KING'S BENCH FOR SASKATCHEWAN

Citation: **2026 SKKB 48**

Date: **2026 02 27**
File No.: QBG-RG-00739-2020
Judicial Centre: Regina

BETWEEN:

DR. IMAFIDON THOMAS IZEKOR

APPELLANT

- and -

JOINT MEDICAL PROFESSIONAL REVIEW COMMITTEE
AND MINISTER OF HEALTH (SASKATCHEWAN)

RESPONDENTS

Counsel:

David Thera K.C. and Anthony Thera	for the appellant
Savannah Downs	for respondents

JUDGMENT — DAVIS J.
FEBRUARY 27, 2026

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[1] Dr. Izekor is a family doctor in Regina. In 2018, the Joint Medical Professional Review Committee [JMPRC] or [committee] reviewed his billings for a 15-month period (June 17, 2016 – September 6, 2017). The JMPRC found that Dr. Izekor had over-billed for his services. It ordered the recovery of $223,358.43. Dr. Izekor appeals that decision.

[2] For the most part, I find the JMPRC's decision was not the product of reversible error. Dr. Izekor billed for appointments that were clearly not medically necessary; it was reasonable to conclude he overbilled in the manner which the JMPRC identified. He failed to document many patient consultations in more than the most

minimal fashion. At the hearing he largely agreed that his documentation was seriously deficient and that many billings were improper. It was open to the JMPRC to interpret the evidence as it did, and it reached its decision after an extensive hearing in which Dr. Izekor participated fully. Its reasons are comprehensible and amenable to review.

[3] I am remitting the matter to the JMPRC in one respect. The JMPRC used its findings regarding a target group of Dr. Izekor's patients to extrapolate across the entire patient body, apart from the Normanview walk-in patients. The JMPRC is not required to review all billings, nor is it required to identify with mathematical precision the proportion of problematic billings. It is entitled to extrapolate findings from a small group to a large one.

[4] However, Dr. Izekor's practice was comprised of a relatively small number of patients whom he saw frequently and a much larger number of infrequent patients whom he may only have seen once and whose attendance at the clinic may not have been within his control. The committee applied its findings drawn from the first group to the entire patient population.

[5] The difference in frequency of appointments is not a barrier to extrapolating across the entire patient population from a small group. But the JMPRC identified problematic practices which appear far more likely to afflict frequent attendances than occasional ones. It is not obvious that some of Dr. Izekor's problematic billing practices were likely to be reproduced across the entire patient body.

[6] It may have been reasonable to treat Dr. Izekor's billing practices in relation to a small subset of frequent patients as representative of his billing practices in relation to all patients, but I find the JMPRC's reasons are not sufficient to allow me to review them. I remit only this portion of the decision to the JMPRC to reconsider what proportion of Dr. Izekor's billings, related to the patients whom he saw fewer than five times, should be subject to recovery.

Fee for service billing and program integrity

[7] Most physicians in Saskatchewan operate on a fee for service basis. Doctors submit their billings and receive payment for services rendered. Doctors bill in accordance with prescribed billing codes. These are set by regulation. Sections 5 and 6 of *The Saskatchewan Medical Care Insurance Payment Regulations, 1994*, RRS c S-29 Reg 19 [*Regulations*] provide that the Minister will pay doctors for services rendered in accordance with the billing codes. These codes are found in a schedule to the *Regulations*. That schedule is updated every six months.

[8] As this Court has noted, the legislation "does not contemplate that the Government will pay every account blindly and without question simply because a service has been performed and billed for": *Colistro v Joint Medical Professional Review Committee*, 2021 SKQB 62 at para 10 [*Colistro*]. Section 14(1) of *The Saskatchewan Medical Care Insurance Act*, RSS 1978, c S-29 [*Act*] says that "medically required services provided in Saskatchewan by a physician are insured services."

[9] Similarly, s. 18 of the *Act* deals with payment for services. It provides that the "minister may, pursuant to this *Act* and the *Regulations*, make payment for the provision of insured services to beneficiaries." The Ministry is not authorised to pay for uninsured services. Section 18 permits direct payment agreements between the Ministry and a physician. The appellant had entered into one of these agreements.

[10] For the purposes of this decision, it is important to understand the nature of some of the more common billing codes, as well as appropriate billing practices.

[11] 5B is the billing code for partial assessments; it is among the most billed codes. A partial assessment involves taking a relevant history, the diagnosis and assessment of an affected body part or system, and advice to the patient.

[12] The billing code for a complete assessment is 3B. Complete assessments – "physicals" in lay language – include taking a more extensive history, examination of all parts and systems, assessment, diagnosis, treatment and advice to the patient. Both 5Bs and 3Bs require doctors to create a record of the service provided. An adequate record is an essential component under any billing code.

[13] Billing codes 40B and 41B are for counselling services. A doctor bills a 40B for the first 15 minutes, and 41B for time spent thereafter. It is important that times be clearly documented to determine which billing code applies to the counselling services in question.

[14] Several payment schedules were in effect throughout the period under review. The criteria listed above for billing a 5B, 3B, 40B and 41B remained unchanged throughout that period. There were changes to other aspects of the payment schedule.

[15] Prior to April 1, 2017, the relevant payment schedules included documentation requirements obliging a physician to maintain a medical record "that appropriately supports the service being provided and billed", that was legible, and that contained the information designated in the payment schedule service code.

[16] These requirements were amended in the April 1, 2017, payment schedule. The schedule now says a record must establish that 1) an insured service was provided; 2) the service billed for was the service rendered; and 3) the service was medically required.

