CITATION: Partap Law Medicine Professional Corporation v Ontario (Minister of Health), 2026 ONSC 1579
DIVISIONAL COURT FILE NO.: 436/25
DATE: 20260318

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

Sachs, Backhouse and A. Himel JJ.

BETWEEN:	
PARTAP LAW MEDICINE PROFESSIONAL CORPORATION (FORMERLY DI-MED SERVICES LIMITED) Appellant	*Sujit Choudhry* for the Appellant
– and –	
ONTARIO (MINISTER OF HEALTH) Respondent	*Susan Keenan* for the Respondent
– and –	
HEALTH SERVICES APPEAL AND REVIEW BOARD Intervenor	*Steven G. Bosnick* for the Intervenor
	HEARD at Toronto: March 2, 2026

Backhouse J.

Overview

[1] The appellant, Partap Law Medicine Professional Corporation (formerly Di-Med Services Limited), operates several independent health facilities for which it received payments for

limited pelvic ultrasounds pursuant to the *Independent Health Facilities Act, R.S.O. 1990, c.I.3.*[1] ("*IHFA*"). The appellant appeals the June 19, 2024 decision of the Health Services Appeal and Review Board ("HSARB" or "the Board") in which the Board upheld three decisions of the Minister of Health ("the Minister") dated August 11, 2022 that ordered the appellant to repay nearly $300,000 in reimbursement of the fees paid for these services ("the Decision").[2]

[2] Specifically, the HSARB upheld the Minister's decisions pursuant to section 24.3(4) of the *IHFA* after finding that the appellant had been improperly billing for limited pelvic ultrasounds that were performed in combination with complete abdominal ultrasounds because these ultrasounds were not properly requested by the referring physician or radiologist and their medical necessity was not adequately documented.

[3] The appellant argues that the Decision was based on several legal errors, including a misinterpretation of the role of the HSARB in reviewing Ministerial decisions and an error in interpreting both the authority to delegate the performance of the ultrasound to sonographers and the documentation requirements necessary to bill for these services. The appellant also argues that the decision was procedurally unfair, as the Minister was allowed to expand the justification for its reimbursement request beyond what was originally included in its August 11, 2022, Opinion Letters. As a result, the appellant requests that the Decision be overturned, and that the Divisional Court substitute its own opinion that the Minister must reimburse the appellant for the fees billed.

[4] The Minister submits that the Decision contains no reviewable error, because the HSARB was correct in finding that its hearings are *de novo* and that requirements for delegation and documentation are clearly outlined in the relevant statutory scheme. The Minister requests that the appeal be dismissed.

[5] The HSARB is intervening only on the question of whether its hearings under the *IHFA* are *de novo.*

[6] For the reasons set out below, I would dismiss the appeal.

Appellant's Motion to Set Aside the Intervenor Decision

[7] The appellant moves to set aside the June 12, 2025 decision of Faieta J. (the "Motion Judge") that granted HSARB's intervenor status in this appeal on the issue of whether the proceeding before it was a hearing *de novo*. The Motion Judge ordered at para. 17:

> The Board is granted leave to intervene as a friend of the court on the issue of whether a hearing under s. 24.9(1)2 of the Act (the

[1] This Act has since been repealed and replaced by *Integrated Community Health Services Centres Act,* SO 2023, c 4, Sch 1. (*ICHSCA*") but continues to apply with respect to facility fees in question in this case.
[2] *Di-Med Services Limited v. Ontario (Health),* 2024 CanLII 55724 (H.S.A.R.B.).

> *IHFA*) is a hearing *de novo*. It may advance any argument in support of its position on this jurisdictional issue regardless of whether those arguments are found in the Board's decision.

[8] The appellant submits that the Motion Judge's decision failed to identify the relevant principles, made errors in principle, and reached an unreasonable result.

