee erred by applying the same reasoning to reassess Dr. Bierman under multiple different Categories in the Final Order
>
> 3) the JMPRC erred by improperly disregarding, overlooking and applying the relevant evidence with respect to Dr. Bierman's billings, or alternatively failed to provide reasonable or adequate explanations for its decisions;
>
> 4) The JMPRC failed to conduct its review in a fair and reasonable manner, breaching the principles of natural justice by failing to advise Dr. Bierman of the case against him;
>
> 5) the JMPRC committed a palpable and overriding error by applying an improper extrapolation of the services performed by Dr. Bierman in its Fina Order; and
>
> 6) the JMPRC committed an error of law by applying a "baseline" $25,000 "additional amount" in supplement to the reassessment ordered by the JMPRC.

Dr. Bierman's oral argument at appeal hearing

[100] In oral argument at the hearing, Dr. Bierman's counsel said there were four primary grounds:

1. Procedural fairness, in failing to inform Dr. Bierman of the case to meet;
2. Failure to consider evidence in coming to a decision;
3. Extrapolation which was not justified; and
4. Additional amount award of $25,000, which was arbitrary and punitive.

Issues to be addressed

[101] The appeal can be resolved by addressing the following issues:

1. Did the Committee err in exercise of its jurisdiction?
2. Was there a breach of natural justice?
3. Did the Committee err in law?
4. Were the findings supported by evidence?
5. What costs, if any, should be awarded?

ANALYSIS

[102] Dr. Bierman, as appellant, has the onus of establishing reviewable error.

[103] At the outset, I find the Decision, which is 70 pages, to be intelligible and transparent in its reasons and justified in its conclusions. The Decision is detailed. The

Committee properly instructs itself on its mandate and process. It separately addresses the areas of concern, referring to evidence to support its findings. It uses examples to illustrate each area of concern. The percentages of recovery are supported by the Committee's findings of fact. While necessarily estimates, those estimates follow from its review of the statistical analysis provided by the Director and the sample records provided by Dr. Bierman. I note that the Committee in some cases gives Dr. Bierman "the benefit of the doubt" on the percentage for recovery. (Decision, pp. 41, 59, and 60; Record, pp. X594, X612 and X613). I take this to mean that the Committee chose its low estimate of errors or unjustified billings, rather than the high estimate.

[104] It is also worth noting that the Committee, in the Decision, makes multiple similar findings of default on the part of Dr. Bierman in his billing practices. The Committee also makes adverse findings on his credibility. See: Decision at p. 19 (Record X572), and p. 59 (Record, X612). The Committee is entitled to deference on these findings, which help to explain its rejection of some of Dr. Bierman's evidence. These findings are not reviewable errors.

[105] The Notice of Appeal stated 27 grounds of appeal. Appellate justices occasionally observe that there is often an inverse relationship between the number of grounds of appeal and the merit of the appeal.

[106] I do not intend to address each ground of appeal. I have considered all of them. Lack of comment means I rejected them for reasons I believe should be apparent from my review of the law and Decision. I will, in this part, address the main arguments presented at the hearing of the appeal.

Jurisdictional error

[107] Dr. Bierman alleged jurisdictional error by the Committee by: restricting Dr. Bierman's professional judgment; improperly substituting its own evidence; and

improperly reassessing billed services. I reject all of these alleged errors.

[108] With respect to Dr Bierman's professional judgment, this argument was rejected in *Colistro* at paras 27-28. The Committee is the judge of medical necessity and acceptable practice, not the subject physician.

[109] The billing review is only concerned with whether the billings were payable under the terms of the Physician Payment Schedule. The billing review is not an assessment of the subject physician's competence. If there are questions about competence, they can be addressed on referral to the College of Physicians and Surgeons of Saskatchewan. (Decision, p. 69 (Record, p. X622))

[110] With respect to improperly substituting evidence, I find no evidence to support this argument. Dr. Bierman relied upon professional misconduct cases which have little application to this appeal. Again, the Committee is the judge of medical necessity and acceptable practice.

[111] With respect to the argument that the Committee improperly reassessed billed services, I find no evidence to support that argument. The Committee's job is to review and, if warranted, reassess billed services. That is precisely its jurisdiction and mandate.

[112] The jurisdictional grounds of appeal are dismissed.

Breach of natural justice

[113] Dr. Bierman argued that the Committee unfairly shifted the onus of proof to Dr. Bierman. (Dr. Bierman's Brief of Law at paras. 13 and 30) As discussed above, there is an onus on the subject physician to justify his billings. If a presumption of improper billing arises from the evidence gathered during the inquiry, then the onus certainly does shift to the subject physician to rebut that presumption. The interview is

the usual forum for doing so. If the presumption is not rebutted, then the Committee certainly may conclude that an adverse finding is warranted by the evidence.

[114] Dr. Bierman argued that he was deprived of his right to know the case to meet. I reject this argument. I find that the Committee informed Dr. Bierman of the case to meet by: the September 28, 2021 letter informing him of the review and requesting documentation; the January 26, 2022 letter requesting additional information; the September 26, 2022 letter requesting an interview and identifying nine areas of concern with Dr. Bierman's billing practices; and the March 16, 2023 interview. Given the advance notice, content of those letters and requests for records, Dr. Bierman should have been left in no doubt of the areas of concern to which he was called upon to respond. I note as well that Dr. Bierman was assisted by counsel experienced in these reviews.

[115] The transcript of the interview on March 16, 2023 records that it began at 9:40 a.m. and concluded at 5:13 p.m. The time taken and manner in which the interview was conducted, which is through inquiry and dialogue, support a conclusion that Dr. Bierman was given a full opportunity to respond.