[17] The JMPRC was created by s. 49 of the *Act*. It has a mandate to review doctors' billings to make sure they bill appropriately, and to take remedial action where there has been overbilling and/or an overpayment: s. 49.2. The Director of Professional Review may search for irregular billing patterns among practitioners under his or her oversight. He or she may then refer matters to the JMPRC for further review.

[18] The JMPRC's mandate is to review a doctor's billings – not the doctor's competence. A doctor who sees more patients than he can competently treat does not invite the JMPRC's intervention unless his billings also warrant such intervention. Even then, the issue is with the doctor's billings; not with the quality of medical care he provides. The JMPRC does have a mandate to consider whether a particular service was medically required. That is because only medically required services are insured services for which a doctor is entitled to payment from the public purse.

Dr. Izekor's practice and the JMPRC

[19] Dr. Izekor began practicing family medicine at the Northgate Medical Centre in 2014. This clinic serves a varied population including many high-needs patients. It is a busy practice.

[20] Dr. Izekor also worked part time at the Normanview Medical Clinic. It was common for him to work a full day at the Northgate Medical Centre and then work an evening shift at the Normanview Medical Clinic. It was common for him to work 12-hour days with few days off. He sometimes saw as many as 120 patients in a day.

[21] During the relevant period, Dr. Izekor saw more than six times as many patients as the average family doctor. His billings were just shy of three times the average. These anomalous patterns caught the Director's attention, and he referred Dr. Izekor's matter to the JMPRC.

[22] The JMPRC selected a sample of patients from Dr. Izekor's patient body. It asked him for those patients' records. Dr. Izekor had seen all these patients five times or more during the period under review. He saw these patients more frequently than most of his patients.

[23] The matter proceeded to a hearing with a panel of physicians including family doctors. Dr. Izekor attended the hearing with his counsel. He made an opening

statement. He answered questions from the panel and provided additional information on the patients whose records had been selected for review. He also frequently agreed with members of the panel that his documentation was inadequate. On other occasions, he agreed that he billed the wrong code for a particular service or billed for an uninsured service. At the end of the hearing, Dr. Izekor's lawyer made closing submissions.

[24] Following the hearing, the JMPRC drafted a proposed order which it provided to Dr. Izekor for comment. Dr. Izekor, through counsel, responded and raised several issues. These remain live issues on appeal. Dr. Izekor questioned the proposal to reassess 20% of all his partial assessments, and the committee's decision to reassess some of his billings based on inadequate documentation.

[25] The JMPRC responded to Dr. Izekor. The parties agree that the response of February 19, 2020, should be read with the order of February 20, 2020. In the February 19 letter, the committee referred Dr. Izekor to several portions of the order which it felt explained matters which Dr. Izekor said were unclear.

[26] The JMPRC ordered a reassessment of Dr. Izekor's billings. It reassessed 20% of his 5B billings, excluding billings from the Normanview Medical Clinic, based on an inappropriate pattern of billing frequent non-medically required partial assessments. It reassessed 11% of remaining partial assessments, including the Normanview patients, for incomplete documentation.

[27] The committee reassessed complete assessments (3Bs) converting 80% of them to partial assessments (5Bs). It then ordered reassessment of 11% of the remaining 3Bs. The basis for the reassessment of 3Bs was Dr. Izekor's incomplete documentation of the services he provided.

[28] Finally, a relatively small portion of Dr. Izekor's counselling billings were reassessed for inadequate or missing documentation, including of the time actually

spent counselling the patient.

[29] After some minor adjustments, the reassessment subtotal was $208,358.43 which Dr. Izekor was required to repay. The committee also ordered Dr. Izekor to pay an additional amount of $15,000. In ordering this amount, the committee noted that physicians share responsibility for appropriate resource allocation and must be jointly accountable to the public to use health care resources prudently. It noted that inappropriate billings divert monies from areas where they are really needed.

[30] Dr. Izekor's total payments for the five-quarter period were reduced from $905,669.83 to $682,311.40 – a reduction of $223,358.43. Dr. Izekor appeals from this decision pursuant to s. 49.21 of the *Act*.

[31] His notice of appeal contains many wide-ranging grounds of appeal. His argument became more focused in his written and oral submissions. While not precisely how he framed this appeal, I understand Dr. Izekor to allege that the JMPRC:

> 1. erred in determining there was a pattern of inappropriate billing for non-medically necessary services by:
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> > A. applying an inconsistent and inaccurate definition of medical necessity.
> >
> > B. placing an onus on him to prove the services billed for were medically necessary.
> >
> > C. failing to consider his evidence.
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> > D. improperly extrapolating from the target patient group across all patients and/or by failing to give adequate reasons for its decision.
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> 2. that it erred in its review of Dr. Izekor's documentation by:

A. requiring documentation to establish medical necessity; and

B. double-counting patients, billings for whom had already been reassessed; and

3. that it exercised its discretion in an arbitrary fashion by ordering that an additional amount of $15,000 be recoverable.

[32] The JMPRC's decision is reviewable according to the appellate standards of review: I must correct errors of law, but I should defer to the JMPRC's findings of fact absent a demonstration of palpable and overriding error. Unless I can extricate a question of law alone, the standard of review for questions of mixed fact and law is palpable and overriding error. Dr. Izekor bears the onus of establishing error: *Colistro* at paras 2-5.