[9] The Motion Judge found that the finality and impartiality concerns raised by the appellant were muted because the issue before the court on this appeal is a correctness review that focuses on the conclusion the court itself would have made in the HSARB's place. The Motion Judge accepted the HSARB's submissions that it has expertise in respect of its home statute and found the court should have the benefit of the HSARB's unique perspective and analysis.[3]

[10] There is nothing unusual in tribunals appearing in this court as intervenors or parties, depending on the specific legislation, to assist in matters in respect of their home statutes.

[11] The appellant has not shown that the Motion Judge's discretionary decision to allow the HSARB to intervene as a friend of the court was so clearly wrong that it amounts to an injustice. Nor has it shown that the Motion Judge gave no or insufficient weight to relevant considerations or misapplied *Ontario (Energy Board) v. Ontario Power Generation Inc.*[4] There is no basis to set the Motion Judge's decision aside. The motion is dismissed.

Background

[12] The *IHFA* provides for the payment of facility fees by the MOH directly to independent health facilities (IHFs) for overhead costs associated with the provision of an insured medical service of OHIP under the *Health Insurance Act*, R.S.O., 1990, c. H.6.

[13] The facility fees that are eligible for payment to IHFs are listed in the *Schedule of Facility Fees for Independent Health Facilities under the Independent Health Facilities Act ("SOFF").* The *SOFF* is published on the Ministry's website[5] and was adopted by the Minister pursuant to s.4(2)(a) of the *IHFA* which states that the Minister may designate "services or classes of services as services for or in respect of which a charge or payment is a facility fee for the purposes of this Act."

Recovery of Facility Fees

[14] Facility fees are paid after standard computerized checks are performed, and are subject to post-payment audit and recovery. Recovery of facility fees is governed by section 24.3 of the *IHFA*. Under subsection 24.3(4), the Minister may require the reimbursement of an

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[3] *Partap Law Medicine Professional Corporation (formerly Di-Med Services Limited) v. Minister of Health,* 2025 ONSC 3351 (CanLII) at para. 16.
[4] *Ontario (Energy Board) v. Ontario Power Generation Inc.*, 2015 SCC 44, [2015] 3 S.C.R. 147.
[5] This has since been replaced with the "*Schedule of Facility Costs"* under the *ICHSCA*.

amount paid to an IHF if the Minister is of the opinion that a circumstance described in subsection 24.3(1) exists. This includes the Minister's opinion that:

(i) all or part of the service was not in fact rendered,

(ii) the service has not been rendered in accordance with a requirement under this Act,

or

(iii) there is an absence of a record described in section 24.1

[15] With respect to (iii), section 24.1(1) of the *IHFA* requires every IHF (licensee) to maintain such records as may be necessary to establish "whether they have provided a service to a person for or in respect of which a facility fee is charged or paid." Section 24.1(3) requires every IHF to maintain such records "as may be necessary to establish whether a service they have provided is medically or therapeutically necessary." Section 24.1(4) requires that the records must be "prepared promptly when the services is provided." Section 24.1(5) provides that, in the absence of a record in s.24.1(3) "it is presumed that a service for or in respect of which a facility fee is charged or paid was provided and that the amount payable is nil."

[16] The effect of these provisions that the Minister can require reimbursement of an amount paid to an IHF for a service where she is of the opinion that there is an absence of a record that establishes that a service provided was medically or therapeutically necessary. Further, where such record is absent, it is presumed that the service was provided but no amount is payable.

[17] The *SOFF*, in the General Preamble, provides at paragraph 6:

> 6. Where a referring physician requests a single site imaging study, any additional imaging study is not an insured service and shall not be charged to the ministry unless the additional study is medically necessary as requested by the radiologist or referring physician and documented in the patient's record.

[18] Based on a claims analysis, the Minister came to the opinion that the appellant's three IHFs were claiming fee code J163 (limited pelvic ultrasound) with fee code J135 (complete abdominal ultrasound) for the same patient on the same service date at a higher rate than the provincial average. The MOH began an audit and requested the IHFs' medical records to support a statistically significant, random sample of records related to facility fees paid for the two fee codes billed for the same patient on the same day between April 1, 2017, and July 31, 2019 (the review period).