[116] Dr. Bierman also argued that the Committee's decision to discontinue its issuance of a Proposed Order before issuing a Final Order breached natural justice by depriving him of the opportunity a Proposed Order would offer of providing further response to specific findings.

[117] The previous issuance of a Proposed Order was described in *Colistro* at para 18 as "unusual" and in *Malhotra* at para 139 as "unique". Crooks J. in *Malhotra* at para 140 held that there is no right to respond after a decision is made:

> [140] Natural justice does not require an opportunity to be heard after a decision is made, but rather that the physician have an opportunity to make submissions and put forward their case before a decision is taken. While there is a fair opportunity to

> respond and provide documents, that does not suggest an endless opportunity to do so. The physician cannot keep returning with more and more documentation until they get the decision they want after the evidentiary portion of the assessment is concluded.

[118] While I agree that this change removed a final right of response, I also find that the Committee was entitled to discontinue that practice under the authority conferred by s. 49(5) of the *Act* and as master of its own procedure. I also find that this change does not significantly detract from the right to know the case to meet. On the contrary, it is consistent with the practice of most administrative tribunals and courts.

[119] Further, Dr. Bierman was not taken by surprise by this change. The Committee, in its letter of September 26, 2022 at p. 2 (Record, p. X548) informed Dr. Bierman of that change in process:

> Proposed Decision – Notice regarding change to JMPRC procedure:
>
> Though the JMPRC has, in the past, provided a proposed decision to physicians under review for commentary prior to issuing its final decision, effective September 26, 2022, it is no longer taking this step. This is intended to streamline the adjudicative process and reduce the draw on resources for the JMPRC, as well as the parties involved.

[120] I dismiss the natural justice grounds of appeal.

Error in law

[121] With respect to the alleged failure to consider evidence, which is an error of law, I reject that ground of appeal.

[122] The Decision is detailed and addressed each category for which an order for repayment was made. The Decision at p. 10 (Record, p. X563) states that the Committee reviewed all of the medical records before the interview:

> Interview Discussion:
>
> The Committee reviews all of the medical records prior to the interview. However, it would not be practical or reasonable to discuss all medical records during the course of the interview due to the large quantity, the repetitive nature of the records in the context of the identified concerns, and for efficiency's sake. In fact, it is not required under legislation that the Committee to do so. …

Nor is the Committee required to detail all evidence or every single omission in the Decision. The form of the Decision is similar to those considered in previous appeals. The Court, in repeated decisions, has accepted the process of inquiry/adjudication and the form of the Decision. Having read the Decision more than once, I am satisfied with its reasons. The fact that some evidence is not mentioned does not mean it was not considered.

[123] Dr. Bierman argued that the Committee failed to take the Covid-19 pandemic into account in reviewing his practice, given that the period of review coincided with the pandemic. I reject that argument and note that the pandemic and its effects was considered by this Court on prior appeals in *Patel, Malhotra* and *Colistro*.

[124] Dr. Bierman argues that the Committee failed to provide adequate reasons. Failure to provide adequate reasons can be an error in law, however, I reject that ground in this case. As discussed above, I find that the reasons are responsive to the issues, support the conclusions and Decision and were sufficient to allow for meaningful appellate review.

[125] Finally, the order for an additional amount of $25,000 is challenged as an error of law because it was arbitrary and presented as a "baseline" amount. I reject this ground of appeal. Section 49.2(7) of the *Act* authorizes the Committee to make such an order. The amount must not exceed $50,000 but is otherwise discretionary. As discussed above, the Court has upheld previous awards of an additional amount ranging

from $15,000 to $50,000. I am not aware of any appeal where the Court interfered with the award of an additional amount. The Committee gave reasons for its order at pp. 61-62 of the Decision (Record, pp. X614 – X615). Those reasons are sufficient to support the order.

[126] I dismiss the error of law grounds of appeal.

Findings not supported by evidence

[127] Dr. Bierman argued that the Decision applied similar reasoning across multiple categories. I find no error in doing so. Dr. Bierman's failures or omissions in patterns of billing, not surprisingly, showed up in multiple categories. While it is repetitious, the Committee was obviously taking care to show it applied the same reasoning for each category.

[128] Dr. Bierman raised the "double counting" argument rejected in *Patel* at paras 87-89 (where failure to document justified findings that the service was not provided and the documentation did not meet the required standard). Since physicians are paid both for time spent in documentation and for time spent providing a medical service, there is no error in reassessing both.

[129] Dr. Bierman argued the extrapolations were improper. I find the Committee's reasons sufficient. This Court has in several decisions accepted the Committee's use of estimates and extrapolation from sample data to the larger group in determining percentage recovery after a reassessment. The point is that there is sufficient evidence of defaults to establish a pattern of practice that departs from what is acceptable and justifies the extrapolation.

[130] Dr. Bierman argued that an example used in the Decision was not raised in the interview. Maybe so, but the examples are used to illustrate the broader finding of concern and pattern of practice which is not acceptable. The point is that the area of

concern was brought to Dr. Bierman's attention and he was given an opportunity to counter it. He failed to do so and the Committee was entitled to make its finding.

[131] I dismiss the grounds of appeal alleging findings of fact not supported by evidence.

Costs

[132] The Ministry has been successful on the appeal and is entitled to an award of costs. This appeal was complex and time-consuming for counsel and the Court. In *Tanyi-Remarck*, Currie J. ordered costs calculated on Column 3 of the Tariff of Costs. I follow him in awarding costs to the Ministry, calculated on Column 3 and payable forthwith by Dr. Bierman.

DECISION

[133] The appeal is dismissed with costs awarded to the Minister of Health on Column 3 of the Tariff of Costs.

[134] I thank counsel for their submission and assistance.

J.
D.N. ROBERTSON