[33] I address whether the JMPRC erred in determining Dr. Izekor exhibited a pattern of inappropriately billing for non-medically necessary services. I then address whether it erred in its treatment of Dr. Izekor's documentation. Finally, I address Dr. Izekor's argument regarding the additional amount. As noted, I am remitting the question of whether it was appropriate to reassess 20% of 5B billings (excluding Normanview patients) to the JMPRC. I dismiss all other grounds of appeal.

Question 1: Did the JMPRC err in its determinations regarding medical necessity?

[34] Saskatchewan does not pay for all medical services. It only pays for services that are "medically required". Determining whether a service is medically required – or medically necessary – is critical to determining whether it was an insured service for which the Ministry had to pay.

[35] Dr. Izekor says the JMPRC made reversible errors in determining whether the services under review were medically necessary. He alleges it erred by

failing to define medical necessity and then erred by placing an onus on him to show he met that ambiguous, shifting, and undefined standard. He says the JMPRC failed to consider his evidence which he says could show many of the services he provided were medically necessary. Finally, he says the JMPRC erred by extrapolating its findings regarding medical necessity across the patient population.

[36] Below I explain why I am not persuaded by the first three arguments. I then address why the JMPRC's reasons do not permit me to assess the appropriateness of the extrapolation, and why I remit that issue for further consideration.

A. Did the JMPRC apply an inconsistent or inaccurate definition of medical necessity?

[37] Dr. Izekor contends that the JMPRC failed to define medical necessity, and that it applied unreasonable and inconsistent definitions of that term in its decision. He says ambiguity around what the JMPRC meant by medical necessity made it difficult or impossible to respond to the committee's concerns. I disagree.

[38] The meaning of medical necessity is suggested by s. 49.2 of the *Act*, and this Court has defined the term with reference to that section. Section 49.2(2) gives the director the power to refer a matter to the JMPRC. The purpose of the review is for the JMPRC to determine whether monies have been or may be paid "by reason of any departure from a pattern of medical practice acceptable to the committee".

[39] As Justice Bardai (as he then was) said in *Colistro*:

> [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. …

[40] A service is medically necessary if the JMPRC finds it to be reasonable and appropriate in the circumstances. I do not see a problem in defining the standard with reference to the committee's opinion. In fact, as Justice Bardai said, the standard has a subjective component and "it is the JMPRC's opinion, belief and understanding that counts." (para. 26)

[41] There is no problem with the JMPRC determining medical necessity on a case-by-case basis. The legislator chose to entrust the proper interpretation of "medically required" or medically necessary to the committee and for good reason. It is well qualified to say what was medically necessary in the circumstances; in fact, these issues are better decided by a panel of medical practitioners than by a judge: *Bierman v Joint Medical Professional Review Committee*, 2026 SKKB 22 at paras 60-65 [*Bierman*]. As noted in *Colistro*, a similar practice obtains across the country.

[42] Dr. Izekor specifically notes two instances, which he says demonstrated application of the wrong standard. These occurred in the same interchange in the space of no more than a minute or two out of a lengthy hearing. In that interchange one member of the committee asked Dr. Izekor what was so life threatening or such a "threat to this patient's well-being" that she had to be seen weekly for fibromyalgia.

[43] Obviously, a condition need not be life-threatening to require frequent medical intervention for which a doctor is entitled to bill. Neither need that condition to be threatening to "well-being" unless that term is broadly construed.

[44] Patients present with conditions ranging from the life-threatening to those that impair function to those that are annoying to those that exist only in the patient's anxious imagination. Assessment or treatment of such complaints may be medically necessary and may justify billing the Ministry even where there is no objective threat to life or "well-being". Screening of healthy patients for certain conditions may also be medically necessary.

[45] If the committee had applied a “life threatening” or even “threatening to well-being” standard when assessing the medical necessity of Dr. Izekor’s services, it would likely have resulted in a reversible error. But I find that the committee did not apply either of those standards.

[46] Selecting ill-judged phrases from a single interchange in a lengthy hearing does not give a complete or fair indication of what the committee was doing. One might look elsewhere in the same hearing to see the invocation of a much lower standard. For instance, on page 132 of the Transcript of the hearing, another member of the committee asked Dr. Izekor whether a particular visit was “medically reasonable”.

[47] The substantive portion of the committee’s decision began by reminding Dr. Izekor that only “medically required” services are insured, pursuant to s. 14 of the *Act*. It then went on to summarise the services Dr. Izekor provided which were not “medically required” or necessary.

[48] For instance, it noted that Dr. Izekor had patients book separate appointments to obtain prescription refills related to each of their multiple medications. He prescribed short-term refills meaning these patients were back in the clinic more than they should have been.

[49] He billed for partial assessments when the only service provided was a pre-booked minor procedure for something already diagnosed, or when he simply gave an injection. He performed and billed for services which he should have delegated to others or, in the case of routine INR (International Normalised Ratio) services, handled over the phone with a different billing code. He billed the government for uninsured services like filling out forms.

[50] I do not think that Dr. Izekor is left with any doubt regarding the standard

the JMPRC applied. It did not commit any reversible error in how it defined or applied that standard. The standard remained consistent throughout the JMPRC's decision. The standard turns on what the JMPRC considers to be "essential, effective, and appropriate" medical care in the circumstances: *Colistro* at para 27. The decision told Dr. Izekor which of his billing practices failed to meet that standard.

B. Did the JMPRC improperly place an onus on Dr. Izekor to establish the services he provided were medically necessary?

[51] Dr. Izekor alleges that the committee applied a subjective and undefined definition of medical necessity and then placed an onus on him to prove he complied with it. I have explained why the committee did not err in defining medical necessity. It is also apparent that the onus is properly on the physician to justify his billings upon request.