[19] The Minister found and the HSARB accepted that almost none of the records contained a referral for a limited pelvic ultrasound from a physician or referring provider, nor was there any documentation of the medical necessity for the limited pelvic ultrasound. In its Decision, HSARB found:

> 93.The Appeal Board notes that in the sample of medical records that the Ministry audited, almost none of the physicians referring patients to Di-Med ordered a limited pelvic ultrasound. There is no dispute that radiologists have the authority to order limited pelvic ultrasounds as an additional service, however, as set out in paragraph 6, in order to bill for that additional service, the radiologist's request must be documented in the patient's record.
>
> 94. There is no dispute that none of the medical records contained a documented request from the radiologist. Rather, the evidence was that the sonographers, not radiologists, made the decision as to whether the limited pelvic ultrasound was necessary using the Medical Directive provided by Dr. Zia. Dr. Zia and the other radiologists then confirmed, by looking at the images after the fact, whether the limited pelvic ultrasound was medically necessary and whether to bill for the service.

[20] The MOH asked the three IHFs to provide a written explanation for billing fee code J163 with fee code J135 for the same patient on the same day when there were no requests for limited pelvic ultrasounds from the referring physician.

[21] In a letter of response dated November 16, 2021, the IHFs advised that the appellant was billing fee code J163 to address the referring physician's clinical concerns and because the standard of care and the best interest of the patient's care required it.

[22] On August 11, 2022, the Minister advised the appellant that based on the audit findings, reimbursement was required for payment of facility fees in the review period for the two fee codes for the same patient on the same day. The Minister's Opinion Letter for each of the three IHFs was nearly identical. As one of the grounds of appeal is that the HSARB's Decision is procedurally unfair because the Minister was allowed to expand the justification for its reimbursement request beyond what was originally included in its Opinion Letter, it is reproduced in part below:

> **Minister's Opinion that a circumstance in subsection 24.3(1) of the *Independent Health Facilities Act* (*IHFA*) exists:**
>
> Specific concern regarding fee code J163 billed with fee code J135
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> The Minister is of the opinion that subsection 24.3(1)1(i) of the *IHFA* applies for 100% of the instances during the review period when fee code J163 was claimed for the same patient on the same day as fee code J135, as there was no request from the referring provider for a pelvic ultrasound, the images provided for the pelvic ultrasound were non-diagnostic, and the interpretive reports did not meet the requirements for the limited pelvic ultrasound. As a result, it is the Minister's opinion that the J163 service was not in fact rendered.

After applying the statistical methods of calculation set out in subsection 24.3(2) of the *IHFA*, the Minister has determined that the Licensee has received [$294,692.25] in facility fees for fee code J163 during the review period, which were not payable. Further details of the ministry's review findings which are the basis for the Minister's opinions, including how the overpayment amounts were determined, and relevant sections of the *IHFA* and *Schedule of Facility Fees for Independent Health Facilities* (*SOFF*), are included in the Supplementary Information section at the end of this letter.

…

Supplementary Information

…

General Information Regarding Unrequested Diagnostic Ultrasound Services:

On page 1 of the *SOFF* it states:

"Where a referring physician requests a single site imaging study, any additional imaging study is not an insured service and shall not be charged to the ministry unless the additional study is medically necessary as requested by the radiologist or referring physician and documented in the patient's record."

…

Details of the Ministry's Review and Findings:

The ministry reviewed 93 records where fee code J163 was claimed for the same patient on the same date as fee code J135. In all cases, the records did not demonstrate that the J163 service was rendered. There was no request from the referring practitioner for a pelvic ultrasound, only for an abdominal ultrasound. There was no documentation as to why an additional pelvic ultrasound was medically necessary. The images reviewed by the ministry were deemed non-diagnostic, and the interpretive reports did not meet the requirements for a pelvic ultrasound. For example, the reports stated: *"no free fluid in pelvis"*, or *"bladder only partially visualized"*. These comments also suggest that patients were not properly prepped for a pelvic ultrasound.

The ministry requested an explanation of this billing practice on November 3, 2021. The response provided on November 16, 2021

did not support that the claims for the added pelvic ultrasounds were payable.

Relevant sections of the *IHFA*:

(S.24.3 of the *IHFA* was reproduced here)

June 19, 2024 Decision of the HSARB

[23] The HSARB held an oral hearing virtually on November 2 and 3, 2023. The appellant called the then President of Di-Med Services Limited, Dr. Peter Zia and Dr. Roy Yang, Site Chief of Diagnostic Imagining at Etobicoke General Hospital. The Ministry called Jeff Hutchison, Program Manager, Physician and Provider Services Division, Ministry of Health. All witnesses were cross-examined.

[24] The HSARB also accepted written closing submissions as part of the hearing. It released its Decision on June 19, 2024, and upheld the requirement for reimbursement on the basis that the appellant failed to establish that it maintained records as required in paragraph 6 of the General Preamble to the *SOFF* and section 24.1(3) of the *IHFA:* Decision, at para. 76 and para. 104.

[25] The Board made the following findings:

• The Board disagreed with the appellant's argument that there is no legal requirement to document medical necessity for the limited pelvic ultrasound. The Board cited paragraph 6 of the General Preamble in the *SOFF:* Decision, at para. 77-78.

• The Board did not accept the appellant's argument that paragraph 3 of the Preamble to the Diagnostic Radiology section of the *SOFF* supersedes paragraph 6 of the General Preamble. Paragraph 3 of the Preamble to the Diagnostic Radiology section provides:

> If insured diagnostic radiology procedures yield abnormal findings or if they would yield information which in the opinion of the radiologist would be insufficient governed by the needs of the patient and the requirements of the referring physician or practitioner, the radiologist may add further views and claim for the additions which are to be noted in the report.

- The appellant had argued that this means there is no requirement for documentation of the medical necessity for the imaging. Instead, it argued that a radiologist can order and bill for additional views and paragraph 3 only requires that the additional imaging itself be noted in the radiologist's interpretive report made after the scan is taken: Decision, at paras. 79-80. The Board rejected this argument first because the fee code in question, J163 (limited pelvic ultrasound) is not found in the

Diagnostic Radiology section of the *SOFF*, but instead in the Diagnostic Ultrasound section, which has its own Preamble, including paragraph 6. As such the Board did not conclude that paragraph 3 applied: Decision, at para. 81.

• Second, even if paragraph 3 did apply, the Board found that it can be read consistently with paragraph 6. Paragraph 6 requires the radiologist to document a medical necessity for the additional scan if the referring physician has not done so. Per paragraph 3, the medical necessity may arise from the radiologist's finding that the original view/scan would be insufficient, governed by the needs of the patient and the requirements of the referring physician or practitioner: Decision, at paras. 79, 82.

• The appellant argued that a request from a referring physician is not required to add a limited pelvic ultrasound scan. The Board agreed, but noted that paragraph 6 requires that, if there is no such request, the Minister cannot be charged for such an additional study "unless the additional study is, among other things, requested by the referring physician or a radiologist.": Decision, at paras. 83-87.

• The Board reviewed the evidence of Dr. Zia of Di-Med, which confirmed that the clinic's practice is that for all abdominal scans, the sonographer does a "targeted look" at the pelvis as well and the sonographer determines whether that look is normal or abnormal. If the sonographer determines it is abnormal, the sonographer will add a limited pelvic ultrasound. The sonographers are guided by a Medical Directive developed by Dr. Zia and may decide to add the additional scan based on new information from the patient obtained during the appointment/scan: Decision, at paras. 83-87.

• Dr. Zia confirmed that it is only after the limited pelvic ultrasound is done, that the radiologist reviews the images, the sonographer's worksheets and prepares his interpretive report. The radiologist can then 'sign off' "after the fact" on the sonographer's earlier decision to add and conduct the scan. If the radiologist determines it should not have been done, they advise the billing clerk not to bill for it: Decision, at para. 88.