[52] Only medically necessary services are insured. Only the physician knows what services he provided. The payment system is built on trust and physician integrity; it is vulnerable to abuse. The Legislature created a mechanism to prevent and detect inappropriate billing. It only makes sense that the onus is on the individual doctor to prove that his billing conforms to the statutory standard of "a pattern of medical practice acceptable to the committee." (s. 49.2(2) of the *Act*)

[53] This is not much different from any other area where a contractor renders a service and seeks payment: see for example *G.T. Parmenter Construction Ltd. v Sanders*, [1947] OJ No 568 (Lexis) (ON H Ct) at para 10. The contractor must tell or show what he did to warrant payment of his invoice.

[54] In the domain of publicly funded medical services, as Justice Crooks held in *Malhotra v The Joint Medical Professional Review Committee and Minister of Health*, 2022 SKQB 124 [*Malhotra*], it is the individual doctor's "onus to demonstrate

[…] entitlement to payment for the services […] billed," para. 91: see also *Patel v Joint Medical Professional Review Committee*, 2022 SKKB 245 at paras 57-59 [*Patel*]. The committee did not err by requiring Dr. Izekor to establish entitlement to payment, even though he was required to prove he met a standard with a subjective component.

C. Did the JMPRC fail to consider Dr. Izekor's evidence?

[55] Dr. Izekor alleges the committee failed to consider his explanations. He says this because the committee reassessed his billings and determined that he had not established that a portion of those were for medically necessary services, even though Dr. Izekor gave explanations to fill some of the gaps left by his absent documentation. I would not give effect to this argument.

[56] It is trite to say that a failure to mention evidence cannot be equated to a failure to consider that evidence. A decision-maker need not address every piece of evidence. Neither is it required to respond to every argument raised by counsel. *R v Morin*, 1992 CanLII 40, [1992] 3 SCR 286 at p 296 (SCC); *R v Necroche*, 2018 SKCA 24 at para 38; *R v Dinardo*, 2008 SCC 24 at para 26.

[57] While Dr. Izekor alleges the committee failed to consider the totality of his evidence, he identified evidence relating to two patients as warranting special comment. I comment on these two patients in particular, and on Dr. Izekor's submissions to the committee more generally. In the following discussion, I explain why I am not persuaded the JMPRC failed to consider Dr. Izekor's submissions.

[58] The first patient to whom Dr. Izekor refers is patient number ******930, addressed on page X618 of the Final Oder. Dr. Izekor billed 20 partial assessments of this patient in less than 9 months. The committee noted that the vast majority of patient records for these visits lacked documentation capable of supporting billing a 5B. Many of these visits were unjustified short-term medication refills or routine INR services.

[59] While Dr. Izekor made somewhat extensive submissions regarding this patient, it is difficult to see what portion of his evidence was so critical that the committee made a reversible error by failing to mention it. Neither was his evidence all that helpful to him. For example, he conceded that he should not have billed a 5B for the INR services. He never clearly explained why he booked various follow ups between three and seven days from the last appointment or why it was necessary that he give the patient a prescription for only one week's worth of a particular medication, requiring her to come back once she had taken it.

[60] He agreed that he did not document much in relation to this patient. He said "perhaps I didn't document it again. This is 2016,": Transcript, vol II, page 97, lines 20 – 23. His practice – he said – had changed. He made many similar comments when discussing this patient. At times he gave somewhat specific details of the undocumented visits. At other times, he was reduced to generalities such as "I would have asked those questions." The subtext was always the same: Just trust me. Dr. Izekor's evidence was not much different from the committee's conclusions nor was it so clearly favourable to his position that the failure to mention it warrants further attention.

[61] Dr. Izekor next highlights patient number ******041, discussion of whom occupied a significant portion of the hearing. The JMPRC found Dr. Izekor billed 13 5Bs, 2 3Bs and 8 counselling sessions for this patient in one year. It found that the "sole purpose" of the "vast majority of these visits" was to provide short-term narcotic refills. The vast majority of visits were inadequately documented to the point the committee could not assess medical necessity or the billing requirements. The JMPRC found one of the visits was a meet and greet; while Dr. Izekor disagrees, the committee's reasons are clear from the record. I must defer to its factual findings.

[62] A more in-depth look at Dr. Izekor's evidence overall, and the committee's decision, shows that the committee considered – and even accepted – many of the factual circumstances that Dr. Izekor relayed. It simply disagreed that these satisfied its concerns. The real problem for Dr. Izekor was that his evidence failed to explain the medical necessity of many of the visits.

[63] His evidence frequently did not dispute that he often billed multiple partial assessments for the same clinical complaint. He did not explain why he billed 5Bs for visits that were primarily medication management. He agreed that he at times inappropriately billed the Ministry for provision of uninsured services such as filling out forms: see for example the discussion of patient number ******594, starting on page 2 of Transcript, vol II.

[64] The JMPRC spent hours with Dr. Izekor and his counsel. In the Final Order, the committee summarised Dr. Izekor's opening statement, briefly quoted from the transcript, and provided a detailed summary of Ms. Bodani's closing submissions including what she said on disputed matters. In the February 19 letter, the committee stated it took Dr. Izekor's explanations into account. In the Final Order, the committee responded directly to some of those explanations.

[65] For example, on page X597 of the Final Order, the committee wrote that "Although it is important that patients have access to their physician in a timely manner, it is equally as important that physicians manage this access appropriately." This was a direct response to Dr. Izekor's suggestion that his hard work and short wait times were the real explanation for what the committee mischaracterised as poor practice management: see for example Transcript, vol II, page 40.

[66] Throughout the hearing, Dr. Izekor consistently agreed that his

documentation was inadequate. He contended that he had provided the services that he failed to document. The committee stated that the records "did not always establish medical necessity and/or did not always contain a record of all the listed service code criteria". It pointed to the uncontroverted facts that "there was often inadequate and/or incomplete documentation of the physical examination, even though it was pertinent to the clinical reason for the visit" and that the records also inadequately documented pertinent history, diagnosis, assessment, plan, and follow-up. (X600).

[67] As I address in more detail, the failure to document was an important part of the Final Order. The committee pointed out that doctors get paid to document, and that documentation is listed as a required element under all service codes. I later address whether the committee erred by requiring documentation to establish medical necessity. For now, in my view, the record demonstrates that the committee considered Dr. Izekor's submissions, including his many concessions, in its decision.

[68] The committee also gave specific reasons for rejecting some of Dr. Izekor's explanations. Regarding Dr. Izekor's failure to manage patients' medication, the committee stated that his explanations were not always reasonable and that it did not always accept them. It went on to provide multiple specific examples of the evidence which it did not accept. For instance, it explained that it did not accept as reasonable Dr. Izekor's blanket practice of only prescribing short-term narcotic refills. It agreed that short term refills are required in some cases, but this must be determined on a case-by-case basis. (X589)

[69] The committee gave similar reasons for rejecting Dr. Izekor's explanations about failing to manage patient access. The problem was not with patients who called the receptionist to book an appointment, over which a doctor may have no control. The problem was that Dr. Izekor billed partial assessments for pre-arranged procedures or other routine services where the assessment had already been done:

(X589). Similarly, the committee explained why Dr. Izekor's stated reasons for various in-person visits did not convince it that he had provided a medically required service. The committee also explained why many services are covered by a different – and less costly – billing code.

[70] It is my view that the JMPRC considered Dr. Izekor's explanations. It provided reasons for rejecting some of those explanations. It accepted other submissions but found that they did not respond to the problems identified. Dr. Izekor has not demonstrated any reversible error in how the JMPRC handled his explanations.

D. Did the JMPRC improperly extrapolate from the target patient group across Dr. Izekor's patients?

[71] Dr. Izekor says the JMPRC improperly extrapolated from the target patients across the patient population. It found errors in how he had billed partial assessments (5Bs) in the target group. It reached a conclusion that 20% of 5B billings should be reassessed, and then it applied that reasoning across the entire patient population, excluding the Normanview walk-in patients.

[72] Dr. Izekor says this amounted to a palpable and overriding error of fact. He says it is illogical to find that 20% of patient encounters were improperly or unnecessarily billed when the patient was seen fewer than five times. Dr. Izekor reasons as though each patient's number of visits must be divisible by five before the committee can conclude that 20% of patient visits were not medically required. This argument is wholly without merit; there is nothing illogical in finding that 20% of several thousand patient encounters were medically unnecessary or were ineligible for payment.

[73] Nonetheless, I am persuaded by one aspect of Dr. Izekor's argument. I cannot say that the committee's reasoning was flawed. But I do agree with Dr. Izekor that the reasons – solely as they relate to the extrapolation issue – do not allow for

meaningful appellate review, and do not tell Dr. Izekor why the JMPRC reached this portion of the decision.

[74] The JMPRC is not required to determine the exact percentage of a doctor's billings that should be subject to reassessment. That is not practicable and may be impossible given the volume of patient encounters for which a doctor may bill the Ministry: *Patel* at para 69; *Bierman* at para 76.

[75] The JMPRC is entitled to view a small number of patient files and apply the conclusions that it draws from them across an entire patient population: *Patel* at para 68*; Mitchell v Saskatchewan (Health),* 2020 SKQB 334 at para 86 [*Mitchell*]; *Bierman* at para 77. Extrapolation is not only permissible; it may be the only workable approach for the JMPRC to fairly assess the propriety of a doctor's billing practices. This decision in no way discourages the JMPRC from what this Court has repeatedly recognised is an appropriate and useful practice.

[76] However, as Justice Robertson said in *Patel*, "the calculation of an assessment cannot be a mystery": para. 69. There is no need for a precise mathematical formula, and the committee certainly need not review every patient file. But the reasons must allow the doctor and the Court to assess whether the decision falls "within a range of possible, acceptable outcomes": *Patel* at para69.

[77] The JMPRC found that Dr. Izekor had overbilled the Ministry for 5B visits because he:

- Failed to adequately manage patients' medication.
- Failed to manage patient access to the clinic.
- Billed injections as partial assessments (5Bs).
- Billed routine INR services as partial assessments; and

- Billed uninsured services as partial assessments.

[78] The JMPRC observed these improper billing practices in its review of the target patient files. The target patients were drawn from those whom Dr. Izekor saw five times or more. Some of them he saw upwards of 20 times during the review period. There were 946 patients whom Dr. Izekor saw 5 times or more between June 2016 and September 2017. This was out of a total patient body of 12,644, including patients from the Normanview walk-in.

[79] The statistics in Dr. Izekor's case do not tell an entirely uniform story. While Dr. Izekor saw six times as many discrete patients as the average family doctor, his patient contacts were just over three times the mean, and his billings and services provided per patient were less than one-third of the mean. The percentage of patient encounters which he billed as major or other assessments also fell below the mean.