• Dr. Zia also testified that the sonographer could call the radiologist before conducting the scan if they need help in deciding whether to do a limited pelvic ultrasound but if that happens, the conversation is not documented in the records. Dr. Zia also acknowledged the sonographer must record the clinical history on the worksheet and why it was added, but stated in reality this documentation does not happen: Decision, at para. 89 and 92.

• The HSARB observed there is no dispute that none of the medical records contained a documented request from the radiologist. Nor is there a dispute that a radiologist has the authority to order limited pelvic ultrasounds as an additional service where, as here, almost none of the referring physicians ordered one: Decision, at paras. 93-94.

• However, the evidence before the HSARB was that sonographers, not radiologists, made the decision as to whether the limited pelvic ultrasound was necessary using the

Medical Directive provided by Dr. Zia. The radiologist only confirmed after the fact whether it was medically necessary and whether to bill for the service: Decision, at para. 94.

• The Board found this was not consistent with paragraph 6 of the General Preamble in the *SOFF* which provides that "in order to bill for that additional service, the radiologist's request must be documented in the patient's record": Decision, at para. 93.

• The Board found that paragraph 6 "does not contemplate this kind of arrangement. Paragraph 6 states that in order to bill for the limited pelvic ultrasound, it must be 'medically necessary as requested by the referring physician or radiologist and documented in the patient's record'. Paragraph 6 does not say that the request may come from the sonographer. Paragraph 6 does not provide that the radiologist may confirm by looking at the images and 'signing off' after the fact that the images were medically necessary. Rather, the word 'request' indicates that the decision that the limited pelvic ultrasound is medically necessary must be made by a radiologist or a referring physician, before the images are rendered": Decision, at para. 95.

• The Board noted that, even if medical necessity could be documented in the radiologist report after the images were taken, both Dr. Zia and Dr. Yang confirmed that the radiology reports do not contain documentation as to why the pelvic ultrasounds were added: Decision, at para. 96.

• The evidence of Dr. Zia and Dr. Yang as to whether standard of care requires radiologists to document why a limited pelvic ultrasound was added or permits delegation to a sonographer of the decision to order one "does not change the above documentary requirements for billing in the *SOFF* and the *Act*.": Decision, at paras. 97-98.

• The Board found it unnecessary to decide on the other arguments at issue, because they would not change the outcome of the decision. The Board found that the appellant failed to establish that it maintains records as required in paragraph 6 of the General Preamble to the *SOFF* and section 24.1(3) of the *IHFA:* Decision, at paras. 91-105.

Court's Jurisdiction and Standard of Review

[26] An appeal from the HSARB's decisions on questions of law or fact or both lies to the Divisional Court, pursuant to s. 24.11 of the *IHFA*.

[27] In a statutory appeal, appellate standards of review apply. Questions of law are reviewable on a correctness standard. Questions of fact and mixed fact and law are reviewable on a standard of palpable and overriding error.[6]

[6] *Housen v. Nikolaisen*, 2002 SCC 33, [2002] 2 S.C.R. 235, at para. 37.

[28] Regarding breaches of procedural fairness, this Court must determine whether the requisite level of procedural fairness was granted by applying the factors set out in *Baker v. Canada (Minister of Citizenship and Immigration)*.[7] The question is whether the decision-making procedure was fair having regard to all of the circumstances.[8]

Issues

1. Did the HSARB err in finding that the hearing before it was a hearing *de novo*?
2. Was the Decision procedurally unfair due to the HSARB relying on two new grounds not relied on in the Minister's Opinion Letter?
3. Did the HSARB err in fact or law in finding that the fees for limited pelvic ultrasounds are not reimbursable?

Analysis

Issue 1: Did the HSARB err in finding that the hearing before it was a hearing de novo?

[29] The appellant submits that in a proceeding under s. 24.9(1)1 of the *IHFA*, the Minister must justify the decisions based on the Minister's Opinion Letters and the record before the Minister when the decisions were made.

[30] S.24.9(1) of the *IHFA* provides:

> 24.9(1) The following persons may request a hearing by the Board with respect to the following matters:
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> 1. A licensee or potential licensee may request a hearing to review a decision of the Minister under subsection 24.3(3) or (4)

[31] The appellant argues:

1) that a "review" is not a hearing *de novo;*
2) the HSARB's "review" power roughly equates to an application for judicial review, where evidence from witnesses is admissible for limited purposes;
3) The leading precedent of *Schuyler Farms*[9] concluded that the proceeding before it was *de novo* because of the absence of the word "review" or "appeal" in s. 44(1) of the *Health Protection and Promotion Act*, R.S.O. 1990, c.H.7; and

[7] *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 S.C.R. 817.
[8] *Afolabi v. Law Society of Ontario*, 2025 ONCA 257, 44 Admin. L.R. (7th) 191, at para. 60.
[9] *Schuyler Farms v. Dr. Nesathurai*, 2020 ONSC 4711.

4) Three other grants of authority to the HSARB under the *IHFA* do not qualify the hearing as a "review" and therefore those provisions confer a right to a hearing *de novo*, whereas s. 24.9(1) does not.

HSARB did not err in finding that the hearing before it was a hearing de novo

[32] While the text in s. 24.9(1) of the *IHFA* is the starting point for the analysis[10], the entire text must be considered along with the statutory context found in other provisions in the *IHFA*, and the overall purpose of the *IHFA* to find a meaning that is "harmonious with the Act as a whole".[11]

[33] S.24.10 (1) of the *IHFA* provides:

> 24.10 (1) If a person requests a hearing, the Board shall appoint a time for and hold the hearing and following the hearing may, by order, direct the Minister to take such action as the Board considers the Minister should take in accordance with this Act and the regulations.

[34] As found by the HSARB, it owes no deference to the Minister's decision (i.e. the Opinion Letter). Instead, s. 24.10(1) confirms the HSARB was free to replace the Minister's decision on the question of whether the fees should be reimbursed with its own decision. The HSARB is granted broad discretion under this section to interpret the *IHFA* and regulations, apply them to the facts, and direct the Minister to take such action as "the Board considers the Minister should take in accordance with this Act and the regulations." This is not limited to what facts or evidence was considered by the Minister or the Minister's interpretation of the *IHFA*. The section does not contemplate that the HSARB is required to show any deference to the reasons given by the Minister nor is such a requirement found anywhere else in the *IHFA*.

[35] Further, the other provisions addressing hearings before the HSARB confirm that it can take into account evidence that was not before the Minister and make new findings of fact based on the new evidence. The HSARB is therefore not limited to the reasons given by the Minister, because it can consider additional reasons that may be revealed in the new evidence.[12]

[36] A fair reading of *Schuyler Farms* does not support that the absence of the words "appeal" or "review" automatically prevents a hearing from being *de novo*. The right to hear

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[10] *Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Directrice de la protection de la jeunesse du CISSS A*, 2024 SCC 43, 498 D.L.R. (4th) 316, at para. 24; *R. v. Kim*, 2025 ONCA 478, 178 O.R. (3d) 266, at para. 32.
[11] *Piekut v. Canada*, 2025 SCC 13, 502 D.L.R. (4th) 1, at para. 43. *Kim*, at para. 31.
[12] SS. 21(1) and (6) of the *IHFA*; SS. 15 and 16 of the *Statutory Powers Procedure Act*, R.S.O. 1990, c. S.22.

evidence and substitute its findings for the underlying order (both present in this case) were also found to support that the hearing was intended to be *de novo*.

[37] The HSARB did not err in finding that the hearing before it was *de novo* and in rejecting the appellant's argument that the hearing was in the nature of a judicial review.[13]

Issue 2: Was the Decision procedurally unfair due to the HSARB relying on two new grounds not relied on in the Minister's Opinion Letter?