[80] This suggests that Dr. Izekor's practice consisted mainly of churning through a high volume of patients to whom he provided few discrete services and many of whom he may have seen only once in the relevant period.

[81] The JMPRC extrapolated the 20% reassessment which it considered appropriate in relation to the target patients across all patients from the Northgate practice. In my view, it is not obvious that the problems the JMPRC identified with billings related to the high frequency patients would or even could be reproduced across the entire patient body which consisted mostly of low frequency patients.

[82] Some of the identified problems, like improperly billing an injection or uninsured services, could just as easily arise in billings for infrequent patients as the frequent ones. It seems to me that other problematic practices, like unnecessarily frequent attendances to refill prescriptions or to manage chronic illnesses, may be more likely amongst the population of frequent patients than amongst those whom Dr. Izekor

saw fewer than five times.

[83] When a problematic practice could reasonably relate to two patient groups that are otherwise unlike, extrapolation is both possible and reasonable as between those groups. In such cases, the reasons for that extrapolation are likely to be self-evident. But when the problematic practice is far more likely to afflict one patient group than another, extrapolation becomes more fraught. The committee will need to explain why unlike patient groups are sufficiently similar or why the problematic practice in question applies to both groups.

[84] It may have been reasonable to extrapolate from the target group across all Dr. Izekor's patients. It may have been reasonable to reassess 20% of all partial assessment billings. However, the reasons given for that extrapolation and reassessment do not allow me to reach a conclusion one way or the other.

[85] I am remitting the 20% of partial assessments (excluding the Normanview patients) to the committee to consider whether it is appropriate to reassess 20% of all billings including those for the less frequent patients. Should the committee find that extrapolation remains appropriate, the reasons should briefly say why. They should indicate in a general way how the JMPRC dealt with differences between patient groups.

[86] I have addressed why I think the JMPRC's reasons were inadequate with respect to the extrapolation to Dr. Izekor's infrequent patients. I have otherwise had no difficulty in assessing the basis for the orders made.

[87] A functional approach to the duty to give reasons requires the decision-maker to tell the parties what the decision is and in at least a general way why – not how – it was reached: *R v R.E.M.*, 2008 SCC 51 at para 17. The reasons must be sufficient for the reviewing Court to understand and assess them for error. Except as

otherwise stated, the reasons here fulfil those functions.

Question 2: Did the JMPRC err in interpreting the need for documentation?

[88] Doctors are required to document patient visits. Documentation is listed as an essential component under each billing code. Adequate documentation serves several important purposes including reminding the treating physician of what happened at the last appointment, communicating pertinent information to other treatment providers, and providing a contemporaneous record of what happened in case issues arise as to the doctor's adherence to the standard of care.

[89] Additionally, documentation fulfils a role akin to that of a detailed invoice, recording which services were provided should there be a question about the appropriateness of a doctor's billings.

[90] To be clear, the adequacy of documentation for billing purposes is not to be confused with adherence to professional standards: *Offiah v Joint Medical Professional Review Committee*, 2011 SKQB 227 at paras 69 – 73. Even though documentation serves the functions outlined above, it is not the committee's role to assess whether the physician demonstrated adherence to standards of professional competency; its role to is assess the appropriateness of the physician's billings.

[91] As the appellant says, this Court has not always favourably received JMPRC decisions related to the quality or completeness of a doctor's records. But the executive has responded to the Court's concerns by adding or amending documentation requirements. Though this Court has not always acceded to the JMPRC's view on what was required, it has consistently highlighted the importance of documentation: *Mitchell* at paras 41 – 44 and 50 – 54; *Patel* at para 97; *Malhotra* at paras 41, 59, and 71 – 73.

[92] The appellant says the committee reviewed his documentation for clinical content or to impose professional standards rather than to assess the appropriateness of

billings. He says it improperly required his documentation to demonstrate the services he provided were medically required. The appellant also says that the committee used inadequate documentation as the basis for reassessing the same group of billings twice for a single deficiency. I am not persuaded by these arguments.

A. Did the JMPRC require documentation to establish medical necessity?

[93] Dr. Izekor alleges that the committee erred by requiring documentation alone to establish his services were medically required. As already noted, the record requirements were updated toward the end of the period under review to specify that documentation must establish the medical necessity of the service provided. This updated payment schedule was in effect for only 4 of the 15 months under review.

[94] Dr. Izekor points to the decision in *Michel v The Joint Medical Professional Review Committee,* 2019 SKQB 209 [*Michel*]. In that case, the committee reassessed the doctor's billings based, among other things, on the clinical content and legibility of his documentation. Justice Barrington-Foote (*ex officio*) extensively reviewed prior decisions touching on the adequacy of documentation.

[95] He concluded that – at least for the JMPRC's purposes – the record requirements did not exist to permit a review of the quality of medical services provided. The JMPRC is not entitled to look behind the doctor's record-keeping to determine whether the doctor met a certain professional standard. I agree with these observations.

[96] Dr. Izekor relies heavily on a particular passage of Justice Barrington-Foote's decision in which he wrote at para. 44 that:

> [44] … The creation of a medical record is a component of a 3B or 5B assessment. The purpose of those medical services, including the record, is not to serve the needs of the Committee by demonstrating medical necessity or justifying frequency in

> the context of a peer review. …

[97] One must read this passage in context. First, Justice Barrington-Foote was responding to a Ministry argument which he found was not raised by the decision under review: para. 44. Second and more importantly, Justice Barrington-Foote was taking some pains to distinguish between a review of the records for the purpose of determining whether they support a doctor's billings and a review of the records to determine whether a doctor adhered to professional standards. As he said, the JMPRC's role involves reviewing records to assess the adequacy of billings and not to delve into the quality of treatment "in the context of a peer review."