[38] The appellant submits that the Decision was procedurally unfair and therefore an error of law because the Minister was allowed to expand its reasons for requiring the reimbursement beyond the Minister's Opinion Letters to include inadequate documentation of "medical necessity" and improper delegation by radiologists to sonographers. In support of this argument, the appellant relies on the cross-examination of Mr. Hutchison, the program manager for the Minister, who acknowledged that the Decision Letter only referred to s.24.3(1)(i) of the *IHFA* and suggested that the Minister made "an error" in not referring to other provisions.

The Decision was not procedurally unfair

[39] The HSARB did not accept the appellant's argument that the issue of inadequate documentation of medical necessity could not be raised on the basis that it was not in the Minister's Opinion Letters. The HSARB noted that page 1 of the letters said further details for the Minister's findings which are the basis of the opinion and relevant provisions of the *IHFA* and *SOFF* were included in the Supplementary Information section at the end of the letter (as reproduced above). This included paragraph 6 quoted in full and a statement that there was no documentation as to why an additional pelvic ultrasound was medically necessary. As such, the HSARB did not err in rejecting the appellant's arguments about procedural unfairness.[14]

[40] HSARB was not limited on a *de novo* hearing to the reasons given by the Minister for requiring the reimbursement. The hearing was not procedurally unfair as the Opinion Letter provided the appellant with notice of the issues to be argued at the hearing. The appellant was aware that the matter of whether the limited pelvic ultrasounds were documented in the patient records was at issue and its witnesses testified on this subject. The appellant also made legal arguments on this subject before the HSARB.

[41] The Board was entitled to find, and did find, that "the appellant did not meet the documentary requirements for medical necessity as set out in paragraph 6 of the General Preamble of the *SOFF* and section 24.1(3) of the *IHFA.*[15]

[13] Decision, at para 107.
[14] Decision, at paras. 108-109.
[15] Decision, at para 76.

[42] In so finding, the HSARB considered the new oral evidence provided by Dr. Zia about the medical directive in place at the IHFs in question.[16] This evidence confirmed that the clinic's practice was that the sonographer decided whether to conduct a limited pelvic ultrasound, with general guidance from a medical directive, and that radiologists reviewed the scans after the fact. The evidence also confirmed that the sonographer's decision did not include documenting the medical necessity of the scan before it was done.

[43] There was nothing procedurally unfair about the Board in a *de novo* hearing considering the evidence led by the appellant about the medical directive and concluding that an after the fact review by a radiologist of a sonographer's decision to undertake a limited pelvic ultrasound pursuant to a medical directive does not meet the requirements for reimbursement as set out in paragraph 6 of the General Preamble to the *SOFF* which bears repeating. It states*:*

> 6. Where a referring physician requests a single site imaging study, any additional imaging study is not an insured service and shall not be charged to the ministry unless the additional study is medically necessary as requested by the radiologist or referring physician and documented in the patient's record.

[44] The ground of appeal based on procedural unfairness is dismissed.

Issue 3*: *Did the Board err in fact or law in finding that the appellant's fees for limited pelvic ultrasounds are not reimbursable?

[45] The appellant argues that there was sufficient documentation of the medical necessity of the pelvic scans, because the *IHFA* does not specify what form the documentation should take. In the absence of form requirements, documentation should only be required to meet the clinical standard of care. Uncontradicted evidence from the appellant's witnesses indicated that the documentation contained in the medical record, when read holistically by a health professional with relevant expertise was sufficient to indicate medical necessity. These witnesses suggested that express documentation of the medical necessity was superfluous, as the necessity was implicit within the medical record.

[46] The appellant further argues that it was a legal error for the Board to find that the requirement that the scan be requested by the radiologist was not met when the decision was taken by the sonographer pursuant to a medical directive issued by a radiologist.

[47] The appellant submitted that this was the case because the word "request" in paragraph 6 of the General Preamble should be interpreted consistently with Regulation 107/96, which permits a radiologist to order a sonographer to perform an ultrasound. "Order" in this provision includes a medical directive that sets out the authority to perform the ultrasound

[16] Decision, at paras 86-92.

to patients who meet specified criteria. The appellant argued that the instructions provided by the radiologist to the sonographers in this case meet the definition of a medical directive and the ultrasounds in question were performed pursuant to that medical directive and therefore, they were ordered by the radiologist. It is submitted that the Board erred in barring physicians from billing for ultrasounds performed pursuant to a medical directive, despite the fact that physicians are allowed to order ultrasounds that way.