[98] It is not the JMPRC's role to conduct a peer review of the doctor's competency or the quality of the medical care provided; neither need the records to allow for a forensic audit of the doctor's practice. A review of billings must not morph into something outside the JMPRC's jurisdiction. Documentation is not deficient solely because it does not permit the JMPRC to conduct a review which is outside its competency.

[99] *Michel* holds that documentation is in fact critical to establishing appropriate billing. One must not read the decision as drawing a hair-splitting distinction between medically necessary services and services for which a doctor is entitled to bill. As previously noted, doctors can only bill the Ministry for medically necessary services. One must not interpret this Court's decisions in a manner that renders their meaning illusory or that frustrates the statutory scheme which the Legislature was entitled to enact.

[100] Medical necessity is part of appropriate billing. The committee must assess medical necessity based on its view of the records together with any explanations the doctor may have offered. In my view this is consistent with the holdings in *Michel*, even if it is inconsistent with Dr. Izekor's interpretation of that decision.

[101] I am supported in that view by my assessment of this Court's decisions after *Michel*.

[102] In *Mitchell*, this Court upheld a reassessment that was based largely on inadequate documentation. The committee's decision in that case closely resembled several aspects of the decision in this one. For instance, the committee assessed the records to determine whether pre-arranged procedures for which the doctor billed 5Bs were adequately documented and whether the 5Bs were medically necessary.

[103] The Court held this part of the decision was "appropriately grounded….in a consideration of whether the requirements of the payment schedule were met": para. 51. This Court upheld a reassessment predicated on a lack of documentation of billing criteria and a lack of medical necessity as could be deduced from those records.

[104] In *Malhotra*, the appellant made nearly identical arguments to Dr. Izekor's, claiming the committee used documentation to assess her competence rather than to assess the appropriateness of her billings. In rejecting those arguments, this Court commented on the JMPRC's consistent focus on the doctor's billings. It held the JMPRC "was not assessing the documentation for quality or competence" but for appropriate billing practices. This included "basic determinations", drawn largely from patient records, regarding whether the doctor provided the service billed for and whether she used the right billing code: paras. 38-41.

[105] This Court went on to uphold the JMPRC's determinations regarding medical necessity, which determinations were largely drawn from the lack of documentation. This Court noted that "there is, inevitably, some overlap between meeting the documentation requirements under the Payment Schedule and confirming medical necessity": para. 54.

[106] Additionally, this Court held that the "record of service is intended to reflect the elements of the Payment Schedule in some form". A record must reflect the required components under a billing code even though "the specific content of the Payment Schedule may venture into an assessment of competence": para. 59. With this background, I consider what the committee said about its role in reviewing Dr. Izekor's documentation.

[107] Almost the first thing the committee chairman said to Dr. Izekor was that "the mandate of the committee is to review the billings submitted…. and that the committee is not reviewing quality of care issues." (Transcript, vol I, page 4) In my view, the committee demonstrated consistent awareness of its mandate.

[108] In the letter of February 19, 2020, the committee addressed Dr. Izekor's contention that it was erroneously requiring documentation to prove medical necessity. It reminded Dr. Izekor that he signed an agreement with the Ministry that he would bill in accordance with the payment schedules and with any statutory or regulatory requirements. The committee stated that its role was not to reassess billings based on the quality of the clinical content of Dr. Izekor's documentation.

[109] It stated that it was not attempting to impose a professional standard for its own purposes; it was attempting to determine whether Dr. Izekor provided insured services and whether he correctly billed for them. It was attempting to "carry out [its] legislative mandate." The committee noted that it was comprised of Dr. Izekor's peers, and that it applied a "practical interpretation" of what documentation was required.

[110] In its decision of February 20, 2020, the JMPRC referred to the standard required of documentation in these terms: "For any service to be billed it must be medically required and all listed components must be performed and documented in the

record." (X606) It stated the standard was not one of perfection. The committee was assessing, in a practical way, "what documentation would be required in order to establish, with a reasonable degree of certainty, that the service is eligible for payment."

[111] In my view, there is nothing wrong with these statements. Neither is there anything wrong with the JMPRC's reminder to Dr. Izekor that he was responsible to bill in accordance with payment schedules and with statutory and regulatory requirements. The committee's focus was precisely where it was supposed to be – in assessing whether an insured service was provided and whether the billing code requirements – including documentation – were met.

[112] Had the committee refused to consider Dr. Izekor's explanations, it might have committed a reversible error. But it did not err by relying on his documentation to determine whether he provided medically necessary services. When his explanations failed to establish medical necessity for a significant number of the questionable billings, it was wholly appropriate to look to the documentation as the only other available evidence. One need not spend much time perusing Dr. Izekor's charts to realise that they frequently give little indication of the diagnosis or of what service was provided, let alone whether that service was something for which he was entitled to bill.

[113] Dr. Izekor makes one more minor point about documentation of counselling sessions. The billing codes for counselling sessions include time-based components. Dr. Izekor argues that the committee erred in its assessment of the time he spent counselling patients in part because it failed to consider the routine documentation of time recorded in the EMR. While Dr. Izekor did not adequately document counselling sessions in the patient record, the EMR gives some indication of the length of these sessions as it can record times such as when a patient was placed in a consultation room or when the doctor entered the room. These times are not automatically reflected in the patient's record.

[114] I would be more sympathetic to Dr. Izekor's position if there was otherwise documentation to support his billings. It is conceivable that a doctor might think that the times recorded in the EMR provide an adequate indication of the start and stop times of the counselling session, even though time spent with a patient is not the same as time spent counselling that patient.

[115] The inadequate record of start and stop times was just one of the problems the JMPRC identified with Dr. Izekor's billings. Dr. Izekor even conceded through his counsel that at least one of the 40Bs was inappropriately billed. In this context, it is immaterial that the JMPRC failed to refer to Dr. Izekor's evidence that he thought the EMR record was sufficient. The JMPRC was entitled to rely on the lack of records in assessing that the baseline requirements for 40B and 41B billings – including time-based components – had not been established.

B. Did the JMPRC err by double counting patients such that billings were improperly reassessed twice?

[116] Dr. Izekor argues that the JMPRC erred by reassessing a portion of his billings twice for inadequate documentation. The committee reassessed 80% of Dr. Izekor's billings for complete assessments (3Bs) as partial assessments (5Bs). It then reassessed 11% of the remaining 3Bs. The basis for both levels of reassessment related to the adequacy of Dr. Izekor's documentation.

[117] Dr. Izekor has pointed to what, at first instance, appears to be two reassessments of the same group of billings for the same reason. If the deficiency is already baked into the first reassessment, it would not make sense and would be unfair to reassess those billings again. However, I conclude that the JMPRC did not double-count these billings.

[118] The JMPRC is allowed to assess the same group of billings for various

deficiencies. It may reassess those billings in stages as it works its way through problematic practices. In *Patel*, the same set of billings was assessed both for medical necessity and for adequacy of documentation. The JMPRC's decision that medical necessity had not been established related in part to the inadequacy of documentation. The JMPRC went on to apply a further reassessment to account for the inadequate documentation as a stand-alone issue.

[119] As this Court explained, there was no contradiction in relying on the records to reassess the non-medically necessary visits and then to reassess the billings for inadequate documentation: *Patel* at para 87; see also *Bierman* at para 128. These are different things related to different billing requirements.

[120] The situation in this case is analogous even though the JMPRC only referred to inadequate documentation for the two stages of reassessment. The JMPRC relied on documentation, in part, to satisfy itself that a service had in fact been rendered. With respect to 80% of Dr. Izekor's 3B billings, the JMPRC could not be satisfied that he had provided a complete assessment. That is why these were reassessed as 5Bs. The JMPRC was satisfied that Dr. Izekor had performed partial assessments.

[121] The JMPRC's decision to convert most of the 3Bs to 5Bs did not mean that Dr. Izekor had appropriately billed the remaining 3Bs. It just meant that the appropriate remedy was not to convert them to the lower billing code but to reassess those billings as they were. The JMPRC held that the records were inadequate. Doctors get paid to create medical records of visits. The JMPRC determined that a "vast majority" of Dr. Izekor's 3B billings demonstrated some deficiency in documentation. It determined that this warranted an 11% reassessment of the remaining 3B billings. In my view, this was reasonable and addressed issues that were different in kind from those justifying the conversion of the other 80% of 3B billings.

[122] While both reassessments related to adequacy of documentation, they

were oriented toward different problems. There is no contradiction in the JMPRC decision. I dismiss this ground of appeal.

Question 3: Did the JMPRC exercise its discretion arbitrarily when it ordered an additional amount?

[123] Dr. Izekor alleges that the committee applied an additional amount as a matter of course, without exercising any discretion and without giving reasons. He says this was unreasonable or arbitrary and justifies appellate intervention. I disagree.

[124] It is unfair and inaccurate to say that the committee gave no reasons or failed to exercise discretion. It exercised its discretion by requiring Dr. Izekor to pay a very modest additional amount which can have represented no more than a portion of the resources expended in conducting the reassessment.

[125] The JMPRC's reasons adequately explain why it imposed the additional amount. The integrity of a publicly funded healthcare system is a responsibility shared by all physicians. The additional amount represented Dr. Izekor's (very modest) contribution to program integrity and enforcement. The committee's stated purpose is in complete harmony with this Court's prior decisions. As this Court very recently noted, an additional amount may be appropriate "as a form of costs to defray the financial cost of the Committee's inquiry" where it found a doctor overbilled: *Bierman* at paras 80 and 83.

[126] In many of the cases to which the parties referred, the JMPRC imposed larger additional amounts. At times, this was tied to particularly flagrant or repeated abuses of the system. In this case, I note that the committee generally accepted Dr. Izekor's submissions that he acted out of ignorance rather than malintent.

[127] Section 49.2(7) gives the committee discretion to impose an additional amount up to $50,000. In exercising that discretion, the committee "may take into

account anything that it considers relevant". The committee's determination of relevance is entitled to a high degree of deference, as is its determination of the appropriate quantum of the additional amount.

[128] In this case, the committee's decision is not arbitrary. Neither is its exercise of discretion abusive or unjudicial. It does not rise to question of law, nor does it invite additional scrutiny – much less interference – by this Court.

Conclusions

[129] I am remitting the reassessment of 5B billings involving the Northgate patients to the committee to consider whether the 20% reassessment is appropriate given the nature of the deficiencies identified and the differences between the high-frequency target patient group and the low-frequency majority patient group.

[130] In all other respects I dismiss Dr. Izekor's appeal. I make no order as to costs.

J.
A.S. DAVIS