The Board did not err in finding that the appellant's fees for limited pelvic ultrasounds are not reimbursable

[48] No legal authority was proffered in support of the appellant's submission that it was a legal error for the Board to find that the requirement that the scan be requested by the radiologist was not met when the decision was taken by the sonographer pursuant to a medical directive issued by a radiologist.

[49] Sections 24.1 (3), (4), and (5) and 24.3(1)(iii) of the *IHFA* are clear about the requirement of documenting the medical necessity of a service in order to bill for it. The HSARB found that these requirements were not met. This is a finding of mixed fact and law and contains no palpable and overriding error. The evidence confirmed that there was no documentation of why these scans were performed. The appellant did not dispute that there was no documented request from the radiologist.

[50] The appellant relied on the medical directive that guided sonographers and the "after the fact" review by radiologists. This did not meet the explicit requirements of the *SOFF* which requires the additional scan be requested by the radiologist and that the medical necessity be documented in the patient's record. Section 24.1(4) of *IHFA* requires that the records must be "prepared promptly when the service is provided." The HSARB did not err in concluding that the radiologist cannot request a scan after it has occurred to meet the requirements for billable services.[17]

[51] The appellant relied on arguments about the clinical standard of care and who is authorized to perform the ultrasound, but that was not at issue here. The HSARB did not err in finding that regardless of whether the standard of care was met, the requirements of the statutory scheme for billable services were not. The HSARB found that even if the type of delegation used by the appellant was permitted, there was still an absence of documentation that failed to meet the requirements for billable services.[18]

[52] Further, the Board's decision did not ultimately turn on whether the scans were medically necessary but rather on the absence of the required documentation in the records. As the Board stated:

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[17] Decision, at para. 95.
[18] Decision, at para. 96.

> [102] Even if the limited pelvic ultrasounds were performed in each case in the audit sample and were medically necessary, the Respondent is entitled to require reimbursement under section 24.1(5), which provides that if the IHF fails to maintain records to show that the limited pelvic ultrasounds were medically necessary, then the service was presumed to have been provided, but the facility fee for that service is nil.[19]

[53] It is not relevant that the Minister chose to exercise its authority to designate facility fees that are reimbursable by adopting a standard, the *SOFF*, rather than enacting a regulation as the appellant argued. What is relevant is that the Minister had the authority pursuant to s. 4(2)(a) of the *IHFA* to "designate services or classes of services as services for or in respect of which a charge or payment is a facility fee for the purposes of this Act."

Conclusion

[54] I would dismiss the appeal. As the successful party, the Minister is entitled to costs. The Minister seeks $15,000 partial indemnity costs which I find to be a reasonable amount. It is substantially lower than its bill of costs and less than the amount the appellant sought if successful, for partial indemnity costs. Accordingly, the appellant shall pay costs to the Minister in the all inclusive amount of $15,000. No costs are claimed by or against the Board and none are awarded.

_____
Backhouse, J.

I agree _____
Sachs, J.

I agree _____
A. Himel, J.

Released: March 18, 2026

[19] Decision, at para. 102.

CITATION: Partap Law Medicine Professional Corporation v Ontario (Minister of Health), 2026 ONSC 1579
DIVISIONAL COURT FILE NO.: 436/25
DATE: 20260318

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

Sachs, Backhouse and A. Himel JJ.

BETWEEN:

PARTAP LAW MEDICINE PROFESSIONAL CORPORATION
(FORMERLY DI-MED SERVICES LIMITED)
Appellant

– and –

ONTARIO (MINISTER OF HEALTH)
Respondent

– and –

HEALTH SERVICES APPEAL AND REVIEW BOARD
Intervenor

REASONS FOR JUDGMENT

Backhouse J.

Released: March 18, 2026